Memorandum

Date NOV 13 1996

From for June Gibbs Brown
Inspector General

Subject OPERATION RESTORE TRUST--Review of Hospice Eligibility at the Hospice of Lake & Sumter, Inc. (A-04-95-02110)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on November 15, 1996 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 Hospice of Lake & Sumter, Inc. (Lake & Sumter) for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

Our review included a medical evaluation of Lake & Sumter's eligibility determinations for 147 beneficiaries who had been in hospice care for more than 210 days. Of the 147 cases, 93 were active in hospice at the time of our review and represented 36 percent of the total active Medicare hospice beneficiaries (260) at Lake & Sumter as of April 30, 1995. The review showed that:

- 71 of the beneficiaries were not eligible for hospice coverage; and
- for 45 beneficiaries, we were unable to conclusively determine their terminal illness.

Our medical determinations were made by physicians employed by or under contract with the Medicare peer review organization (PRO) for Florida. In addition, 30 cases reviewed by the PRO were also reviewed by fiscal intermediary (FI) Medical staff as part of their initial review of all the cases. The FI agreed with all 30 of the PRO's decisions.

We believe the identified problems occurred for the 71 beneficiaries because hospice physicians made inaccurate prognoses of life expectancy based on the medical evidence in the patients' files . For the 45 beneficiaries, the evidence in the patients' medical files was not sufficient to determine that the beneficiary was terminally ill.

Lake & Sumter received improper Medicare payments totaling $4 million for the 71 ineligible beneficiaries and $2.5 million relating to 45 beneficiaries for whom we were unable to determine that a terminal illness existed at the time of admission to the hospice.

We are recommending the intermediary:

- Recover payments of $4 million for the 71 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice care after December 31, 1995.

- Conduct medical reviews of the 45 cases, for which the hospice received $2.5 million, that we were unable to conclusively determine that the beneficiary was terminally ill. Based on the results of these reviews, take appropriate action to recover amounts determined to be overpayments.

- 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 on September 26, 1996 to a draft of this audit report. Aetna generally agreed with our recommendations and stated it is committed to working closely with HCFA to strengthen program procedures and controls to ensure proper payment of hospice claims.

For further information, contact:

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV
(404) 331-2446, extension 102

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OPERATION RESTORE TRUST

REVIEW OF HOSPICE ELIGIBILITY AT THE HOSPICE OF LAKE & SUMTER, INC.

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1996
A-04-95-02110

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
P.O. BOX 2047
ATLANTA, GEORGIA 30301

November 15, 1996

CIN: A-04-95-02110

Mr. Reginald R. Williams, Vice President
AHP-Medicare Administration, MAA8
151 Farmington Avenue
Hartford, Connecticut 06156

Dear Mr. Williams:

This report provides you with the results of our audit of Medicare hospice beneficiary eligibility determinations at the Hospice of Lake & Sumter, Inc. (Lake & Sumter) in Tavares, Florida. This audit was part of a joint initiative among various Department of Health and Human Services components called Operation Restore Trust (ORT). The ORT seeks to identify specific vulnerabilities in the Medicare program and pursue ways to reduce Medicare exposure to abusive practices. The hospice audits focused on Medicare beneficiaries in hospice care for at least 210 days.

EXECUTIVE SUMMARY

OBJECTIVE

The objective of our review was to evaluate hospice eligibility determinations for beneficiaries in hospice care for more than 210 days. We also determined the amount of overpayments made to Lake & Sumter for those Medicare beneficiaries that did not meet Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Our review included a medical evaluation of Lake & Sumter's eligibility determinations for 147 beneficiaries who had been in hospice care for more than 210 days. The evaluations of the medical records showed that:

- 71 of the beneficiaries were not eligible for hospice coverage; and
- for 45 beneficiaries, we were unable to conclusively determine their terminal illness.

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 the hospice operation. We did not review the hospice eligibility determinations for all Medicare beneficiaries who were or had been in the program. We limited our review to hospice beneficiaries with over 210 days of hospice coverage as of April 30, 1995 and who were still active in hospice or had been discharged for reasons other than death between the period January 1, 1993 and April 30, 1995. We offer no opinion nor have any conclusion on the accuracy of payments made to the hospice outside the scope of our audit.

We identified 147 Medicare beneficiaries who met the criteria of our audit scope. To place the scope of our audit (147 cases) in perspective, we offer the following comparisons:

- There were 260 Medicare beneficiaries in the hospice as of April 30, 1995. We found that 93 (36 percent) of these had been in hospice care beyond 210 days (7 months).

- Medicare length of stays in the hospice averaged 177 days compared to 120 days for non-Medicare hospice stays for Fiscal Year (FY) 1994. The national average length of stay for all Medicare hospice beneficiaries for FY 1994 was 59 days.

- Medicare payments made to Lake & Sumter totaled $24.8 million during the period October 1, 1990 through December 31, 1995. Our review showed that $6.5 million (26 percent) of this total related to beneficiaries that our review showed were ineligible for hospice care or for those that we were unable to determine that they were terminally ill.

Our medical determinations were made by physicians who were employed by or under contract to Florida Quality Assurance Inc., the Florida Medicare Peer Review Organization (PRO).

We believe the identified problems with the 71 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files. For the 45 beneficiaries, we do not believe that sufficient evidence was present in the medical files to support the fact that the beneficiaries had a terminal illness.

We believe these cases need to be further reviewed by the fiscal intermediary to ensure that providing Medicare hospice payments is appropriate. Lake & Sumter received Medicare payments totaling $4 million for the 71 ineligible beneficiaries and $2.5 million relating to 45 beneficiaries placed in the questionable category.

RECOMMENDATIONS

We recommend the intermediary:

- recover payments of $4 million for the 71 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice after December 31, 1995.

- conduct medical reviews of the 45 cases, for which the hospice received $2.5 million, that did not contain sufficient documentation to determine hospice eligibility. Based on the results of these reviews, take appropriate action to recover amounts determined to be overpayments.

- 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.

On September 26, 1996, the intermediary responded to a draft of this audit report. Aetna stated that in general, it agreed that strong procedural controls and review activities would ensure hospice benefits are properly paid, has historically included hospice claims in program safeguard activities, has worked with HCFA in an effort to prevent inappropriate payments, and is committed to working closely with HCFA to strengthen program procedures and controls to ensure proper payment of hospice claims. The intermediary's written comments in their entirety are included as Appendix B to this report.

BACKGROUND

Hospice of Lake & Sumter

Lake & Sumter began services in 1984. It is a private, not-for-profit community health care organization serving Lake and Sumter counties. Lake & Sumter serves Medicare under the provisions of a certificate of need issued by the State of Florida. From January 1, 1991 to August 31, 1995, Lake & Sumter admitted 2,913 Medicare patients. The hospice estimated the average daily census at the time of our review was 251 patients. Care is delivered by more than 200 health care professionals and more than 300 volunteers.

Regulations

Title XVIII Section 1861(dd) of the Social Security Act set forth the provisions for hospice care. Hospice is an approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption in normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, social, psychological, emotional, and spiritual services through the use of a broad spectrum of professional and other care-givers with the goal of making the individual as physically and emotionally comfortable as possible.

In order to be eligible for hospice care under Medicare, an individual must be entitled to Part A benefits and be certified as terminally ill by a hospice physician and, where applicable, the beneficiary's attending physician. For purposes of the hospice program, a beneficiary is deemed to be terminally ill if the medical prognosis of the patient's life expectancy is 6 months or less if the terminal illness runs its normal course. Federal regulations require that medical records be maintained for every individual receiving hospice care and services.

A Medicare beneficiary's inclusion in the hospice program is voluntary and can be revoked at any time by the beneficiary. A hospice may discharge a patient if it concludes the patient no longer meets the definition of terminally ill. The beneficiary has four election periods for hospice care and must be certified as terminally ill for each of those periods. The first and second election periods are 90 days each, the third election period is 30 days and the fourth and last election period has an indefinite duration. The first 3 election periods total 210 days of service.

Intermediary Responsibilities

The HCFA has designated eight regional intermediaries to service hospices. Aetna Life Insurance Company (Aetna) in Clearwater, Florida is the Regional Home Health Intermediary that serves Lake & Sumter. The intermediary is responsible for

administrative duties including making payments to providers and serving as a center for and communicating to providers, any information or instructions furnished by HCFA.

OBJECTIVE, SCOPE & METHODOLOGY

Objective

The objective of our review 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 April 30, 1995 or had been discharged for reasons other than death from January 1, 1993 to April 30, 1995. We also determined the amount of payments made to Lake & Sumter for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

Scope

Our review was conducted in accordance with generally accepted government auditing standards. We limited our review to hospice beneficiaries with over 210 days of hospice coverage and who were still active as of April 30, 1995 or had been discharged for reasons other than death later than January 1, 1993. These beneficiaries were selected from the Medicare Enrollment Database maintained by HCFA's Bureau of Data Management and Strategy. A total of 147 Medicare beneficiaries met our selection criteria and were included in the review. Of the 147, 93 were active hospice Medicare beneficiaries and 54 had been discharged for reasons other than death. Lake & Sumter's Medicare census on April 30, 1995 was 260; thus, the 93 active hospice beneficiaries that were included in our review represented 36 percent of the total active Medicare beneficiaries at that time.

We did not review the overall internal control structure at the intermediary or hospice. Our internal control review was limited to obtaining an understanding of the hospice's admission and recertification procedures and the intermediary's procedures for reviewing claims and provider audit activities. We did not test the internal controls because the objective of our review was accomplished through substantive testing. Field work was conducted from September to December 1995 at the offices of Lake & Sumter in Tavares, Florida.

Methodology

The HCFA arranged for the PRO to provide us medical review assistance. Either a PRO physician or a PRO contracted physician reviewed the patients' clinical records and determined whether the hospice's initial determinations of beneficiary eligibility were correct. A beneficiary was deemed ineligible if 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. If there was insufficient

clinical evidence to support a prognosis of 6 months or less, the PRO physician made no determinations of eligibility, but included those cases in a "could not determine" category. As part of the medical review, the PRO physician considered the terminal diagnosis and other factors contained in the medical file such as the certification of terminal illness, the beneficiary election form, the plan of care, the beneficiary's medical history, hospital and medical laboratory reports, and the hospice physician's and nurses' notes.

Our calculation of the payments made on behalf of ineligible beneficiaries or beneficiaries whose medical records did not contain sufficient information to make a determination was based on payment history data obtained from Aetna.

Thirty cases which the PRO physician determined were ineligible or lacking sufficient evidence to make a determination were reviewed by medical staff from Aetna. In all 30 cases, the PRO determination was affirmed.

DETAILED RESULTS OF REVIEW

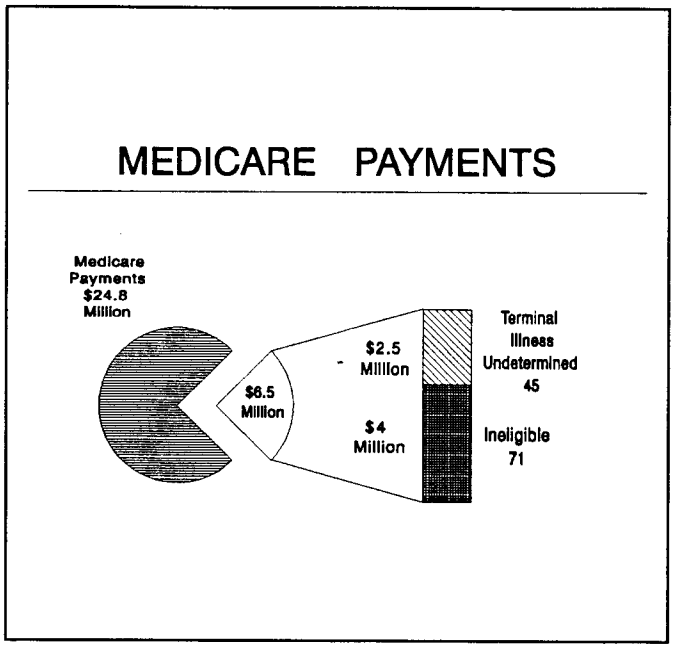
Our review, which included a medical evaluation of Lake & Sumter's eligibility determinations, showed that:

- the medical records for 71 of the beneficiaries did not support a determination that the beneficiary had an illness that would have been terminal within 6 months if the illness followed a normal course; and

- the medical records for 45 beneficiaries did not contain sufficient medical information to determine the terminal illness of the beneficiary.

The medical determinations were made by physicians who were employed by or under contract with the PRO.

We believe the identified problems occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files or because the hospice physicians certified beneficiaries as terminal based on insufficient clinical data.



The amount of Medicare payments Lake & Sumter received on behalf of the 116 beneficiaries was ascertained from payment files provided by Aetna. According to the payment data included on those files through December 31, 1995, Lake & Sumter received $4 million for the 71 ineligible beneficiaries and $2.5 million relating to 45 beneficiaries for whom the PRO physicians were unable to determine terminal illness based on the medical records maintained by Lake & Sumter. These payments represented 26 percent of total Medicare payments of $24.8 million that Lake & Sumter received between January 1, 1991 and December 31, 1995. Some of these beneficiaries were active at the time of our review and Lake & Sumter may still be receiving payments on behalf of these beneficiaries.

Of the 147 beneficiaries selected for review, 93 were still active as of April 30, 1995. The 93 beneficiaries still active as of April 30, 1995 represented 36 percent of the actual Medicare patient census of 260 as of that date.

Criteria for Certification of Hospice Services

The Code of Federal Regulations (CFR) 42, Section 418.20 stipulates 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 Section 418.22. The initial certification must include the statement that the individual's medical prognosis is that his or her life expectancy is 6 months or less and be signed by a hospice physician and the individual's attending physician if the individual has an attending physician. The hospice 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 CFR 412, Section 418.58 provides that a written plan of care must be established and maintained for each individual admitted to a hospice program prior to providing care, and the care provided to an individual must be in accordance with the plan.

The CFR 42, Section 418.74 specifies that the hospice must establish and maintain a clinical record for every individual receiving care and services. The 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 forms; (5) pertinent medical histories; and (6) complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

Analysis of Cases Reviewed

We analyzed 147 admissions and the corresponding length of service as of August 31, 1995. We found the average length of service for these admissions was 23 months. Twenty-four beneficiaries were in the hospice program over 36 consecutive months and 2 were in for 65 months. These beneficiaries had all been certified and re-certified as having a life expectancy of 6 months or less.

We also analyzed the diagnoses for both the ineligible beneficiaries and those whose records did not support the terminal illness determination. The following is a summary of the primary diagnosis areas for the 116 cases found to be ineligible or lacking sufficient documentation to make a determination.

Disease Area	No. of Beneficiaries
Cardiac	41
Cancer	33
Pulmonary	10
Vascular	7
Alzheimer	4
Renal	3
Other	18
Total	116

Although the diagnoses for these 116 beneficiaries indicated serious medical conditions, the PRO physicians did not find adequate justification in the medical records for Lake & Sumter's determinations that the conditions would result in a life expectancy of 6 months or less. For 71 of the cases, the PRO physicians concluded that the individual was not eligible for hospice services; for 45 of the cases the documentation was not sufficient to evaluate the life expectancy of the individual. Lake & Sumter indicated additional information from outside sources could be obtained for each case but was not included in the medical records.

Hospice officials informed us that they identified and did not admit patients that were not eligible for hospice. They also stated that they identified and discharged patients that improved to the point that they were expected to live longer than 6 months.

We recognize that in some cases, the beneficiary will exceed the 6 month life expectancy. However, the certification of an individual as terminally ill must be based on documented medical evidence that supports a life expectancy of 6 months or less. In the cases reviewed, the medical records either contradicted life expectancy of 6 months or less or the medical documentation was inadequate to determine life expectancy.

Medical Review staff at the intermediary examined 30 of the 116 cases that were determined to be either ineligible or insufficiently documented by the PRO physician reviewers. They also concluded that all 30 either did not meet Medicare guidelines of eligibility or had inadequate support for the certification. Eventually, all of the cases included in our audit will be provided to the intermediary staff for their adjudication.

Cause of Incorrect Eligibility Determinations

We believe the identified problems occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients files or because the hospice physicians certified beneficiaries as terminal based on insufficient clinical data. In some cases, the hospice physicians relied on the patient's personal (referring) physician.

We found that hospice physicians, at times, did rely, at least partly, on the referring physicians. For example, in response to one of our findings, a hospice physician stated "His medical condition was continuous and it was felt by his referring physician that he had a limited life expectancy due to those complicating and multiple medical problems. Thus, he was referred and admitted to hospice...." In another response, he stated it was in the attending physician's opinion that patient's disease would take her life sometime in the near future; thus, she was referred to hospice and admitted.

Although the referring physician's opinion can and should be considered, the final determination of hospice eligibility is the responsibility of the hospice physician. We believe that in the cases the PRO physicians determined were ineligible, the clinical evidence did not support the referring physician's prognosis.

The intermediary medical review staff and the PRO physicians advised us that a hospice physician should be able to obtain enough clinical evidence to reliably determine whether a patient will more likely than not die within 6 months. In addition, the hospice physician should obtain sufficient information on the patient to make a determination of life expectancy independent of the attending physician.

The medical director of Lake & Sumter expressed disagreement with the determinations of the PRO physicians, but at the same time, communicated that it is difficult to prognosticate how long patients will live, especially those with non-cancer diagnoses. We continue to believe that in the cases the PRO physician determined were ineligible, the clinical evidence did not support a prognosis of 6 months or less to live.

Intermediary Activity

The intermediary's Medical Review staff conducted a review on the medical necessity of hospice inpatient services in 1991. As a result, Aetna originally denied approximately 500 claims overall for several providers that were later overturned by HCFA. Specifically, 55 out of 59 original denials for one provider were overturned. Since that time, there was minimal intermediary oversight of the medical necessity of hospice services or of documentation supporting the certifications until FY 1995.

In July 1995, the intermediary conducted a focused medical review based on admitting diagnoses. Ultimately, a total of 50 claims from 17 providers were scrutinized under this review. Lake & Sumter was not one of the 17 providers. Out of those 50 cases, 26 were denied. Aetna found 22 did not have documentation supporting a life expectancy of 6 months or less, 3 did not have sufficient documentation of inpatient days and physician visits, and 1 routine day was billed outside the billing period. Providers were notified of the results of the review and were advised to review the June 12, 1995 correspondence from the Regional Administrator of HCFA that was sent to all hospice providers serviced by Aetna-Florida and Palmetto Government Benefit Administrators. This letter generally reiterated Medicare eligibility guidelines and documentation standards and communicated that the intermediaries were increasing emphasis on hospice medical reviews.

The intermediary's Provider Audit staff stated that no desk audits have been done of hospices because they are not required to file a cost report which is necessary for a desk audit. Provider Audit does not have the resources to conduct alternative on-site review work. Intermediary officials attributed the minimal medical review activity to a lack of support for hospice claim denials and weak review guidelines from HCFA.

RECOMMENDATIONS

We recommend the intermediary:

- recover payments of $4 million for the 71 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice after December 31, 1995.

- conduct medical reviews of the 45 cases, for which the hospice received $2.5 million, that did not contain sufficient documentation to determine hospice eligibility. Based on the results of these reviews, take appropriate action to recover amounts determined to be overpayments.

- 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 the hospices are obtaining sufficient medical documentation and other information to make valid eligibility determinations.

INTERMEDIARY'S RESPONSE

On September 26, 1996, the intermediary responded to a draft of this audit report. Aetna stated that in general, it agreed that strong procedural controls and review activities would ensure hospice benefits are properly paid and has historically included hospice claims in program safeguard activities. Aetna has worked with HCFA in an effort to prevent inappropriate payments, and is committed to working closely with HCFA to strengthen program procedures and controls to ensure proper payment of hospice claims.

The full text of Aetna's response is found in Appendix B. With regard to the specific recommendations Aetna made the following comments:

- Regarding recovery of payments made for beneficiaries who did not meet Medicare hospice guidelines, Aetna stated that hospices are reimbursed on a prospective payment system and do not file cost reports. Payments would, therefore, be recovered on an individual claim-by-claim basis through the adjustment process and several issues would need to be addressed. Among these are the form of notification to beneficiaries and providers, the determination of whether providers or beneficiaries are held responsible for the overpayments, and the possible need for any review of the determinations made by the Florida PRO. Aetna will be happy to discuss these issues with HCFA and the Office of Inspector General (OIG) to determine specific guidelines to be followed.

- Regarding reviewing of 45 cases that did not contain sufficient documentation, Aetna stated it would conduct the medical reviews and it would work with HCFA on appropriate recovery action.

- Regarding training hospice providers and physicians on eligibility requirements, Aetna stated it would work with HCFA to help HCFA develop and provide clear instructions to hospice providers and physicians on eligibility requirements for hospice beneficiaries, particularly the 6 month prognosis.

- Regarding analyzing trends and conducting medical necessity reviews, Aetna stated its Limited-On-Line Access process will be used to analyze utilization trend data for hospice providers with large increases in claims for beneficiaries with over 210 days of hospice coverage and would conduct medical reviews working closely with HCFA to determine appropriate sample sizes and necessary follow-up activities.

- In regard to conducting periodic medical documentation reviews, Aetna stated that it will conduct periodic reviews of hospice claims and follow-up educational activities to encourage hospices to obtain necessary medical documentation in order for them to make valid patient assessments.

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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,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

HHS Action Official
Associate Regional Administrator
Division of Medicare
Health Care Financing Administration, Region IV
101 Marietta Tower, Suite 702
Atlanta, Georgia 30323

APPENDICES

APPENDIX A

MAJOR CONTRIBUTORS TO THIS REPORT

From HHS OIG CAS Region IV:	Gerald Dunham, HCFA Audit Manager (404) 331-2446, ext. 107 Vincent Imbriani, Senior Auditor Kimberly Henderson, Auditor in Charge Mervyn Carrington, Auditor
From HHS OIG OAS Region V:	Robert Wiedeman, Senior Auditor Tom Tucker, Auditor
From HCF Audits Division:	Ben Jackson, Audit Manager Rich Warczynski, Senior Auditor
From the Florida PRO:	Robert Turkel, MD Felix LoCicero, MD Ferdinand Richards, MD
From the Regional Home Health Intermediary:	Barbara Jenkins, RN, BS Karen McCall, LPN Terri Ginetti, RN Trudy Wood

Aetna

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Hartford, CT 06156

Janet M. Kalas
Medicare Administration, MAA8
Aetna Health Plans
(860) 636-5667
Fax: (860) 636-1659

September 26, 1996

Gerald Dunham, Audit Manager
PO Box 2047
Atlanta, Georgia 30301-2047

Dear Mr. Dunham:

Re: Common Identification #A-04-95-02110

Thank you for the opportunity to comment on the draft report entitled Review Beneficiary Eligibility at Hospice of Lake & Sumter, Inc. dated August 26, 1996. In general, we recognize that strong procedural controls, review activities, and clear definition and communication of Program requirements can further strengthen payment safeguards for hospice benefits. The draft report states that you "believe the identified problems occurred due to inaccurate prognoses of life expectancy by hospice physicians based upon the medical evidence in the patient files or because the hospice physicians certified beneficiaries as terminal based upon insufficient clinical data." It should be noted that Aetna has historically included hospice claims in its program safeguard activities and has worked successfully with HCFA in an effort to prevent inappropriate payments, and increase provider awareness of coverage provisions.

With regard to the specific recommendations in your report, we offer the following comments:

Recover payments of $4 million made for the 71 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice after December 31, 1995.

Hospices are reimbursed on a prospective payment system and do not file cost reports. Payments would therefore be recovered on an individual claim-by-claim basis through the adjustment process and several issues would need to be addressed. Among these are the form of notification to beneficiaries and providers, the determination of whether providers or beneficiaries are held responsible for the overpayment, and possible need for any review of the determinations made by the Florida PRO. Aetna will be happy to discuss these issues with HCFA and the OIG to determine specific procedures to be followed.

Conduct medical reviews of the 45 cases for which the hospice received $2.5 million that did not contain sufficient documentation to determine hospice eligibility. Based on the results of these reviews, take appropriate action to recover amounts determined to be overpayments.

Records will be requested to allow medical reviews of these cases, and we will work with HCFA to determine the appropriate recovery action should overpayments be identified as a result of this review.

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.

Aetna will work closely with HCFA to help HCFA develop and provide clear instructions 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.

Aetna's Limited On-Line Access process (LOLA) will be used to analyze utilization trend data for hospice providers with large increases in claims for beneficiaries with over 210 days of hospice coverage and we will conduct medical reviews working closely with HCFA to determine appropriate sample sizes and necessary follow-up activities.

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

Aetna will conduct periodic reviews of hospice claims and follow-up educational activities to encourage hospices to obtain necessary medical documentation in order for them to make valid assessments of patients.

* * * * *

Comments deleted because it pertains to information no longer in report.

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In summary, Aetna has demonstrated its commitment to working closely with HCFA to strengthen Program procedures and controls to ensure proper payment of hospice claims.

Sincerely,

Janet M. Kalas
Medicare Administration
Aetna Life Insurance Company