May 6, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Physician Therapy Services Provided During Home Health Episodes in Calendar Year 2008 (A-01-09-00530)

The attached final report provides the results of our review of physician therapy services provided during home health episodes in calendar year 2008.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to contact me at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-01-09-00530 in all correspondence.

Attachment

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PHYSICIAN THERAPY SERVICES PROVIDED DURING HOME HEALTH EPISODES IN CALENDAR YEAR 2008

Daniel R. Levinson
Inspector General

May 2011
A-01-09-00530

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Medicare home health prospective payment system (HH PPS) requires consolidated billing of home health services. Pursuant to the Social Security Act, §§ 1842(b)(6)(F) and 1862(a)(21), the home health agency that establishes the beneficiary's plan of care is responsible for billing Medicare for the services included in the prospective payment rate.

Prior to the implementation of the HH PPS on October 1, 2000, therapy services furnished to beneficiaries receiving home health care were separately billable to Part B by outside providers such as physicians, therapists, and outpatient facilities. A portion of the 60-day episode base rate included reimbursement for therapy services that were separately billable to Part B before implementation of the PPS. In May 2003, the Centers for Medicare & Medicaid Services (CMS) instructed Medicare contractors to allow Part B payments for therapy services furnished during home health episodes whenever those services were billed with a physician specialty code.

Beginning in 2014, CMS must rebase home health payments to improve payment accuracy for home health agencies.

Our review included an analysis of the development of the base rate and of updates through 2010. According to CMS officials, CMS did not maintain the original episode data that were used to calculate the base rate and could not recreate the episodes. Thus, we could not determine the portions of the base rate attributable to specific types of therapy providers.

OBJECTIVE

Our objective was to determine whether the HH PPS base rate includes reimbursement for physician-provided therapy services that are also separately billable by physicians and are not subject to the consolidated billing requirement.

SUMMARY OF FINDING

CMS includes in the HH PPS base rate reimbursement to home health agencies for physician-provided therapy services that are not subject to the consolidated billing requirement and are billable by physicians. Although CMS has allowed Part B payments to physicians for therapy services furnished during home health episodes since 2003, the home health base rate was not adjusted because CMS officials believed that the effort to determine the extent of physician-provided therapy included in the base rate did not justify the perceived benefit in improved payment accuracy. As a result, when a physician bills Part B for therapy provided to a beneficiary during a home health episode, Medicare pays twice for the same service: once to the physician under Part B and again to the home health agency under the HH PPS. For example, during calendar year 2008, Medicare Part B paid physicians $13.5 million for therapy services furnished during home health episodes. For the same period, we calculated that home health agencies received approximately $117.5 million to provide therapy services that, prior to PPS, were separately billable to Part B by all outside therapy providers. We did not have sufficient

data to determine how much of the payment received by home health agencies was attributable to therapy services provided only by physicians.

RECOMMENDATION

We recommend that CMS eliminate any duplicate payments when rebasing home health payments by adjusting the HH PPS rate to exclude physician-provided therapy services or by making physician therapy services subject to the consolidated billing requirement again.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its written comments on our draft report, CMS agreed with our recommendation and provided information on action that it planned to take to address the recommendation. CMS's comments are included in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Medicare Home Health Benefit

The Medicare program, which the Centers for Medicare & Medicaid Services (CMS) administers, covers home health services to eligible beneficiaries who are generally home bound and need skilled care. Medicare Parts A and B pay for home health services. As a condition of participation in the Medicare program, home health agencies must establish a written plan of care for each beneficiary. The plan of care includes the types of services required and the frequency of visits.

Home Health Prospective Payment System and Consolidated Billing

Section 1895 of the Social Security Act (the Act) established a prospective payment system for home health services (HH PPS) effective October 1, 2000. Under the HH PPS, CMS established a base rate for a 60-day episode of care that accounts for the costs of skilled nursing services, therapy services, medical social services, home health aide services, and medical supplies. CMS updates the base rate annually using the home health market basket index. For each 60-day episode of care, CMS also adjusts the base rate for geographic factors and case mix.

Pursuant to the Act, §§ 1842(b)(6)(F) and 1862(a)(21), the home health agency that establishes the beneficiary's plan of care is responsible for consolidated billing for all Medicare services included in the prospective payment rate. A portion of the HH PPS base rate includes reimbursement for therapy services that were separately billable to Part B before implementation of the HH PPS (Part B therapy portion of the base rate). Prior to the implementation of the HH PPS, therapy services furnished to beneficiaries receiving home health care were separately billable to Part B by outside providers such as physicians, therapists, and outpatient facilities.

In May 2003, CMS issued Program Transmittal B-03-037, Change Request 2705, which states that therapy services are not subject to the home health consolidated billing requirement when performed by a physician.

Requirement To Rebase Home Health Payments

The Medicare Payment Advisory Commission has reported, "[p]ayments have consistently and substantially exceeded costs in the home health prospective payment system."[1] The Patient Protection and Affordable Care Act requires CMS to rebase home health payments starting in 2014 to improve payment accuracy for home health agencies. The rebasing should reflect such

[1] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2010, section 3B, page 200.

factors as changes in the number of visits, mix of services, level of intensity of services in an episode, and average cost of providing care per episode.[2]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the HH PPS base rate includes reimbursement to home health agencies for physician-provided therapy services that are also separately billed by physicians and are not subject to the consolidated billing requirement.

Scope

Our review included an analysis of the development of the base rate and subsequent updates through 2010. The objective of our audit did not require an understanding or assessment of the overall internal control structure of the HH PPS. According to CMS officials, CMS did not maintain the original episode data that were used to calculate the base rate and could not recreate the episodes. Thus, we could not determine the portions of the base rate attributable to specific types of therapy providers.

Methodology

To accomplish our objective, we:

- reviewed applicable laws and regulations and Medicare policy;
- interviewed CMS officials regarding the development of, and updates to, the base rate and the availability of data used to calculate the Part B therapy portion of the base rate;
- applied the annual HH PPS updates to the Part B therapy portion of the base rate through calendar year (CY) 2008 and used data from the National Claims History file to determine the number of CY 2008 home health episodes (Appendix A);
- calculated CY 2008 payments to home health agencies for therapy services that could have been separately billable to Part B before the implementation of the PPS (Appendix B);
- used data from the National Claims History file to determine CY 2008 Part B payments for therapy services billed with a physician specialty code and furnished during a home health episode;

[2] The Patient Protection and Affordable Care Act, P.L. No. 111-148, §§ 3131 and 10315, which added § 1895(b)(3)(A)(iii) to the Social Security Act; 42 U.S.C. § 1395fff(b)(3)(A)(iii).

- analyzed the CY 2008 physician-provided therapy payment data; and

- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusion based on our audit objective.

FINDING AND RECOMMENDATION

CMS includes in the HH PPS base rate reimbursement to home health agencies for physician-provided therapy services that are not subject to the consolidated billing requirement and are separately billable by physicians. Although CMS has allowed Part B payments to physicians for therapy services furnished during home health episodes since 2003, the home health base rate was not adjusted because CMS officials believed that the effort to determine the extent of physician-provided therapy included in the base rate did not justify the perceived benefit in improved payment accuracy. As a result, when a physician bills Part B for therapy provided to a beneficiary during a home health episode, Medicare pays twice for the same service: once to the physician under Part B and again to the home health agency under the HH PPS.

FEDERAL REQUIREMENTS

Pursuant to the Act, §§ 1842(b)(6)(F) and 1862(a)(21), the home health agency that establishes the plan of care is responsible for billing Medicare for the services included in the prospective payment rate. Medicare pays the home health agency under the HH PPS for these services regardless of whether the services were furnished by the agency or by an outside provider.

In a policy change in May 2003, CMS instructed the Medicare contractors to allow Part B payments for therapy services furnished during home health episodes whenever those services were billed with a physician specialty code.

POTENTIAL DUPLICATE PAYMENTS FOR PHYSICIAN-PROVIDED THERAPY DURING HOME HEALTH EPISODES

The home health base rate includes reimbursement for physician-provided therapy services that are not subject to the consolidated billing requirement and therefore are separately billable by physicians. In establishing the base rate for home health services, CMS included reimbursement for therapy services that were previously separately billable to Part B by physicians, therapists, and outpatient facilities. The amount included in the base rate for these therapy services was $17.67 per episode.

When CMS changed its policy in 2003 to allow separate Part B payments for physician-provided therapy services, CMS should have reduced the base rate accordingly. However, CMS officials

stated that the effort to determine the extent of physician-provided therapy included in the base rate did not justify the perceived benefit in improved payment accuracy. Because the base rate was not adjusted, Medicare may pay twice for physician-provided therapy services—once to the home health agency under the HH PPS and again to the physician under the Part B physician fee schedule.

During CY 2008, Medicare Part B paid physicians $13.5 million for therapy services furnished during home health episodes. These services included therapeutic exercises, neuromuscular reeducation, therapeutic activities, manual therapy, and massage therapy. For the same period, we calculated that home health agencies received approximately $117.5 million to provide therapy services that, before PPS, were separately billable to Part B by all outside therapy providers. However, without the simulated episodes that CMS used to establish the base rate, we could not determine how much of the $117.5 million was attributable to therapy services provided only by physicians.

RECOMMENDATION

We recommend that CMS eliminate any duplicate payments when rebasing home health payments by adjusting the HH PPS rate to exclude physician-provided therapy services or by making physician therapy services subject to the consolidated billing requirement again.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its written comments on our draft report, CMS agreed with our recommendation. When it rebases the home health PPS rates, as required by the Patient Protection and Affordable Care Act, CMS stated it will ensure that the costs of providing physician-provided therapy services are not included in the rebased rates.

OTHER MATTER

We noted that more than $5.2 million of the $13.5 million in Medicare Part B payments for physician-provided therapy during CY 2008 home health episodes was paid to one physician. The physician in question was recently indicted for billing therapy services that were not provided. This level of payments to a single provider may indicate that prepayment controls are insufficient to identify physician billing and utilization patterns that represent a high risk of improper payment activity.

APPENDIXES

APPENDIX A: CALCULATION DESIGN AND METHODOLOGY

Description of Calculation

We calculated the amount that home health agencies were reimbursed under the prospective payment system (PPS) in calendar year (CY) 2008 for therapy services that were separately billable to Part B before implementation of the PPS.[1]

Calculation Methodology

Under the PPS, Medicare pays home health agencies using a base rate. When the PPS was implemented on October 1, 2000, the base rate included a payment of $17.67 (Part B therapy portion of the base rate) to reimburse home health agencies for therapy services previously separately billable to Part B.

As required by § 1895(b)(3)(B) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) updates the PPS rate annually. We applied the annual updates to the original Part B therapy portion of the base rate of $17.67, yielding a CY 2008 Part B therapy portion of the base rate of $19.37.

Home health agencies received PPS payments for 6,065,749 episodes in CY 2008. We calculated payments to home health agencies in CY 2008 for therapy services that were separately billable to Part B before implementation of the PPS by multiplying the number of episodes by the Part B therapy portion of the base rate for CY 2008.

Sources of Data

CMS generally publishes annual updates to the home health PPS rate in the *Federal Register*. In addition, CMS publishes policy updates in Change Request transmittals. The following references document the calculation of the original Part B therapy portion of the base rate and subsequent updates to the base rate:

- 65 Fed. Reg. 41128, 41183–41184 (July 3, 2000)
- 66 Fed. Reg. 34687, 34689–34690 (June 29, 2001)
- 67 Fed. Reg. 43616, 43619 (June 28, 2002)
- 68 Fed. Reg. 39764, 39767 (July 2, 2003)
- CMS Transmittal 59, Change Request 3085 (Feb. 20, 2004)
- 69 Fed. Reg. 62124, 62133 (Oct. 22, 2004)
- 70 Fed. Reg. 68132, 68134 (Nov. 9, 2005)

[1] For purposes of our calculation, we assumed that the rate used was for a typical home health beneficiary residing in an average market. Thus, we did not adjust our calculation for case mix and geographic factors.

- CMS Transmittal 211, CMS Change Request 4282 (Feb. 10, 2006)
- 71 Fed. Reg. 65884, 65887 (Nov. 9, 2006)
- 72 Fed. Reg. 49762, 49850 and 49864–49865 (Aug. 29, 2007)

We extracted data from CMS's National Claims History file to determine the number of paid PPS home health episodes in CY 2008.

APPENDIX B: CALCULATION RESULTS

Number of CY 2008 Home Health PPS Paid Episodes		Calculated CY 2008 Part B Therapy Portion of the Base Rate	Calculated Part B Therapy Portion of the Base Rate Applicable to CY 2008 Episodes
6,065,749	X	$19.37	$117,493,558

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 2 4 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Review of Physician Therapy Services Provided During Home Health Episodes in Calendar Year 2008 (A-01-09-00530)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and respond to the OIG Draft Report titled "Review of Medicare Review of Physician Therapy Services Provided During Home Health Episodes in Calendar Year 2008 '' (A-01-09-00530).

The OIG states that beginning in 2003 CMS changed its policy to allow separate Part B payments for physician-provided therapy services to home health patients. Moreover, the OIG states that the home health prospective payment system (HH PPS) base rate includes reimbursement for therapy services that were previously separately billable under Part B by physicians, therapists, and outpatient facilities. As a result, the OIG asserts that when physicians bill Part B for therapy they provided to a beneficiary in a home health episode, Medicare pays twice for the same service.

Section 1861(m) of the Social Security Act (the Act) defines home health services under the Medicare program as including a range of health services, including therapy services. Section 1842(b)(6)(F) of the Act requires the consolidated billing of all home health services (with the exception of durable medical equipment) while a beneficiary is under a home health plan of care authorized by a physician. However, therapy services provided by a physician are not part of the definition of Medicare home health services and are thus not subject to the home health consolidated billing requirement. Beginning in 2003, through the issuance of Transmittal B-03-037 / Change Request #2705 (dated May 2, 2003), CMS corrected the home health consolidated billing system requirements to allow for payment for therapy services provided by physicians to beneficiaries who are in a Medicare home health episode of care.

OIG Recommendation

The OIG recommends that CMS eliminate these duplicate payments when rebasing home health payments by adjusting the HH PPS rate to exclude physician-provided therapy services or by making physician therapy services subject to the consolidated billing requirement again.

CMS Response

The CMS concurs with this recommendation. In rebasing the HH PPS rates, as required by section 3131(a) of the Patient Protection and Affordable Care Act, CMS will take into account only those therapy services provided either directly (or indirectly) by the home health agency and reported on the home health claim. As such, the costs of providing physician-provided therapy will not be included in the rebased HH PPS rates.

We thank the OIG for presenting its findings and we appreciate their perspective on these issues.