DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JAN 15 1997

From June Gibbs Brown
Inspector General

Subject OPERATION RESTORE TRUST--Review of Hospice Eligibility at the Visiting Nurse Association of Texas (CIN: A-06-96-00027)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on January 16, 1997 of our final report. A copy is attached.

The objective of our review was to evaluate hospice eligibility determinations for beneficiaries that remained in hospice care for more than 210 days. We also determined the amount of payments made to the Visiting Nurse Association of Texas (VNA) for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

Our review included a medical evaluation of VNA's eligibility determinations for 77 Medicare beneficiaries who had been in hospice care for more than 210 days. Of the 77 cases, 55 were active in hospice at the time of our review and represent 28 percent of the 199 patients who were active Medicare hospice beneficiaries at VNA as of February 8, 1996. Our review showed that 25 beneficiaries were not eligible for hospice coverage at the time of admission. One of these 25 beneficiaries became eligible 4 months after his first admission.

Our medical determinations were made by physicians who were consultants to the Texas Medical Foundation, the Texas Peer Review Organization (PRO). Staff from the fiscal intermediary, Palmetto Government Benefits Administrators (PGBA), have also reviewed narrative information written by the PRO physicians as well as data extracted from medical files for each of the 77 cases. The PGBA agrees with the PRO's decisions.

We believe the identified discrepancies with the 25 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files. The VNA received Medicare payments for hospice services totaling $1,242,806 for ineligible patients.

We are recommending that the intermediary:

- Recover payments of $1,242,806 for the 25 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of ineligible beneficiaries after February 29, 1996.

- Coordinate with the Health Care Financing Administration (HCFA) in providing training to hospice providers and physicians on eligibility requirements for hospice beneficiaries, particularly the requirement for a 6-month prognosis.

- Analyze utilization trends to identify hospices with large increases in claims for beneficiaries with over 210 days of hospice coverage and conduct medical reviews on a sample of their claims.

- Conduct periodic reviews of hospice claims to ensure the hospices are obtaining sufficient medical information to make valid eligibility determinations.

The intermediary responded to a draft of this audit report on November 18, 1996. The intermediary officials have reviewed information that we provided and they concur with the eligibility determinations made by the PRO physicians. However, they stated that they would be reluctant to recover payments. These officials believe that the beneficiary would be held liable in these situations and HCFA had instructed them to educate providers rather than deny services for the time period in question. The intermediary officials stated that hospice data is currently included in the intermediary's focused medical review data analysis process and its education department regularly conducts education workshops on eligibility requirements for hospice providers and physicians. A copy of the intermediary's full response is included as an appendix to this report.

We will be working with HCFA on the beneficiary liability issue and the recovery of overpayments from the hospice.

If you wish to discuss this information further, please contact:

Donald L. Dille
Regional Inspector General
for Audit Services
Region VI
(214) 767-8415

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OPERATION RESTORE TRUST REVIEW OF HOSPICE ELIGIBILITY AT THE VISITING NURSE ASSOCIATION OF TEXAS

JUNE GIBBS BROWN
Inspector General

JANUARY 1997
A-06-96-00027

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 4A5
Dallas, TX 75242

Common Identification Number: A-06-96-00027

Mr. Bruce Hughes
Vice President, Medicare Operations
Palmetto Government Benefits Administrators
Columbia, South Carolina 29202

Dear Mr. Hughes:

This report provides you with the results of our audit of Medicare hospice beneficiary eligibility determinations at the Visiting Nurse Association of Texas Hospice (VNA) in Dallas, Texas. This audit was part of Operation Restore Trust (ORT), a joint initiative among various Department of Health and Human Services components. The ORT seeks to identify specific vulnerabilities in the Medicare program and pursue ways to reduce Medicare's exposure to abusive practices.

EXECUTIVE SUMMARY

Our objective was to evaluate hospice eligibility determinations for beneficiaries in hospice care for more than 210 days and who were active in the hospice program on February 8, 1996 or had been discharged for reasons other than death during the prior 37 months. We also determined the amount of payments made to VNA for those beneficiaries who did not meet the Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Our audit included a medical evaluation of VNA's eligibility determinations for 77 beneficiaries. This evaluation showed that 25 beneficiaries were not eligible for hospice coverage at the time of admission. One of these 25 beneficiaries became eligible 4 months after his first admission.

Medicare regulations state that an individual must be terminally ill with a life expectancy of 6 months or less in order to be eligible for hospice benefits. The regulations also require that the clinical records for each individual contain assessment information, a plan of care, pertinent medical histories and complete documentation of all services and events.

Our audit was a limited review of VNA's activities. We did not review the hospice eligibility determinations for all Medicare beneficiaries who were or had been in the VNA program. We limited our review to hospice beneficiaries with over 210 days of hospice coverage as of February 8, 1996 and who were still active in hospice or had been discharged for reasons other

than death between the period January 1, 1993 and February 8, 1996. We offer no opinion nor have any conclusion on the accuracy of payments made to VNA outside the scope of our audit.

We identified 77 Medicare beneficiaries who met the criteria of our audit scope. To place the scope of our audit (77 cases) in perspective, we offer the following comparisons:

- There were 199 Medicare beneficiaries in VNA's program as of February 8, 1996. We found that 55 (28 percent) of these 199 active Medicare beneficiaries had been in hospice care beyond 210 days (7 months).

- Medicare lengths of stay in VNA's hospice care averaged 42 days compared to 38 days of service for non-Medicare patients, during Fiscal Year (FY) 1994. The national average length of stay for all Medicare hospice beneficiaries for FY 1994 was 64 days.

- Medicare payments made to VNA were approximately $24.4 million during the period February 13, 1991 through February 29, 1996. Our audit showed that $1.2 million (5 percent) of this total related to beneficiaries ineligible for hospice care.

We believe the identified discrepancies with the 25 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files. Based on determinations made by physicians who were consultants to the Texas Medical Foundation, the Texas Peer Review Organization (PRO), we believe that the payments by Medicare to VNA, amounting to $1,242,806, were inappropriate.

We are recommending that the intermediary:

- Recover payments of $1,242,806 for the 25 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of ineligible beneficiaries after February 29, 1996.

- Coordinate with the Health Care Financing Administration (HCFA) in providing training to hospice providers and physicians on eligibility requirements for hospice beneficiaries, particularly the requirement for a 6-month prognosis.

- Analyze utilization trends to identify hospices with large increases in claims for beneficiaries with over 210 days of hospice coverage and conduct medical reviews on a sample of their claims.

- Conduct periodic reviews of hospice claims to ensure the hospices are obtaining sufficient medical information to make valid eligibility determinations.

The intermediary responded to a draft of this audit report on November 18, 1996. The intermediary officials have reviewed information that we provided and they concur with the eligibility determinations made by the PRO physicians. However, they stated that they would be reluctant to recover payments. These officials believe that the beneficiary would be held liable in these situations and HCFA had instructed them to educate providers rather than deny services for the time period in question. The intermediary officials stated that hospice data is currently included in the intermediary's focused medical review data analysis process and its education department regularly conducts education workshops on eligibility requirements for hospice providers and physicians. A copy of the intermediary's full response is included as an appendix to this report.

BACKGROUND

The Visiting Nurse Association of Texas

The Visiting Nurse Association of Texas is a non-profit corporation, based in Dallas, Texas, which began hospice services in 1978. It is licensed by the Texas Department of Health as a Home and Community Support Services Agency to provide hospice services. During its Fiscal Year 1995, the VNA cared for 1,643 patients in 36 Texas counties and has offices providing hospice services in Fort Worth, Denton, McKinney, Kaufman and Brownwood, Texas. As of February 29, 1996, the VNA was serving approximately 230 patients with 90 employees, including physicians, nurses, medical social workers, pastoral counselors, home health aides, therapists and volunteers. The enrolled patient status was as follows:

Hospice Care Paid By:	Percentage
Medicare	68.6%
Medicaid	14.0%
Insurance, Grants and Self-Pay	13.5%
Community Funds	3.3%

Regulations

The Tax Equity and Fiscal Responsibility Act of 1982 provided for hospice care services under Medicare, beginning in November 1983. Hospice care is a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. This type of care emphasizes supportive services, such as home care and pain control, rather than the cure-oriented services that are otherwise the primary focus of the Medicare program. According to § 1861 (dd) of Title XVIII of the Social Security Act, which sets forth provisions for hospice care, benefits covered by Medicare include the following services and supplies:

Nursing Care	Short-term Inpatient Care
Medical Social Services	Medical Appliances & Supplies
Physicians' Services	Home Health Aid & Homemaker Services
Counseling Services To Include: Dietary & Bereavement	Physical Therapy, Occupational Therapy, Speech-Language Pathology Services

Hospice services are covered by Medicare only for those individuals who are eligible for Part A Medicare benefits and who are certified as terminally ill. For purposes of the hospice program, a beneficiary is terminally ill if the medical prognosis of the patient's life expectancy is 6 months or less, anticipating that the terminal illness runs its normal course. The certification must be made by a hospice physician and, if applicable, the beneficiary's attending physician. Federal regulations require that medical records be maintained for every individual receiving hospice care and services.

Subject to physicians' certifications, enrollment in the hospice program is by voluntary election of the Part A Medicare beneficiary who may choose to withdraw (revoke) from the program at any time. The election is for four distinct periods--the first two for 90 days, the third for 30 days and a fourth for an indefinite period of time. The first three election periods total 210 days of hospice care. The hospice may also discharge patients from the hospice program if, for example, the patient's health condition is no longer terminal. As of the date of our review, 4,084 Medicare patients had been admitted to VNA's hospice care, since January 1, 1993.

In addition to the Code of Federal Regulations (CFR) for Public Health (Title 42), which implements § 1861(dd) of the Social Security Act, hospices are guided by HCFA's Medicare Hospice Manual. This document provides instructions for implementing the provisions of Medicare law and regulations, particularly as they relate to the hospice benefits. It amplifies the basic statutory provisions for coverage of services and the requirements which must be met for Medicare payment to be made. The manual also contains information the hospice may need to answer questions which patients often ask about the program and helps to assure that the law is uniformly applied nationally without regard to where covered services are furnished.

Intermediary Responsibilities

The HCFA has designated eight regional hospice intermediaries (RHHIs) to process bills and to reimburse hospices for services provided to Medicare patients. The intermediary is further responsible for communicating to providers, any information or instructions furnished by HCFA. The New Mexico Blue Cross and Blue Shield, Inc. (NMBCBS) was the regional intermediary for VNA until November 30, 1995. However, HCFA has contracted with the Palmetto Government Benefits Administrators (PGBA) in South Carolina to serve as the RHHI since this date. There

were no officials at the former regional intermediary, NMBCBS, with which we could discuss the results of our audit. We, therefore, are addressing these matters to the succeeding RHHI, PGBA.

OBJECTIVE, SCOPE & METHODOLOGY

Objective

The objective of this audit was to evaluate hospice eligibility determinations for beneficiaries in hospice care for more than 210 days and who were either active in hospice as of February 8, 1996 or discharged for reasons other than death, from January 1, 1993 to February 8, 1996. We also determined the amount of payments made to VNA for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

Scope

Our audit was conducted in accordance with generally accepted government auditing standards. We interviewed VNA staff and spoke with officials from the RHHIs and the Texas Department of Health. We reviewed hospice policies and procedures, patient census data and medical records for Medicare beneficiaries. We selected VNA for review in the State of Texas, based on higher levels of Medicare beneficiary activity as indicated by HCFA's Medicare Enrollment Database maintained by the Bureau of Data Management and Strategy.

We limited our audit to Medicare beneficiaries at VNA with over 210 days of hospice care as of February 8, 1995, and who were active in the hospice program or who had been discharged for reasons other than death, later than January 1, 1993. The beneficiaries were selected from current enrollment data maintained by VNA. Of the 77 Medicare beneficiaries who met our selection criteria, 55 were active hospice Medicare beneficiaries on February 8, 1996 and 22 had been discharged for reasons other than death. The VNA's Medicare beneficiary census on February 8, 1996 was 199; thus, the 55 active hospice beneficiaries that were included in our review represented 28 percent of the total active Medicare beneficiaries at that time.

We did not review the overall internal control structure at the hospice. Our internal control review was limited to obtaining an understanding of the hospice's admission and recertification procedures. We did not test the internal controls because the objective of this audit was accomplished through substantive testing. We conducted our field work at the VNA location in Dallas, Texas, from February 12, 1996 through February 29, 1996.

Methodology

The HCFA arranged for the PRO to provide medical review assistance. The PRO consulting physicians reviewed patients' medical records and determined whether the hospice's initial determinations of beneficiary eligibility were correct. The PRO physicians reviewed the intake forms, the plans of care, nurses' and social work assessments, activity sheets, nurses' aide notes

and the patients' history and physical. They also reviewed medical documentation, subsequent to the period of admission, to determine whether any of the ineligible patients had become eligible since their admission to VNA.

A beneficiary was determined ineligible if, in the opinion of the PRO physician, the clinical evidence of the patient's condition, contained in the medical record, indicated at the time of initial certification that the beneficiary had a life expectancy of greater than 6 months. There was sufficient documentation, in each patient's medical record reviewed, to allow for a determination by the PRO physician.

Our calculation of the payments made to VNA, on behalf of Medicare beneficiaries in the hospice, was based on beneficiary history information. This payment data is provided in HCFA's Health Insurance Master Record which includes hospice claim data stored in HCFA's Common Working File.

DETAILED RESULTS OF REVIEW

Twenty-five cases of the 77 selected for review did not meet Medicare guidelines for determining eligibility, at the time of admission. However, the PRO physicians determined that one of these beneficiaries later became eligible, based on changes in his health condition. We believe the identified problems occurred due to inaccurate prognoses of life expectancy by hospice physicians. Furthermore, the clinical data documented in the patients' files could not support the patients' prognoses of less than 6 months to live. As a result, the VNA received $1,242,806 for the 25 ineligible beneficiaries.

Criteria for Certification of Hospice Services

The 42 CFR 418.20 states that in order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and certified as being terminally ill in accordance with § 418.22. The initial certification must include the statement that the individual has a medical prognosis that his or her life expectancy is 6 months or less. This first certification must be signed by a hospice physician and the patient's attending physician if the individual has an attending physician. The hospice physician must certify that the beneficiary is terminally ill for each of the three subsequent periods of hospice coverage, including the fourth indefinite period.

The periods are (1) an initial 90-day period, (2) a subsequent 90-day period, (3) a subsequent 30-day period, and (4) a subsequent extension period of unlimited duration during the individual's lifetime.

The medical data that PRO physicians used to evaluate Medicare beneficiary eligibility was that required by Medicare as a condition of participation in the Medicare hospice program. According to 42 CFR 418.74, these records must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. Each individual's record must

contain: (1) the initial and subsequent assessments; (2) the plan of care; (3) identification data; (4) consent and authorization and election form; (5) pertinent medical history; and (6) complete documentation of all services and events (including evaluations, treatment, progress notes, etc.). If a hospice complies with the condition of participation, with regard to clinical records, then the information contained in the Medicare patient files, which our professionals reviewed, should be sufficient to allow for accurate certifications of terminal illness.

Analysis of Cases Reviewed

The PRO physicians, who assisted us in this review determined that the medical records for 25 beneficiaries did not support a determination that the beneficiary had an illness that would have been terminal within 6 months if the illness followed its normal course. Based upon information in the medical records, one of these 25 beneficiaries became eligible 4 months after his first admission.

We analyzed 77 cases and the corresponding lengths of service as of February 8, 1996. The length of service for each case ranged between 210 and 1,390 days, averaging 530 days or 18 months These beneficiaries had all been certified and recertified as having a life expectancy of 6 months or less (180 days).

The following is a summary of primary diagnoses for these beneficiaries.

Classification of Disease	Number of Ineligible Beneficiaries
Diseases of the Circulatory System	
Cerebrovascular Accident	2
Congestive Heart Failure	1
Cardiomyopathy	2
Cerebral Hemorrhage	1
Diseases of the Nervous System	
Alzheimer's Disease	1
Parkinson's Disease	3
Neoplasms	
Prostate	4
Colon Cancer	1
Lung cancer	2
Breast	1
Abdomen	1
Respiratory System	
Chronic Obstructive Pulmonary Disease	2
Emphysema	2
Lung Lesions	1
Infectious and Parasitic Disease	
AIDS	1
Totals	25

Although the diagnoses for the 25 beneficiaries indicated serious medical conditions, the PRO physicians did not find adequate justification in the medical records for VNA's determinations that, at the time of admission, the conditions would result in a life expectancy of 6 months or less. For these 25 cases, the PRO physicians concluded that the individual was not eligible for hospice services. In addition to making a preliminary determination of eligibility, we asked the physicians to assure us that the ineligible patients did not become eligible subsequent to admission. Based on information contained in the medical files, one patient was found to later become eligible, due to a change in his medical condition. We excluded, from our monetary finding, amounts paid by Medicare to VNA for services rendered during the period that this one patient was determined eligible for hospice care.

Cause of Incorrect Eligibility Determinations

As noted in the criteria above, a patient must be certified by the hospice physicians and the patient's attending physician (if there is one), as having a need for hospice care at the time of enrollment. The hospice physicians must also certify to the patient's eligibility for subsequent periods of enrollment. All patients, for which we reviewed records, were in hospice care for a time beyond their third election period, and therefore, the fourth certification by hospice physicians. We believe the identified discrepancies with the 25 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians. The medical records for these 25 beneficiaries did not support a determination that the beneficiaries had an illness that would have been terminal within 6 months if the illness followed its normal course.

Effect

We determined the amount of Medicare payments VNA received, on behalf of the 25 patients, based on data included in HCFA's Common Working File history for designated beneficiaries. According to the payment data included on those records through February 29, 1996, the VNA received $1,242,806 for the 25 ineligible beneficiaries. Sixteen of these beneficiaries were active at the time of our review and VNA may have received additional payments on behalf of these beneficiaries.

Intermediary Officials' Preliminary Comments

We met with PGBA officials in Camden, South Carolina on May 1, 1996, to explain the nature of our audit work related to hospice activities and to discuss the results of our review. We gave these officials copies of the PRO physicians' narratives and other documents, such as plans of care and nurses' assessments, which the physicians used in reaching their determinations. We asked that, after reviewing this information, they share with us their opinion of our approach and if they agree, from a preliminary perspective, with our findings.

As a result of its own work, PGBA firmly believed that a large number of Medicare beneficiaries did not qualify for hospice care, as highlighted by the OIG's review. Overall, PGBA found that the level of ineligible beneficiaries, shown by the OIG, was very comparable to eligibility studies that they have conducted in past years.

RECOMMENDATIONS

We recommend that the intermediary:

- Recover payments of $1,242,806 for the 25 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice care after February 29, 1996.

- Coordinate with HCFA in providing training to hospice providers and physicians on eligibility requirements for hospice beneficiaries, particularly the requirement for a 6-month prognosis.

- Analyze utilization trends to identify hospices with large increases in claims for beneficiaries with over 210 days of hospice coverage and conduct medical reviews on a sample of their claims.

- Conduct periodic reviews of hospice claims to ensure that the hospices are obtaining sufficient medical information to make valid eligibility determinations.

INTERMEDIARY'S RESPONSE

On November 18, 1996, the intermediary responded to a draft of this audit report. The PGBA officials have reviewed information that we provided as noted on page 8 above, and they concur with the eligibility determinations made by the PRO physicians. However, they stated that they would be reluctant to recover payments. These officials believe that the beneficiary would be held liable in these situations and HCFA had instructed them to educate providers rather than deny services for the time period in question. The PGBA officials stated that hospice data is currently included in the intermediary's focused medical review data analysis process and its education department regularly conducts education workshops on eligibility requirements for hospice providers and physicians. A copy of the intermediary's full response is included as an appendix to this report.

We will be working with HCFA on the beneficiary liability issue and the recovery of overpayments from the hospice.

Final determinations as to the actions to be taken on all matters reported will be made by the Department of Health and Human Services official identified below. An action official representative will contact you in the near future. This report includes your response to the findings, however, you may want to update or provide any additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5)

Sincerely yours,

Donald L. Dille
Regional Inspector General
for Audit Services

HHS Action Official
Associate Regional Administrator
Division of Medicare
Health Care Financing Administration, Region VI
1200 Main Tower, Room 2000
Dallas, Texas 75202

APPENDIX

Medicare
Palmetto Government Benefits Administrators
Part A Intermediary, Regional Home Health Intermediary
2300 Springdale Drive, Post Office Box 7004
Camden, South Carolina 29020-7004

Common Identification Number: number deleted by the OIG
inserted by the OIG: A-06-96-00027

November 18, 1996

Donald L. Dille
Regional Inspector General for
Audit Services
Office of Inspector General
1100 Commerce, Room 4A5
Dallas, TX 75242

Dear Mr. Dille,

This letter is in response to your draft audit report entitled, Medicare Hospice Beneficiary Eligibility Determinations at the deleted by the OIG Visiting Nurse Association of Texas (VNA) in Dallas, Texas.

Although we would concur with the eligibility determinations as indicated in your report, we would be reluctant to recover payments. The beneficiary would be held liable in these situations and HCFA had instructed us to educate providers rather than deny services for the time period in question.

Hospice data is currently included in our focused medical review data analysis process. Edits are established when appropriate. Our education department regularly conducts education workshops on eligibility requirements for hospice providers and physicians.

We appreciate the opportunity to provide comments on this draft report.

Sincerely,

Don G. Wells

Don G. Wells

Director, Medicare Part A

Medical Review and MSP