NELSON HARDIMAN
HEALTHCARE LAWYERS

Home Health Agencies and the OIG 2012 Work Plan

From 2000 to the present, Medicare spending on home health agencies (HHA's) has increased eighty-one percent (81%). From OIG's perspective, the increased utilization of -and resultant billing by -HHA's is not driven by greater clinical need, but in significant part by fraud and abuse. Although reimbursement to HHA's was intended as a short-term benefit to permit homebound Medicare beneficiaries to convalesce at home after hospitalization, HHA's have come to service a much broader range of patients. In general, Medicare scrutiny of HHA's focuses on the perceived "scope creep" of the benefit and attempts to identify bad operators and abusive billing practices.

For Medicare-certified home health agencies, OIG will continue its review of patient outcome data, known as Outcome and Assessment Information Set (OASIS). The OASIS data – which summarizes clinical needs, patient functional status, and service utilization needs – and the resulting assessment of the extent to which HHA's were effective in rehabilitating patients, are anticipated to lead towards a pay-for-performance system for HHA services in the future. OIG will also continue its review of coding by HHA's, which have been subjected to overpayment audits based on allegations of lack of medical necessity and upcoding.

The 2012 Work Plan identifies five new areas of review for home health agencies, including:

(1) verification of triennial survey outcomes, to identify "problem" HHA's;

(2) comparison of OASIS data to billing codes (as well as review of cases for which OASIS data was not submitted);

(3) HHA's with billing practice that are identified as "questionable" and indicative of fraud (no examples provided);

(4) review of the Medicare Administrative Contractor (i.e. carrier) fraud and abuse prevention efforts, including payment errors in specific claims as well as in the Medicare Prospective Payment System (PPS); and

(5) reviewing whether HHA's are receiving excessive PPS payments by using incorrect wage indexes.

In general, the 2012 OIG Work Plan highlights the need for HHA's to be run more tightly, with better controls not only on service delivery and billing practices, but on overall operations. The coming year will almost certainly bring a rise of post-payment recovery audits by contractors, relying on sampling and extrapolation to recover significant amounts of money from HHA's, along with a rise in the rate of pre-payment review and suspensions for suspect providers. One observable trend in home health review is OIG's increasing ability to leverage data mined from electronic databases of claim submissions and OASIS data to identify questionable practices. HHA's need to be proactive in doing what they can to ensure that their operations and billing practices are beyond reproach. We recommend that home health clients work to adopt compliance programs to address both new priorities, such as readiness for survey and attention to complaints, together with a careful focus on clinical care and billing practices.

Nelson Hardiman advises healthcare providers on compliance issues, and designs and implements compliance programs. For more information on our efforts on behalf of home health providers, contact Aaron Lachant at aaron@nelsonhardiman.com