Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF SEA VIEW HEALTH CARE SERVICES, INC.

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Office of Inspector General

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EXECUTIVE SUMMARY

Sea View Health Care Services, Inc., did not fully comply with Medicare requirements for billing home health services, resulting in overpayments of at least $184,000 over 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of reviews of home health agencies (HHAs). Using computer matching, data mining, and data analysis techniques, we identified certain types of home health claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2014, Medicare paid HHAs about $19 billion for home health services. The Centers for Medicare & Medicaid Services' (CMS) Comprehensive Error Rate Testing (CERT) program determined that the 2014 improper payment error rate for home health claims was approximately 51 percent, or about $9.4 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 over 20 percent of the total 2014 fee-for-service improper payments ($46 billion).

The objective of this review was to determine whether Sea View Health Care Services, Inc., (the Agency) complied with Medicare requirements for billing home health services on selected types of claims.

BACKGROUND

Under the home health prospective payment system (PPS), CMS pays 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, covered therapy (physical, speech-language pathology, and occupational), medical social services, and medical supplies. CMS adjusts the 60-day episode payment by 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 outcome and to determine whether adjustments to the case-mix groups are warranted.

The Agency is a home health care agency located in Charlotte Amalie, on the island of St. Thomas, U.S. Virgin Islands. National Government Services, its Medicare contractor, paid the Agency approximately $1.3 million for 539 claims for services provided to beneficiaries during CYs 2012 and 2013 (audit period) that met certain high risk areas based on CMS's National Claims History data.

Our audit covered $1,289,894 in Medicare payments to the Agency for 438 beneficiary starts-of-care. A beneficiary start-of-care represents all contiguous home health episodes of care during the audit period for the same beneficiary. A home health agency submits a claim for Medicare payment for each episode of care. The 438 beneficiary starts-of-care included 539 claims for

home health services that had dates of service in CY 2012 and/or CY 2013. We selected a stratified random sample of 166 beneficiary starts-of-care (including 253 claims) with payments totaling $703,847 for review. We evaluated compliance with selected billing requirements and subjected 250 of the 253 claims to focused medical review to determine whether the services met coverage, medical necessity, and coding requirements. We did not subject the remaining three claims to medical review because the Agency cancelled the claims after we selected our sample.

WHAT WE FOUND

The Agency did not comply with Medicare billing requirements for 95 of the 166 starts-of-care (122 of the 253 home health claims) we reviewed. Specifically, the 95 starts-of-care had billing errors resulting in net overpayments of $109,272 ($110,627 in overpayments and $1,355 in underpayments) for the audit period. The Agency incorrectly billed Medicare for (1) some beneficiaries who were not homebound, (2) some beneficiaries who did not require skilled services, (3) some services for which the documentation from the certifying physician or the plan of care was missing or insufficient to support the services billed, and (4) some services for which the Health Insurance Prospective Payment System (HIPPS) payment code was incorrect. These errors occurred primarily because the Agency did not have adequate controls to prevent the incorrect billing of Medicare claims within selected risk areas.

On the basis of our sample results, we estimated that the Agency received net overpayments of at least $184,746 for the audit period.

WHAT WE RECOMMEND

We recommend that the Agency:

- refund to the Medicare contractor $184,746 in estimated net overpayments for claims incorrectly billed;

- identify claims in subsequent years that did not meet Medicare payment requirements and refund any associated overpayments; and

- strengthen its procedures to ensure that:

    - the homebound status of a Medicare beneficiary is verified and the specific factors qualifying a beneficiary as homebound are documented,

    - beneficiaries are receiving only reasonable and necessary skilled services,

    - the physicians' certification and plan of care comply with Medicare documentation requirements and support the services the Agency provided, and

    - the correct HIPPS code is billed.

SEA VIEW HEALTH CARE SERVICES, INC., COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Agency agreed with our second and third recommendations and described actions it had taken and planned to take to address these recommendations. However, the Agency did not agree with our first recommendation (financial disallowance) because it believed that refunding our estimate of Medicare overpayments would financially devastate the Agency. Rather than refunding the money, the Agency proposed using its limited resources to improve its documentation and compliance processes or be allowed the opportunity to discuss repayment options with the Office of the Inspector General (OIG). Under separate cover, the Agency also provided additional medical record documentation that had not been previously reviewed by our medical review contractor for 14 starts-of-care (16 claims).

After our medical review contractor reviewed this additional documentation, we revised our determinations for four claims associated with four starts-of-care. Specifically, we are no longer questioning one start-of-care (one claim) for which the beneficiary did not require skilled services, three starts-of-care (three claims) for which there was missing or insufficient documentation, and one start-of-care (one claim) for which the HIPPS code was incorrect. The total exceeds four because one of the claims had more than one deficiency that we are no longer questioning. We revised our findings and related recommendations accordingly; however, claims associated with three of the four starts-of-care remain unallowable for other reasons. Finally, we note that CMS—not OIG—will make final determination as to the amount to be refunded and will work with the Agency on making arrangements for repayment.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of reviews of home health agencies (HHAs). Using computer matching, data mining, and data analysis techniques, we identified certain types of home health claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2014, Medicare paid HHAs about $19 billion for home health services. The Centers for Medicare & Medicaid Services' (CMS) Comprehensive Error Rate Testing (CERT) program determined that the 2014 improper payment error rate for home health claims was approximately 51 percent, or about $9.4 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 over 20 percent of the total 2014 fee-for-service improper payments ($46 billion).

OBJECTIVE

Our objective was to determine whether Sea View Health Care Services, Inc., (the Agency) 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) covers eligible home health services under a prospective payment system (PPS) that covers intermittent skilled nursing care and home health aide visits, covered therapy (physical, speech-language pathology, occupational), medical social services, and medical supplies. Under the home health PPS, CMS pays HHAs a standardized payment for each 60-day episode of care that a beneficiary receives.

CMS adjusts the 60-day episode payments by 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,[1] to monitor the effects of treatment on patient care and outcome and to determine whether adjustments to the case-mix groups are warranted. The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the HIPPS rate codes and represent specific sets of patient characteristics. CMS requires the submission of OASIS data as a condition of payment.[2]

[1] CMS uses case-mix groups as the basis for the Health Insurance Prospective Payment System (HIPPS) rate codes in Medicare's prospective payment system. CMS designed case-mix groups to classify patients who are similar clinically in terms of resources used.

[2] 42 CFR § 484.210(e), 74 Fed. Reg. 58110 (Nov. 10, 2009) and CMS's *Program Integrity Manual*, chapter 3, § 3.2.3.1.

CMS administers the Medicare program and contracts with four of its Medicare Administrative Contractors (MACs) to, among other things, 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 several areas at risk of noncompliance, including:

- beneficiary homebound status,
- beneficiary need for skilled services,
- timely submission of OASIS,
- home health visits overlapping an institutional stay, and
- adequate documentation to support billed services.

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas." We reviewed these and other risk areas as part of this review.

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) and 1835(a)(2) of the Act establish, and regulations at 42 CFR part 409 implement, as a condition of payment for home health services the requirement that a physician certify and recertify that the Medicare beneficiary is:

- confined to the home (homebound);
- in need of skilled nursing care on an intermittent basis or physical, speech-language pathology, or have 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.

Further, these sections require that the certification document a face-to-face encounter between the physician (or other allowable practitioner) and the Medicare beneficiary during the 6 months preceding the certification or at another reasonable timeframe as determined by the Secretary of

Health and Human Services.[3] 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)).[4]

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 (the Manual, chapter 7, § 20.1.2).

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

Sea View Health Care Services, Inc.

The Agency is a for-profit HHA located and licensed in Charlotte Amalie, on the island of St. Thomas, U.S. Virgin Islands. National Government Services, its Medicare contractor, paid the Agency a total of approximately $1.3 million for 539 claims for services provided to beneficiaries during calendar years (CYs)[5] 2012 and 2013 (audit period) that met certain high risk areas based on CMS's National Claims History (NCH) data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $1,289,894 in Medicare payments to the Agency for 438 beneficiary starts-of-care.[6] These beneficiary starts-of-care included 539 claims for home health services that had dates of service in CY 2012 and/or CY 2013. We selected a stratified random sample of 166 beneficiary starts-of-care (including 253 claims) with payments totaling $703,847 for review. We evaluated compliance with selected billing requirements and subjected 250 of the 253 sample claims to focused medical review to determine whether the services met coverage, medical necessity, and coding requirements. We did not subject the remaining three claims to medical review because the Agency cancelled the claims after we selected our sample.

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

[3] CMS's *Medicare Benefit Policy Manual* (the Manual), Pub. No. 100-02, chapter 7, § 30.5.1.1.3 requires the face-to-face encounter to occur no more than 90 days prior to the home health start-of-care date or within 30 days after the start-of-care.

[4] Federal regulations at 42 CFR part 409 implement the conditions for payment in sections 1862(a)(1)(A), 1814(a)(2), and 1835(a)(2) of the Act. Federal regulations at 42 CFR part 424 implement additional conditions of payment specified in section 1833 of the Act.

[5] CYs were determined by the home health agency claims' "through" date of service. The "through" date is the last day on the billing statement covering services rendered to the beneficiary.

[6] A beneficiary start-of-care represents all contiguous home health episodes of care during the audit period for the same beneficiary. A beneficiary start-of-care series could range from one to several individual 60-day episodes of care. A home health agency submits a claim for Medicare payment for each episode of care.

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 contains the details of our scope and methodology.

FINDINGS

The Agency did not comply with Medicare billing requirements for 95 of the 166 starts-of-care[7] (122 of the 253 home health claims) we reviewed. Specifically, the 95 starts-of-care had billing errors resulting in net overpayments of $109,272 ($110,627 in overpayments and $1,355 in underpayments). The Agency incorrectly billed Medicare for (1) some beneficiaries who were not homebound (14 starts-of-care, including 17 claims), (2) some beneficiaries who did not require skilled services (42 starts-of-care, including 45 claims), (3) some services for which the documentation from the certifying physician or the plan of care was missing or insufficient to support the services (15 starts-of-care, including 16 claims), and (4) some services for which the HIPPS payment code was incorrect (58 starts-of-care, including 72 claims). These errors occurred primarily because the Agency did not have adequate controls to prevent the incorrect billing of Medicare claims within selected risk areas.

On the basis of our sample results, we estimated that the Agency received net overpayments of at least $184,746 for the audit period.[8]

Appendix C contains our sample design and methodology, Appendix D contains our sample results and estimates, and Appendix E contains the types of errors by sample item.

AGENCY BILLING ERRORS

The Agency incorrectly billed Medicare for 95 of the 166 starts-of-care (122 of the 253 claims) which resulted in net overpayments of $109,272.

Beneficiaries Were Not Homebound

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and Federal regulations (42 CFR § 409.42) require for reimbursement of home health services that the beneficiary is "confined to the home." Section 1814(a) states that a beneficiary qualifies as "confined to the 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

[7] Thirty-nine of the 95 starts-of-care contained claims which had more than 1 type of error.

[8] 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 will be less than the actual overpayment total at least 95 percent of the time.

> 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.... Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration.

For 14 starts-of-care (17 claims), the Agency incorrectly billed Medicare for home health episodes for beneficiaries who did not meet the above criteria for being homebound.[9] For example, documentation for one beneficiary did not support that the patient was homebound, as the patient was working light duty as an engineer. On another claim, documentation did not support that the patient was homebound, as the patient was able to walk independently and perform daily living activities. In addition, the therapist documented that the patient had good balance. These errors occurred because the Agency did not have adequate oversight procedures to ensure that it verified the homebound status of Medicare beneficiaries and did not properly document the specific factors that qualify the beneficiaries as homebound.

As a result of these errors, the Agency received overpayments of $31,183.

Beneficiaries Did Not Require Skilled Services

Section 1395 of the Act and Federal regulations (42 CFR § 409.42(c)) require that the Medicare beneficiary be in need of skilled nursing care on an intermittent basis or physical, speech-language pathology, or have a continuing need for occupational therapy. In addition, Federal regulations (42 CFR § 409.44(b)) and the Manual (chapter 7, §40.1) state that 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. Also, Federal regulations (42 CFR § 409.44(c)) and the Manual (chapter 7, § 40.2.1) state that skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition.

For 42 starts-of-care (45 claims), the Agency incorrectly billed Medicare for an entire home health episode (18 claims) or part of the episode (27 claims)[10] for beneficiaries who did not meet the Medicare requirements for coverage of skilled nursing and/or therapy services. For example, the Agency provided skilled nursing care to a beneficiary who was stable, healing well, and independent with wound care. There were no changes to wound care treatment or medications to

[9] Nine of these claims had other errors. In the majority of cases, the beneficiary also did not require skilled services in addition to not being homebound. Appendix E provides detail on the extent of errors, if any, per sample item reviewed.

[10] For five claims for which the Agency incorrectly billed for part of the episode, the agency was underpaid for its services. We determined this through repricing the claims using the appropriate HIPPS rate code and reflected the underpayments in our estimates.

warrant the skills of a licensed nursing professional.[11] In addition, the skills of the occupational therapist were not needed, as there had been no changes to the beneficiary's function to suggest the beneficiary would benefit from further therapy. Therefore, skilled nursing and occupational therapy services were not considered reasonable and necessary. These errors occurred because the Agency did not always provide sufficient clinical review to verify that beneficiaries required skilled services.

As a result of these errors, the Agency received net overpayments of $39,580.

Missing or Insufficient Documentation

Sections 1814(a)(2) and 1835(a)(2)(A) of the Act and Federal regulations (42 CFR § 424.22(a)) state that Medicare pays for home health services only if a physician certifies that the beneficiary meets the coverage requirements specified in the statute and regulations. Prior to certifying a patient's eligibility for home health services, the certifying physician must document that he or she (or an allowed non-physician practitioner) had a face-to-face patient encounter related to the primary reason the patient requires home health services, no more than 90 days prior to the home health start-of-care date or within 30 days of the start-of-care. In addition, Federal regulations (42 CFR § 424.22(a)) and the Manual (chapter 7, § 30.5.1.1) state 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.

The Manual (chapter 7, § 30.2.2) also states that the orders on the patient's 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. Federal regulations (42 CFR § 409.43(e)) and the Manual (chapter 7, § 30.2.6) further state that 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.

Further, the Manual (chapter 7, § 40.1.2.8) states that for skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made.

For 15 starts-of-care (16 claims), the Agency incorrectly billed Medicare for home health episodes that did not meet the Medicare documentation requirements for the physician certification or the plan of care. These claims contained the following types of errors:

- The plan of care was missing (one claim), not signed by a physician (one claim), or did not indicate the frequency for skilled services (seven claims).

- The face-to-face encounter documentation conflicted with the support for homebound status (one claim), or was not completed timely (i.e., more than 90 days prior to the home

[11] In addition, the beneficiary's spouse had been educated on symptoms of infection.

health start-of-care date (three claims) or not within 30 days of the start-of-care (two claims)).

- Skilled nursing notes did not contain the information needed to determine whether treatment of a wound was reasonable and necessary (one claim).

These errors occurred primarily because the Agency did not always have sufficient procedures to ensure that the physician's certification and the plan of care complied with Medicare documentation requirements and supported the services the Agency provided.

As a result of these errors, the Agency received overpayments of $20,881.

Incorrectly Billed Health Insurance Prospective Payment System Codes

Federal regulations (42 CFR § 484.210(e) and CMS's Program Integrity Manual (chapter 3, § 3.2.3.1) state that HHAs are required to submit OASIS data as a condition of payment and instructs Regional Home Health Intermediaries not to pay claims that lack OASIS data. The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the HIPPS rate codes. In addition, CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 1, § 80.3.2.2, states that in order for a Medicare claim to be processed correctly and promptly, it must be completed accurately.

For 58 starts-of-care (72 claims), the HIPPS code on the claim was incorrect. Specifically, the OASIS and other supporting medical records did not support the HIPPS code the Agency used. For most of these claims, the error resulted in overstated levels of clinical and/or supply severity.[12] These errors occurred because the Agency did not have adequate oversight procedures to ensure that its billing contractor was accurately using the appropriate HIPPS code for the services provided.

As a result of these errors, the Agency received net overpayments of $17,628.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Agency received net overpayments of at least $184,746 for the audit period.

RECOMMENDATIONS

We recommend that the Agency:

- refund to the Medicare contractor $184,746 in estimated net overpayments for claims incorrectly billed;

[12] For 10 claims for which the HIPPS code was incorrect, the agency was underpaid for its services. We determined this through repricing the claims using the appropriate HIPPS rate code and reflected the underpayments in our estimates.

- identify claims in subsequent years that did not meet Medicare payment requirements and refund any associated overpayments; and

- strengthen its procedures to ensure that:

    - the homebound status of a Medicare beneficiary is verified and the specific factors qualifying a beneficiary as homebound are documented,

    - beneficiaries are receiving only reasonable and necessary skilled services,

    - the physicians' certification and plan of care comply with Medicare documentation requirements and support the services the Agency provided, and

    - the correct HIPPS code is billed.

SEA VIEW HEALTH CARE SERVICES, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Agency agreed with our second and third recommendations and described actions it had taken and planned to take to address these recommendations. However, the Agency did not agree with our first recommendation (financial disallowance) because it believed that refunding our estimate of Medicare overpayments would financially devastate the Agency. Rather than refunding the money, the Agency proposed using its limited resources to improve its documentation and compliance processes or be allowed the opportunity to discuss repayment options with the Office of the Inspector General (OIG). Under separate cover, the Agency also provided additional medical record documentation that had not been previously reviewed by our medical review contractor for 14 starts-of-care (16 claims). The Agency's comments are included as Appendix F.

After our medical review contractor reviewed this additional documentation, we revised our determinations for four claims associated with four starts-of-care. Specifically, we are no longer questioning one start-of-care (one claim) for which the beneficiary did not require skilled services, three starts-of-care (three claims) for which there was missing or insufficient documentation, and one start-of-care (one claim) for which the HIPPS code was incorrect. The total exceeds four because one of the claims had more than one deficiency that we are no longer questioning. We revised our findings and related recommendations accordingly; however, claims associated with three of the four starts-of-care remain unallowable for other reasons. Finally, we note that CMS–not OIG–will make final determination as to the amount to be refunded and will work with the Agency on making arrangements for repayment.

APPENDIX A: MEDICARE REQUIREMENTS FOR COVERAGE AND PAYMENT OF CLAIMS FOR HOME HEALTH SERVICES

GENERAL MEDICARE REQUIREMENTS

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

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

OUTCOME AND ASSESSMENT INFORMATION SET DATA

The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical needs, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups, to monitor the effects of treatment on patient care and outcome, and to determine whether adjustments to the case-mix groups are warranted. HHA beneficiaries can be classified into 153 case-mix groups that are used as the basis for the HIPPS rate codes used by Medicare in its prospective payment systems. Case-mix groups represent specific sets of patient characteristics and are designed to classify acute care inpatients 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. 58110 (Nov. 10, 2009), and CMS's *Medicare Program Integrity Manual*, 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, speech-language pathology, or occupational therapy;[13] (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A), 42 CFR § 409.42 and the Manual, chapter 7, § 30).

[13] 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 that requirement for covered occupational therapy has been met, however, all subsequent occupational therapy services that continue to meet the reasonable and necessary statutory requirements are considered qualifying services in both the current and subsequent certification periods (subsequent adjacent episodes).

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 set, 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)).

The Affordable Care Act added an additional requirement to §§ 1814(a)(2)(C) and 1835(a)(2)(A) of the Act requiring the physician to have a face-to-face encounter with the beneficiary. In addition, the physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days 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.

Confined to the Home

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and Federal regulations (42 CFR § 409.42) require for reimbursement of home health services that the beneficiary is "confined to the home." Section 1814(a) states that a beneficiary qualifies as "confined to the 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.... Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration.

Need for Skilled Services

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 §§ 409.42(c) and 409.44(b) and the Manual, chapter 7, § 40.1).

Intermittent Skilled Nursing Care

The Act defines "part-time or intermittent services" as skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case

basis as to the need for care, less than 8 hours each day, and 35 or fewer hours each week) (the Act § 1861(m) and the Manual, chapter 7, § 50.7).

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 cannot 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 although a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service does not make it a skilled service when a nurse provides the service.

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

Reasonable and Necessary Therapy Services

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

- inherently complex, which means that they can be performed safely and/or 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)) 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 non-physician practitioner, had a face-to-face encounter with the patient, which is related to the primary reason the patient requires home health services. In addition, the Manual (chapter 7, § 30.5.1.1) 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, § 30.2.2). The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review (42 CFR § 409.43(e) and the Manual, chapter 7, § 30.2.6).

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $1,289,894 in Medicare payments to the Agency for 438 beneficiary starts-of-care. We selected for review a stratified random sample of 166 beneficiary starts-of-care[14] with payments totaling $703,847. These beneficiary starts-of-care included a total of 253 claims for home health services that the Agency provided to Medicare beneficiaries during the audit period.[15]

We evaluated compliance with selected coverage and billing requirements and subjected 250 claims to focused medical review.

We limited our review of the Agency'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; however, we did not assess the completeness of the file.

We conducted our fieldwork at the Agency from October 2014 through November 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Agency's paid claims data from CMS's NCH file for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 166 beneficiary starts-of-care which included 253 claims totaling $703,847 for detailed review (Appendix C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- obtained and reviewed billing and medical record documentation provided by the Agency to support the claims contained in the sampled beneficiary starts-of-care;

[14] A beneficiary start-of-care may include more than one claim.

[15] Audit period CYs were determined by the home health agency claims' "through" date of service. The "through" date is the last day on the billing statement covering services rendered to the beneficiary.

- used an independent medical review contractor to determine whether 250 of the 253 sample claims were reasonable and necessary and met Medicare coverage and coding requirements;[16]

- reviewed the Agency's procedures for billing and submitting Medicare claims;

- discussed the incorrectly billed claims in our sample with Agency personnel to determine the underlying causes of noncompliance with Medicare requirements;

- verified State licensure information for selected nurses and therapists providing services to the patients in our sample;

- calculated the correct payments for those claims requiring adjustments;

- used the results of the sample to estimate the total Medicare net overpayments to the Agency for our audit period (Appendix D); and

- discussed the results of our review with Agency 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.

[16] We did not subject the remaining three claims to medical review because the Agency cancelled the claims after we selected our sample.

APPENDIX C: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of the Agency's claims that were for home health services that it provided to Medicare beneficiaries during the audit period.

SAMPLING FRAME

We obtained a database of 539 home health claims from CMS's NCH file. This database contained a higher risk subset of the population. We grouped these claims by beneficiary Health Insurance Claim Number and the start-of-care date. We defined the grouping of claims or frame unit as a beneficiary start-of-care. The grouping resulted in 438 frame units (beneficiary starts-of-care) valued at $1,289,894. All statistical estimates included in this report are restricted to the scope of this frame.

SAMPLE UNIT

The sample unit was a beneficiary start-of-care.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into two strata based on total payments for all claims within an individual beneficiary start-of-care.

Stratum	Dollar Range of Frame Units	Number of Frame Units	Dollar Value of Frame Units
1	$172.63 to $3,954.54	352	$758,428
2	$4,040.87 to $20,194.63	86	$531,466
Totals		**438**	**$1,289,894**

SAMPLE SIZE

We randomly selected 80 beneficiary starts-of-care from stratum one and all 86 beneficiary starts-of-care from stratum two. Our total sample size was 166 beneficiary starts-of-care.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units within stratum one. After generating the random numbers for stratum one, we selected the corresponding beneficiary starts-of-care. We selected all beneficiary starts-of-care from stratum two.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of Medicare overpayments paid to the Agency during the audit period. We estimated the overpayments at the lower limit of the 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results[17]

Stratum	Frame Size	Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Net Overpayments In Sample
1	352	$758,428	80	$172,381	37	$37,151
2*	86	531,466	86	531,466	58	72,121
Total	**438**	**$1,289,894**	**166**	**$703,847**	**95**	**$109,272**

***** We reviewed all sample items in this stratum.

Estimated Value of Net Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$ 235,587
Lower Limit	$ 184,746
Upper Limit	$ 286,427

[17] The sample of 166 beneficiary starts-of-care included 253 claims. Ninety-five of the sample of 166 starts-of-care contained billing errors, which included 122 of 253 claims.

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

STRATUM 1

Sample						
1	1	-	1	-	1	$206.65
2	1	-	-	-	-	-
3	1	-	1	-	1	(122.87)
4	1	-	1	1	-	1,187.07
5	1	-	-	-	-	-
6	1	-	-	-	-	-
8	1	-	-	-	-	-
9	1	-	-	-	1	(270.27)
10	3	2	-	1	-	2,416.25
11	1	-	-	-	-	-
12	1	-	1	-	-	778.04
13	1	1	-	-	-	2,929.09
14	1	-	-	1	-	3,291.56
15	1	1	1	-	-	2,797.44
16	1	-	-	-	1	280.20
17	1	-	-	-	-	-
18	1	-	-	-	-	-
19	1	-	-	-	1	164.34
20	1	-	-	-	-	-
21	1	-	-	1	-	443.40
22	1	-	1	-	-	286.07
23	1	1	1	-	-	1,783.35
24	1	-	-	1	-	2,091.96
25	1	1	1	-	-	3,106.47
26	1	-	-	-	-	-
27	1	1	1	-	-	1,445.37
28	1	-	-	-	-	-
29	1	1	1	-	-	(82.41)
30	1	-	-	-	-	-
31	1	-	-	-	-	-
32	1	-	-	-	-	-
33	1	-	-	-	1	27.40
34	1	-	-	-	-	-
35	1	-	-	-	-	-
36	1	-	-	-	-	-
37	1	-	-	-	-	-

STRATUM 1 (Continued)

Sample						
38	1	-	1	-	1	(168.69)
39	1	-	-	-	-	-
40	1	-	1	-	-	207.34
41	1	1	-	-	-	2,619.30
42	1	-	1	-	-	2,079.28
43	1	-	-	-	-	-
44	1	-	-	-	-	-
45	1	-	-	-	-	-
46	1	-	-	-	1	371.64
47	1	-	-	-	-	-
48	1	-	-	-	-	-
49	1	-	-	-	1	136.64
50	1	-	1	1	-	2,334.52
51	1	-	-	-	-	-
52	1	-	-	-	1	285.99
53	1	-	-	-	-	-
54	1	-	-	-	-	-
55	1	1	-	-	-	1,805.40
56	1	-	-	-	-	-
57	1	-	-	-	-	-
58	1	-	-	-	-	-
59	1	-	-	-	-	-
60	1	-	-	-	-	-
61	1	-	-	-	-	-
62	1	-	-	-	1	70.68
63	1	-	-	-	-	-
64	1	-	-	-	1	26.41
65	1	-	-	-	-	-
66	1	-	-	-	-	-
67	1	-	-	-	-	-
68	1	-	-	-	-	-
69	1	-	-	-	1	952.96
70	2	-	-	1	-	1,760.38
71	1	1	-	-	1	(51.23)
72	1	-	-	-	-	-
73	1	1	-	-	-	245.86
74	1	-	-	-	-	-
75	1	-	-	1	-	876.37
76	1	-	-	-	-	-

STRATUM 1 (Continued)

Sample	No. of Claims	Not Homebound	Did Not Require Skilled Services	Missing or Insufficient Documentation	Incorrect HIPPS Code	Overpayment/ Underpayment
77	1	-	-	-	-	-
78	1	-	-	-	-	-
79	1	-	-	-	-	-
80	1	-	1	-	1	368.09

STRATUM 2

Sample						
81	2	-	-	-	-	-
82	1	-	-	-	1	$93.14
83	1	-	-	-	1	409.00
84	1	-	-	-	1	794.27
85	1	-	1	-	-	776.67
86	1	-	-	-	-	-
87	1	-	-	-	-	-
88	1	-	1	-	-	1,353.88
89	1	-	-	-	-	-
90	1	-	1	-	-	1,678.55
91	1	-	1	-	1	2,306.19
92	1	-	-	-	-	-
93	1	-	-	-	-	-
94	2	-	1	1	-	4,305.37
95	1	-	-	1	-	4,430.48
96	1	-	-	-	-	-
97	1	-	-	-	-	-
98	3	-	-	1	1	529.56
99	1	-	-	1	-	919.24
100	1	-	1	-	1	461.82
101	2	-	-	-	-	-
102	2	-	1	-	-	1,324.37
103	1	-	-	-	-	-
104	2	-	-	-	-	-
105	2	2	2	1	-	4,685.08
106	1	-	-	-	-	-
107	1	-	-	-	1	311.97

STRATUM 2 (Continued)

Sample	No. of Claims	Not Homebound	Did Not Require Skilled Services	Missing or Insufficient Documentation	Incorrect HIPPS Code	Overpayment/ Underpayment
108	1	-	-	-	-	-
109	2	-	-	-	-	-
110	2	-	-	-	-	-
111	2	-	1	-	1	439.84
112	1	-	-	-	1	449.00
113	1	-	-	-	-	-
114	1	-	-	-	-	-
115	1	-	-	-	1	17.44
116	1	-	1	-	-	453.12
117	1	-	-	-	-	-
118	1	-	1	-	1	465.75
119	1	-	-	-	1	311.97
120	1	-	-	-	-	-
121	1	-	-	-	-	-
122	1	-	-	-	-	-
123	1	-	-	-	1	772.30
124	1	-	-	-	-	-
125	1	1	1	-	-	5,122.85
126	1	-	-	-	-	-
127	2	-	-	-	1	421.20
128	1	-	-	-	1	654.45
129	1	-	-	-	-	-
130	1	-	-	-	-	-
131	2	-	-	-	1	707.26
132	1	-	-	-	-	-
133	3	-	-	-	2	251.62
134	2	-	-	-	2	709.49
135	2	-	1	-	2	398.85
136	2	-	1	-	1	(131.79)
137	2	-	1	-	1	2,038.68
138	2	-	1	-	1	2,703.96
139	3	-	-	-	1	(189.25)
140	4	-	3	-	1	2,011.02
141	2	-	-	-	1	1,105.99
142	2	-	-	-	-	-
143	2	-	-	-	1	363.82
144	3	-	-	-	1	80.58
145	2	-	-	-	1	323.61
146	2	-	1	-	-	2,767.98

STRATUM 2 (Continued)

Sample						
147	2	-	-	-	1	493.87
148	4	-	-	-	1	(93.14)
149	2	-	1	-	1	3,481.71
150	2	-	-	-	1	466.58
151	2	-	1	-	1	2,734.72
152	2	-	-	-	1	515.90
153	3	-	1	-	2	1,641.77
154	2	-	-	-	-	-
155	4	-	1	-	1	(93.14)
156	2	-	-	-	1	38.65
157	3	2	-	-	-	4,400.50
158	2	-	-	-	1	(60.01)
159	3	-	1	-	3	764.24
160	3	-	1	-	-	2,491.40
161	5	-	-	-	2	173.40
162	2	-	1	-	-	225.39
163	2	-	1	-	1	455.40
164	3	-	-	-	2	487.95
165	12	-	-	2	-	2,347.76
166	12	-	-	1	7	5,018.49
Total	**253**	**17**	**45**	**16**	**72**	**$109,272.09**
Total	**Starts-of-Care**	**14**	**42**	**15**	**58**	**129***

Note: There were a total of 150 errors associated with the 253 claims. In all, 122 different claims contained errors.

*Thirty-nine of the 95 starts-of-care in error contained claims which had more than 1 type of error.

APPENDIX F: SEA VIEW HEALTH CARE SERVICES, INC., COMMENTS

Sea View Health Care Services

"Where Hospitality and Quality Health Care Meet"

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January 28, 2016

Mr. James P. Edert
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: Report # A-02-14-01027

Dear Mr. Edert,

Sea View Health Care Services Inc. (SVHCS) is pleased to have the opportunity to respond to the Draft Audit Report entitled Sea View Health Care Services Inc. Did Not Fully Comply With Medicare Requirements for Billing Home Health Services. SVHCS is highly committed to ensuring that it administers services in compliance with current local and Federal laws, policies and procedures and is committed to working to resolve the issues identified in this audit review. As part of that commitment, SVHCS has had a compliance program covering SVHCS clinical and billing activities in place for fourteen years. SVHCS continues to improve its internal controls and to perform proactive reviews to prevent billing errors. Sea View Health Care Services, Inc. is appreciative of all the efforts on the part of OIG to gather information from Medicare providers. Your observations have been used to improve policies and procedures already in place as well as to, implement process measures to ensure continued compliance.

SVHCS is the only Medicare Certified Home Health Agency operating on St. Croix and one of only two operating on St. Thomas. SVHCS is also the only homecare agency in the Virgin Islands that offers therapy and social work services. Our agency serves a small population and our census fluctuates greatly. For the past several months our combined census has averaged less than 24 patients, with no indication of making any major shifts. At this rate our already struggling organization is having difficulty staying viable. This proposed reimbursement on services that were provided in good faith may unwantedly have the devastating effect of leaving our population without the valuable services we currently provide.

Set forth below are Sea View Health Care Services Inc., responses to each of the preliminary findings and recommendations identified in the Draft Audit Report.

OIG RECOMMENDATION: Refund to Medicare contractor $197,639 in estimated net overpayments for claims incorrectly billed.

SVHCS RESPONSE: Do Not Concur

In response to OIG findings SVHCS requests consideration of the following:

1. Sea View Health Care Services, Inc. respectfully requests that OIG accept our proposed resolution of using our limited and strained resources to improve our documentation and

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compliance process measures rather than submitting a payment that would financially devastate SVHCS.

2. Since the start of this audit, SVHCS has identified and implemented a new software vendor, inclusive of billing services. This software has stronger internal controls and will greatly assist with the transition from ICD 9 to IDC 10 coding.
3. Currently coding services are performed by clinical staff; SVHCS actively seeks to identify/employ an independent coding service or specialist.
4. SVHCS actively seeks to identify/employ a Quality Assurance Officer who would be responsible for the oversight of the Audit Committee, review and revision of internal policies and procedures related to audits and the assignment and completion of random, monthly and quarterly audits.
5. SVHCS has identified standardized continuing education programs that would address many of the areas of deficiency identified by OIG.
6. At minimum SVHCS respectfully requests that OIG allow SVHCS the opportunity to further discuss with OIG repayment options that would satisfy OIG requests without pushing the agency towards the brink of bankruptcy.

OIG RECOMMENDATION: Identify Claims in subsequent years that did not meet Medicare payment requirements and refund any associated overpayments

SVHCS RESPONSE: Concur.

In response to OIG findings SVHCS has taken the following action:

1. SVHCS is in the process of identifying a qualified individual to perform internal audits focusing on the areas identified by OIG to potentially identify any claims that did not meet Medicare payment requirements.
2. Claims identified as overpayments will be submitted to Medicare.

OIG RECOMMENDATION: Strengthen its procedures to ensure that:

- The homebound status of a Medicare beneficiary is verified and the specific factors qualifying a beneficiary as homebound are documented.
- Beneficiaries are receiving only reasonable and necessary skilled services.
- The physicians' certification and plan of care comply with Medicare documentation requirements and support the services the Agency provided.
- The correct HIPPS code billed.

SVHCS RESPONSE: Concur.

In response to OIG findings SVHCS has taken the following action:

- Homebound Status
  1. SVHCS has revised our agency referral form to make the documentation streamlined for physicians/referral sources to indicate homebound status.

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2. Revision of the agency patient referral process to address proper review of agency referral form.
3. In-serviced staff to instruct on the proper review of referral form to ensure it addresses all Medicare requirements for admission.
4. Will host provider training regarding homecare for community health professionals.

- Skilled Services
  1. In-services and continuing education held to improve patient teaching strategies.
  2. Documentation training provided to improve accuracy of clinician documentation.
  3. Improved process which defines points of communication to ensure the information on-going skilled need is reviewed and addressed at weekly case conference.
- Documentation Requirements
  1. An initiative formed to educate external providers and their staff on the Medicare guidelines. Continuous outreach is done with our external providers in order to provide education in an effort to eliminate noncompliance with Medicare regulations.
  2. Internal documentation training provided to improve accuracy of clinician documentation.
  3. Plans to utilize external consulting services while continually monitoring best practices and guideline changes to ensure compliance within our documentation and coding practices.
- HIPPS
  1. SVHCS ended contract with long time software and billing vendor.
  2. SVHCS has identified a new billing & coding company which is highly respected in the health care community for its accuracy.
  3. ICD10 training materials purchased and staff on-going training conducted to improve clinician accuracy with coding.
  4. We have modified our internal coding processes to require a secondary clinical review.
  5. Plans are underway to develop an internal billing audit that will review claims to assure continued accuracy of HIPPS designation.

Sea View Health Care Services would like to thank the OIG audit staff who conducted the compliance review of SVHCS for their openness, collegiality and willingness to work with the SVHCS Compliance staff. We appreciate the opportunity to respond to the draft audit report and take these findings seriously. We are committed to improving our processes and remain committed to having an active and strong compliance program to help ensure our billing is accurate and in compliance with Medicare billing rules.

Sincerely,

Kim Jerome

Kim T. Jerome, RN, BSN
Administrator
Sea View Health Care Services, Inc.