

**Memorandum**

Date **MAR 11 1997**

From June Gibbs Brown  
Inspector General *June G Brown*

Subject OPERATION RESTORE TRUST--Review of Medicare Hospice Eligibility at the  
San Diego Hospice Corporation (A-09-96-00064)

To Bruce C. Vladeck  
Administrator  
Health Care Financing Administration

This memorandum is to alert you to the issuance on March 13, 1997, of our final report. A copy is attached.

The objective of our review was to evaluate hospice eligibility determinations by the San Diego Hospice Corporation (SDH) for beneficiaries that remained in hospice care for more than 210 days. We also determined the amount of payments made to the SDH for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

Our review included a medical evaluation of the SDH's eligibility determinations for 78 beneficiaries who had been in hospice care for more than 210 days. The review showed that:

- o 37 of the beneficiaries were not eligible for hospice coverage; and
- o for 19 beneficiaries, we were unable to conclusively determine their eligibility status.

Our medical determinations were made by physicians employed by or under contract with the Medicare peer review organization for California. All of the 37 ineligible determinations were confirmed by medical review staff of Blue Cross of California, fiscal intermediary for the SDH.

The incorrect eligibility determinations were due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files or because the physicians certified beneficiaries as terminally ill based on insufficient clinical data.

The SDH received improper Medicare payments totaling \$2.1 million for the 37 ineligible beneficiaries and \$1.35 million relating to 19 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:

- o Recover payments of \$2.1 million made through May 15, 1996 for the 37 beneficiaries who were not eligible for Medicare hospice benefits. Recover any improper payments made on behalf of those beneficiaries enrolled in hospice care after May 15, 1996.
- o Conduct medical reviews of the 19 cases, for which the hospice received \$1.35 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.
- o 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.
- o Analyze utilization trends to identify hospices with numerous claims for beneficiaries with over 210 days of hospice coverage and conduct medical reviews on a sample of their claims.
- o Conduct periodic reviews of hospice claims to ensure the hospices are obtaining sufficient medical information to make valid eligibility determinations.

The intermediary did not provide any comments concerning its concurrence or nonconcurrence to our recommendations. It plans to perform medical reviews for the 19 beneficiaries whose medical records did not contain sufficient information and consult with HCFA before recovering any overpayments. A copy of the intermediary's full response is included as an appendix to this report.

For further information, contact:

Lawrence Frelot  
Regional Inspector General  
for Audit Services, Region IX  
(415) 437-8360

Attachment

Department of Health and Human Services

OFFICE OF  
INSPECTOR GENERAL

REVIEW OF MEDICARE HOSPICE  
ELIGIBILITY AT  
SAN DIEGO HOSPICE CORPORATION  
FOR THE PERIOD JANUARY 1, 1993  
THROUGH MARCH 31, 1996

*The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG Office of Audit Services. Final determination on these matters will be made by authorized officials.*



CIN: A-09-96-00064



Region IX  
Office of Audit Services  
50 United Nations Plaza  
San Francisco, CA 94102

Common Identification Number: A-09-96-00064

Ms. Jacqueline Anderson  
General Manager  
Medicare Administration  
Blue Cross of California  
Van Nuys, California 91470

Dear Ms. Anderson:

This report provides you with the results of our audit of eligibility determinations for Medicare hospice beneficiaries at the San Diego Hospice Corporation (SDH), San Diego, California. 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

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 payments made to the SDH for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

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.

### SUMMARY OF FINDINGS

Our review included a medical evaluation of SDH's eligibility determinations for 78 beneficiaries who had been in hospice care for more than 210 days. The evaluation of the medical records showed that:

- o 37 beneficiaries were not eligible for hospice coverage; and
- o for 19 beneficiaries, we were unable to conclusively determine their terminal illness.

Our audit was a limited review of SDH's hospice operation. We did not review the hospice eligibility for all Medicare beneficiaries who were or had been in SDH's program. We limited our review to hospice beneficiaries with over 210 days of hospice coverage as of March 31, 1996 and who were still active in hospice or had been discharged for reasons other than death between the period January 1, 1993 and March 31, 1996. We offer no opinion nor have any conclusion on the accuracy of payments made to SDH outside the scope of our audit.

We identified 78 Medicare beneficiaries who met the criteria of our audit scope. To place the scope of our audit (78 cases) in perspective, we offer the following comparisons:

- o There were 159 Medicare beneficiaries active in SDH as of March 31, 1996. We found that 48 (30 percent) of these had been in hospice care beyond 210 days. The balance of the 78 cases reviewed (30) had been discharged for reasons other than death after at least 210 days of hospice care.
- o According to SDH's officials, the average length of stay for discharged Medicare patients was 64 days, compared to 44 days for discharged non-Medicare patients.
- o The hospice reported that they provided hospice care to 3,250 Medicare beneficiaries during the period January 1, 1993 through March 31, 1996. Of these, 265 (8 percent) received hospice care for more than 210 days. Seventy-eight of these were included in our review; the remaining 187 had died.

Our medical determinations were made by physicians under contract to the California Medicare Peer Review Organization (PRO). All of the 37 ineligible determinations were confirmed by the medical review staff of Blue Cross of California.

The 37 beneficiaries were found to be ineligible due to inaccurate prognoses of life expectancy by the SDH physicians based on the medical evidence in their files. For the 19 beneficiaries, sufficient evidence was not present in the medical files to support a terminal illness. These cases need to be further reviewed by the fiscal intermediary to ensure that providing Medicare hospice payments to SDH are appropriate. SDH received Medicare payments totaling \$2.1 million for the 37 ineligible beneficiaries and \$1.35 million relating to 19 beneficiaries placed in the questionable category.

Based on our audit work, we recommend that Blue Cross of California:

- o Recover payments of \$2.1 million made through May 15, 1996 for the 37 beneficiaries who were not eligible for Medicare hospice benefits. Recover any improper payments made on behalf of those beneficiaries enrolled in hospice care after May 15, 1996.
- o Conduct medical reviews of the 19 cases, for which the hospice received \$1.35 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.
- o 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.
- o Analyze utilization trends to identify hospices with numerous claims for beneficiaries with over 210 days of hospice coverage and conduct medical reviews on a sample of their claims.
- o Conduct periodic reviews of claims to ensure the hospices are obtaining sufficient medical information to make valid eligibility determinations.

The intermediary did not provide any comments concerning its concurrence or nonconcurrence with our recommendations. It plans to perform medical reviews for the 19 beneficiaries whose medical records did not contain sufficient information and consult with HCFA before recovering any overpayments.

## BACKGROUND

### *San Diego Hospice Corporation*

The SDH was founded in 1977. It is a nonprofit public benefit corporation located in and serving San Diego County, California. The SDH is licensed by the State of California to operate as a hospice, home health agency, and hospital.

Patient care at the SDH began with volunteer care and expanded to both professional staff and volunteers in 1978. The SDH was selected by the HCFA as one of the original demonstration sites for the "Medicare Hospice Pilot Project" which began in October 1980. In October 1984, it received designation as a Medicare certified hospice. In January 1989, a special licensing bill passed by the California Legislature allowed for the creation of the SDH's 24-bed acute care center for terminally ill patients whose pain or symptoms can no longer be managed at home.

### *Regulations*

Title XVIII, section 1861(dd) of the Social Security Act sets 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. Federal regulations require that medical records be maintained for every individual receiving hospice care and services.

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.

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 three election periods total 210 days of service.

### ***Intermediary Responsibilities***

The HCFA has designated eight regional intermediaries to service hospices. Blue Cross of California is the Regional Home Health Intermediary that serves the SDH. The intermediary is responsible for administrative duties including making payments to providers and serving as a center for and communicating to providers information or instructions furnished by the HCFA.

## **OBJECTIVE, SCOPE, & METHODOLOGY**

### ***Objective***

The objective of our review was to evaluate eligibility determinations for beneficiaries in hospice care for more than 210 days and who were either active in hospice as of March 31, 1996 or had been discharged for reasons other than death from January 1, 1993 to March 31, 1996. We also determined the amount of payments made to the SDH 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 performed a limited review of the SDH hospice operation. We did not review the hospice eligibility determinations for all Medicare beneficiaries who were or had been in the SDH program. We limited our review to beneficiaries with over 210 days of hospice coverage as of March 31, 1996 and who were still active in hospice or had been discharged for reasons other than death during the period January 1, 1993 through March 31, 1996.

The SDH provided hospice care to 3,250 Medicare beneficiaries from January 1, 1993 through March 31, 1996. Of these beneficiaries, 265 of them received 210 or more days of hospice care. Of these 265 beneficiaries, 48 were active as of March 31, 1996, 30 had been discharged, and 187 had died. Our review was limited to the 78 Medicare beneficiaries who were active or discharged.

We also performed a limited review of Blue Cross of California's claims processing procedures and medical review policies relating to hospice beneficiaries. We offer no opinion nor have any conclusion on the accuracy of Medicare payments made to the SDH outside the scope of our audit.

We did not review the overall internal control structure at the SDH or Blue Cross of California. 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 performing medical reviews. We did not test the internal controls because the objective of our review was accomplished through substantive testing. Field work was conducted from April 1996 to June 1996 at the offices of the SDH in San Diego, California and at Blue Cross of California in Van Nuys, California.



### ***Methodology***

Beneficiaries were selected from the SDH's computer database. Our assessment of their eligibility was based on the PRO physicians and Blue Cross of California's medical staff reviews of patient records.

The HCFA arranged for the PRO to provide us medical review assistance. The PRO contracted physicians reviewed the patients' clinical records and determined if the SDH's initial determinations of beneficiary eligibility were correct. A beneficiary was deemed ineligible if the clinical evidence indicated that the beneficiary had a life expectancy of greater than 6 months at the time of initial certification. Cases were classified in the "could not determine" category if there was insufficient clinical evidence to support a prognosis of 6 months or less. 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 plan of care, the beneficiary's medical history, hospital and lab reports, and the hospice physician's and nurses' notes. Also, copies of the HCFA's Medicare guidelines on hospice eligibility and coverage and the HCFA's adopted National Hospice Organization's "Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases" were made available to the PRO physicians during their review.

Blue Cross of California reviewed all ineligible determinations made by the PRO physicians. Its medical review staff conducted a desk review of the medical information obtained during our on-site review, including the PRO physicians' notes.

Our calculation of the Medicare payments made on behalf of ineligible beneficiaries and for those beneficiaries eligibility could not be determined was based on payment data obtained from Blue Cross of California for the period November 16, 1990 through May 15, 1996. Further, our calculations reflect only payments made by Blue Cross of California to the SDH.

## **DETAILED RESULTS OF REVIEW**

Medical evaluation of the SDH's eligibility determinations of 78 beneficiaries by both the PRO physicians and Blue Cross of California's medical review staff disclosed that the medical records for:

- o 37 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;
- o 19 beneficiaries did not contain sufficient medical information to determine the terminal illness of the beneficiary; and
- o 22 beneficiaries supported a determination that the beneficiary had an illness that would have been terminal within 6 months if the illness followed a normal course.

The incorrect eligibility determinations were due to inaccurate prognoses of life expectancy by the SDH physicians based on the medical evidence in the patients' files or because the physicians certified beneficiaries as terminal based on insufficient clinical data.

As of May 15, 1996, the SDH received Medicare payments totaling \$2.1 million for the 37 ineligible beneficiaries and \$1.35 million for the 19 beneficiaries whose medical records did not contain sufficient information to make a determination of eligibility. Some of these beneficiaries continued to receive care after May 15, 1996 and Medicare may have been billed for the care.

### *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 if the terminal illness runs its normal course 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 42, 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.). Ensuring that all of the above data is present in the medical records provides adequate support for decisions on the terminal illness of beneficiaries.

### *Analysis of Cases Reviewed*

As of March 31, 1996, the average length of service was 523 days for the 37 ineligible beneficiaries. Twenty-one of the ineligible beneficiaries received hospice care for over 1 year. In fact, one beneficiary received care for over 4 years. These beneficiaries had all been certified and recertified by the SDH as having a life expectancy of 6 months or less.

We analyzed the diagnoses for the 37 ineligible beneficiaries. The following is a summary of their primary diagnoses:

<u>Diagnoses</u>	<u>No. of Beneficiaries</u>
Cancer	9
Cardiac Related Diseases	9
Alzheimer	4
Dementia	3
Pulmonary Related Diseases	3
GI Hemorrhage	2
Other	<u>7</u>
Total	<u>37</u>

Although the diagnoses indicated serious medical conditions, the PRO physicians did not find adequate justification in the medical records for the SDH's determinations that the conditions would result in a life expectancy of 6 months or less.

### ***Intermediary Activity***

In 1994, Blue Cross of California's medical review staff conducted a review of the medical necessity of the SDH's inpatient hospital services. No significant findings were noted.

In August 1995, Blue Cross of California implemented seven computer edits directly related to hospice services. These edits relate to non-hospital based hospices and were designed to detect certain diagnoses for possibly unallowable general inpatient care or routine home care services. Blue Cross of California does not maintain any statistics concerning the overpayments or collections resulting from these computer edits. Since the SDH's is a "hospital based hospice" it was not subject to these computer edits.

Presently, Blue Cross of California's medical review staff is not focusing any of their efforts on hospice providers.

## **RECOMMENDATIONS**

We recommend the intermediary:

- o Recover payments of \$2.1 million made through May 15, 1996 for the 37 beneficiaries who were not eligible for Medicare hospice benefits. Recover any improper payments made on behalf of those beneficiaries still enrolled in hospice care after May 15, 1996.
- o Conduct medical reviews of the 19 cases, for which the hospice received \$1.35 million, that we were unable to determine that the beneficiary was terminal ill. Based on the results of these reviews, take appropriate action to recover amounts determined to be overpayments.
- o 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.
- o Analyze utilization trends to identify hospices with numerous claims for beneficiaries with over 210 days of hospice coverage and conduct medical reviews on a sample of their claims.
- o Conduct periodic reviews of claims to ensure the hospices are obtaining sufficient medical information to make valid eligibility determinations.

## **INTERMEDIARY'S RESPONSE**

At this time, the intermediary did not have any comments concerning its concurrence or nonconcurrence on our recommendations. It plans to perform medical reviews for the 19 beneficiaries whose medical records did not contain sufficient information.

Further, the intermediary stated that due to the excellent reputation of San Diego Hospice, it will need to consult with HCFA before recovering the overpayments. The full text of Blue Cross' response is found in Appendix A.

## **AUDITOR'S COMMENTS**

Blue Cross should recover the \$2.1 million of identified overpayments. Medicare law and regulations do not provide for any wavier or delay of the collection of overpayments due to the reputation of the provider. The 37 beneficiaries were not eligible for the hospice services. Similar action should be taken to collect any overpayments identified for the 19 beneficiaries to be reviewed.

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Page 10 - Ms. Jacqueline Anderson

Final determination 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 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,



Lawrence Frelot  
Regional Inspector General  
for Audit Services, Region IX

HHS Action Official  
Regional Administrator  
Health Care Financing Administration, Region IX  
75 Hawthorne Street, 4th Floor  
San Francisco, California 94105

APPENDIX A

INTERMEDIARY'S RESPONSE

MEDICARE PROGRAM

Federal Medicare  
Intermediary

P.O. Box 70000  
Van Nuys, California 91470  
(818) 593-2006

Mr. Vincent Lee  
Region IX  
Office of Audit Services  
50 United Nations Plaza  
San Francisco, CA 94102

Re: CIN A-09-96-00064

Dear Vincent:

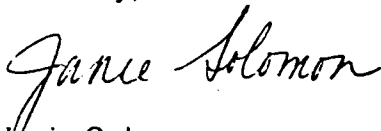
I reviewed the draft report "Review of Medicare Hospice Eligibility at the San Diego Hospice Corporation."

At this time, we do not have any comments. The medical review department was instructed to conduct the medical reviews of the 19 beneficiaries whose medical records did not contain sufficient information.

Due to the excellent reputation of San Diego Hospice, I will need to consult with HCFA before recovering the overpayments. Therefore, at this time, I cannot issue a statement of concurrence or nonconcurrence until we review the additional cases and meet with HCFA.

Further comments will be issued at a later time. If you have any questions, please let me know.

Sincerely,



Janie Solomon  
Manager  
Program Compliance  
(818) 703-4563

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