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After Extrapolating, OIG Says Four HHAs Were Overpaid Millions; CMS Revised Extrapolation Use

By Nina Youngstrom

Home health agencies (HHAs) may want to audit their documentation before submitting claims, now that the HHS Office of Inspector General has released a series of reports on HHAs that recommend huge Medicare refunds based on extrapolations from relatively small overpayments. And providers with doubts about the use of extrapolation—a contentious subject in Medicare audits—may have better luck challenging the statistical sampling because of a January change to the Medicare Program Integrity Manual, a statistician says.

In the most recent OIG audit report, posted June 6, OIG said Great Lakes Home Health Services, Inc., a for-profit HHA in Jackson, Michigan, was overpaid $64,114 for services provided to patients in 2014 and 2015. The overpayment was extrapolated to $10.48 million. OIG audited a stratified random sample of 100 claims worth $341,150 and concluded that 38 claims had errors, because Great Lakes billed Medicare for patients who weren't homebound and didn't need skilled services (i.e., nursing care or speech and physical therapy). OIG recommended the HHA return the portion of the $10.48 million to Medicare that's within the reopening period and "for the remaining portion of the estimated $10,486,922 overpayment for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule." Great Lakes refuted all of OIG's findings.

The flurry of OIG audits raises the stakes for auditing documentation before HHAs bill Medicare, says Kathleen Hessler, director of compliance and risk at Simione Healthcare Consultants, LLC. She recommends that clinicians review visit notes to confirm patients satisfy Medicare requirements for homebound status, medical necessity and a face-to-face encounter with a physician or non-physician practitioner. "Clinicians should be documenting the services they are providing, including all teaching for the diagnosis and disease process and objective measurements of improvement or decline," Hessler says. Although it won't be relevant to audits of historical claims, patient involvement in care planning should appear in documentation because of changes to the Medicare conditions of participation that took effect January 2018. "They require a more patient-centered focus in the clinical record," Hessler says. "What are the written goals and how are we measuring and resolving the goals? How are we documenting and showing the patient's progress?"