DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JUN 7 1995

From June Gibbs Brown
Inspector General

Subject Review of Improper Payments Made to Hospitals and Skilled Nursing Facilities For Beneficiaries Electing Hospice Benefits (A-02-93-01029)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final audit report entitled, "REVIEW OF IMPROPER PAYMENTS MADE TO HOSPITALS AND SKILLED NURSING FACILITIES FOR BENEFICIARIES ELECTING HOSPICE CARE." The objective of this nationwide review was to determine the amount of improper payments made to hospitals and skilled nursing facilities (SNF) for services provided to Medicare beneficiaries enrolled in hospice programs.

Our results indicate that during the period January 1, 1988 through December 31, 1992, hospitals and SNFs were improperly paid an estimated $21.6 million for services related to hospice beneficiaries' terminal illnesses. We reviewed an unrestricted random sample of 100 out of a total of 10,348 potential improper payments which were identified by a computer match. It appears that the claims were improperly paid because of claims processing weaknesses in the Health Care Financing Administration's (HCFA) Common Working File (CWF) system and or adjudication of claims. We are, in an additional current review, evaluating the adequacy and effectiveness of the CWF hospice system edits and the claims adjudication process using 1993 hospice, hospital, and SNF data.

We are recommending that HCFA instruct the fiscal intermediaries (FI) to recover from the hospitals the $208,873 of improper payments identified in our review of 100 sampled claims. We are also recommending that for the remainder of the potential improper payments identified by our computer match but not included in our sample review (10,248 potential improper payments for Calendar Years 1988 through 1992), HCFA instruct the FIs to review related medical records and other available information. If the FIs determine that improper payments were made, the FIs should seek refunds of incorrect payments and make appropriate adjustments to hospital cost reports. We estimate that these reviews by FIs will generate about $21.4 million from the hospitals/SNFs.

On March 31, 1995, HCFA responded to a draft of this report indicating concurrence with our findings and recommendations except for several suggested editorial changes.

The HCFA also suggested that we add a recommendation that the FIs make appropriate adjustments to hospital cost reports. We agree, and have incorporated HCFA's proposed changes in our final report.

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) 966-7104.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF IMPROPER PAYMENTS MADE TO HOSPITALS AND SKILLED NURSING FACILITIES FOR BENEFICIARIES ELECTING HOSPICE BENEFITS

JUNE GIBBS BROWN
Inspector General

JUNE 1995
A-02-93-01029

DEPARTMENT OF HEALTH & HUMAN SERVICES

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From June Gibbs Brown
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Subject Review of Improper Payments Made to Hospitals and Skilled Nursing Facilities For Beneficiaries Electing Hospice Benefits (A-02-93-01029)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This report provides you with the results of our "REVIEW OF IMPROPER PAYMENTS MADE TO HOSPITALS AND SKILLED NURSING FACILITIES FOR BENEFICIARIES ELECTING HOSPICE CARE." When a beneficiary elects hospice care, no Medicare payments are allowed to hospitals or skilled nursing facilities (SNF) for services related to the beneficiary's terminal illness. In such situations, the hospitals or SNFs should be reimbursed by the hospice facility in which the beneficiary is enrolled. The objective of our nationwide review was to determine the amount of improper payments made to hospitals and SNFs for services provided to Medicare beneficiaries enrolled in hospice programs.

Our review, which included a medical evaluation of beneficiary medical records for an unrestricted random sample of payments to hospitals and SNFs, showed they were improperly paid an estimated $21.6 million during the period January 1, 1988 through December 31, 1992. The improper payments were for inpatient hospital or SNF services rendered to beneficiaries enrolled in hospice programs where the hospitalization or SNF services were related to the beneficiary's terminal illness.

It appeared that claims were improperly paid because of claims processing weaknesses in the Health Care Financing Administration's (HCFA) Common Working File (CWF) system. We did not review CWF system edits or the adjudication of claims that CWF identified as potential improper payments during this review. We are, in an additional current review, reviewing those edits and adjudication of claims using 1993 hospice data. In the interim, we are recommending that HCFA immediately instruct the fiscal intermediaries (FI) to recover the improper payments from the hospitals identified in our sample review ($208,873). We are also recommending that HCFA, using the unreviewed portion of our universe of 10,348 potential improper payments for Calendar Years (CY) 1988 through 1992, instruct the FIs to review related medical records and, where appropriate, seek reimbursement (we estimate about $21.4 million) from the hospitals/SNFs.

INTRODUCTION

Background

In 1982 the Congress passed the Tax Equity and Fiscal Responsibility Act which extended Medicare coverage to include hospice care services. Hospice care emphasizes supportive (palliative) services, such as pain control and symptom management, rather than curative care. Hospice care is a method of caring for the terminally ill, helping them to continue their lives with as little disruption as possible.

When a beneficiary elects hospice care, the Medicare program reimburses the hospice a fixed rate for each day of care. While under hospice care, a beneficiary waives his/her rights to most Medicare benefits and the hospice assumes fiscal responsibility for all Medicare Part A services related to the beneficiary's terminal illness. Hospices should have available short-term inpatient care for pain control, symptom management, and respite purposes. The hospices ensure the availability of this service by means of contracts and agreements with participating Medicare or Medicaid facilities or by providing inpatient care directly.

For inpatient stays related to the hospice beneficiary's terminal illness, the hospital should not submit an inpatient reimbursement claim to its assigned Medicare Part A FI (currently, there are 45 Part A FIs nationwide). Instead, the hospital is required to bill the hospice, and the hospice bills Medicare for the inpatient stay by submitting a claim to its assigned regional FI (currently, there are nine regional FIs which process hospice claims). However, inpatient hospital stays unrelated to a hospice beneficiary's terminal illness are covered under the regular Medicare program.

On August 10, 1992, based on the results of a limited survey, we alerted HCFA that during CYs 1988 and 1989, hospitals and SNFs may have improperly received Medicare payments totaling about $13 million for beneficiaries enrolled in hospice programs (CIN A-14-92-02067). At that time, HCFA officials informed us that during CYs 1988 and 1989, HCFA did not have computer edits that would prevent improper payments to hospitals or SNFs for hospice covered services to beneficiaries with hospice elections. However, HCFA also informed us that effective in CY 1991, CWF incorporated edits designed to identify and prevent payments to hospitals and SNFs for services related to the patient's terminal illness. Under the CWF system, a computerized Medicare utilization history for each beneficiary is maintained at one of nine designated CWF processing sites. Before bills and claims for a beneficiary are authorized for payment by 1 of the 45 Medicare Part A FIs, they must be electronically received and processed at the designated CWF site.

Due to the significance of the potential improper payments, we expanded the scope of our review to include CY 1990, the period prior to implementation of CWF edits and two subsequent years (CYs 1991 and 1992) to assess the effectiveness of CWF in identifying potential improper payments.

Scope of Review

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine the amount of improper payments made to hospitals and SNFs for services related to the hospice enrolled beneficiaries' terminal illnesses. This nationwide review covered the period January 1, 1988 through December 31, 1992.

Through a computer data match of a file identifying Medicare beneficiaries with hospice elections and payments to hospitals and SNFs during CYs 1988 through 1992, as recorded in the Medicare Data Retrieval System (MDRS), we identified 10,348 potential improper payments made to hospitals and SNFs on behalf of beneficiaries with hospice elections. The potential improper payments for these years totaled about $42 million (we did not validate the reliability of the payment data included on the MDRS). From the identified universe of potentially improper payments, an unrestricted random sample of 100 payments was selected for review.

To evaluate the allowability of payments made by Medicare to hospitals or SNFs for the 100 sample items, we requested for review the corresponding beneficiary medical records from hospitals or SNFs and hospices. We received 92 responses and a physician, contracted by the Puerto Rico Peer Review Organization (PRO), reviewed the medical records to determine whether the services provided by the hospital or SNF were related to the beneficiary's terminal illness. If the physician determined that the services rendered were related, then the payments made by Medicare to the hospital or SNF were considered improper.

The audit objective of our financial related audit did not require preforming a complete assessment of the CWF system as it relates to the hospice program. However, the results of this audit identified potential problems with the CWF hospice edits. Therefore, we are currently reviewing hospice related edits and adjudication of claims using 1993 hospice, hospital and SNF data.

Our audit work was performed at our field office in Puerto Rico during the period June 1993 through November 1994.

RESULTS OF REVIEW

Our review showed that during CYs 1988 through 1992, approximately $21.6 million was improperly paid to hospitals and SNFs for services related to terminal illnesses of hospice-enrolled beneficiaries. We believe that the underlying cause of the improper payments was a lack of adequate claims processing controls in the CWF system and the adjudication of claims, which is the subject of an additional current Office of Inspector General review. The $21.6 million is a statistical estimate of the results of our review of an unrestricted random sample of 100 payments to hospitals or SNFs on behalf of beneficiaries enrolled in hospice programs.

Title 42, chapter IV, section 418.24(d) of the CFRs', "Waiver of Other Benefits," states that for the duration of an election of hospice care, an individual waives all rights to Medicare payments for services that are related to the treatment of the terminal condition for which the hospice care was elected or a related condition.

The HCFA categorizes hospice payment amounts into four types of hospice services...namely, routine home care, continuous home care, general inpatient care, and inpatient respite care. General inpatient care includes care provided at an inpatient facility for pain control and symptom management which cannot be managed at other settings [42 CFR 418.302(b)(4)]. For inpatient stays related to a hospice beneficiary's terminal illness, the hospital is required to bill the hospice, and the hospice bills Medicare for the inpatient stay. However, inpatient hospital stays unrelated to a hospice beneficiary's terminal illness are covered under the regular Medicare program.

Through a computer match of a file identifying Medicare beneficiaries with hospice elections in force during CYs 1988 through 1992, and hospital and SNF payments recorded in the MDRS, we identified 10,348 potential improper payments made to hospitals and SNFs on behalf of beneficiaries with hospice elections. The potential improper payments for these years totaled about $42 million.

Calendar Year	Number of Potentially Improper Payments	Amount
1988	1,262	$ 4,746,118
1989	1,767	6,664,403
1990	2,748	10,675,095
1991	2,421	9,974,991
1992	2,150	9,917,756
Total	10,348	$ 41,978,363

Our review of the 10,348 potentially improper payments was limited to an unrestricted random sample of 100 payments. To evaluate the propriety of the payments for the 100 sample items, we requested for review the corresponding beneficiary medical records from hospices and hospitals (our randomly selected sample did not include any payments to SNFs). Of the 100 medical records requested, we received 92. The medical records received were reviewed by a physician contracted by the Puerto Rico PRO to provide a medical determination regarding whether the services provided by the hospital were related to the beneficiary's terminal illness.

Upon review of the medical records, the PRO physician determined that the hospitalization of 51 hospice beneficiaries was related to the terminal illness and, therefore, the related Medicare payments to the hospitals were improper. Also, based on our sample methodology, we considered three hospital payments improper because the hospitals were nonresponsive to our repeated requests to provide the medical records. Based on the hospital payment information contained on MDRS for the 54 improper payments (51 determined to be unallowable by the PRO physician and 3 where medical records were not provided), we determined that a total of $208,873 (see Exhibit), was improperly paid to hospitals because the services were related to the beneficiary's terminal illness. As a result of our review, we statistically estimate that approximately $21,614,178 was improperly paid to hospitals and SNFs during our audit period. The $21,614,178 represents the midpoint of the 90 percent confidence interval with a precision of +/- $3,991,107.

The table below provides a breakdown by calendar year of the number of payments selected for review and those that were determined to be improper.

No. of Calendar Year	No. of Payments Reviewed	Improper Payments	Error Rate
1988	19	10	53%
1989	17	9	53%
1990	25	16	64%
1991	21	11	52%
1992	18	8	44%
Total	100	54	54%

An example of an improper payment, included in our sample, involves a beneficiary who's terminal prognosis was based on a diagnosis of multiple myeloma and alzheimer disease. The beneficiary elected to receive hospice services and was enrolled in a hospice on October 2, 1991. On October 14, 1991, with the hospice's knowledge, the beneficiary was admitted to a hospital with symptoms of dehydration and arm pain,

which were related to the diagnosis for which the beneficiary was enrolled in the hospice program. The hospital stabilized the beneficiary and provided treatment for pain and agitation. Even though the hospital and the hospice were, or should have been, aware that the hospice was responsible for reimbursing the hospital for the beneficiary's inpatient stay, the hospital submitted a claim to the Medicare FI and was improperly reimbursed by the FI for the 8 days of the inpatient stay. In this example, the hospice also claimed and was reimbursed by Medicare for the 8 days of inpatient care at the general hospice inpatient rate.

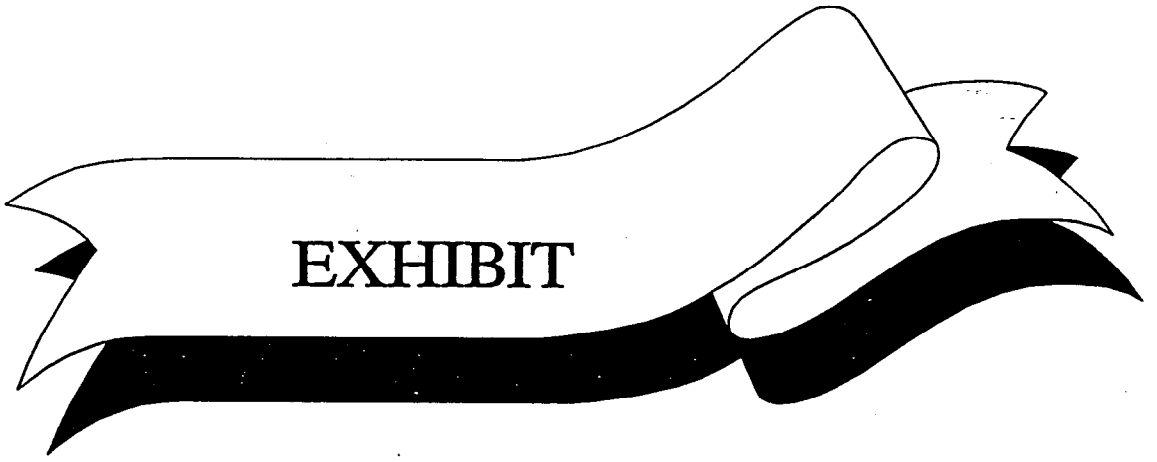
We believe that the underlying cause of improper payments to hospitals and SNFs was the lack of adequate edits in the CWF. During our review, HCFA informed us that the CWF edits started to be implemented in early CY 1991 and became fully-operational effective on or about July 1, 1991. According to HCFA, those edits were designed to identify and prevent payments to hospitals and SNFs for services provided during a beneficiary's hospice election period. We found that the potential improper payments identified in our computer match of claims data for CY 1992 (2,150), was not significantly less than the number of potential improper payments identified for prior years (CY 1991 - 2,421; CY 1990 - 2,748; CY 1989 - 1,767; CY 1988 - 1,262). Additionally, the results of our sample review, which included 18 payments in CY 1992, showed that the percentage of CY 1992 payments found to be improper (44 percent), was not significantly less than the error rates for prior years (CY 1991 - 52 percent; CY 1990 - 64 percent; CY 1989 - 53 percent; CY 1988 - 53 percent). We are, in an additional current review, evaluating the adequacy and effectiveness of the CWF system edits and the claims adjudication process and plan to review potential improper payments using 1993 hospice data.

Recommendations

We are recommending that HCFA immediately instruct the FIs to recover from the hospitals the $208,873 of improper payments identified in our review. We are also recommending that for the remainder of the potential improper payments identified by our computer match but not included in our sample review (10,248 potential improper payments for CYs 1988 through 1992), HCFA instruct the FIs to review related medical records and other available information. If the FIs determine that improper payments were made, the FIs should seek refunds of incorrect payments and make appropriate adjustments to hospital cost reports. We estimate that these reviews by FIs will generate about $21.4 million from the hospitals/SNFs.

HCFA COMMENTS TO DRAFT REPORT AND OIG RESPONSE

On March 31, 1995, HCFA responded to a draft of this report indicating concurrence with our findings and recommendations except for several suggested editorial changes. The HCFA also suggested that we add a recommendation that the FIs make appropriate adjustments to hospital cost reports. We agree, and have incorporated HCFA's proposed changes in our final report. The HCFA's comments are included in their entirety as an appendix to this report.



EXHIBIT

HOSPICE AND PART A PAYMENTS REVIEW
RESULTS OF STATISTICAL SAMPLING REVIEW
JANUARY 1, 1988 THROUGH DECEMBER 31, 1992

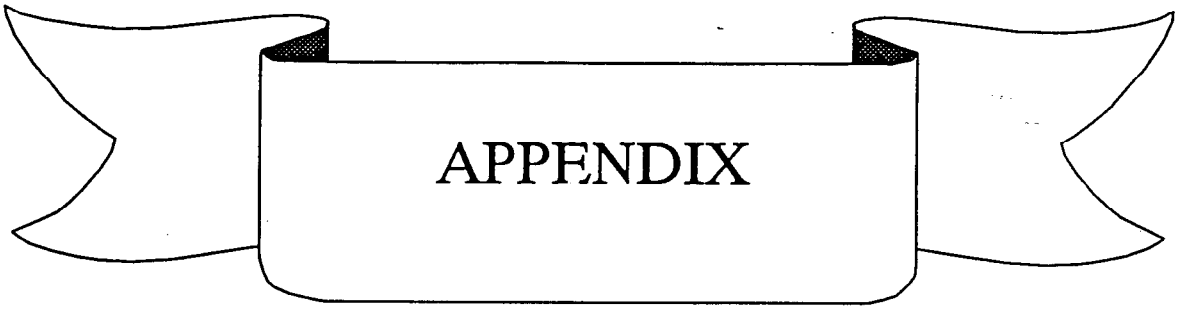
	HOSPITAL SERVICE DATES		MEDICARE PAYMENT TO HOSPITAL	RELATIONSHIP OF INPATIENT STAY TO HOSPICE RELATED DIAGNOSIS		
	FROM	TO		RELATED (IMPROPER PAYMENT)	NOT RELATED	UNABLE TO DETERMINE
1	05/30/91	06/03/91	$2,246		$2,246	
2	01/12/90	01/15/90	2,170	$2,170		
3	04/16/90	04/27/90	6,260		6,260	
4	10/22/88	10/25/88	4,100		4,100	
5	03/08/90	03/12/90	3,013	3,013		
6	10/18/89	11/20/89	5,782		5,782	
7	07/05/91	07/16/91	8,226	8,226		
8	07/19/90	08/03/90	3,458			$3,458
9	02/06/91	02/25/91	3,214	3,214		
10	06/15/89	06/17/89	3,816	3,816		
11	08/18/92	08/18/92	4,092	4,092		
12	07/29/92	08/05/92	6,378	6,378		
13	07/19/91	UNKN	1,036		1,036	
14	10/20/89	10/25/89	370		370	
15	01/28/88	02/02/88	2,693	2,693		
16	02/20/89	02/22/89	2,578		2,578	
17	02/18/88	03/06/88	2,675	2,675		
18	08/08/90	08/10/90	2,657	2,657		
19	03/16/91	03/20/91	4,683		4,683	
20	06/13/92	06/23/92	7,080		7,080	
21	02/16/90	02/21/90	7,912		7,912	
22	06/27/89	07/10/89	8,155		8,155	
23	12/24/89	12/28/89	3,708	3,708		
24	02/02/89	02/17/89	2,569	2,569		
25	07/13/90	07/21/90	3,826	3,826		
26	02/17/90	02/22/90	3,281	3,281		
27	08/10/90	08/22/90	3,186	3,186		
28	01/09/90	01/22/90	10,057	10,057		
29	08/27/88	09/13/88	7,007		7,007	
30	02/13/92	02/18/92	5,426	5,426		
31	02/05/90	02/08/90	369			369
32	01/31/91	02/08/91	3,029	3,029		
33	01/29/88	02/22/88	8,753	8,753		
34	07/23/92	07/24/92	2,753		2,753	
35	02/18/92	02/27/92	8,908		8,908	
36	07/19/91	07/23/91	4,397		4,397	
37	02/20/91	03/09/91	2,007		2,007	
38	02/01/88	02/16/88	3,708	3,708		

HOSPICE AND PART A PAYMENTS REVIEW
RESULTS OF STATISTICAL SAMPLING REVIEW
JANUARY 1, 1988 THROUGH DECEMBER 31, 1992

	HOSPITAL SERVICE DATES		MEDICARE PAYMENT TO HOSPITAL	RELATIONSHIP OF INPATIENT STAY TO HOSPICE RELATED DIAGNOSIS		
	FROM	TO		RELATED (EMPLOYER PAYMENT)	NOT RELATED	UNABLE TO DETERMINE
39	03/09/90	03/19/90	3,583	3,583		
40	05/14/89	05/19/89	7,007	7,007		
41	03/08/91	03/28/91	2,028	2,028		
42	03/10/92	03/15/92	3,261	3,261		
43	11/18/92	11/24/92	3,997	3,997		
44	05/01/92	06/02/92	4,422		4,422	
45	10/16/88	10/26/88	2,319		2,319	
46	05/19/91	05/30/91	10,262		10,262	
47	09/22/92	09/24/92	2,366		2,366	
48	11/20/89	11/27/89	3,852		3,852	
49	10/29/90	11/05/90	5,276	5,276		
50	02/12/89	02/15/89	3,439	3,439		
51	11/19/88	12/09/88	5,240	5,240		
52	06/15/91	06/17/91	5,980	5,980		
53	09/24/88	10/03/88	4,125		4,125	
54	10/14/91	10/22/91	4,556	4,556		
55	04/06/90	04/22/90	4,180	4,180		
56	02/18/88	03/03/88	3,710	3,710		
57	01/04/91	01/08/91	2,966	2,966		
58	05/23/88	06/03/88	3,043	3,043		
59	11/22/90	11/23/90	43	43		
60	11/13/92	11/19/92	4,942	4,942		
61	01/26/91	02/28/91	3,298	3,298		
62	08/26/92	09/03/92	2,661		2,661	
63	02/15/90	02/16/90	3,148	3,148		
64	10/23/90	11/05/90	3,285		3,285	
65	09/19/89	09/25/89	6,529		6,529	
66	08/17/92	09/02/92	2,806			2,806
67	05/19/91	05/27/91	2,754		2,754	
68	05/04/89	05/13/89	3,885	3,885		
69	11/05/88	11/10/88	3,004	3,004		
70	04/17/90	05/30/90	8,804		8,804	
71	07/17/88	07/20/88	1,307		1,307	
72	06/20/88	06/27/88	4,062	4,062		
73	04/11/90	04/16/90	3,717	3,717		
74	07/08/91	07/23/91	3,762	3,762		
75	05/19/89	05/20/89	2,824	2,824		
76	07/03/90	07/16/90	3,777	3,777		
77	07/02/91	07/17/91	6,743		6,743	

HOSPICE AND PART A PAYMENTS REVIEW
RESULTS OF STATISTICAL SAMPLING REVIEW
JANUARY 1, 1988 THROUGH DECEMBER 31, 1992

	HOSPITAL SERVICE DATES		MEDICARE PAYMENT TO HOSPITAL	RELATIONSHIP OF INPATIENT STAY TO HOSPICE RELATED DIAGNOSIS		
	FROM	TO		RELATED (IMPROPER PAYMENT)	NOT RELATED	UNABLE TO DETERMINE
78	11/14/90	11/17/90	3,884		3,884	
79	06/15/91	06/24/91	7,137			7,137
80	05/17/91	05/25/91	4,523	4,523		
81	11/06/90	11/15/90	2,082		2,082	
82	10/14/88	10/28/88	9,738		9,738	
83	12/02/90	12/15/90	3,626		3,626	
84	10/29/89	11/08/89	4,831		4,831	
85	10/20/90	10/21/90	3,452	3,452		
86	04/16/88	04/20/88	3,534		3,534	
87	09/24/89	10/03/89	4,847	4,847		
88	09/05/92	09/10/92	3,717	3,717		
89	09/27/92	10/16/92	5,471		5,471	
90	10/17/92	10/19/92	3,298	3,298		
91	05/08/88	06/13/88	8,671		8,671	
92	02/22/91	03/01/91	3,367		3,367	
93	01/30/89	02/06/89	1,452	1,452		
94	09/17/88	10/02/88	3,473	3,473		
95	05/02/91	05/05/91	2,837	2,837		
96	06/14/92	06/19/92	2,562		2,562	
97	04/18/89	04/20/89	2,919			2,919
98	04/27/92	06/01/92	1,674		1,674	
99	01/12/90	01/19/90	69	69		
100	08/03/88	08/09/88	1,967		1,967	
			$411,672	$208,873	$186,110	$16,689


APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date MAR 31 1995

From Bruce C. Vladeck
Administrator

Subject Office of Inspector General (OIG) Draft Report: "Review of Improper Payments Made to Hospitals and Skilled Nursing Facilities for Beneficiaries Electing Hospice Benefits" (A-02-93-01029)

To June Gibbs Brown
Inspector General

We reviewed the above-referenced report in which OIG concluded that hospitals and skilled nursing facilities were improperly paid for services provided to Medicare beneficiaries enrolled in hospice programs.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this draft report. Please contact us if you would like to discuss our comments and response.

Attachment

IG
SAIG
PDIG ✓
DIG-AS
DIG-EI
DIG-OI
AIG-CFAA
AIG-MP
OGC/IG ✓
EXSEC
DATE SENT 4/6

Health Care Financing Administration's (HCFA) Comments
on Office of Inspector General (OIG) Draft Report:
"Review of Improper Payments Made to Hospitals and Skilled
Nursing Facilities for Beneficiaries Electing Hospice Benefits"
(A-02-93-01029)

Recommendation 1

HCFA should immediately instruct the fiscal intermediaries (FI) to recover from the hospitals the $208,873 of improper payments identified in our report.

HCFA Comments

We concur, and HCFA will take appropriate action to recover payments determined to be improper after we review the payments identified in your review.

Recommendation 2

HCFA should instruct the FIs to review related medical records for the remainder of the potential improper payments identified by OIG's computer match but not included in their sample review (10,248 potential improper payments for calendar years 1988 through 1992) and, where appropriate, seek refunds of incorrect payments.

HCFA Comments

We concur; however, we believe the recommendation should state that FIs should be instructed to review medical records or other information to determine if payments were proper. If FIs discover that improper payments were made, HCFA will then instruct them to ensure that the Medicare charge data used in the hospital(s) cost report settlement reflect only covered charges.

Technical Comments

Page 2, first paragraph, second sentence should be changed to the following, "Hospice care emphasizes supportive (palliative) services, such as pain control and symptom management, rather than curative care."

Page 2, second paragraph, last sentence should be modified by removing the last two words, "with hospitals", and replacing them with "with participating Medicare or Medicaid facilities or by providing inpatient care directly."