

# OIG Work Plan 2012: Home Health

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Another year is almost over and that means another Department of Health and Human Services, Office of Inspector General (“OIG”) Work Plan is upon us. This year’s Work Plan has a lot in it for home health providers. This is not a surprising development given the last few years. Providers will recognize some recurring themes - home bound status, for example, but also see some new items that should give providers additional areas to monitor in the coming year. So, let’s briefly review the home health issues announced in this year’s Work Plan.

## Medicare Reviews

### 1. Review of State Survey and Certification

The good news is that someone other than providers is the subject of the OIG concern in this year’s Work Plan. The OIG proposes to review the timeliness of surveys conducted by both State Survey Agencies and Accreditation Organizations. The OIG will also be reviewing the outcomes of those surveys and the nature and follow-up on complaints involving home health agencies (“HHAs”). The OIG will also be looking at CMS’s efforts and activities aimed at overseeing the survey and certification process.

### 2. Oversight of OASIS data

The OIG will not only be reviewing the survey and certification process, but will also be looking at CMS’ oversight of the OASIS submission process. The OIG specifically mentions that it will be reviewing CMS’s process for ensuring that HHAs submit accurate and complete OASIS data. The Work Plan does not explain what concerns the OIG has that has led it to review this process.

### 3. Missing or Incorrect OASIS Data

This is where the Work Plan starts to impact providers more directly. The OIG will be reviewing OASIS data to identify episodic payments for which OASIS data were not submitted. The OIG will also be reviewing episodes for which OASIS data was submitted, but for which it determines the code that was billed on the claim is not consistent with the OASIS data submitted. This could, in theory, lead directly to audits of providers whose claims the OIG determines are inconsistent with the OASIS data.

### 4. Questionable Billing Characteristics

This Work Plan issue raises some red flags. The OIG proposes to review home health claims to identify agencies that exhibited “questionable billing” in 2010. The Work Plan defines “questionable billing” as claims that exhibit “certain characteristics that may indicate potential fraud.” They will identify and review HHAs that had a “high percentage” of claims that meet at least one of the questionable billing characteristics. Unfortunately, the OIG does not define what these questionable billing characteristics are. The OIG specifically mentions that originally the home health benefit was intended for short-term post hospital recovery. This may be an indication they will be looking at length of stay and homebound status. The only thing that is clear from this is that the OIG will be scrutinizing home health claims and following up with providers.

#### 5. HHA Claims compliance with coverage and coding requirements

In yet another provider audit related entry to the Work Plan, the OIG states it will review Medicare home health claims to determine the extent to which the claims meet Medicare coverage requirements. They will “assess the accuracy” of resource group codes and identify characteristics of miscoding. This appears to be an additional audit based focus on coding creep that Medicare has been so concerned about the past few years. It is not clear how they intend to assess the accuracy of HHRG coding, unless they intend to audit providers and determine if the documentation supports the case mix scores and HHRG.

#### 6. MAC Oversight of HHA Claims

MACs are supposed to reduce payment errors preventing initial payment of claims that are not “compliant with Medicare’s coverage, coding, payment and billing policies.” The OIG is concerned about the pattern of home health utilization growth that appears to be unrelated to clinical or patient characteristics. In response, the OIG will review the fraud and abuse prevention practices, as well as the reduction of payment errors by the MACs. I would anticipate this leading to additional pre-payment reviews or similar efforts to stop payment from going out.

#### 7. Wage Indexes used to calculate Home Health Payments

The OIG is concerned that the Wage Indexes used to calculate home health payments are inaccurate. The OIG is concerned that inaccurate wage indexes is resulting in reimbursement calculations that are incorrect (read too high).

#### 8. Home Health PPS requirements

The OIG will review home health documentation for compliance with Home Health PPS requirements such as homebound status and need for intermittent nursing care. It is important to note that, yet again, the OIG is specifically mentioning homebound status. The OIG also mentions the requirement of part-time or intermittent skilled nursing need. Because of the specific mention in the Work Plan, it is highly recommended that compliance with homebound status and need for intermittent nursing be specifically addressed in your audit plan for the year.

## 9. Home Health Agency trends in Revenues and Expenses

The OIG will use cost report data to analyze trends in home health agency revenue and expenses under the home health PPS. The purpose of this analysis will be to identify whether the home health PPS system needs to be adjusted. They will analyze overall revenue and expense trends for both free standing and hospital based agencies. The OIG feels this is necessary, because of the dramatic increase in home health services expenditures since 2000. This is another reminder that, even though cost based reimbursement is no longer part of home health, timely and accurate submission of cost report data is extremely important.

### **Medicaid Reviews - Home, Community, and Personal Care Services**

#### 1. Screenings of Health Care Workers

The OIG will review the health screening records of Medicaid home health workers to determine whether these individuals were screened in accordance with Federal and State requirements. These screenings can vary depending upon the state, but most states require some level of screening for communicable diseases. Providers in the Medicaid and Medicaid Waiver sectors should plan to audit their personnel charts to verify appropriate and timely health screenings have been performed and follow-up has occurred as necessary.

#### 2. Agency Claims

The OIG will be monitoring HHA claims to determine whether providers have met applicable criteria to provide the services and whether the beneficiaries have met eligibility criteria. This is more than a claims review. The OIG proposes to monitor for compliance with the provider enrollment requirements for Medicaid, as well as claims documentation. The OIG proposes to look at whether an agency has met state licensure criteria as well as that the agency has met requirements such as home bound status and presence of a plan of care. This is a broader review than the claims related audits proposed under the Medicare Work Plan.

#### 3. Home Bound requirements

In the prior paragraph, we noted that the OIG would be reviewing Medicaid claims for homebound status. The OIG will also be reviewing CMS's efforts to oversee states' efforts to enforce compliance with the Medicaid home health eligibility requirements. The OIG appears to be concerned about states inappropriately restricting eligibility for home health services to homebound recipients. This may have an impact on providers indirectly, but the focus here is on state Medicaid agencies.

#### 4. Waiver Programs Quality of Care

As quality continues to be an area of concern, the OIG announces it will be reviewing CMS and State oversight of home- and community-based services waiver programs to determine the extent to which CMS oversees States' efforts to ensure quality of care provided under these waiver programs. Again, this may lead to increased state efforts to oversee and enforce quality of care issues, but it will not directly impact providers.

## **Conclusion**

Although the OIG proposes a number of efforts to monitor CMS and the states, this year's OIG Work Plan also contains many of the "usual suspects" for home health providers. In anticipation of the OIG's upcoming efforts, providers should be auditing their claims for compliance with coding and claims requirements, such as homebound status and need for intermittent nursing. Providers should also be auditing/monitoring claims to ensure their documentation supports the manner in which the claims is coded, because the OIG is officially looking at coding creep.

There are also new areas mentioned by the OIG. For example, the OIG is going to be looking for questionable billing characteristics. The OIG does not provide much detail on what it considers to be questionable characteristics, but it is not hard to guess: high therapy utilization, extended length of stay, and other types of care which the OIG has long been suspicious. If the Senate Finance Committee report did not get your attention, the Work Plan should cause you to go back and carefully review you therapy utilization and therapy documentation.

The OIG is also going to be looking at revenue and expense trends. Providers should anticipate that the OIG will conclude, as MedPAC, CMS, the Senate Finance Committee and others already have, that home health agencies are overcompensated for their efforts. This review makes it even more important for providers to be thorough and accurate in their cost reporting. The cost report data is what OIG, and others, use to perform these reviews. Because of this, your cost report data continues to have an impact on reimbursement.

For additional information, please contact a member of Benesch's Health Care Practice Group.

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