INAPPROPRIATE AND QUESTIONABLE BILLING BY MEDICARE HOME HEALTH AGENCIES

Data collected and analyzed by the Office of Inspector General (OIG) since 2010, indicate that home health agencies (HHAs) are predisposed to commit Medicare fraud, waste and abuse. In 2010, Medicare inappropriately paid $5 million for erroneous claims submitted by HHAs. With one in four claims being suspect, the OIG established six (6) criteria that identify HHAs submitting potentially fraudulent claims and/or employing questionable billing practices. Primarily, these criteria are based on higher than average payments, visits, late episodes, therapy visits and Medicare payment amounts per beneficiary, as well as a higher than average number of beneficiaries.

The results have motivated the OIG to recommend to the Centers for Medicare & Medicaid Services (CMS) that it encourage Medicare Administrative Contractors (MACs) to increase monitoring of the claims processed utilizing the six (6) identifiers, and to enforce the remedies of lower payment caps and fewer HHA enrollments in certain geographic areas. Interestingly, eighty percent (80%) of the HHAs with questionable billing were located in Texas, Florida, California and Michigan.

The goals of this new initiative by the OIG and CMS/MACs are to identify and reduce reimbursement abuse by HHAs and to increase and ensure the quality of services being provided to HHA beneficiaries.

The complete report by Daniel R. Levinson, Inspector General, can be accessed here.

If you have questions or concerns regarding the foregoing or would like additional information, please contact your regular Hall Render attorney, or Todd Selby at tselby@hallrender.com or 317.977.1440; Brian Jent at bjent@hallrender.com or 317.977.1402; or David Bufford at dbufford@hallrender.com or 502.568.9368.

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