Common Errors That Lead to Improper Payments for Home Health Services and Agency-Provided Supplies, Equipment, and Appliances

The Centers for Medicare & Medicaid Services (CMS) and the States are increasing educational outreach about Home and Community-Based Services (HCBS) to enhance awareness of and engage providers and beneficiaries in efforts to reduce payment errors and fraud, waste, and abuse in the Medicaid program.

The Medicaid Integrity Program, established under the Deficit Reduction Act of 2005, and the President's November 2009 Executive Order 13520 Reducing Improper Payments and Eliminating Waste in Federal Programs are two comprehensive strategies that protect the integrity of the Medicaid program.

As part of these programs, CMS has analyzed data produced by the Payment Error Rate Measurement (PERM) program to identify areas that may be at high risk for improper payments and to target root causes for errors. Due to these PERM-identified payment errors, CMS implemented a supplemental measure to further assess HCBS. Through its analysis, CMS identified multiple payment errors and root causes.

This fact sheet has been developed to educate beneficiaries and providers about the major causes of payment errors and to maintain program integrity.

These are the key terms used in this document:

- **Beneficiary:** includes the person receiving Medicaid HCBS and their legal guardian, family member, or other support;
- **Provider:** includes physician; nurse practitioner; registered nurse; licensed practical nurse; aide; private or not-for-profit agency; case manager; State Medicaid agency or State sister agency; Medicaid durable medical equipment, supplies, and devices supplier; home modification business; or other providers of HCBS; and
- **Person-centered plan:** synonymous with plan of care, care plan, individual service plan (ISP), individual education plan (IEP), or other terms used to describe a written individual plan that includes HCBS.

This fact sheet summarizes the Medicaid benefit regarding common documentation and billing errors identified by PERM analysis. After reading this fact sheet, providers should be able to describe:

- The most common home health-related documentation and billing errors as identified by PERM analysis;
- Promising practices to reduce or eliminate these errors; and
- Where to go for additional resources.

Overview of Home Health Services and Agency-Provided Supplies, Equipment, and Appliances

Medicaid home health services are a mandatory benefit under the State plan for patients eligible for nursing facility care. Federal regulations require that home health services include part-time nursing, home health aides, medical supplies, medical equipment, and appliances suitable for use in the home. The States have the option of covering additional therapeutic services such as physical therapy, occupational therapy, and speech pathology and audiology services under the home health benefit. States also have the flexibility to establish coverage limits for the amount, duration, and scope of services, but must ensure that the coverage limits are sufficient to achieve the purpose of the service. All home health services must be medically necessary and authorized by a physician's order as part of a person-centered plan.[1]

Overview of Common Errors

Improper payments for home health services may occur when Medicaid funds are paid to the wrong entity, are paid in the wrong amount, are not supported by documentation or policy, or are used for services other than those identified in the person-centered plan. PERM data was analyzed to determine the root cause of payment errors for home health services and agency-provided supplies, equipment, and appliances. The analysis identified two common errors: number of units error and insufficient documentation.

Number of Units Error

A number of units error occurs when a provider bills for an incorrect number of units for a procedure code. Common errors for home health services and agency-provided supplies, equipment, and appliances include:

- The number of units billed for a procedure code differs from the number of units documented;
- The number of units billed exceeds the number of units authorized by the physician's order in the person-centered plan;
- Services provided overnight are not appropriately divided into units per day. Documentation must show date span for proper billing;
- The wrong procedure code and number of units are billed in error; and
- The units are not calculated correctly for the procedure code such as billing for units of service in 15-minute increments when the requirements specify one-hour increments.

  For example, the provider bills for 144 units of procedure code S9122-Home Health Aide or Certified Nurse Assistant providing care in the home, per hour, for services provided over a 4-week period. The person-centered plan authorizes 9 hours of S9122 per week, and documentation indicates 36 hours of service were provided. The number of units billed was calculated at 15 minutes per unit instead of 1 hour per unit as required.

Insufficient Documentation

Insufficient documentation errors occur when a provider submits documentation but it does not fully support the procedure code billed. Common errors for home health services and agency-provided supplies, equipment, and appliances include:

- Service logs are missing the provider name, dates of service, time spent, and activities performed. Logs were not signed by the provider or validated by beneficiary;
- Progress notes do not indicate if the services billed were provided, are not signed, or are missing for the date of service; and
- Written person-centered plan with physician authorization is missing signatures.

Promising Practices

There are some practices that can be integrated into daily practice to correct most of the errors found. They include:

- Quality control on services:
  - Check to make sure the staff person providing the service is authorized to provide the service;
  - Check to make sure that the services provided are authorized in the written person-centered plan;

    - Check that documentation includes the date, time, type, and service provider; and
    - Check for signatures to validate services provided.
- Quality control on beneficiary records:
    - Check for required forms in the record (person-centered plan);
    - Check for physician orders; and
    - Check for a beneficiary identifier on each document.
- Quality control for claims processing:
    - Check the calculation of the number of units for the procedure code or service code;
    - Check the procedure code;
    - Check the unit pricing of supplies;
    - Check to make sure the dates of service entered match the dates of service on the documentation; and
    - Check the person-centered plan for the number of units authorized for the procedure or service code.

Conclusion

Medicaid home health services are a mandatory benefit for patients entitled to nursing facility care and include part-time nursing, home health aides, medical supplies, medical equipment, and appliances suitable for use in the home. The services must be medically necessary and authorized by a physician's order as part of a person-centered plan. States establish the amount, duration, and scope of coverage, but must ensure that coverage limits are sufficient to achieve the intended purpose of the service.

Improper payments for home health services may occur when Medicaid funds are paid to the wrong entity, are paid in the wrong amount, are not supported by documentation or policy, or are used for services other than those identified in the person-centered plan. Analysis of PERM data for root causes of payment error for home health services identified two types of errors: number of units error and insufficient documentation. Implementation of quality controls for services, records, and claims processes would eliminate or reduce most common errors.

Providers can play a significant role in the fight against Medicaid fraud, waste, and abuse. CMS hopes you share its commitment to eliminate payment errors and fraud, waste, and abuse in the Medicaid program. By increasing your awareness of common errors and applying remedies in your daily practice, you will help strengthen the integrity of the Medicaid program and reduce improper payments. For further information, review the toolkits about HCBS at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

Additional Resources

Links to State Medicaid agency websites are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html on the Medicaid website.

Information about Medicaid HCBS is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html on the Medicaid website.

Information about payment accuracy and improper payments is available at https://paymentaccuracy.gov/about-improper-payments on the Internet.

Information about the PERM program is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM on the CMS website.

To see the electronic version of this fact sheet and the other products included in the "Home and Community-Based Services" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/edmic-landing.html on the CMS website.

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References

1 U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. (2010). Understanding Medicaid Home and Community Services: A Primer. 2010 Edition. Retrieved September 10, 2015, from http://aspe.hhs.gov/sites/default/files/pdf/76201/primer10.pdf

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