



Memorandum

Date SEP 28 1999

From June Gibbs Brown
Inspector General *June G Brown*

Subject Review of Costs Claimed by Eddy Visiting Nurse Association of the Capital Region
(A-02-97-01026)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled "Review of Costs Claimed by Eddy Visiting Nurse Association of the Capital Region." This report provides you with the results of our review of Medicare home health claims submitted by the Eddy Visiting Nurse Association of the Capital Region (Eddy), which is a home health agency located in Troy, New York (Medicare provider number 33-7152).

From a universe of 7,056 claims submitted by the Eddy for Medicare reimbursement during Calendar Year (CY) 1996, we randomly selected 100 claims for review. Those selected were for 1,115 services provided to 98 Medicare beneficiaries. Our review disclosed 59 claims which contained 443 services that were ineligible for Medicare reimbursement. The 59 claims included:

- ▶ 206 services which were not, in the opinion of medical experts, reasonable and necessary;
- ▶ 166 services that did not have valid physician orders;
- ▶ 31 services where there was no evidence that a medical service was performed;
- ▶ 23 services which were rendered to beneficiaries who, in the opinion of medical experts, were not homebound;
- ▶ 12 services which we determined had not been rendered; and
- ▶ 5 services that did not meet the intermittent criteria related to skilled nursing.

For CY 1996, the Eddy claimed reimbursement for 100,269 Medicare services. After audit, the Eddy's actual claimed costs for the period were \$5,368,028. Based on the results of our

review, we estimate that at least \$1,131,593 is ineligible for Medicare reimbursement. Using the 90 percent confidence interval, we believe the overpayment is between \$1,131,593 and \$1,932,554.

We recommend that the Health Care Financing Administration (HCFA) instruct the regional home health intermediary (RHHI) to recover the estimated overpayment of \$1,131,593. We further recommend that HCFA take steps to ensure home health services billed to Medicare by the Eddy have the proper authorization, appropriate supporting documentation, and are otherwise allowable for reimbursement. These steps should include requiring the RHHI to monitor more closely the claims submitted by the Eddy and to conduct subsequent periodic in-depth reviews of its claims.

In its written response to our draft report, HCFA concurred with both recommendations. The complete text of HCFA's response is presented as APPENDIX B.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-02-97-01026.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF COSTS CLAIMED
BY EDDY VISITING NURSE
ASSOCIATION OF THE
CAPITAL REGION**



**JUNE GIBBS BROWN
Inspector General**

**SEPTEMBER 1999
A-02-97-01026**

**Memorandum**

Date SEP 28 1999

From June Gibbs Brown
Inspector General *June G Brown*

Subject Review of Costs Claimed by Eddy Visiting Nurse Association of the Capital Region
(A-02-97-01026)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of the Eddy Visiting Nurse Association of the Capital Region (Eddy) in Troy, New York (Medicare provider number 33-7152). Our audit was performed under the auspices of Operation Restore Trust (ORT) and included working closely with and receiving considerable assistance from our ORT partner, United Government Services (UGS), the regional home health intermediary (RHHI) for this home health agency (HHA).

OBJECTIVE

The audit objective was to determine whether the home health care visits claimed by the Eddy met Medicare reimbursement guidelines.

SUMMARY OF FINDINGS

We estimate that, of the \$5.4 million claimed by the Eddy for Calendar Year (CY) 1996, at least \$1.1 million was for services which did not meet Medicare guidelines. Using the 90 percent confidence interval, we believe the overpayment is between \$1.1 and \$1.9 million. We found that 59 of 100 home health claims reviewed, containing 443 of 1,115 services, were not reimbursable under Medicare. The 443 services were found to be unallowable for the following reasons:

- ▶ 206 services which were not, in the opinion of medical experts, reasonable and necessary;

- ▶ 166 services that did not have valid physician orders;
- ▶ 31 services where there was no evidence that a medical service was performed;
- ▶ 23 services which were rendered to beneficiaries who, in the opinion of medical experts, were not homebound;
- ▶ 12 services which we determined had not been rendered; and
- ▶ 5 services that did not meet the intermittent criteria related to skilled nursing.

We believe our findings clearly indicate a serious lack of compliance by this provider with Medicare regulations and controls. The reasons why the Eddy submitted inappropriate claims to the RHHI which were ultimately approved for payment included:

- ▶ Inadequate controls related to determining the eligibility of beneficiaries and services for Medicare coverage, the obtaining of proper physician authorizations, and the billing of services to the Medicare program.
- ▶ The lack of active physician involvement in the authorization of home health services and lack of physician knowledge of Medicare regulations regarding home health services.

We are recommending the Health Care Financing Administration (HCFA):

- ▶ Instruct the RHHI to recover the estimated overpayment of \$1,131,593.
- ▶ Take steps to ensure that home health services billed to Medicare by the Eddy have the proper authorization, appropriate supporting documentation, and are otherwise allowable for reimbursement. These steps should include requiring the RHHI to monitor more closely the claims submitted by the Eddy and to conduct subsequent periodic in-depth reviews of its claims.

In its written comments to our draft report, HCFA concurred with both recommendations. The complete text of HCFA's response is presented as APPENDIX B to this report.

BACKGROUND

Eddy Visiting Nurse Association of the Capital Region

The Eddy was a Medicare certified HHA with a principal place of business in Troy, New York. It was a not-for-profit corporation that employed or subcontracted with nurses, home health aides, and therapists.

A Medicare certified agency, such as the Eddy, can either provide home health services itself or make arrangements with other medical providers to render home health services. Such services are rendered to Medicare beneficiaries during visits to their residences. Although some of the services claimed by the Eddy were provided by its own employees, many of the sample services were provided under subcontract with other medical providers.

For CY 1996, the Eddy provided 175,705 home health services to both Medicare and non-Medicare patients. Of this total, 100,269 (57 percent) were Medicare services. The Eddy was reimbursed by the RHHI for services to Medicare beneficiaries under the periodic interim payment method which approximates the cost of covered visits rendered by the provider. The interim payments are then adjusted to actual costs based on the annual cost report filed with the RHHI. For CY 1996, the Eddy received interim reimbursement from Medicare totaling \$5.3 million. After audit, this amount was adjusted to reflect the Eddy's actual claimed costs of \$5.4 million.

Authority and Requirements for Home Health Services

The legislative authority for coverage of home health services is contained in sections 1814, 1835, and 1861 of the Social Security Act; governing regulations are found in 42 CFR; and HCFA coverage guidelines are found in the Medicare HHA Manual.

Regional Home Health Intermediary Responsibilities

The HCFA contracts with RHHIs, usually large insurance companies, to assist in administering the home health benefits program. The RHHI for the Eddy was UGS of Milwaukee, Wisconsin.

The RHHI is responsible for:

- ▶ processing claims for HHA services,
- ▶ performing liaison activities between HCFA and the HHAs,

- ▶ making interim payments to HHAs, and
- ▶ conducting audits of cost reports submitted by HHAs.

SCOPE AND METHODOLOGY

The objective of our audit was to determine whether the home health care visits claimed by the Eddy met Medicare reimbursement guidelines. This audit was performed under ORT, in partnership with UGS.

For CY 1996, the Eddy claimed reimbursement for home health services on 7,056 claims. We reviewed a statistical sample of 100 claims totaling 1,115 services and \$57,303 in covered charges for 98 different individuals (2 individuals appeared twice in the sample). We are reporting the overpayment projected from this sample at the lower limit of the 90 percent confidence interval. APPENDIX A contains the details of our sampling methodology. We used applicable laws, regulations, and Medicare guidelines to determine whether the visits claimed met the reimbursement guidelines.

Generally, for each of the 100 claims, we interviewed:

- ▶ the beneficiary or a knowledgeable acquaintance,
- ▶ the physician who certified the plan of care, and
- ▶ the beneficiary's personal physician if different from the certifying physician.

We interviewed beneficiaries or knowledgeable acquaintances associated with 97 of the 100 claims; 3 beneficiaries refused to be interviewed. We were unable to interview the six certifying physicians related to eight cases because they either refused to talk to us (two physicians - two claims), could not be located (two physicians - two claims), had retired (one physician - three claims), or were deceased (one physician - one claim).

In addition, we reviewed and made copies of pertinent supporting medical records maintained by the Eddy for all 100 claims in our sample. The interview forms and copied medical records were also reviewed by UGS medical personnel to determine if the beneficiary was homebound, whether all services provided were reasonable and necessary and covered by the proper authorization, and whether there was adequate medical documentation for services billed.

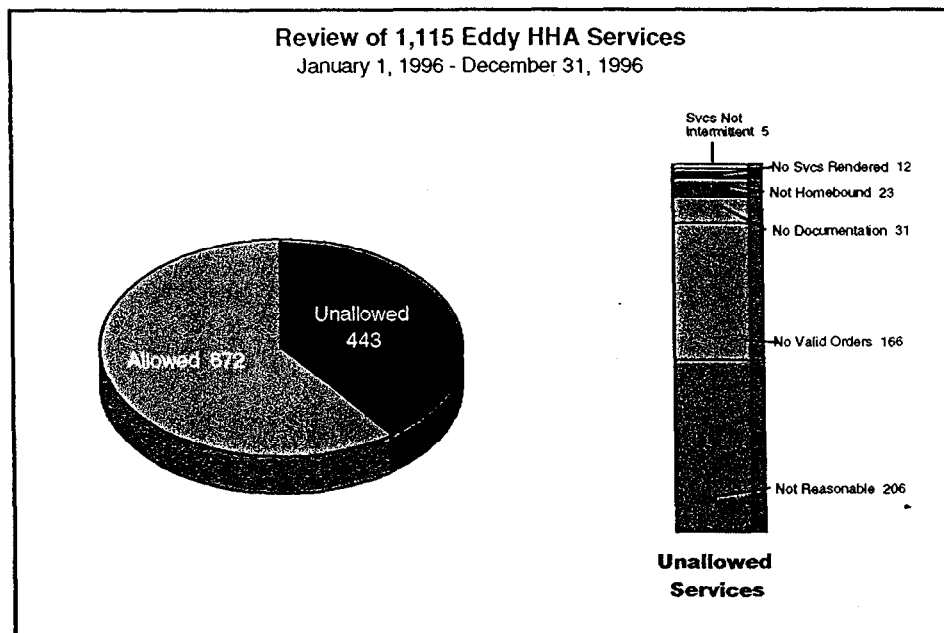
Our audit was conducted in accordance with generally accepted government auditing standards. We conducted a limited review of the Eddy's internal controls over determining the eligibility of beneficiaries and services for Medicare coverage, the authorization of services by physicians, and the billing of services to Medicare. These controls were further evaluated through our substantive testing.

Our field work was performed at the Eddy's office in Troy, New York. Interviews were conducted in the beneficiaries' residences and physicians' offices when appropriate, otherwise via the telephone. Copied beneficiary records were reviewed by UGS personnel at their headquarters in Milwaukee, Wisconsin. Our field work was completed in October 1998.

DETAILED RESULTS OF REVIEW

Fifty-nine of the 100 claims in our random sample, containing 443 of 1,115 services and \$21,713 of \$57,303 tested, did not meet the Medicare reimbursement requirements. Based on these results, we estimate the Eddy claimed between \$1,131,593 and \$1,932,554 for services that were unallowable for Medicare reimbursement. The midpoint of the confidence interval amounted to \$1,532,074. Our tests were based on simple random sampling techniques and the ranges shown have a 90 percent level of confidence with a sampling precision as a percentage of the midpoint of 26.14.

The results of our review of 1,115 Eddy HHA services are summarized below and discussed in detail thereafter.



Requirements for Provision of Home Health Services

The Medicare home health benefit allows people with restricted mobility to remain noninstitutionalized and receive needed care at home. To qualify for home health benefits, a beneficiary must be:

- ▶ confined to home except for infrequent or short absences or trips for medical care;
- ▶ under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine; and
- ▶ in need of one or more of the following qualifying services: skilled nursing, physical therapy, or speech pathology.

Services Not Reasonable and Necessary

Our review disclosed 206 services which were not, in the opinion of the RHHI's medical experts, reasonable and necessary.

Regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "...in need of intermittent skilled nursing care or physical or speech therapy...." Section 203.1 of the Medicare HHA Manual states the beneficiary's health status and medical need as reflected in the plan of care and medical records provide the basis for determination as to whether services provided are reasonable and necessary.

As stated above, medical personnel at UGS made the determinations concerning the reasonableness and necessity of services included on each claim. We provided them with our interview data and the information copied from the case files for each of the 100 sample claims and they reviewed this material to make their determinations.

Services in this category were deemed unreasonable and unnecessary for the following reasons:

- Medical documentation did not support the need for and/or the actual provision of skilled services.
- No personal care, as defined in Medicare guidelines, was provided during the visit.
- The beneficiary's medical condition did not justify the need for an aide.
- The qualifying skilled service was determined to be unnecessary.

Services Without Valid Physician Orders

Our review showed 166 services that were rendered and billed without valid physician orders.

Regulations at 42 CFR 424.22 state, in part: "Medicare Part A or B pays for home health services only if a physician certifies and recertifies..." that "(iii) A plan for furnishing the services has been established and is periodically reviewed by a physician...." The plan of care must be established and certified by a physician initially and the certification must be updated every 2 months. The plan of care must specify the type and frequency of services to be provided and must be signed and dated by a physician before the bill is submitted to the RHHI for payment.

This error category included instances where the plans of care covering rendered and billed services were not signed prior to the submission of the claim to Medicare or not signed at all by the physician and plans of care where a secretary or nurse practitioner signed on the doctor's behalf. There were also cases where services rendered exceeded the physician's orders. Finally, other services were not specified in a plan of care nor were they covered by a verbal order.

Services Not Documented

Evidence, in the form of a progress note or activity sheet, that a medical service had been rendered was missing for 31 services. Section 484.48 of 42 CFR states: "A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains...activity orders; signed and dated clinical and progress notes...."

For each service date billed, we checked to ensure that an activity sheet (for aide services) or skilled note (for all other visits) existed to support that a medical service had been provided. If a note or activity sheet was not found, the service was considered ineligible for Medicare reimbursement.

Services to Beneficiaries Who Were Not Homebound

Twenty-three services were provided to beneficiaries who were not homebound at the time the services were provided. The determinations in all these cases were made by RHHI medical experts based on their review of the beneficiaries' case records, and information gathered during our interviews with the beneficiaries and the certifying and personal physicians.

The regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "...confined to the home or in an institution that is neither a hospital nor primarily engaged in providing skilled nursing or rehabilitation services...." 42 CFR 424.22 states that Medicare pays for home health services only if a physician certifies the services are needed and that the individual is homebound. The Medicare HHA manual at section 204.1 contains guidance regarding the "homebound" requirement. In general, this section indicates the condition of the beneficiary should be such that there exists a normal inability to leave the home and consequently leaving the home would require a considerable and taxing effort. Furthermore, if the beneficiary does leave the home, he/she may still be considered homebound if the absences are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment.

Beneficiaries or their families, when interviewed, or the Eddy's records indicated the beneficiaries could leave their homes without considerable effort at the time the home health services were provided. For example:

- In one case, the beneficiary and his wife indicated he was able to ambulate without the use of any supportive devices, was going to church and shopping and even took occasional, unaccompanied walks outdoors. Furthermore, the Eddy's records did not substantiate that this beneficiary was homebound as there was no noted need for assistive devices when moving about, no restriction on ambulation, and no physical deficit identified.
- In another case, the beneficiary did not consider himself to be homebound as he was able to go out and drive his own car at the time home health services were provided. In addition, the authorizing physician concurred with the beneficiary's belief that he was not confined to the home. Finally, the Eddy's records indicated that the beneficiary was independent in activities of daily living and general mobility, and was able to leave the home to go bowling.

Services Not Rendered

We found evidence that 12 services were not rendered to the beneficiary for a date billed. This determination was made by comparing time documentation (i.e., time sheets) to detailed billing summaries, case notes, Part A inpatient hospitalization records, and other information deemed necessary. Two examples of cases where we determined services were not rendered are as follows:

- On one date of service, the Eddy billed a home health aide visit on a date when the beneficiary was taken to the emergency room by her niece. Medicare hospitalization information showed the beneficiary was admitted to the emergency room at 10:55 a.m. The aide's time sheet for this date indicates the aide serviced the beneficiary from 10:25 a.m. to 12:25 p.m., however, a nursing note found in the HHA's records showed a call being made to the beneficiary's home at 10:45 a.m. and there was no answer.

- On another claim, the Eddy billed a total of 13 skilled nursing services. Supporting medical and time documentation was found for 8 of the 13 billed visits. Upon further investigation, we were told by Eddy officials that five services were never rendered to this particular beneficiary and were inappropriately billed to Medicare. We were also informed the Eddy had submitted an adjustment claim to correct the overbilling, however, according to the RHHI's billing records, no adjustment was ever submitted to reduce the number of skilled nursing visits.

Intermittent Criteria Not Met

There were five skilled nursing services which the RHHI's medical experts found were not in compliance with the intermittent eligibility criteria. Specifically, for these services, RHHI personnel determined that the finite period identified in the plan of care, i.e., "wound will heal w/in (sic) 9 weeks", was not medically predictable; this determination was based on the documentation in the medical record.

As stated previously, regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "...in need of intermittent skilled nursing care or physical or speech therapy..." Furthermore, section 205.1C of the HHA manual indicates "To meet the requirement for 'intermittent' skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services."

Effect

In summary, our review of a sample of 100 home health claims, representing a total of 1,115 services, showed that 59, containing 443 services, were not reimbursable under Medicare. We estimate with 95 percent confidence that the Eddy was overpaid by at least \$1,131,593 for CY 1996.

Causes

The unallowable home health services disclosed by our review occurred because of the inadequacy of both the Eddy and existing Medicare program controls. We found that the Eddy's controls related to determining the eligibility of beneficiaries and services for Medicare coverage, the obtaining of proper physician authorizations, and the billing of services to the Medicare program were not sufficient to ensure claims submitted for payment were for allowable services. Further, HCFA relies on the treating physicians to ensure services are provided only to eligible beneficiaries; i.e., to act as "gatekeepers". However, we found the physicians in our review were not fulfilling this responsibility and depended primarily on Eddy personnel to make these determinations.

Inadequate Eddy Controls--As the result of our (and UGS personnel) review, 443 services, of a total of 1,115 in the sample, were determined to be unallowable. In our opinion, one cause of this significant level of errors was the lack of adequate Eddy controls over the authorization, provision, and billing of home health services.

The majority of the unallowable sample services were denied either due to the lack of a valid physician order or because UGS medical experts determined they were not reasonable and necessary or the receiving beneficiary was not homebound. Finally, numerous billing problems were noted which included billing for the wrong type of service, billing Medicare for non-covered services, and submitting claims for services that were either not supported by medical documentation or were not rendered at all.

During our site visit, we were informed by Eddy officials that there were policies and procedures in effect to ensure the proper physician authorization of services, the provision of services only to homebound beneficiaries who needed them, and the appropriate billing of services to Medicare. However, based on our review and the significance of our findings, it is apparent these controls were not sufficient to ensure the Eddy's compliance with Medicare program requirements.

Inadequate Physician Involvement--The Medicare program recognized the physician would have an important role in determining utilization of home health services. The law indicates that payment can be made only if a physician certifies the need for services and establishes a plan of care.

We interviewed the authorizing physicians for 92 of the 100 sample claims. The interviews disclosed that often the physicians' involvement in home health care was limited to signing plans of care prepared by the Eddy without proper evaluation of the patients to assess their needs and homebound status. In many cases, the Eddy was determining the need, type, and frequency of home health visits without the physicians' participation.

The physicians' interviews disclosed inadequate involvement in the preparation of plans of care or the determination of homebound status. For example,

- In only 36 of the 92 cases was the physician familiar with the Medicare criteria that requires a beneficiary to be homebound in order to receive home health services.
- In only six cases did the physician personally make the determination the beneficiary was eligible for services; i.e., the beneficiary was homebound and in need of skilled services.

- None of the physicians interviewed indicated they had personally prepared the plan of care, and in 65 instances, the physician relied on the Eddy to prepare it.

Currently, Medicare does not require physicians to personally examine their patients before signing certifications for home care. Thus, the failure of physicians to personally examine their patients does not render the home care unallowable. However, we believe the lack of active, informed physician involvement in the assessment of their patients' needs and homebound status was a contributing cause of the unallowable services disclosed by our review. The fact that the physicians did not fulfill the "gatekeeping" responsibilities assigned to them by the Medicare regulations created a vulnerability which worsened the impact of the Eddy's lack of adequate controls.

Further, our findings related to the lack of physician involvement in the authorization of home health care services are similar to those discussed in our earlier report to HCFA entitled *Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas* (A-04-96-02121). That review found that too often the physician's involvement in home health care was limited to signing plans of care prepared by the HHAs without proper evaluation of the patients to assess their needs and homebound status. It was also found that HHAs were determining the need, type, and frequency of home health services without physician participation.

RECOMMENDATIONS

We recommend that HCFA:

- ▶ Instruct the RHHI to recover the estimated overpayment of \$1,131,593.
- ▶ Take steps to ensure that home health services billed to Medicare by the Eddy have the proper authorization, appropriate supporting documentation, and are otherwise allowable for reimbursement. These steps should include requiring the RHHI to monitor more closely the claims submitted by the Eddy and to conduct subsequent periodic in-depth reviews of its claims.

HCFA's Comments

In its written response to our draft report, HCFA concurred with both recommendations. The HCFA also noted that data obtained from its Online Survey Certification and Reporting System indicated the Eddy (Medicare provider number 33-7152) had voluntarily terminated from the Medicare program on December 31, 1998; the reason listed for the voluntary action was categorized as a "merger or closure". The HCFA further noted the type of action

taken by the Eddy, i.e., merger or closure, might impact on the options available to HCFA. The complete text of HCFA's response is presented as APPENDIX B.

OIG Response

Based on documentation obtained from HCFA's New York regional office personnel, we have determined the Eddy's voluntary termination involved transferring its assets to "its sister corporation, Home Aide Service of Eastern New York, Inc. (HASENY)." Its Medicare provider number (33-7152) was terminated December 31, 1998; however, the provider number originally assigned to the former Eddy Visiting Nurse Association of Twin Counties (33-7203), already owned by HASENY, remained in effect. We noted further that HASENY was and continues to be part of LTC (Eddy), Inc. (d/b/a "The Eddy") and the address for the main office of the consolidated HHA was the same as that which had been listed for the Eddy.

Thus, the voluntary termination of provider number 33-7152 by the Eddy, the HHA we audited, basically involved the transfer of its assets to another part of "The Eddy" umbrella organization. In our opinion, it did not involve a change of ownership, i.e., a closure or merger, as discussed in 42 CFR 489.18 and section 3210 of the State Operations Manual. This view was supported by HCFA New York regional office personnel in our discussions with them on the matter. Therefore, the impact of the Eddy's action on the options available to HCFA should be minimal and it is our opinion the identified overpayments can be recouped.

SAMPLING METHODOLOGY

Objective:	To determine whether home health services claimed by the Eddy Visiting Nurse Association of the Capital Region (Eddy) met Medicare reimbursement guidelines.
Population:	The universe consisted of 7,056 claims for which the Eddy reported \$5.4 million in costs for Calendar Year 1996.
Sampling Unit:	The sampling unit was a paid home health claim for a Medicare beneficiary. A paid claim included multiple home health service visits.
Sampling Design:	A simple random sample was used.
Sample Size:	A sample of 100 paid claims representing 1,115 services and \$57,303.
Source of Random Numbers	Department of Health and Human Services, Office of Inspector General, Office of Audit Services Random Number Generator
Estimation Methodology:	<p>We used the cost per visit for each type of service as contained in the Eddy Calendar Year 1996 audited cost report. The amount of error for a sampling unit was computed by multiplying the number of each type of unallowed service by the applicable cost per visit contained in the Eddy Calendar Year 1996 audited cost report.</p> <p>Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services Variables Appraisal Program, we estimated the overpayments on claims for services that either did not meet reimbursement requirements, were not authorized, or were not rendered.</p>



DATE: JUL 15 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash *Michael M. Hash*
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Costs Claimed by Eddy Visiting Nurse Association," A-02-97-01026

We appreciate the opportunity to comment on the issues raised in the above-referenced report. The OIG review of 100 randomly selected claims for the Eddy Visiting Nurse Association (VNA) of the Capital Region disclosed 59 claims which contained 443 services that were ineligible for Medicare reimbursement. The rationale for ineligibility included: a lack of physician orders; the rendering of services determined not to be "reasonable and necessary", etc.

HCFA's survey and certification protocol for home health agencies includes a review of clinical records in order to ensure that a patient's care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine (42 CFR 484.18). We will continue to monitor home health agencies for compliance with this regulation and require a plan of correction if they are not in compliance. We will also continue to instruct state survey agency surveyors to report suspected fraud and abuse practices to the appropriate authorities.

In addition, data from the Online Survey Certification and Reporting System (OSCAR) indicate that the Wesley VNA/Eddy VNA of the Capital Region (provider number 337152), located at 433 River Street, Suite 3000, Troy, NY 12180, voluntarily terminated from the Medicare program December 31, 1998. The reason listed for this provider's voluntary action was categorized as a "merger or closure." Specific information about this action can be obtained from the New York Regional Office (RO) or the New York State Agency.

The OIG report does not include the provider number for Eddy VNA of the Capital Region; however, we believe we have correctly identified the home health agency by the name and location. If this home health agency has indeed voluntarily terminated from the Medicare program, the type of action taken by the agency, i.e., merger or closure, may impact the options available to HCFA.

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OIG Recommendation 1

Instruct the RHHI to recover the estimated overpayment of \$1,131,593

HCFA Comment

We concur. However, we cannot attest to the exact overpayment figure stated in the report until the responsible intermediary receives the audit work papers which the OIG previously agreed to furnish. In this case, the United Government Services (UGS), the provider's intermediary, worked closely with the OIG in completing the audit. A copy of this report will be sent to the Chicago region so that it can review the audit findings and ensure that the intermediary receives the necessary workpapers from the OIG for establishing and recouping the correct overpayment amount.

OIG Recommendation 2

Take steps to ensure that home health services billed to Medicare by the Eddy have the proper authorization, appropriate supporting documentation, and are otherwise allowable for reimbursement. These steps should include requiring the RHHI to monitor more closely the claims submitted by the Eddy and to conduct subsequent periodic reviews of its claims.

HCFA Comment

We concur and assuming Eddy VNA is still under operation under a merger entity, we will instruct our Chicago Regional office to work with the RHHI to assure that Eddy has been properly educated as to how to submit claims for home health services. The RHHI will also be instructed to more closely monitor claims submitted by Eddy and to conduct periodic review of its claims.