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Medicare Home Health Agency Provider Compliance Audit: Bridge Home Health

REPORT HIGHLIGHTS

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Why OIG Did This Audit

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.
- This audit report, the first of a nationwide series of home health audits, examined whether Bridge Home Health complied with Medicare requirements.

What OIG Found

Bridge Home Health complied with Medicare billing requirements for 90 of the 100 home health claims we reviewed. For the remaining 10 claims, Bridge Home Health incorrectly billed Medicare for claims with unsupported codes, invalid face-to-face encounters, and skilled services that did not meet requirements.

- Six claims did not meet billing and coding requirements, resulting in a net underpayment totaling $291.
- Three claims did not meet face-to-face requirements, resulting in overpayments totaling $6,337.
- One claim did not meet skilled need requirements but did not result in an overpayment.

Bridge Home Health received net overpayments totaling $6,046 for the claims in the sample.

What OIG Recommends

We recommend that Bridge Home Health: (1) refund the $6,046 in overpayments to the Medicare program; (2) identify similar instances of noncompliance that occurred before, during, and after the audit period and determine the impact and return any overpayments to the Federal Government; and (3) strengthen its review of medical record documentation to ensure compliance with Medicare billing requirements.

Bridge Home Health concurred with our recommendations and provided detailed corrective actions it has taken since the audit period to address and prevent the types of findings identified during our audit.

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INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year (CY) 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare (enrollees). In that year, nearly 10,000 HHAs participated in Medicare. The Centers for Medicare & Medicaid Services (CMS) determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims (which is calculated based on July 1, 2021 – June 30, 2022, payments) was 7.7 percent, or about $1.2 billion. This audit is part of a series of audits of HHAs. Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk for noncompliance with Medicare billing requirements. Bridge Home Health was one of those HHAs.

OBJECTIVE

Our objective was to determine whether Bridge Home Health complied with Medicare requirements for billing home health services on selected types of claims.[1]

BACKGROUND

The Medicare Program and Payments for Home Health Services

Medicare (Parts A and B) covers eligible home health services such as intermittent skilled nursing and home aide visits, covered therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. Under the home health Prospective Payment System (PPS), CMS pays HHAs a national, standardized 30-day period payment rate.[2] This standardized payment rate is adjusted by using variables in the Patient-Driven Groupings Model (PDGM)[3] that account for the enrollee's condition and healthcare needs. For the purposes of adjusting payment under the PDGM, each 30-day period is categorized into 1 of 432 case-mix groups, called Home Health Resource Groups (HHRGs).

HHRGs are different payment groups based on five main case-mix variables under the PDGM: timing, admission source, principal diagnosis, other diagnoses, and functional impairment. The patient-specific data for these variables are derived from Medicare claims and the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements, including therapy needs and functional impairment, that HHA clinicians use when assessing an

[1] We did not include the following types of claims in our review that we judged as low risk for waste and abuse: Requests for Anticipated Payment, Notices of Admission, Low Utilization Payment Adjustments, and Partial Episode Payments.

[2] Adjustments are made for geographic differences in wage levels.

[3] The PDGM was effective January 1, 2020.

enrollee who will, or will continue, to receive home health services. CMS requires HHAs to submit OASIS data as a condition of payment.[4] CMS uses the HHRGs as the basis for the Health Insurance Prospective Payment System (HIPPS) codes, which determine payment.[5]

While home health PPS payment is made for each 30-day period, patient eligibility is determined based on a 60-day certification period. Medicare permits continuous 60-day recertifications for patients who continue to be eligible for the home health benefit. Medicare does not limit the number of continuous 60-day recertifications as long as the enrollee meets eligibility requirements. Each 60-day certification can include two 30-day payment periods.

CMS administers the Medicare program and contracts with four Medicare administrative contractors (MACs) to process and pay claims submitted by HHAs.

Medicare Requirements for Home Health Services and Claims

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 and 424.22 require, as a condition of payment for home health services, that a physician or other allowed practitioner[6] certify and recertify that the Medicare enrollee is:

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

Furthermore, as a condition for payment, a practitioner must certify that a face-to-face (F2F) encounter occurred no more than 90 days prior to the home health start-of-care date or within

[4] 42 CFR §§ 484.45, 484.205(c) and 484.250; and 84 Fed. Reg. 60478, 60490-60493 (Nov. 8, 2019).

[5] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies. For more information, see CMS | HIPPS Codes, accessed on Oct. 23, 2024.

[6] An allowed practitioner means a nurse practitioner, physician assistant, or clinical nurse specialist. For brevity we will use the term "practitioner" to refer to all allowable practitioner types, including a physician.

30 days of the start of care (42 CFR § 424.22(a)(1)(v)).[7] 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 provided on the forms and in the medical record (e.g., plan of care, certification or recertification statement, the OASIS, progress notes) concerning the unique medical condition of the individual. 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 enrollee's individual need for care (42 CFR § 409.44(a)).

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

Bridge Home Health

Bridge Home Health is a for-profit HHA headquartered in San Diego, California. National Government Services, its MAC, paid Bridge Home Health approximately $30 million for 14,307 claims for services provided to enrollees during CYs 2021 and 2022 (audit period) based on CMS's Integrated Data Repository (IDR) data.[8]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $26,445,098 in Medicare payments to Bridge Home Health for 10,877 claims provided during the audit period.[9] We selected a simple random sample of 100 claims with payments totaling $256,976 for review. We evaluated these claims for compliance with selected billing requirements and submitted these claims to independent medical review 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

[7] The face-to-face encounter can be performed by the certifying physician or allowed practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health (42 CFR § 424.22(a)(1)(v)).

[8] This was the most recent timeframe for which claims data were available at the start of the audit.

[9] Our sampling frame included home health claim payments for 30-day billing periods with dates of service within our audit period that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse. We did not include Requests for Anticipated Payment (42 CFR § 484.205(i)), Notices of Admission (42 CFR § 484.205(j)), Low Utilization Payment Adjustments (42 CFR § 484.230), or Partial Episode Payments (42 CFR § 484.235) in our review of claims.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

FINDINGS

Bridge Home Health complied with Medicare billing requirements for 90 of the 100 home health claims that we reviewed. For the remaining 10 claims, Bridge Home Health incorrectly billed Medicare for services that did not meet billing and coding requirements (6 claims), did not meet F2F requirements (3 claims), and did not meet skilled need requirements (1 claim). For four of these claims, the errors did not result in overpayments.[10] For six of these claims, Bridge Home Health received net overpayments of $6,046.[11, 12]

These errors occurred because Bridge Home Health did not always adequately review medical record documentation to prevent the incorrect billing of Medicare claims. Bridge Home Health attributed the errors to turnover of leadership and field staff, implementation of a new electronic medical record (EMR) system, and utilization of a new coding review company.

SERVICES DID NOT MEET BILLING AND CODING REQUIREMENTS

Effective January 1, 2020, Medicare pays HHAs for home health services under the Home Health PPS by means of a national, standardized 30-day payment rate calculated using the PDGM. Each 30-day billing period is categorized into 1 of 432 HHRGs for the purpose of adjusting payment under the PDGM.[13] In particular, 30-day billing periods are placed into different subgroups for each of the following broad categories: Admission Source, Timing of the Billing Period, Clinical Grouping, Functional Impairment Level, and Comorbidity Adjustment.[14]

[10] While these claim billing errors may not always result in overpayments, findings such as these can and do result in overpayments. Therefore, these findings are relevant to our objective of determining Bridge Home Health's compliance with Medicare requirements for billing home health services.

[11] Two of the six claims qualified for partial Medicare reimbursement. For these two claims, we questioned the difference between what was originally reimbursed and what was eligible for reimbursement. One of the six claims qualified for a higher Medicare reimbursement, which resulted in an underpayment. The net overpayment includes this underpayment.

[12] We have chosen not to report any estimates of overpayments in the sampling frame (i.e., extrapolated overpayments) because the lower limit of the two-sided 90-percent confidence interval was less than the known overpayment amount in the sample.

[13] Adjustments are also made for geographic differences in wage levels.

[14] 84 Fed. Reg. 60478, 60485-60495 (Nov. 8, 2019); 85 Fed. Reg. 70298, 70302-70305 (Nov. 4, 2020); 86 Fed. Reg. 62240, 62245-62246 (Nov. 9, 2021); CMS | Home Health PPS, accessed on Oct. 23, 2024.

The home health PPS Grouper automatically draws information from the home health claim and submitted OASIS assessment to group the 30-day billing period into a HHRG and assigns a corresponding HIPPS code. The HIPPS code is a distinct five-position alphanumeric code that represents the case mix on which payment determinations are made.

The primary and secondary diagnoses billed on the home health claim, which are used to determine the HHRG and resulting HIPPS code, must be supported by information in the certifying practitioner's and/or the acute or post-acute facility's medical record (83 Fed. Reg. 56406, 56461 (Nov. 12, 2018); ICD-10-CM Official Guidelines for Coding and Reporting, Section I.B.14; Medicare Program Integrity Manual (PIM), ch. 6, § 6.2.4).

For six of the sampled claims, Bridge Home Health submitted claims for services that did not meet billing and coding requirements. Specifically, Bridge Home Health submitted claims with unsupported or incorrect codes. For three of these claims, the errors did not result in overpayments. For the remaining three claims, the errors resulted in a net underpayment of $291.

Claims Billed With Unsupported Secondary Diagnosis Codes

For four of the six claims in error, Bridge Home Health incorrectly billed Medicare for unsupported secondary diagnosis codes. For three of these claims, removal of the unsupported secondary diagnosis codes did not result in overpayments. For the remaining claim, removal of the unsupported secondary diagnosis codes changed the comorbidity adjustment portion of the HIPPS code and resulted in an overpayment of $222.[15]

Example: Secondary Diagnosis Not Supported

A patient was referred to Bridge Home Health for skilled nursing services to provide wound care for non-healing venous ulcers. Bridge Home Health reported diagnoses on the home health claim that included encounter for change/removal of wound dressing, varicose veins with ulcers of both ankles, chronic non-pressure ulcers of both ankles, asthma, and long-term use of opiates. These combined diagnosis codes resulted in a comorbidity adjustment of "high." Medical review found that the documentation did not support the secondary diagnosis of asthma. Removal of this secondary diagnosis code changed the comorbidity adjustment to "low." Higher comorbidity adjustments indicate the patient has higher needs, and so higher payments are given. The change from a high to low comorbidity adjustment resulted in an overpayment.

[15] The comorbidity adjustment reflects medical conditions that coexist in addition to the principal diagnosis and is based on the presence of certain secondary diagnoses billed on the claim. The comorbidity adjustment is categorized as none, low, or high.

Incorrectly Billed Admission Source Code

For two of the six claims in error, Bridge Home Health billed Medicare for an incorrect admission source.[16] For one claim, Bridge Home Health incorrectly billed for an institutional admission when the documentation showed a community admission. The patient was admitted to home health after they had a same-day outpatient surgery, and no inpatient stay occurred. Patients who are admitted to home health after an inpatient stay generally have higher needs and receive more intensive services, so higher payments are given to claims with an institutional admission source. Adjustment of the claim admission source from institutional to community changed the HIPPS code and resulted in an overpayment of $515. For the remaining claim, Bridge Home Health incorrectly billed for a community admission when the documentation showed an institutional admission. The patient was discharged from an acute-care hospital stay within 14 days of the claim start date. Adjustment of the claim admission source from community to institutional changed the HIPPS code and resulted in an underpayment of $1,028.

SERVICES BILLED DID NOT MEET FACE-TO-FACE ENCOUNTER REQUIREMENTS

As a condition for payment of home health services under Medicare, a practitioner must certify the patient's eligibility for the home health benefit, including the occurrence of a F2F encounter. The F2F encounter must be documented in the patient's medical record and:

- be related to the primary reason the patient requires home health services;
- occur timely, no more than 90 days prior to the home health start-of-care date or within 30 days of the start-of-care date; and
- be performed by the certifying practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health (42 CFR § 424.22(a)(1)(v)).

For three of the sampled claims, Bridge Home Health submitted claims that did not meet face-to-face encounter requirements, resulting in overpayments of $6,337. For one claim, the F2F encounter was performed during a hospital admission for insertion of a nephrostomy tube and was not related to the primary reason for home health services, which was treatment for a

[16] The admission source can be either community or institutional and is categorized based on the setting from which the patient was admitted to home health. If the enrollee was discharged from an acute or post-acute facility within 14 days prior to the home health claim start date, the admission source is institutional. If the enrollee does not meet the definition of an institutional admission, the admission source is community.

stage 4 pressure ulcer of the sacrum.[17, 18] For another claim, the F2F encounter was not performed timely, i.e., within 30 days of the start of care; it was completed over 3 weeks late, which was 52 days after the start of home health care. For the remaining claim, the F2F encounter was performed by a nurse practitioner who was not the certifying practitioner and who did not care for the enrollee in an acute or post-acute care facility before admission to home health.

SERVICES DID NOT MEET SKILLED NEED REQUIREMENTS

The need for skilled services must be substantiated by supporting documentation ((SSA §§ 1814(a)(2)(C) and (a)(concluding paragraph), and 1835(a)(2)(A) and (a)(concluding paragraph); 42 CFR § 424.22(c); 42 CFR § 409.42(c); 42 CFR § 409.44; Medicare National Coverage Determinations Manual, chapter 1, part 3, § 170.1)).

To qualify for home health services, a Medicare enrollee must need 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)). 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 Medicare Benefit Policy Manual, chapter 7, § 40).[19]

For one of the sampled claims, Bridge Home Health incorrectly billed Medicare for skilled services that did not meet Medicare requirements. Specifically, Bridge Home Health incorrectly billed skilled nursing services for a portion of a home health billing period that were not reasonable and necessary for the treatment of the patient's condition. Removal of the unallowable visits did not result in an overpayment.

CAUSES FOR THE NONCOMPLIANCE WITH MEDICARE BILLING REQUIREMENTS

The errors occurred because Bridge Home Health did not always sufficiently review: (1) medical records from the certifying practitioner or the inpatient facility to ensure that all codes billed were supported by documentation, (2) F2F documentation from the certifying practitioner or the inpatient facility to ensure that the encounter met all F2F requirements, and (3) the documentation of the patient's condition and the services ordered to ensure that skilled services met Medicare requirements. Bridge Home Health attributed the errors to turnover of

[17] A nephrostomy tube is a thin, flexible tube that drains urine directly from the kidney into a bag outside the body.

[18] The sacrum is a triangular bone at the base of the spine that connects the spine to the pelvis.

[19] Skilled nursing services can include, among other things, overall management and evaluation of a care plan, observation and assessment of a patient's condition, and patient education services (42 CFR §§ 409.44(b) and 409.33).

leadership and field staff, implementation of a new EMR system, and utilization of a new coding review company.

RECOMMENDATIONS

We recommend that Bridge Home Health:

- refund the $6,046 in overpayments to the Medicare program;[20]

- identify similar instances of noncompliance that occurred before, during, and after the audit period and determine the impact and return any overpayments to the Federal Government; and

- strengthen its review of medical record documentation to ensure compliance with Medicare billing requirements.

BRIDGE HOME HEALTH COMMENTS

Bridge Home Health concurred with our recommendations and provided detailed corrective actions it has taken since the audit period to address and prevent the types of findings identified during our audit. These corrective actions include improved review processes for coding and billing; a new EMR system with 100 percent pre-claim review; 100 percent review of face-to-face encounters; and in-service trainings for agency leaders and clinicians on diagnosis code validation, face-to-face criteria, and Medicare coverage criteria for medical necessity.

Bridge Home Health's comments appear in their entirety as Appendix F.

[20] OIG audit recommendations do not represent final determinations. 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.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $26,445,098 in Medicare payments to Bridge Home Health for 10,877 home health claims with service dates in CYs 2021 and 2022.[21, 22] From this sample frame, we selected for review a simple random sample of 100 home health claims with payments totaling $256,976.

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

We assessed Bridge Home Health's internal controls and compliance with laws and regulations necessary to satisfy the audit objective. Our review of internal controls focused on Bridge Home Health's procedures when providing and billing home health services. Specifically, we assessed whether Bridge Home Health had a robust control environment that included establishing and overseeing an internal control system, and control activities that included policies for complying with Medicare regulations. Our review showed that Bridge Home Health's controls were logically designed and applied consistently for most of the claims in our sample. Our internal control review was limited to these areas and may not have disclosed internal control deficiencies that could have existed at the time of this audit.

To assess the reliability of the data obtained from CMS's Integrated Data Repository, we: (1) performed electronic testing for obvious errors in accuracy and completeness, (2) reviewed existing information about the data and the system that produced the data, and (3) traced our random sample of 100 home health claims to source documents. We determined that the data were sufficiently reliable for the purposes of this report.

We conducted our audit from August 2023 through November 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[21] We did not include Requests for Anticipated Payment (42 CFR § 484.205(i)), Notices of Admission (42 CFR § 484.205(j)), Low Utilization Payment Adjustments (42 CFR § 484.230), or Partial Episode Payments (42 CFR § 484.235) in our review of claims.

[22] 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 enrollee. We selected claims with "through" dates falling within CYs 2021 and 2022; therefore, claims subjected to audit could include services that began prior to CY 2021.

- extracted Bridge Home Health's paid claim data from CMS's NCH file for the audit period;

- created a sampling frame of 10,877 claims totaling $26,445,098;[23]

- 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 Bridge Home Health to support the claims sampled;

- used an independent medical review contractor to determine whether the 100 claims in the sample were reasonable and necessary and met Medicare coverage and coding requirements;

- reviewed Bridge Home Health's procedures for billing and submitting Medicare claims;

- verified State licensure information for selected medical personnel providing services to the patients in our sample;

- verified that claims were billed with the appropriate Core Based Statistical Area (CBSA) and Federal Information Processing Standards (FIPS) codes according to the address where the home health services were provided;[24]

- calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our audit with Bridge Home Health 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.

[23] Our sampling frame included home health claim payments for 30-day billing periods with dates of service within our audit period that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.

[24] CMS requires that claims for home health services include the CBSA and FIPS codes to indicate where the services were provided.

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

GENERAL MEDICARE BILLING 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 including therapy needs and functional impairment, that HHA clinicians use when assessing an enrollee who will, or will continue, to receive home health services. CMS requires the submission of OASIS data as a condition of payment ((42 CFR §§ 484.45, 484.205(c) and 484.250; and 84 Fed. Reg. 60478, 60490-60493 (Nov. 8, 2019).

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Under the home health PPS, CMS pays HHAs a national, standardized 30-day period payment rate.[25] This standardized payment rate is adjusted by using variables in the PDGM that account for the enrollee's condition and healthcare needs. For the purposes of adjusting payment under the PDGM, each 30-day period is categorized into 1 of 432 case-mix groups, called HHRGs.

HHRGs are different payment groups based on five main case-mix variables under the PDGM: timing, admission source, principal diagnosis, other diagnoses, and functional impairment. The patient-specific data for these variables are derived from Medicare claims and the OASIS. CMS uses the HHRGs as the basis for the HIPPS codes, which determine payment.[26]

HOME HEALTH COVERAGE AND PAYMENT REQUIREMENTS

To qualify for home health services, Medicare enrollees must: (1) be confined to the home; (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

[25] Adjustments are made for geographic differences in wage levels.

[26] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies. For more information, see CMS | HIPPS Codes, accessed on Oct. 23, 2024.

occupational therapy;[27] (3) be under the care of a physician or allowed practitioner; and (4) be under a plan of care that has been established and periodically reviewed by the certifying physician or allowed practitioner (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act; and 42 CFR § 409.42).[28]

Whether care is reasonable and necessary is based on information provided on the forms and in the medical record concerning the unique medical condition of the individual patient (42 CFR § 409.44(a)).

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

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 424.22(a)(1)(v) state that the certifying physician or allowed practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health, must have a F2F encounter with the enrollee. In addition, the practitioner responsible for the initial certification must document that the F2F 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 (42 CFR § 424.22(a)(1)(v)).

Confined to the Home

For the reimbursement of home health services, the enrollee must be "confined to his home" (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 409.42). Additionally, the law requires that a practitioner certify in all cases that the patient is confined to his or her home (42 CFR § 424.22(a)(1)(ii)). For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

[27] 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)).

[28] An allowed practitioner means a nurse practitioner, physician assistant, or clinical nurse specialist. For brevity we will use the term "practitioner" to refer to all allowable practitioner types, including a physician.

Criterion 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 Criterion One conditions, then the patient must also meet two additional requirements defined in Criterion Two below.

Criterion 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).

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)).

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 enrollee, 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 enrollee or to the enrollee'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.

The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the patient's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time. (42 CFR § 409.44(b)(3)(iii)).

Reasonable and Necessary Therapy Services

Federal regulations (42 CFR § 409.44(c)) state that skilled services must require the skills of a qualified physical therapist or a qualified physical therapy assistant under the supervision of a qualified physical therapist, a qualified speech-language pathologist, or a qualified occupational therapist or a qualified occupational therapy assistant under the supervision of a qualified occupational therapist and must be reasonable and necessary. 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.

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. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel (42 CFR § 409.44).[29]

[29] For additional information, see CMS | Jimmo Settlement, accessed on Oct. 23, 2024.

Documentation Requirements

Face-to-Face Encounter

Federal regulations (42 CFR § 424.22(a)(1)(v)) state that, a practitioner must certify the patient's eligibility for the home health benefit, including the occurrence of a F2F encounter. The F2F encounter must be documented in the patient's medical record and:

- be related to the primary reason the patient requires home health services;
- occur timely, no more than 90 days prior to the home health start-of-care date or within 30 days of the start-of-care date; and
- be performed by the certifying practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health.

Plan of Care

The practitioner's orders for services in the plan of care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the services and at what frequency the services will be furnished (42 CFR § 409.43(b)). The plan of care must be reviewed and signed by the practitioner 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 practitioner and the date of review (42 CFR § 409.43(e).

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 10,877 claims for home health services provided by Bridge Home Health with ending dates of service from January 1, 2021, through December 31, 2022. Medicare payments for those claims totaled $26,445,098.

SAMPLE UNIT

The sample unit was a Medicare home health claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We randomly selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG/Office of Audit Services (OAS) Statistical Software, RAT-STATS.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in the sampling frame by IDR_LINK_NUM[30] and then consecutively numbered the items in the sampling frame. After generating random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We have chosen not to report any estimates of overpayments in the sampling frame because the lower limit of the two-sided 90-percent confidence interval was less than the known overpayment amount in the sample. Therefore, we are recommending recovery of only the net overpayment for the items in our sample.

[30] This field uniquely identifies claims in CMS's IDR.

APPENDIX D: SAMPLE RESULTS

Sample Details and Results

Sampling Frame Size	Total Value of Sampling Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Net Value of Overpayments in Sample
10,877	$26,445,098	100	$256,976	10	$6,046

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Face-to-Face Requirements	Services Did Not Meet Skilled Need Requirements	Overpayment (Underpayment)
1				-
2		X		$2,643
3				-
4				-
5				-
6				-
7				-
8				-
9				-
10				-
11				-
12				-
13				-
14				-
15				-
16				-
17	X			(1,028)
18				-
19				-
20				-
21				-
22				-
23				-
24				-
25				-
26				-
27				-
28	X			222
29				-
30				-
31				-
32				-
33				-
34				-
35				-
36				-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Face-to-Face Requirements	Services Did Not Meet Skilled Need Requirements	Overpayment (Underpayment)
37				-
38				-
39				-
40		X		1,838
41				-
42	X			515
43				-
44				-
45				-
46				-
47				-
48				-
49				-
50				-
51	X			0
52				-
53				-
54				-
55				-
56				-
57				-
58				-
59	X			0
60				-
61				-
62				-
63				-
64				-
65	X			0
66				-
67				-
68				-
69				-
70				-
71				-
72				-
73			X	0
74				-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Face-to-Face Requirements	Services Did Not Meet Skilled Need Requirements	Overpayment (Underpayment)
75				-
76				-
77				-
78				-
79				-
80				-
81				-
82				-
83				-
84				-
85				-
86				-
87				-
88				-
89				-
90				-
91				-
92				-
93		**X**		1,856
94				-
95				-
96				-
97				-
98				-
99				-
100				-
Totals	**6**	**3**	**1**	**$6,046**

APPENDIX F: BRIDGE HOME HEALTH COMMENTS

bridge HOME HEALTH & HOSPICE

December 4, 2024

Report Number: A-05-23-00017

Sheri Fulcher
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General

Dear Sheri Fulcher:

Please find the response to the OIG Findings in the attached document. We concur with the recommendations set forth in the report number referenced above. If you have any questions, please contact Marsha Lambert, Chief Compliance Officer, at Mlambert@bridgehh.com.

Sincerely,

Jeff mongonia 12/3/24

Jeff Mongonia
Chief Executive Officer

Date

Phone: 858-251-4242 | Fax: 858-408-3210

Bridge Home Health San Diego
3636 Nobel Drive, Suite 450, San Diego, CA 92122

Response to OIG Findings

Findings	Response	Corrective Actions Taken

Services did not meet billing and coding requirements on six claims with unsupported or incorrect codes	No Appeal	The organization implemented several changes to its vendor relationships:
		
		• Terminated the contract with the previous coding and review provider.
		• Partnered with a more comprehensive coding and OASIS review organization that offers in-depth reviews conducted by qualified experts.
		• Introduced a new EMR system with enhanced clinical oversight processes, including:
		  ○ 100% clinical review to ensure the accuracy of documentation submitted for all comprehensive time points.
		  ○ 100% review of ICD-10 coding and sequencing accuracy.
		  ○ A 100% pre-claim review process to guarantee billing compliance.
		
		In-service training was provided to agency leaders and clinicians on the selection of primary and secondary diagnoses, including provider validation of diagnoses. This training is also incorporated into the orientation process for all new employees.
		
		• An annual corporate billing compliance audit was conducted, and any findings were presented to the QAPI committee for corrective action as needed. These internal compliance audits are ongoing annually and/or quarterly based on results

Services billed did not meet Face-To-Face requirements on three claims	No Appeal	• A new process was implemented for 100% review of Face-To-Face encounter at various stages, including:
		  ○ Intake
		  ○ After the initial submission of the comprehensive assessment
		  ○ After ICD10 coding and sequencing by the external vendor.

Findings	Response	Corrective Actions Taken
		○ Prior to claim submission • In-service education was provided to agency leaders and clinicians on Medicare Face-To-Face criteria and requirements. This education is included in orientation for new employees. • Face-To-Face encounter criteria are incorporated into the annual corporate billing compliance audit, with findings reported to the QAPI committee for corrective action if necessary.
Services did not meet skilled need requirements on one claim	No Appeal	• A case conferencing process is implemented at designated intervals to review patient status and determine the need for skilled care. • In-service education was provided to agency leaders and clinicians on Medicare coverage criteria, with specific focus on medical necessity by discipline. This education is also part of the orientation for new employees. • Medicare medical necessity and skilled care criteria are included in the annual corporate billing compliance audit with findings brought to QAPI committee for corrective action if necessary

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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