Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SERVICIOS SUPLEMENTARIOS DE SALUD, INC., IMPROPERLY CLAIMED MEDICARE REIMBURSEMENT FOR SOME HOSPICE SERVICES

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

James P. Edert
Regional Inspector General
for Audit Services

August 2014
A-02-11-01017

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Servicios Suplementarios de Salud, Inc., improperly claimed at least $450,000 in Medicare reimbursement for hospice services.

WHY WE DID THIS REVIEW

The Medicare hospice benefit allows providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of 6 months or less and who have elected hospice care. Previous Office of Inspector General reviews found that a high percentage of hospice claims did not meet certain Medicare requirements.

Our objective was to determine whether hospice services claimed for Medicare reimbursement by Servicios Suplementarios de Salud, Inc. (the Hospice) complied with Medicare requirements.

BACKGROUND

Federal regulations provide the Medicare hospice benefit to eligible beneficiaries. To be eligible for the Medicare hospice benefit, a beneficiary must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course. Inclusion in the Medicare hospice program is voluntary and can be revoked at any time by the beneficiary.

HOW WE CONDUCTED THIS REVIEW

Our review covered 5,801 beneficiary-months for which the Hospice received Medicare reimbursement totaling $14,485,126 for hospice services provided during the period July 1, 2008, through June 30, 2010. A beneficiary-month includes all hospice services provided to a beneficiary during 1 month. We reviewed all Medicare payments for hospice services related to our random sample of 100 beneficiary-months.

WHAT WE FOUND

The Hospice claimed Medicare reimbursement for some hospice services that did not comply with certain Medicare requirements. Of the 100 beneficiary-months in our random sample for which the Hospice claimed Medicare reimbursement, 82 beneficiary-months complied with Medicare requirements, but 18 did not.

The improper payments occurred because the Hospice did not have adequate policies and procedures to ensure that it documented hospice services, including beneficiaries' hospice election and/or revocation certifications.

On the basis of our sample results, we estimated that the Hospice improperly received at least $453,558 in Medicare reimbursement for hospice services that did not comply with certain Medicare requirements.

WHAT WE RECOMMEND

We recommend that the Hospice:

- refund $453,558 to the Federal Government and

- strengthen its procedures to ensure that hospice services are documented in accordance with Medicare requirements.

SERVICIOS SUPLEMENTARIOS DE SALUD, INC., COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospice did not indicate concurrence or nonconcurrence with our recommendations; however, it stated that it agreed with our determinations for 13 of the 18 sampled beneficiary-months that we identified as noncompliant. Under separate cover, the Hospice provided additional documentation for the 5 sampled beneficiary-months for which it did not agree with our determinations. The Hospice also stated that it has completed a corrective action plan to address our findings and ensure that it complies with Medicare requirements.

After reviewing the Hospice's comments and the additional documentation, we maintain that our findings and recommendations are valid.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

The Medicare hospice benefit allows providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of 6 months or less and who have elected hospice care. Previous Office of Inspector General reviews found that a high percentage of hospice claims did not meet certain Medicare requirements.

OBJECTIVE

Our objective was to determine whether hospice services claimed for Medicare reimbursement by Servicios Suplementarios de Salud, Inc. (the Hospice) complied with Medicare requirements.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Part A, also known as Hospital Insurance, provides for the coverage of various types of services, including hospice services. CMS contracts with four Home Health and Hospice Medicare Administrative Contractors (MAC) to process and pay Medicare hospice claims.

The Medicare Hospice Benefit

Medicare Part A covers hospice services provided to eligible beneficiaries (sections 1812(a)(4) and (5) of the Act). The Medicare hospice benefit has four levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care. Each level has an all-inclusive daily rate that is paid through Part A.[1] The goals of hospice care are to help terminally ill beneficiaries continue life with minimal disruption and to support beneficiaries' families and other caregivers throughout the process. This care is palliative (supportive), rather than curative and includes, among other things, nursing care, medical social services, hospice aide services, medical supplies, and physician services.

To be eligible for hospice care, a beneficiary must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course.[2] Upon a beneficiary's election of hospice care, the hospice assumes responsibility for the medical care of the beneficiary's terminal illness. The beneficiary waives

[1] 42 CFR § 418.302.

[2] Sections 1814(a)(7)(A) and 1861(dd)(3)(A) of the Act and 42 CFR § 418.20.

all rights to Medicare payment for services related to the curative treatment of the terminal condition or a related condition.[3] Inclusion in the Medicare hospice program is voluntary and can be revoked at any time by the beneficiary.[4]

Beneficiaries are entitled to receive hospice care for two 90-day periods, followed by an unlimited number of 60-day periods.[5] At the start of the initial 90-day period of care, the hospice must obtain written certification of the beneficiary's terminal illness from the hospice medical director or the physician member of the hospice interdisciplinary group and the beneficiary's attending physician, if any. For subsequent periods, a written certification by the hospice's physician is required. [6] The initial certification and all subsequent re-certifications must include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.[7]

Servicios Suplementarios de Salud, Inc.

The Hospice is a nonprofit organization that has provided hospice services to Medicare beneficiaries residing in Puerto Rico since 1991. During the period July 2008 through June 2010, the Hospice employed 152 health care professionals and served 9 regional areas throughout Puerto Rico.

National Government Services, Inc., (NGS) serves as the Home Health and Hospice MAC for hospice providers in Jurisdiction 6, which includes Puerto Rico.

HOW WE CONDUCTED THIS REVIEW

Our review covered 5,801 beneficiary-months for which the Hospice received Medicare reimbursement totaling $14,485,126 for hospice services provided during the period July 1, 2008, through June 30, 2010. A beneficiary-month includes all hospice services provided to a beneficiary during 1 month. We reviewed all Medicare payments for hospice services related to our random sample of 100 beneficiary-months. For certain sample items, we sought NGS's assistance in determining whether the associated hospice services met Medicare requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[3] Section 1812(d)(2)(A) of the Act.

[4] Section 1812(d)(2)(B) of the Act.

[5] 42 CFR § 418.21(a).

[6] 42 CFR § 418.22(c).

[7] 42 CFR § 418.22(b)(3).

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The Hospice claimed Medicare reimbursement for some hospice services that did not comply with certain Medicare requirements. Of the 100 beneficiary-months in our random sample for which the Hospice claimed Medicare reimbursement, 82 beneficiary-months complied with Medicare requirements, but 18 did not. Specifically:

- For 8 beneficiary-months, the associated beneficiary's case record did not contain documentation to support the beneficiary's eligibility for hospice services.

- For 6 beneficiary-months, the associated beneficiary's progress notes did not meet Medicare requirements for some of the services provided.

- For 4 beneficiary-months, the Hospice claimed Medicare reimbursement for hospice services provided to a beneficiary who had not elected hospice care or had revoked their election.

The improper payments occurred because the Hospice did not have adequate policies and procedures to ensure that it documented hospice services, including beneficiaries' hospice election and/or revocation certifications.

On the basis of our sample results, we estimated that the Hospice improperly received at least $453,558 in Medicare reimbursement for hospice services that did not meet Medicare requirements.

BENEFICIARY ELIGIBILITY NOT DOCUMENTED

To be eligible for the Medicare hospice benefit, a beneficiary must be entitled to Medicare Part A and be certified as being terminally ill.[8] For the initial period of care, the hospice must obtain from the hospice's physician and the beneficiary's attending physician (if any) a written certification of the terminal illness that specifies the beneficiary's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.[9] The certification must be accompanied by clinical information and other documentation that supports the medical prognosis and must be signed and dated by the physician(s). The written certification must be obtained before the hospice submits a claim for payment.[10]

For 8 beneficiary-months, the Hospice claimed Medicare reimbursement for services provided to a beneficiary for whom the Hospice did not provide documentation that the beneficiary was

[8] Sections 1814(a)(7)(A) and 1861(dd)(3)(A) of the Act and 42 CFR § 418.20.

[9] For subsequent periods of care, only a written certification from the hospice's physician is required.

[10] 42 CFR § 418.22.

eligible for the Medicare hospice benefit. Specifically, the beneficiary's case records did not contain a written certification of the beneficiary's terminal illness.

SERVICES NOT SUPPORTED

Payments to Medicare providers shall not be made unless the provider has furnished information necessary to determine the amounts due the provider.[11] In this respect, the hospice must maintain a clinical record containing past and current findings for each hospice patient. All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.[12]

For 6 beneficiary-months, the Hospice claimed Medicare reimbursement for services that were not adequately supported. Specifically, for 3 beneficiary-months, there were no progress notes in the associated beneficiary's case record to support physician services billed by the Hospice. For 3 other beneficiary-months, the progress notes were not signed (i.e., authenticated) by a physician.

BENEFICIARY DID NOT ELECT HOSPICE CARE OR HAD REVOKED ELECTION

Beneficiaries eligible for the Medicare hospice benefit may elect hospice care by filing a signed election statement with a hospice.[13] The beneficiary or their representative may revoke the beneficiary's election of hospice care at any time during an election period.[14]

For 4 beneficiary-months, the Hospice claimed Medicare reimbursement for services provided to a beneficiary who had not elected hospice care or had revoked their election. Specifically, for 2 beneficiary-months, there was no signed election statement in the associated beneficiary's case record and, for 2 other beneficiary-months, the beneficiary had revoked the hospice election.

[11] Section 1815(a) of the Act.

[12] 42 CFR §418.104.

[13] 42 CFR § 418.24. If the beneficiary is physically or mentally incapacitated, their representative may file the election statement. The election statement must include the identification of the hospice that will provide care, an acknowledgement that the beneficiary or their representative has a full understanding of the palliative rather than curative nature of hospice care and that certain Medicare services are waived by electing hospice care, the effective date of the election, and the signature of the beneficiary or their representative.

[14] 42 CFR § 418.28. To revoke the election of hospice care, the beneficiary or their representative must file a statement with the hospice that includes a signed statement that the beneficiary revokes election of hospice care and the effective date of the revocation.

RECOMMENDATIONS

We recommend that the Hospice:

- refund $453,558 to the Federal Government and

- strengthen its procedures to ensure that hospice services are documented in accordance with Medicare requirements.

SERVICIOS SUPLEMENTARIOS DE SALUD, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospice did not indicate concurrence or nonconcurrence with our recommendations; however, it stated that it agreed with our determinations for 13 of the 18 sampled beneficiary-months that we identified as noncompliant. Under separate cover, the Hospice provided additional documentation for the 5 sampled beneficiary-months for which it did not agree with our determinations. The Hospice also stated that it has completed a corrective action plan to address our findings and ensure that it complies with Medicare requirements. The Hospice's comments appear as Appendix D.

After reviewing the Hospice's comments and the additional documentation, we maintain that our findings and recommendations are valid. For 3 of the 5 beneficiary-months for which the Hospice disagreed with our determinations, the additional documentation it provided did not relate to the sampled service month. For the other 2 beneficiary-months, we could not determine whether written certifications were timely because the certifications were not dated by the Hospice's physician, as required. We also noted that the additional documentation provided for one of these cases was not related to the beneficiary's terminal illness and did not support a prognosis for a life expectancy of 6 months or less.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 5,801 beneficiary-months for which the Hospice received Medicare reimbursement totaling $14,485,126 for hospice services provided during the period July 1, 2008, through June 30, 2010. A beneficiary-month includes all hospice services provided to a beneficiary during 1 month.

We did not assess the Hospice's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of the Hospice's procedures related to documenting and billing Medicare for hospice services.

We conducted our fieldwork at the Hospice's central office in San Juan, Puerto Rico.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations and guidelines;
- met with CMS officials to gain an understanding of the Medicare hospice benefit;
- discussed with NGS officials hospice billing requirements and recent edits it implemented related to hospice services;
- met with Hospice officials to gain an understanding of the Hospice's procedures related to the administration of its hospice program;
- obtained from the CMS National Claims History file a sampling frame of 5,801 beneficiary-months, totaling $14,485,126, for the period July 1, 2008, through June 30, 2010;
- selected a simple random sample of 100 beneficiary-months from the sampling frame;
- obtained and reviewed case records for each of the sampled beneficiary-months to determine whether:
    - the associated beneficiary was eligible for hospice services,
    - the associated beneficiary had elected hospice services, and
    - documentation supported the services claimed;

- reviewed claim payment data to determine whether hospice services were reimbursed prior to the beneficiary electing hospice care or after the hospice election had been revoked;

- submitted case records for certain sample items to NGS for their assistance in determining whether the associated hospice services met Medicare requirements; and

- estimated the total unallowable Medicare reimbursement paid in the total population of 5,801 beneficiary-months.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of all Medicare Part A payments made to the Hospice for a beneficiary-month during the period July 1, 2008, through June 30, 2010. A beneficiary-month is defined as all hospice services provided to a beneficiary by the Hospice during 1 month.

SAMPLING FRAME

The sampling frame was an Access database containing 5,801 beneficiary-months, totaling $14,485,126. The data was extracted from the CMS National Claims History file.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiary-months.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the beneficiary-months in our sampling frame. After generating 100 random numbers, we selected the corresponding sampling frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the total amount of inappropriate Medicare payments for unallowable hospice services made to the Hospice at the lower limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Beneficiary-Months in Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Beneficiary-Months	Value of Unallowable Beneficiary-Months
5,801	$14,485,126	100	$242,123	18	$17,961

Estimated Value of Unallowable Beneficiary-Months
(Limits calculated for a 90-Percent Confidence Interval)

Point Estimate	$1,041,905
Lower Limit	$ 453,558
Upper Limit	$1,630,253

APPENDIX D: SERVICIOS SUPLEMENTARIOS DE SALUD, INC., COMMENTS

Servicios Suplementarios de Salud, Inc.
Hospicio Gregoria Auffant

H-121 Calle Atenas
Forest Hill
Bayamón, PR 00956
Tel. 787-780-4010/ 787-780-4294
Fax 787-787-5787

114 calle Eleanor Roosevelt
2do Piso
San Juan, PR 00918-3105
Tel. 787 763-0091 / 759-7036
Fax 787-751-1909

784 Avenida Campo Rico
Country Club
Rio Piedras, PR 00924
Tel. 787 762-7666 / 769-0630
Fax 787-762-7715

June 23, 2014

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

RE: **OIG Audit –Draft Report Number: A-02-11-01017**

Dear Mr. Edert:

According to your request for submitting you our views on the draft report, about the validity of the facts and reasonableness of the recommendations in the report, on reference, we are providing you our comments as follows:

A. **Statements of concurrence**
We agree with your findings on thirteen (13) beneficiaries –months which did not comply with the Hospice Medicare requirements. We have completed our corrective action plan submitted to the auditors on January 2012. Our corrective action plan included actions for seven (7) identified problems relevant to the audit's findings, except the electronic medical record, which is still in the development process. We are giving annual follow up to the referred action plan, and we expect to complete during the next twelve months the plan to automate the medical record.

B. **Nonconcurrence statements**
We have reviewed your *Draft Report Results by Sample Case*, and we have found that sample cases No. 44, 52, 67, and 68, have documented evidence at their medical records that support the beneficiary's eligibility for hospice services.

The documented evidence at the medical record in sample case No. 18, also demonstrates that the physician's notes met the medical requirements for the services provided.

We are submitting you the detailed evidence as it appears in the five (5) audited medical records, including our written clarification summary for each case. We are also including a reference from the Office of Medicare Hearings and Appeals, with content relevant to the audit's findings.

[1]

Thank you very much for the opportunity you are permitting us to communicate you our facts in regard to this report. Let us know if the comments that we are providing here in this letter, will change your final report.

Sincerely,

Carmen M. Martinó
Executive Director

CMM; EMJ|sie/Carta Contestación Plan Correctivo OIG Junio 2014-Final

C: -Mrs. Margie Colón, DHHS/OIG/OAS Auditor
-Mrs. Omayra Cruz, DHHS/OIG/OAS Auditor

[2]