



Memorandum

Date JAN 15 1997

From June Gibbs Brown
Inspector General *June Gibbs Brown*

Subject OPERATION ASSISTANT TRUSTEES - Review of Hospice Eligibility at the Family Hospice of Dallas (CIN: A-06-95-00095)

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 Family Hospice of Dallas (FHD) for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

Our review included a medical evaluation of FHD's eligibility determinations for 60 Medicare beneficiaries who had been in hospice care for more than 210 days. Of the 60 cases, 26 were active in hospice at the time of our review and represent 20 percent of the 133 patients who were active Medicare hospice beneficiaries at FHD as of September 7, 1995. The review showed that:

- ▶ 20 beneficiaries were not eligible for hospice coverage at the time of admission, and
- ▶ medical records for 2 other beneficiaries were insufficient to conclusively determine a life expectancy of 6 months or less, as required by the Medicare program.

Our medical determinations were made by physicians who were consultants to the Texas Medical Foundation, the Texas Peer Review Organization (PRO). As part of their initial review, all 22 cases, which were found ineligible or inconclusive, have been reviewed by staff from the fiscal intermediary, Palmetto Government Benefits Administrators (PGBA). The PGBA agreed with the PRO's decisions.

We believe the identified discrepancies with the 20 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files. For the two other questionable beneficiaries, we believe the evidence in the medical files was not sufficient to permit a determination

of eligibility. The FHD received Medicare payments for hospice services totaling \$973,094 for 20 ineligible patients and \$69,648 related to the 2 beneficiaries for whom we were unable to determine that a terminal illness existed at the time of admission to the hospice.

We are recommending that the intermediary

- ▶ Recover payments of \$973,094 for the 20 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of ineligible beneficiaries after September 7, 1995.
- ▶ Conduct medical reviews of the two cases for which we were unable to conclusively determine whether the **beneficiary** was terminally ill. Based on the results of these reviews, take appropriate action to recover amounts (\$69,648) 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 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.

Page 3- **Bruce C. Vladeck**

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

Donald L. Dine
Regional Inspector General
for Audit Services
R e g i o n V I
(214) 767-8415

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OPERATION RESTORE TRUST
REVIEW OF HOSPICE ELIGIBILITY AT
THE FAMILY HOSPICE OF DALLAS**



**JUNE GIBBS BROWN
Inspector General**

**JANUARY 1997
A-06-95-00095**



Common Identification Number: A-06 -95-00095

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 d-terminations at the Family Hospice of Dallas (FHD) 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 September 7, 1995, or had been discharged for reasons other than death during the prior 32 months. We also determined the amount of payments made to FHD for those beneficiaries who did not meet the Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Our audit included a medical evaluation of FHD's eligibility determinations for 60 beneficiaries. This evaluation showed that:

- ▶ 20 beneficiaries were not eligible for hospice coverage at the time of admission, and
- ▶ medical records for 2 other beneficiaries were insufficient to conclusively determine a life expectancy of 6 months or less.

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 FHD's activities. We did not review the hospice eligibility determinations for all Medicare beneficiaries who were or had been in the FHD program.

We limited our review to hospice beneficiaries with over 210 days of hospice coverage as of September 7, 1995 and who were still active in hospice or had been discharged for reasons other than death between the period January 1, 1993 and September 7, 1995. We offer no opinion nor have any conclusion on the accuracy of payments made to FHD outside the scope of our audit.

We identified 60 Medicare beneficiaries who met the criteria of our audit scope. To place the scope of our audit (60 cases) in perspective, we offer the following comparisons:

- ▶ There were 174 active hospice patients, of which 133 were Medicare beneficiaries in FHD's program as of September 7, 1995. We found that 26 (20 percent) of these 133 active Medicare beneficiaries had been in hospice care beyond 210 days (7 months),
- ▶ Medicare lengths of stay in FHD's hospice care averaged 66 days compared to 37 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 FHD totaled \$15.8 million during the period April 23, 1990 through September 7, 1995. Our audit showed that \$973,094 (6 percent) of this total related to beneficiaries ineligible for hospice care. An additional \$69,648 related to beneficiaries whose records were insufficient to determine whether the beneficiary was terminally ill.

We believe the identified discrepancies with the 20 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files. For the two other questionable beneficiaries, we believe the evidence in the medical files was not sufficient to permit a determination of eligibility. The FHD received Medicare payments for hospice services totaling \$973,094 for ineligible patients and an additional \$69,648 related to the beneficiaries in the questionable category. 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 FHD were inappropriate.

We are recommending that the intermediary:

- ▶ Recover payments of \$973,094 for the 20 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of ineligible beneficiaries after September 7, 1995.
- ▶ Conduct medical reviews of the two cases for which we were unable to conclusively determine whether the beneficiary was terminally ill. Based on the results of these reviews, take appropriate action to recover amounts (\$69,648) 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 April 17, 1996, we presented our findings to FHD officials. On May 14, 1996, after giving FHD the opportunity to consider the findings and to perform its own research of patients' medical records, we met again to discuss FHD's verbal comments. These discussions are summarized below on page 9 of our Detailed Results of Review.

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 Family Hospice of Dallas

The Family Hospice is a for-profit, limited partnership established in 1988 and based in Dallas, Texas. It also has offices with employees providing hospice services in Fort Worth and San Antonio, Texas as well as Oklahoma City and Tulsa, Oklahoma. As of September 7, 1995, the Family Hospice of Dallas was serving approximately 133 Medicare patients with 65 employees, including registered nurses, social workers, pastoral counselors, home health aides, homemakers and therapists. It is licensed by the Texas Department of Health as a Home and Community Services Agency to provide hospice services.

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 (old) 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, 199 Medicare patients had been revoked or discharged from FHD's hospice care, since January 1, 1993.

In addition to the Code of Federal Regulations (**CFR**) for Public Health (Title 42), which implements § 1861 (old) 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 finished.

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 FHD 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 September 7, 1995 or discharged for reasons other than death, from January 1, 1993 to September 7, 1995. We also determined the amount of payments made to FHD 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 FHD 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 FHD 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 FHD with over 210 days of hospice care as of September 7, 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 FHD. Of the 60 Medicare beneficiaries who met our selection **criteria**, 26 were active hospice Medicare beneficiaries on September 7, 1995 and 34 had been discharged for reasons other than death. The FHD's Medicare beneficiary census on September 7, 1995 was 133; thus, the 26 active hospice beneficiaries that were included in our review represented 20 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 FHD location in Dallas, Texas, from September 11, 1995 through September 27, 1995.

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 FHD.

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. If there was insufficient clinical evidence to support a prognosis of 6 months or less, the PRO physician made no determination of eligibility, but included those cases in a "could not determine" category.

Our calculation of the payments made to FHD, 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

Our audit included a medical evaluation of FHD's eligibility determinations for 60 beneficiaries who had received hospice services for 210 or more days and who were active on September 7, 1995 or discharged for reasons other than death during the preceding 32 months. This evaluation showed that:

- ▶ 20 beneficiaries were not eligible for hospice coverage at the time of admission, and
- ▶ the medical records for 2 beneficiaries did not contain sufficient medical information to determine that the Medicare beneficiary had a life expectancy of 6 months or less.

We believe the identified problems occurred due to inaccurate prognoses of life expectancy by hospice physicians based on medical evidence in the patient's file or because the clinical data documented in the patients' files was insufficient to establish that the patients had prognoses of less than 6 months to live.

As a result, the FHD received \$973,094 for the 20 ineligible beneficiaries and \$69,648 for the 2 beneficiaries whose medical records did not sufficiently document the patients' terminal illness.

Criteria for Certification of Hospice Services

The 42CFR418.20 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 20 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; and
- ▶ the medical records for 2 other beneficiaries did not contain sufficient medical information to conclusively determine a life expectancy of 6 months or less.

We analyzed 60 admissions and the corresponding lengths of **service** for these cases, as of September 7, 1995. The length of service for each case ranged between 210 and 1,540 days, averaging 472 days or 15.8 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 the beneficiaries found to be ineligible (20) or lacking sufficient documentation to make a determination (2).

Classification of Disease	Number of Ineligible Beneficiaries	, Number That Could Not Be Determined
Diseases of the Circulatory System		
Arteriosclerotic Heart Disease	2	
Arteriosclerotic Cardiovascular Disease	1	
Cardiac Decompensation	1	
Cardiomyopathy	1	
Congestive Heart Failure	3	
Peripheral Vascular Disease	1	
Cerebrovascular Accident	4	
Diseases of the Nervous System		
Alzheimer's Disease	1	1
Hydrocephalus	1	
Parkinson's Disease	1	
Neoplasms		
Lung Cancer	1	
Unspecified Cancer	1	
Myeloma	1	
Colon Cancer		1
Mental Disorders		
Multi-infarct Dementia	1	
Totals	20	2

Although the diagnoses for the beneficiaries reviewed indicated serious medical conditions, the PRO physicians did not find adequate justification in the medical records for FHD's determinations that the conditions would result in a life expectancy of 6 months or less. For 20 of the cases, the PRO physician concluded that the individual was not eligible for hospice services. For 2 of the cases, the documentation was not sufficient to evaluate the life expectancy of the individual.

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 20 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians. The medical records for 20 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. For the two other questionable beneficiaries, we believe the evidence in the medical files was not sufficient to permit a determination **of eligibility**.

Effect

We determined the amount of Medicare payments FHD received, on behalf of the 20 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 September 7, 1995, the FHD received \$973",094 for the 20 ineligible beneficiaries and \$69,648 for the 2 beneficiaries whose medical records did not sufficiently document the patients' terminal illness. Five of these beneficiaries-were active at the time of our review and FHD may have received additional payments on behalf of these beneficiaries.

Hospice Officials' Comments

On April 17, 1996, we met with FHD **officials** to share our specific audit results. **After** having been given the opportunity to review our findings in detail, the hospice officials met with us again, on May 14, 1996, for an exit conference. During this conference, we did not discuss the individual cases for reconsideration of the ineligible determinations. We are deferring such discussions regarding medical evaluations to qualified **RHHI** officials or physicians working on behalf of **HCFA**. However, FHD officials **verbally** provided the following general comments.

The FHD Medical Director explained that his staff found documentation in the Medical records, for all but six cases, sufficient to meet Medicare's criteria for hospice eligibility. While he admitted that some of the patients' medical records, which we selected for review, did not have all the necessary supporting documentation, FHD will work with the attending physicians to obtain this information. According to **FHD, HCFA's** Medicare guidelines are general and provide little specific information **useful** in making eligibility determinations. In addition to Medicare's guidelines, however, FHD uses the National Hospice Organization's (**NHO**) guidelines to better **inform** their physicians and staff about hospice eligibility. These NHO guidelines have not been adopted by HCFA.

After our meeting with FHD officials on April 17, 1996, **FHD** nurses performed chart audits (medical record reviews) of 11 cases included in our findings. The **FHD officials** believe, that based on these subsequent reviews of the medical records, most of these 11 cases should be excluded from our findings. The Medical Director **further** noted one case which may have been determined ineligible, due to a clerical error in the medical records. The FHD officials believe that

consideration of these records by the RI-D-II, or discussions with the PRO physicians about the individual cases, would result in much less than 20 ineligible determinations, as found in our audit.

One FHD official explained that, since the time of our audit field work, they have changed their procedures for documenting eligibility re-determinations to now explain **why** the patient is being recertified. If the interdisciplinary team has insufficient information to make a decision about recertification, FHD obtains, from the attending physician, a letter which documents the patient's continued need for hospice care. To better document trends in patient's medical condition, FHD plans more in-service training for field staff on completing the plan of care. Such plans have, in the past, emphasized quality of life descriptions, rather than decline in the patient's condition.

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 \$973,094 for the 20 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice care after September 7, 1995.
- ▶ Conduct medical reviews of the two cases, for which the hospice received \$69,648. For these cases, 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 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 10 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.

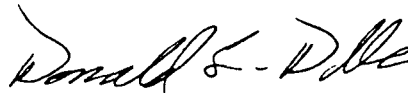
We will be working with **HCFA** on the beneficiary liability issue and the recovery of overpayments from the hospice.

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.

Page 12 - Mr. Bruce Hughes

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



Memorandum

Date JAN 15 1997

From June Gibbs Brown
Inspector General *June G Brown*

Subject OPERATION RESTORE TRUST--Review of Hospice Eligibility at the Family
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Our medical determinations were made by physicians who were consultants to the Texas Medical Foundation, the Texas Peer Review Organization (PRO). As part of their initial review, all 22 cases, which **were found** ineligible or inconclusive, have been reviewed by staff from the fiscal intermediary, Palmetto Government Benefits Administrators (PGBA). The PGBA agreed with the PRO's decisions.

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Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OPERATION RESTORE TRUST
REVIEW OF HOSPICE ELIGIBILITY AT
THE FAMILY HOSPICE OF DALLAS**



**JUNE GIBBS BROWN
Inspector General**

**JANUARY 1997
A-06-95-00095**



Common Identification Number: A-06-95 -OO095

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

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This report provides you with the results of our audit of Medicare hospice beneficiary eligibility determinations at the Family Hospice of Dallas (FHD) 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 September 7, 1995, or had been discharged for reasons other than death during the prior 32 months. We also determined the amount of payments made to FHD for those beneficiaries who did not meet the Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Our audit included a medical evaluation of FHD's eligibility determinations for 60 beneficiaries. This evaluation showed that:

- 20 beneficiaries were not eligible for hospice coverage at the time of admission, and
- medical records for 2 other beneficiaries were insufficient to conclusively determine a life expectancy of 6 months or less.

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 FHD's activities. We did not review the hospice eligibility determinations for all Medicare beneficiaries who were or had been in the FHD program.

We limited our review to hospice beneficiaries with over 210 days of hospice coverage as of September 7, 1995 and who were still active in hospice or had been discharged for reasons other than death between the period January 1, 1993 and September 7, 1995. We offer no opinion nor have any conclusion on the accuracy of payments made to **FHD** outside the scope of our audit.

We identified 60 Medicare beneficiaries who met the criteria of our audit scope. To place the scope of our audit (60 cases) in perspective, we offer the following comparisons:

- ▶ There were 174 active hospice patients, of which 133 were Medicare beneficiaries in **FHD's** program as of September 7, 1995. We found that 26 (20 percent) of these 133 active Medicare beneficiaries had been in hospice care beyond 210 days (7 months).
- ▶ Medicare lengths of stay in **FHD's** hospice care averaged 66 days compared to 37 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 **FHD** totaled \$15.8 million during the period April 23, 1990 through September 7, 1995. Our audit showed that \$973,094 (6 percent) of this total related to beneficiaries ineligible for hospice care. An additional \$69,648 related to beneficiaries whose records were insufficient to determine whether the beneficiary was terminally ill.

We believe the identified discrepancies with the 20 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files. For the two other questionable beneficiaries, we believe the evidence in the medical files was not sufficient to permit a determination of eligibility. The **FHD** received Medicare payments for hospice services totaling \$973,094 for ineligible patients and an additional \$69,648 related to the beneficiaries in the questionable category. 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 **FHD** were inappropriate.

We are recommending that the intermediary:

- ▶ Recover payments of \$973,094 for the 20 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of ineligible beneficiaries after September 7, 1995.
- ▶ Conduct medical reviews of the two cases for which we were unable to conclusively determine whether the beneficiary was terminally ill. Based on the results of these reviews, take appropriate action to recover amounts (\$69,648) 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 April 17, 1996, we presented our findings to FHD **officials**. On May 14, 1996, after giving FHD the opportunity to consider the findings and to perform its own research of patients' medical records, we met again to discuss FHD's verbal comments. These discussions are summarized below on page 9 of our Detailed Results of Review. .

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 Family Hospice of Dallas

The Family Hospice is a for-profit, limited partnership established in 1988 and based in Dallas, Texas. It also has offices with employees providing hospice services in Fort Worth and San Antonio, Texas as well as Oklahoma City and Tulsa, Oklahoma. As of September 7, 1995, the Family Hospice of Dallas was serving approximately 133 Medicare patients with 65 employees, including registered nurses, social workers, pastoral counselors, home health aides, homemakers and therapists. It is licensed by the Texas Department of Health as a Home and Community Services Agency to provide hospice services.

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 (old) 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, 199 Medicare patients had been revoked or discharged from FHD's hospice care, since January 1, 1993.

In addition to the Code of Federal Regulations (CFR) for Public Health (Title 42), which implements § 1861 (old) 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 **FHD** 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 September 7, 1995 or discharged for reasons other than death, from January 1, 1993 to September 7, 1995. We also determined the amount of payments made to FHD 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 FHD 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 FHD 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 **FHD** with over 210 days of hospice care as of September 7, 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 FHD. Of the 60 Medicare beneficiaries who met our selection **criteria**, 26 were active hospice Medicare beneficiaries on September 7, 1995 and 34 had been discharged for reasons other than death. The **FHD's** Medicare beneficiary census on September 7, 1995 was 133; thus, the 26 active hospice beneficiaries that were included in our review represented 20 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 **FHD** location in Dallas, Texas, from September 11, 1995 through September 27, 1995.

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 FHD.

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. If there was insufficient clinical evidence to support a prognosis of 6 months or less, the PRO physician made no determination of eligibility, but included those cases in a "could not determine" category.

Our calculation of the payments made to FHD, 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

Our audit included a medical evaluation of **FHD's** eligibility determinations for 60 beneficiaries who had received hospice services for 210 or more days and who were active on September 7, 1995 or discharged for reasons other than death during the preceding 32 months. This evaluation showed that:

- ▶ 20 beneficiaries were not eligible for hospice coverage at the time of admission, and
- ▶ the medical records for 2 beneficiaries did not contain sufficient medical information to determine that the Medicare beneficiary had a life expectancy of 6 months or less.

We believe the identified problems occurred due to inaccurate prognoses of life expectancy by hospice physicians based on medical evidence in the patient's file or because the clinical data documented in the patients' files was insufficient to establish that the patients had prognoses of less than 6 months to live.

As a result, the FHD received \$973,094 for the 20 ineligible beneficiaries and \$69,648 for the 2 beneficiaries whose medical records did not sufficiently document the patients' terminal illness.

Criteria for Certification of Hospice Services

The 42CFR418.20 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 **20** 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; and
- ▶ the medical records for 2 other beneficiaries did not contain sufficient medical information to conclusively determine a life expectancy of 6 months or less.

We analyzed 60 admissions and the corresponding lengths of service for these cases, as of September 7, 1995. The length of service for each case ranged between 210 and **1,540** days, averaging 472 days or 15.8 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 the beneficiaries found to be ineligible (20) or lacking sufficient documentation to make a determination (2).

Classification of Disease	Number of Ineligible Beneficiaries	, Number That Could Not Be Determined
Diseases of the Circulatory System		
Arteriosclerotic Heart Disease	2	
Arteriosclerotic Cardiovascular Disease	1	
Cardiac Decompensation	1	
Cardiomyopathy	1	
Congestive Heart Failure	3	
Peripheral Vascular Disease	1	
Cerebrovascular Accident	4	
Diseases of the Nervous System		
Alzheimer's Disease	1	1
Hydrocephalus	1	
Parkinson's Disease	1	
Neoplasms		
Lung Cancer	1	
Unspecified Cancer	1	
Myeloma	1	
Colon Cancer		1
Mental Disorders		
Multi-infarct Dementia	1	
Totals	20	2

Although the diagnoses for the beneficiaries reviewed indicated serious medical conditions, the PRO physicians did not find adequate justification in the medical records for FHD's determinations that the conditions would result in a life expectancy of 6 months or less. For 20 of the cases, the PRO physician concluded that the individual was not eligible for hospice services. For 2 of the cases, the documentation was not sufficient to evaluate the life expectancy of the individual.

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 20 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians. The medical records for 20 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. For the two other questionable beneficiaries, we believe the evidence in the medical files was not sufficient to permit a determination of eligibility.

Effect

We determined the amount of Medicare payments FHD received, on behalf of the 20 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 September 7, 1995, the FHD received \$973,094 for the 20 ineligible beneficiaries and \$69,648 for the 2 beneficiaries whose medical records did not **sufficiently** document the patients' terminal illness. Five of these beneficiaries-were active at the time of our review and **FHD** may have received additional payments on behalf of these beneficiaries.

Hospice Officials' Comments

On April 17, 1996, we met with **FHD officials** to share our specific audit results. **After** having been given the opportunity to review our findings in detail, the hospice officials met with us again, on May 14, 1996, for an exit conference. During this conference, we did not discuss the individual cases for reconsideration of the ineligible determinations. We are deferring such discussions regarding medical evaluations to qualified **RHHI officials** or physicians working on behalf of HCFA. However, FHD officials **verbally** provided the following general comments.

The FHD Medical Director explained that his **staff found** documentation in the Medical records, for all but six cases, sufficient to meet Medicare's criteria for hospice eligibility. While he admitted that some of the patients' medical records, which we selected for review, did not have all the **necessary** supporting documentation, FHD will work with the attending physicians to obtain this information. According to FHD, **HCFA's** Medicare guidelines are general and provide **little** specific information **useful** in making eligibility determinations. In addition to Medicare's guidelines, however, FHD uses the National Hospice organization's (**NHO**) guidelines to better **inform** their physicians and staff about hospice eligibility. These NHO guidelines have not been adopted by **HCFA**.

After our meeting with FHD officials on April 17, 1996, FHD nurses performed chart audits (medical record reviews) of 11 cases included in our findings. The **FHD officials** believe, that based on these subsequent reviews of the medical records, most of these 11 cases should be excluded from our findings. The Medical Director **further** noted one case which may have been determined ineligible, due to a clerical error in the medical records. The FHD officials believe that

consideration of these records by the **RHHI**, or discussions with the PRO physicians about the individual cases, would result in much less than 20 ineligible determinations, as found in our audit.

One FHD **official** explained that, since the time of our audit field work, they have changed their procedures for documenting eligibility re-determinations to now explain **why** the patient is being recertified. If the interdisciplinary team has insufficient information to make a decision about recertification, **FHD** obtains, from the attending physician, a letter which documents the patient's continued need for hospice care. To better document trends in patient's medical condition, **FHD** plans more in-service training for field staff on completing the plan of care. Such plans have, in the past, emphasized quality of life descriptions, rather than decline in the patient's condition.

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 \$973,094 for the 20 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice care after September 7, 1995.
- ▶ Conduct medical reviews of the two cases, for which the hospice received \$69,648. For these cases, 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 HCFA in providing training to hospice providers and physicians on eligibility requirements for hospice beneficiaries, **particularly** the requirement for a 6-month prognosis.

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- ▶ 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 10 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.

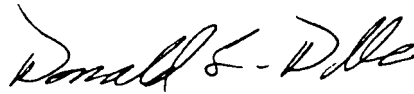
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Final determinations as to the actions to **be taken** on all matters reported will be made by the Department of Health and Human Services official identified below. An action official representative **will** contact you in the near **future**. This 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.

Page 12 - Mr. Bruce Hughes

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,

A handwritten signature in black ink, appearing to read "Donald L. Dine". The signature is fluid and cursive, with a large initial "D" and a long horizontal stroke.

Donald L. Dine
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: .4-06-95-00095

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. Dine,

This letter is in response to your draft audit report **entitled**, Medicare Hospice Beneficiary Eligibility Determinations at the Family Hospice of Dallas (**FHD**) information deleted by the OIG 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

Director, Medicare Part A

Medical Review and MSP
