Department of Health and Human Services
Office of Inspector General
Office of Audit Services

November 2024 | A-09-23-03024

Medicare Improperly Paid Acute-Care Hospitals an Estimated $190 Million Over 5 Years for Outpatient Services Provided to Hospice Enrollees

Report in Brief
Date: November 2024
Report No. A-09-23-03024

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Improperly Paid Acute-Care Hospitals an Estimated $190 Million Over 5 Years for Outpatient Services Provided to Hospice Enrollees

Why OIG Did This Audit

A prior OIG audit found that Medicare Part B improperly paid suppliers for durable medical equipment, prosthetics, orthotics, and supplies provided to hospice enrollees. Because payments to acute-care hospitals for outpatient services provided to hospice enrollees may also be at risk for being improper, we conducted this audit to determine whether Medicare properly paid for these services from calendar years 2017 through 2021 (audit period).

Our objective was to determine whether Medicare payments to acute-care hospitals for outpatient services provided to hospice enrollees complied with Medicare requirements.

How OIG Did This Audit

Our audit covered $283.7 million in Part B payments to acute-care hospitals for 1.3 million outpatient services billed with condition code 07 and provided to hospice enrollees during our audit period. (This code indicates that a service is not related to an enrollee's terminal illness and related conditions.) We selected for review a stratified random sample consisting of 100 outpatient service line items. For each sample item, we submitted medical records to an independent medical reviewer contractor (medical reviewer) to assess whether the outpatient service palliated or managed the enrollee's terminal illness and related conditions.

What OIG Found

For 30 of 100 sample items, payments to acute-care hospitals for outpatient services provided to hospice enrollees complied with Medicare requirements. For the remaining 70 sample items, however, payments did not comply with the requirements. Specifically, our medical reviewer found that Medicare paid acute-care hospitals for outpatient services that palliated or managed hospice enrollees' terminal illnesses and related conditions. These services were already covered as part of the hospices' per diem payments and should have been provided directly by the hospices or under arrangements between the hospices and acute-care hospitals. Medicare improperly paid the acute-care hospitals because, among other causes: (1) the prepayment edit process was not properly designed; (2) most acute-care hospitals reviewed only whether outpatient services palliated or managed terminal illnesses, not related conditions; (3) Medicare guidance lacks details; and (4) Medicare contractors did not conduct prepayment or postpayment reviews.

On the basis of our sample results, we estimated that Medicare could have saved $190.1 million for our audit period if payments had not been made to acute-care hospitals that provided outpatient services to hospice enrollees for services related to the palliation and management of the enrollees' terminal illnesses and related conditions. In addition, we estimated that enrollees could have saved $43.6 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.

What OIG Recommends and CMS Comments

We made six recommendations to CMS, including that CMS: (1) improve system edit processes to help reduce improper payments for outpatient services provided by acute-care hospitals to hospice enrollees; (2) educate acute-care hospitals to analyze whether outpatient services palliated or managed conditions related to enrollees' terminal illnesses; and (3) clarify Medicare guidance to specifically mention "related conditions."

CMS concurred with five of six recommendations but did not concur with our first recommendation. CMS stated that it has concerns about the feasibility and effectiveness of the type of modifications to the system edits described in our report. After reviewing CMS's comments, we refined our first recommendation. Improving CMS's system edit processes could help reduce improper payments going forward.

The full report can be found on the OIG website.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

A prior Office of Inspector General (OIG) audit found that Medicare paid $6.6 billion to nonhospice providers from 2010 through 2019 for items and services provided to hospice enrollees during a hospice period of care. The majority of those payments were for Part B items and services.[1] The audit also found that nonhospice payments for Part B items and services increased by 38 percent over that 10-year period.

Another OIG audit found that Medicare Part B improperly paid $117 million to suppliers for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items provided to hospice enrollees from January 1, 2015, through April 30, 2019.[2] These items were provided to palliate or manage enrollees' terminal illnesses and related conditions, so the items were covered as part of Medicare Part A's per diem payments to hospices. Because payments to acute-care hospitals for outpatient services provided to hospice enrollees may also be at risk for being improper, we conducted this audit to determine whether Medicare properly paid for these services from calendar years 2017 through 2021 (audit period). In general, Medicare should not separately pay an acute-care hospital if the outpatient services provided to a hospice enrollee palliated or managed the enrollee's terminal illness and related conditions.[3] Instead, these services should be provided under arrangements between the hospice and acute-care hospital.

This audit is one in a series of audits related to services provided to hospice enrollees by various provider types.

OBJECTIVE

Our objective was to determine whether Medicare payments to acute-care hospitals for outpatient services provided to hospice enrollees complied with Medicare requirements.

[1] *Medicare Payments of $6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight* (A-09-20-03015), Feb. 14, 2022.

[2] *Medicare Improperly Paid Suppliers an Estimated $117 Million Over 4 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Hospice Beneficiaries* (A-09-20-03026), Nov. 16, 2021.

[3] "Palliative care" is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs, and facilitating patient autonomy, access to information, and choice (42 CFR § 418.3).

BACKGROUND

Medicare Program and the Role of Medicare Contractors

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. Medicare Part A covers hospice services provided to eligible enrollees, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. Medicare enrollees are responsible for certain out-of-pocket costs, such as deductibles and coinsurance.[4]

The Centers for Medicare & Medicaid Services (CMS) administers Medicare. CMS contracts with a hospice Medicare Administrative Contractor (hospice MAC) in each Medicare jurisdiction to, among other things, process and pay Medicare Part A claims submitted by hospices. CMS also contracts with Part A and Part B Medicare Administrative Contractors (MACs) to process and pay outpatient claims. In addition, CMS contracts with other entities such as the Supplemental Medical Review Contractor, Recovery Audit Contractors, and Unified Program Integrity Contractors.[5]

Seven MACs process claims for 12 jurisdictions covering all 50 States, the District of Columbia, and U.S. Territories. An acute-care hospital submits a claim to the MAC that services the State or Territory in which services were provided. In addition to processing claims, MACs' responsibilities include educating acute-care hospitals on Medicare requirements and billing procedures through CMS's Targeted Probe and Educate (TPE) programs. Through a TPE program, a MAC works with an acute-care hospital to identify and correct billing errors.[6] To select providers for TPE reviews, MACs analyze Medicare claims data to identify acute-care hospitals that have high claim error rates or unusual billing practices. MACs also apply system edits to claims to determine whether claims are complete and should be paid.[7]

[4] Medicare Part B deductibles and coinsurance amounts could be paid directly by an enrollee or someone on their behalf (e.g., through another insurance program).

[5] The Supplemental Medical Review Contractor performs medical review activities directed by CMS. Recovery Audit Contractors are tasked with identifying and recovering Medicare overpayments and identifying underpayments. Unified Program Integrity Contractors perform fraud, waste, and abuse detection, deterrence, and prevention activities for Medicare claims.

[6] TPE programs use three rounds of review. In each round, a MAC selects 20 to 40 claims from an acute-care hospital for review. After each round, based on the results of the claim review, the MAC offers individualized education to the acute-care hospital.

[7] An edit is programming within the standard claim processing system that: (1) selects certain claims; (2) evaluates or compares information on the selected claims or other accessible sources; and (3) takes action on the claims—depending on the evaluation—such as paying claims in full or in part, denying payments, or suspending claims for manual review.

Hospital Outpatient Prospective Payment System

CMS implemented the outpatient prospective payment system (OPPS), effective for services furnished on or after August 1, 2000, for hospital outpatient services as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays an acute-care hospital for outpatient services on a rate-per-service basis.

Medicare Part B Payment Requirements

Medicare payments may not be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury, or to improve the functioning of a malformed body member (the Act § 1862(a)(1)(A)). In addition, payments may not be made to any provider of services or other person without information necessary to determine the amount due to the provider (the Act § 1833(e)). Federal regulations state that the provider must furnish to the MAC sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)). The *Medicare Claims Processing Manual* (Manual) requires providers to complete claims accurately so that MACs may process them correctly and promptly (Manual, chapter 1, section 80.3.2.2).

Medicare Part A Hospice Services

The Tax Equity and Fiscal Responsibility Act of 1982 created the Medicare hospice benefit.[8] Medicare Part A covers hospice services provided to eligible enrollees. The goal of hospice care is to help terminally ill enrollees continue life with minimal disruption and support enrollee families and other caregivers. The care is palliative rather than curative. The goal of palliative care is to improve an enrollee's quality of life by managing pain and relieving symptoms and by providing physical and emotional comfort. Hospice care may be provided to an enrollee residing at home or another place of residence, such as a skilled or other nursing facility.

Eligibility for Hospice Care

To be eligible for Medicare hospice care, an enrollee 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 illness runs its normal course.[9] Hospice care is available for two, 90-day benefit periods and an unlimited number of 60-day benefit periods during the remainder of the hospice enrollee's

[8] CMS implemented the hospice benefit through regulation in the final rule that went into effect on Nov. 1, 1983 (48 Fed. Reg. 56008 (Dec. 16, 1983)).

[9] 42 CFR § 418.20. Certification is based on an attending physician's or a hospice medical director's clinical judgment regarding the normal course of a disease (42 CFR § 418.22).

lifetime.[10] An enrollee eligible for the Medicare hospice benefit may elect hospice care by filing a signed election statement with a hospice.

When an enrollee elects hospice care, the hospice must complete a notice of election that must be submitted to the hospice MAC within 5 calendar days of the beginning of the enrollee's hospice care (42 CFR § 418.24(a)).[11] The notice of election contains information such as the code for the principal diagnosis (which is usually the terminal illness).[12] After the enrollee has elected a hospice, the hospice assumes responsibility for palliative care related to the enrollee's terminal illness and related conditions (the Act § 1861(dd); 42 CFR §§ 418.20, 418.22, and 418.24).[13, 14] The enrollee waives Medicare coverage for services related to treatment of the terminal illness and related conditions but retains Medicare coverage for services to treat conditions unrelated to the terminal illness and related conditions (42 CFR § 418.24(f)).

Coverage under the Medicare hospice benefit requires that hospice services be reasonable and necessary for the palliation and management of a terminal illness and related conditions.[15] Figure 1 shows items and services covered under the Medicare hospice benefit.

[10] A "benefit period" refers to a 90-day or a 60-day period. An "election period" is the range of time from the beginning through the end of hospice care, which may include multiple 90-day and 60-day benefit periods (42 CFR § 418.21; the Manual, chapter 11, § 20.1.6).

[11] A hospice submits a notice of election electronically or by submitting Form CMS-1450 (the Manual, chapter 11, § 20.1.1).

[12] A diagnosis code is a seven-character, alphanumeric code. Each code begins with a letter, followed by two numbers. The first three characters represent a "category." The category describes a general type of injury or disease. These characters are followed by a decimal point and characters for a subcategory.

[13] In the proposed rule addressing the fiscal year (FY) 2015 hospice wage index and payment rate updates, CMS solicited comments on the definitions of "terminal illness" and "related conditions" (79 Fed. Reg. 26538, 26541–42 (May 8, 2014)). However, CMS did not include these definitions in the FY 2015 final rule and has not included them in subsequent final rules. Even though CMS has not defined these terms in a rule, CMS has described a "terminal illness" as an advanced and progressively deteriorating illness that has been diagnosed as incurable, and "related conditions" as physical or mental conditions that are related to or caused by either the terminal illness or the medications used to manage the illness.

[14] An example of a terminal illness is chronic obstructive pulmonary disease, and a related condition is dyspnea (i.e., shortness of breath). Another example of a terminal illness is Alzheimer's disease, and a related condition is decubitus ulcer (i.e., bedsore) due to immobility.

[15] The Act § 1862(a)(1)(C); 42 CFR § 418.200.

Figure 1: Examples of Items and Services Covered Under the Medicare Hospice Benefit

Levels of Care and Medicare Part A Payments to Hospices

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 (i.e., a per diem rate) that is paid through Medicare Part A. A per diem payment is intended to cover not only visit costs but also other costs that a hospice incurs for palliation and management of an enrollee's terminal illness and related conditions.[16]

CMS's General View

". . . we reiterated our long-standing position that services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit."

Hospices must provide substantially all necessary services that palliate or manage a terminal illness and related conditions either directly or through arrangements.[17] In the 1983 final rule, CMS states: "It is our general view that the [Act § 1812(d)(1) 'exceptional and unusual circumstances'] waiver required by the law is a broad one and that hospices are required to provide virtually all the care that is needed by terminally ill patients" (48 Fed. Reg. 56008, 56010–11 (Dec. 16, 1983)). In addition, CMS states in the *Federal Register* that "it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life" (83 Fed. Reg. 20934, 20946 (May 8, 2018)). CMS reiterated this point in 2019, stating that its "long-standing position [is] that services unrelated to the terminal illness and related conditions should be exceptional,

[16] 42 CFR § 418.302. There has been little change in the hospice payment structure since the hospice benefit's inception. The per diem rate based on the level of care was established in 1983, and this payment structure remains today with some adjustments.

[17] Social Security Act § 1861(dd)(2)(A)(ii)(I)-(II). Necessary services include core services and non-core services. Examples of core services include nursing services, medical social services, and counseling (42 CFR § 418.64). Examples of non-core services include physical therapy services, occupational therapy services, speech-language pathology services, hospice aide and homemaker services, and volunteer services (42 CFR §§ 418.72 through 418.78).

unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit" (84 Fed. Reg. 38484, 38506 (Aug. 6, 2019)).

Medicare should not separately pay an acute-care hospital for outpatient services provided to an enrollee during a hospice stay if the services were given to palliate or manage a terminal illness and related conditions.[18] Instead, the outpatient services should be provided under arrangements between the hospice and the acute-care hospital (42 CFR §§ 418.24, 418.64, and 418.70).[19] Medicare pays the hospice for the outpatient services provided to the enrollee as part of the hospice's per diem payment.

Outpatient Services Provided to Hospice Enrollees

Hospices provide a wide range of services such as nursing care, physician services, and any other service that is specified in an enrollee's plan of care as reasonable and necessary for the palliation and management of the enrollee's terminal illness and related conditions (42 CFR § 418.202). Therefore, a hospice must: (1) directly provide all services that are necessary for the palliation and management of an enrollee's terminal illness and related conditions; or (2) arrange for acute-care hospital outpatient services to be provided to an enrollee by an acute-care hospital, and include the cost of those services on hospice claims submitted to Medicare.

Medicare Billing for Outpatient Services That Acute-Care Hospitals Provide to Hospice Enrollees Not Related to a Terminal Illness and Related Conditions

A Medicare Part B payment may be made for an outpatient service that is unrelated to a hospice enrollee's terminal illness and related conditions. The acute-care hospital bills Medicare for the outpatient service using an institutional claim and must include on the claim condition code 07.[20] The MAC processes the claim and pays the acute-care hospital. If warranted, a MAC may conduct prepayment or postpayment reviews to validate that the outpatient service billed with condition code 07 was not related to the enrollee's terminal illness and related conditions.[21]

Condition Code 07

Condition code 07 indicates that a service is not related to a hospice enrollee's terminal illness and related conditions. If an outpatient service is provided to an enrollee to treat a condition that is not related to the enrollee's terminal illness and related conditions, the acute-care hospital may bill Medicare Part B and include condition code 07 on its claim.

[18] The Act § 1861(dd)(1); 42 CFR §§ 418.24(f) and 418.202(f).

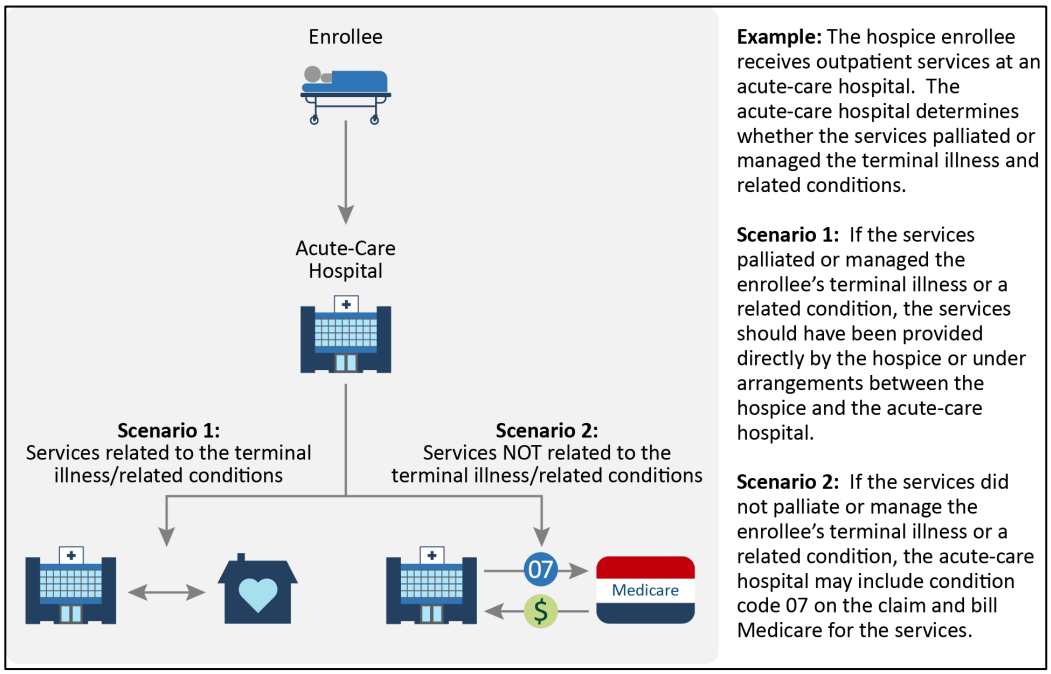
[19] Federal regulations define "arrangements" as those "which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services" (42 CFR § 409.3). CMS is silent on the specifics of the arrangements between the two parties.

[20] 79 Fed. Reg. 26538, 26549 (May 8, 2014).

[21] The Manual, chapter 11, § 50.

Figure 2 shows two billing scenarios for an acute-care hospital that provides outpatient services to a hospice enrollee. The scenarios involve: (1) services related to the terminal illness and related conditions and provided under arrangements with the hospice; and (2) services unrelated to the terminal illness or a related condition, and the acute-care hospital bills Medicare with condition code 07 for the services.

Figure 2: Two Billing Scenarios for Outpatient Services That an Acute-Care Hospital Provides to a Hospice Enrollee



Hospice Election Statement Addendum for Outpatient Services Unrelated to a Terminal Illness and Related Conditions

CMS modified the hospice election statement content requirements in the Fiscal Year 2020 Hospice Payment Rate Update and Final Rule for several reasons.[22] One reason was to promote greater transparency regarding coverage under the Medicare hospice benefit. Another reason was to potentially reduce the need for enrollees to seek care outside of the hospice benefit. A third reason was to assist in making treatment decisions and facilitate communication and benefit coordination between hospices and nonhospice providers (such as acute-care hospitals).

For hospice elections beginning on or after October 1, 2020, the hospice election statement must include acknowledgment that an enrollee has been provided information indicating that services unrelated to a terminal illness and related conditions are exceptional and unusual and the hospice should be providing virtually all care needed by the individual who has elected

[22] 84 Fed. Reg. 38484, 38507 (Aug. 6, 2019).

hospice care (42 CFR § 418.24(b)(3)). In addition, for hospice elections beginning on or after October 1, 2020, a hospice must provide notification of the right of an enrollee (or the enrollee's representative) to receive an election statement addendum. The addendum notifies the enrollee whether the hospice has determined that there are conditions, items, services, and/or drugs unrelated to the enrollee's terminal illness and related conditions that, therefore, would not be covered by the hospice (42 CFR §§ 418.24(b)(6) and 418.24(c)(1)–(7)). The addendum also notifies the enrollee that the unrelated items, services, and/or drugs may be covered under other Medicare benefits (e.g., Medicare Part B).[23] The addendum is provided at the request of the enrollee (or the enrollee's representative), nonhospice provider, or Medicare contractor (42 CFR § 418.24(c)).

Medicare Contractors and the Common Working File's Prepayment Edit Process

Hospice MACs use the Fiscal Intermediary Standard System (FISS) to process Medicare Part A claims that hospices submit for services provided to hospice enrollees. In addition, hospice MACs process in CMS's Common Working File (CWF) the notices of election submitted by hospices.

MACs use the FISS to process outpatient claims. Before a payment is made, an acute-care hospital's outpatient claim is sent to the CWF for verification, validation, and payment authorization. The CWF contains a prepayment edit process designed to prevent improper payments. For an enrollee who elects hospice care, the prepayment edit is only applied to an outpatient claim that is processed after the enrollee's notice of election is processed in the CWF. After the CWF has processed the outpatient claim for payment, the CWF notifies the MAC about any potential errors on the claim for further investigation. If an outpatient claim is billed without condition code 07, the MAC denies payment of the claim. However, if an outpatient claim is billed with condition code 07, the MAC automatically processes the claim for payment.[24]

HOW WE CONDUCTED THIS AUDIT

Our nationwide audit covered $283.7 million in Medicare Part B payments to acute-care hospitals for 1.3 million outpatient services billed with condition code 07 and provided to hospice enrollees during our audit period. To identify these services, we first identified hospice claims with dates of service during our audit period. We then used enrollee information and service dates from those claims to identify outpatient services that had service dates within the

[23] 84 Fed. Reg. 38484, 38512 (Aug. 6, 2019).

[24] Falsely appending condition code 07 to a claim for an outpatient service that was given to palliate or manage an enrollee's terminal illness and related conditions may violate Federal laws governing Medicare fraud and abuse, including the False Claims Act, Anti-Kickback Statute, Physician Self-Referral Law, Social Security Act (which includes the Exclusion Statute and the Civil Monetary Penalties Law), and other provisions of the U.S. Criminal Code.

hospice claims' dates of service, excluding the first and last days of each enrollee's hospice services.[25]

We selected a stratified random sample consisting of 100 outpatient service line items, totaling $120,059. For each sample item, we contacted the hospice and the acute-care hospital's officials and obtained written responses to questionnaires to understand their processes in billing for outpatient services provided to hospice enrollees. In addition, we requested that the hospice and the acute-care hospital assess whether the outpatient services palliated or managed the enrollee's terminal illness and related conditions, and we requested the enrollee's medical records. After analyzing their responses, we provided the medical records to an independent medical review contractor to determine whether the outpatient services: (1) met coverage, medical necessity, and coding requirements; and (2) palliated or managed the enrollee's terminal illness and related conditions (i.e., clinical assessments).[26]

We focused on Medicare Part B payments to acute-care hospitals for outpatient services billed with condition code 07. We did not conduct medical review to determine whether the hospices' Medicare Part A services were medically necessary.

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

FINDINGS

Most Medicare payments to acute-care hospitals for outpatient services provided to hospice enrollees did not comply with Medicare requirements. For 30 of 100 sample items, Medicare payments to acute-care hospitals for outpatient services provided to hospice enrollees complied with the requirements. Our independent medical review contractor found that these services palliated or managed conditions not related to the enrollees' terminal illnesses and related conditions. For the remaining 70 sample items, however, Medicare payments to acute-care hospitals for outpatient services provided to hospice enrollees did not comply with Medicare requirements. Specifically, our independent medical review contractor found that Medicare paid these acute-care hospitals for outpatient services that palliated or managed the

[25] A claim could have had more than one distinct outpatient service. Each outpatient service on a claim represented a line item, which this report refers to as a "sample item."

[26] To determine whether a condition is related to a terminal illness or whether an outpatient service treated a terminal illness or related condition, medical records need to be assessed and a clinical judgment needs to be made on a case-by-case basis.

enrollees' terminal illnesses and related conditions. These services were already covered as part of the hospices' per diem payments and should have been provided directly by the hospices or under arrangements between the hospices and acute-care hospitals. Instead, the acute-care hospitals improperly billed Medicare using condition code 07 on their outpatient claims, indicating that the outpatient services were not related to the enrollees' terminal illnesses and related conditions.

Improper payments to acute-care hospitals occurred because, among other causes: (1) the CWF prepayment edit process was not properly designed to prevent payments for outpatient services improperly billed with condition code 07, (2) Medicare guidance does not specifically mention related conditions in describing billing for outpatient services unrelated to an enrollee's terminal illness, and (3) none of the MACs conducted TPE reviews of acute-care hospitals that routinely used condition code 07, which could have allowed MACs to educate hospitals on the code's proper use.

Estimate of Savings

Over 5 years, Medicare could have saved **$190.1 million**, and enrollees could have saved **$43.6 million** in deductibles and coinsurance.

On the basis of our sample results, we estimated that Medicare could have saved $190.1 million for our audit period if payments had not been made to acute-care hospitals that provided outpatient services to hospice enrollees for services related to the palliation and management of the enrollees' terminal illnesses and related conditions.[27] In addition, we estimated that enrollees could have saved $43.6 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.[28]

FEDERAL REQUIREMENTS

Hospices are required to provide—directly or under arrangements—nursing care; medical social services; home health aide or homemaker services; physical or occupational therapy and speech-language pathology services; medical appliances and supplies (including drugs and biologics); physician services; short-term inpatient care; counseling; and any other item or service that is specified in the plan of care as reasonable and necessary for the palliation and management of enrollees' terminal illnesses and related conditions (the Act §§ 1861(dd)(1)(A) through (I); 42 CFR § 418.202). A hospice enrollee waives all rights to Medicare coverage for services that are related to the treatment of a terminal illness for which hospice care was elected or a related condition (42 CFR § 418.24(f)). The hospice per diem payment is to include all of the hospice services needed to manage an enrollee's care (Fed. Reg. 79, 26538, 26543 (May 8, 2014)). Therefore, Medicare Part B should not separately pay for an outpatient service already covered as part of a hospice's per diem payment.

[27] The estimated savings amount is $190,110,930.

[28] The estimated savings amount is $43,622,535.

MOST MEDICARE PAYMENTS TO ACUTE-CARE HOSPITALS FOR OUTPATIENT SERVICES PROVIDED TO HOSPICE ENROLLEES DID NOT COMPLY WITH MEDICARE REQUIREMENTS

For 70 of 100 sample items, Medicare payments to acute-care hospitals for outpatient services provided to hospice enrollees did not comply with Medicare requirements. Specifically, our independent medical review contractor found that Medicare paid acute-care hospitals for outpatient services that palliated or managed enrollees' terminal illnesses and related conditions. These services were already covered as part of the hospice per diem payments. These services should have been provided directly by the hospices or under arrangements between the hospices and acute-care hospitals.

Example 1 illustrates an improper payment made to an acute-care hospital for outpatient services provided to a hospice enrollee that palliated or managed the enrollee's terminal illness. The acute-care hospital improperly billed the claim with condition code 07, indicating that the services were not related to the enrollee's terminal illness and related conditions.

Example 1: Improper Payment to an Acute-Care Hospital for Outpatient Services Provided to a Hospice Enrollee That Palliated or Managed the Enrollee's Terminal Illness

A Medicare enrollee elected hospice care in May 2021. The enrollee resided at home but was receiving services from a hospice. The enrollee's terminal illness was myelodysplastic syndrome (a group of cancers in which immature blood cells in the bone marrow do not mature or become healthy blood cells). The enrollee visited an acute-care hospital, and the hospital provided to the enrollee transfusions of platelets, pheresis, and leukocytes on September 13, 2021, while the enrollee was in hospice care. The acute-care hospital billed Medicare with condition code 07 for the outpatient services, and Medicare paid the acute-care hospital $988 for the transfusions. The enrollee (or the enrollee's representative) and the acute-care hospital had the right to request an election statement addendum from the hospice to assist in determining whether the outpatient services palliated or managed the enrollee's terminal illness and related conditions. However, neither the enrollee (or a representative) nor the acute-care hospital requested the addendum.

Our independent medical review contractor reviewed the enrollee's medical records and provided a clinical assessment that found that the transfusions were necessary for the palliation and management of the enrollee's terminal illness. Although the transfusions were provided and were necessary, these services should have been provided directly by the hospice or under arrangements with the acute-care hospital, and Medicare should not have paid $988 for the transfusions. Moreover, the hospice stated that the transfusions provided relief of symptoms, were related to the terminal illness, and were coordinated with the acute-care hospital. The acute-care hospital acknowledged that the transfusions were related to the enrollee's terminal illness and were intended to make the enrollee more comfortable and therefore should have been covered by the hospice. The acute-care hospital stated that it should not have billed Medicare using condition code 07 and attributed the improper billing to human error. Independently, the acute-care hospital identified an additional 84 improperly billed outpatient claims (not in our sample) for this enrollee, for which Medicare had paid a total of $96,761 for other transfusions. The acute-care hospital refunded this amount to Medicare in September 2022.

PREPAYMENT EDIT PROCESS WAS NOT EFFECTIVE, MEDICARE GUIDANCE LACKS DETAILS, AND MACS DID NOT CONDUCT TARGETED PROBE-AND-EDUCATE REVIEWS

Medicare improperly paid acute-care hospitals for outpatient services provided to hospice enrollees because: (1) the CWF prepayment edit process was not properly designed to prevent improper payments; (2) hospice election statement addenda were available on request but were not requested by acute-care hospitals; (3) most acute-care hospitals reviewed only whether outpatient services palliated or managed enrollees' terminal illnesses, not related conditions; (4) the Manual does not specifically mention related conditions in describing billing for outpatient services unrelated to enrollees' terminal illnesses; and (5) none of the MACs conducted TPE reviews to identify acute-care hospitals that routinely used condition code 07 and to educate the hospitals on the code's proper use. Each of these causes is discussed in greater detail in the following sections.

Prepayment Edit Process Was Not Properly Designed To Prevent Improper Payments

The CWF contains a prepayment edit process designed to prevent improper payments for outpatient claims for services provided to a hospice enrollee. If an outpatient claim is billed without condition code 07, the MAC denies payment of the claim. However, if the outpatient claim is billed with condition code 07, the MAC automatically processes the claim for payment. Using condition code 07 bypasses the CWF edit process because this edit works on the presumption that outpatient services are related to an enrollee's terminal illness and related conditions unless the hospital uses condition code 07 on the claim. Had the prepayment edit process been designed to automatically compare an outpatient claim's diagnosis codes with the hospice claim's diagnosis codes, either by doing an exact match of diagnoses or a "familial" match (i.e., a match within the family of diagnosis codes), the edit would have rejected many of these claims. For 41 of the 70 improperly paid sample items, the diagnosis code or codes on the outpatient claim had exact matches with the hospice claim's diagnosis codes (35 sample items) or had matches within the family of diagnosis codes (6 sample items).[29]

Hospice Election Statement Addenda Were Available but Not Requested by Acute-Care Hospitals

For outpatient services provided after October 1, 2020 (the hospice election statement addendum effective date), the addendum contains information on: (1) an enrollee's conditions present on admission to the hospice; (2) associated items, services, and drugs not covered by the hospice; and (3) clinical explanations of why the identified conditions, items, services, and drugs are considered unrelated to the enrollee's terminal illness and related conditions and are not needed for pain management. For all 50 sample items for outpatient services provided after October 1, 2020, acute-care hospitals did not request addenda despite having the right to request addenda. These addenda would have assisted the acute-care hospitals in assessing

[29] A match between the first three characters of a diagnosis code on an outpatient claim and on a hospice claim is considered a match within a family of diagnosis codes.

whether outpatient services palliated or managed the enrollees' terminal illnesses and related conditions and in appropriately using condition code 07.

Most Acute-Care Hospitals Reviewed Only Whether Outpatient Services Palliated or Managed Enrollees' Terminal Illnesses, Not Related Conditions

For 62 of the 70 improperly paid sample items, acute-care hospitals limited reviews to whether outpatient services palliated or managed an enrollee's terminal illness and did not review whether those services palliated or managed related conditions. Example 2 illustrates an improper payment made to an acute-care hospital for outpatient services that were not reviewed by the hospital to determine whether the services treated a condition related to the terminal illness.

Example 2: Improper Payment to an Acute-Care Hospital for Outpatient Services Provided to a Hospice Enrollee That Palliated or Managed a Condition Related to the Terminal Illness

A Medicare enrollee elected hospice care in February 2015. The enrollee resided at home but was receiving services from a hospice. The enrollee's terminal illness was heart failure, and the enrollee had the following related conditions: atrial fibrillation, hyperlipidemia, and chronic pulmonary edema. The acute-care hospital provided outpatient services for a planned surgery, including our sample item, which was the battery exchange of a pacemaker on January 10, 2017, while the enrollee was in hospice care. The acute-care hospital billed Medicare with condition code 07 for the outpatient services, and Medicare paid the acute-care hospital $7,416 for exchanging the battery of a pacemaker. At the time, the right to request an election statement addendum from the hospice was not in effect; therefore, neither the enrollee (or a representative) nor the acute-care hospital requested an addendum to assist in determining whether the outpatient service palliated or managed the enrollee's terminal illness and related conditions.

Our independent medical review contractor reviewed the enrollee's medical records and provided a clinical assessment that found that exchanging the pacemaker's battery was necessary for the palliation and management of a condition related to the enrollee's terminal illness. Specifically, the enrollee's conditions of heart failure and atrial fibrillation caused an irregular heart rhythm. A pacemaker is an implanted, battery-powered medical device that generates electrical pulses to help keep the heartbeat at a normal rate and rhythm. A pacemaker can also be used to help the heart chambers beat in sync so that the heart can pump blood more efficiently to the body. Moreover, the hospice stated that the outpatient service was related to the enrollee's terminal illness and related conditions. Although the service to exchange the battery of the pacemaker was performed and was necessary, the service should have been provided directly by the hospice or under arrangements with the acute-care hospital, and Medicare should not have paid $7,416 for the service.

The acute-care hospital informed us that the outpatient service was not related to the enrollee's terminal illness of heart failure. However, the acute-care hospital reviewed only whether the service treated the enrollee's heart failure; it did not review whether the service treated a condition related to heart failure. Medicare should not have paid the acute-care hospital for the outpatient service provided to the enrollee during the hospice stay because the service was given to palliate or manage a condition related to the terminal illness. Instead, the service should have been provided under arrangements between the hospice and the acute-care hospital.

Medicare Guidance Does Not Specifically Mention Related Conditions in Describing Billing for Outpatient Services Unrelated to a Terminal Illness

Unlike Federal regulations and the *Federal Register*, the Manual does not specifically mention related conditions in describing billing for outpatient services unrelated to enrollees' terminal illnesses. Specifically, the Manual states that any service not related to a terminal illness for which hospice care was elected may be billed with condition code 07 but does not include "related conditions" as a factor for acute-care hospitals to review (chapter 11, section 50). Moreover, the guidance that MACs provide to acute-care hospitals is based on what is outlined in the Manual. For six of seven MACs, the guidance provided to acute-care hospitals mentions only that services may be reimbursed if not related to a terminal illness.

An acute-care hospital that billed one of the outpatient services in our sample stated that it reviews only whether outpatient services palliated or managed an enrollee's terminal illness (not the related conditions) according to how the Manual describes billing for outpatient services unrelated to a terminal illness. Table 1 compares the billing descriptions in the Manual with those in the Federal regulations and *Federal Register*.

Table 1: Comparison of the Manual's Description of Billing for Services Unrelated to a Terminal Illness With Descriptions in Federal Regulations and the *Federal Register*

The Manual vs. Federal Regulations and the Federal Register	
The Manual, chapter 11, section 50—Billing and Payment for Services Unrelated to Terminal Illness "Any covered Medicare services not related to the treatment of **the terminal condition for which hospice care was elected** [emphasis added—no mention of "related conditions"], and which are furnished during a hospice election period, may be billed by the rendering provider using . . . institutional claims for non-hospice Medicare payment."	**42 CFR § 418.24(f) – Election of hospice care: waiver of other benefits** ". . . an individual waives all rights to Medicare payments for . . . [a]ny Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or **a related condition** [emphasis added] . . . ." **84 Fed. Reg. 38484, 38506 (Aug. 6, 2019)** CMS "reiterated [its] long-standing position that services unrelated to the terminal illness and **related conditions** [emphasis added] should be exceptional, unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit . . . ." **79 Fed. Reg. 26538, 26549 (May 8, 2014)** "When [an enrollee] elects the Medicare hospice benefit, [the enrollee] waives the right to Medicare payment for services related to the terminal illness and **related conditions** [emphasis added] . . . ." "Medicare payment is allowed for covered Medicare items or services which are unrelated to the terminal illness and **related conditions** [emphasis added]."

MACs Conducted Neither Targeted Probe-and-Educate Reviews nor Any Prepayment or Postpayment Reviews Related to Acute-Care Hospitals' Appropriate Usage of Condition Code 07

The responsibilities of the seven MACs include conducting data analysis to identify acute-care hospitals that have aberrant billing patterns and to educate those hospitals on Medicare requirements and billing procedures through CMS's TPE program, through which a MAC works with an acute-care hospital to identify billing errors and correct them. During our audit period, the MACs did not: (1) analyze Medicare claims data to identify acute-care hospitals that have aberrant billing patterns for condition code 07, and conduct targeted TPE reviews of these acute-care hospitals; and (2) conduct any prepayment or postpayment reviews related to acute-care hospitals' appropriate usage of condition code 07.

In addition, four of the seven MACs do not have access to hospice medical records. For a MAC to determine whether an outpatient service palliated or managed an enrollee's terminal illness and related conditions, assistance from the hospice MAC would be needed.[30]

MEDICARE COULD HAVE SAVED AN ESTIMATED $190.1 MILLION IN PAYMENTS MADE TO ACUTE-CARE HOSPITALS FOR OUTPATIENT SERVICES PROVIDED TO HOSPICE ENROLLEES

On the basis of our sample results, we estimated that for our audit period Medicare could have saved $190.1 million in payments made to acute-care hospitals for outpatient services improperly billed with condition code 07, and enrollees could have saved $43.6 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf. For more details, see Appendix C.

CONCLUSION

The hospice benefit covers a wide range of services, such as nursing care, physician services, physical therapy, short-term inpatient care, medical supplies, and any other service that is specified in the plan of care as reasonable and necessary. To reduce the risk of enrollees not receiving needed services, hospices are required to provide all necessary services for the palliation and management of enrollees' terminal illnesses and related conditions or, regarding acute-care hospital outpatient services, make arrangements with an acute-care hospital to provide services to an enrollee and include those costs on hospice claims submitted to Medicare. An acute-care hospital's separate billing of Medicare for outpatient services provided to an enrollee and related to an enrollee's terminal illnesses and related conditions should not be occurring. If an acute-care hospital bills Medicare for these services, Medicare could be paying twice for the same services.

[30] After our audit period, a MAC that is also a hospice MAC initiated a prepayment review of Medicare Part B claims for items that durable medical equipment suppliers billed with modifier GW, a code similar to condition code 07. A supplier appends this modifier to a claim to indicate that a DMEPOS item is not related to a hospice enrollee's terminal illness and related conditions.

This report highlighted that Medicare paid acute-care hospitals $283.7 million for outpatient services with dates of service during our audit period that were provided to hospice enrollees and billed by acute-care hospitals as unrelated to terminal illnesses and related conditions (i.e., billed with condition code 07). It also highlighted that enrollees paid $67.1 million in deductibles and coinsurance collected from them or from someone on their behalf.

On the basis of our sample results, we estimated that for our audit period Medicare could have saved $190.1 million in payments made to acute-care hospitals for outpatient services that palliated or managed enrollee terminal illnesses and related conditions. These services should have been provided directly by hospices or under arrangements between the hospices and acute-care hospitals. Medicare pays hospices for the services provided to enrollees as part of the hospices' per diem payments. In addition, we estimated that enrollees could have saved $43.6 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services take the following actions, which could have saved Medicare an estimated $190.1 million in payments made to acute-care hospitals for outpatient services provided to hospice enrollees and could have saved enrollees an estimated $43.6 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf during our audit period:

- Improve system edit processes to help reduce improper payments for outpatient services provided by acute-care hospitals to hospice enrollees.

- Educate acute-care hospitals to understand that each hospice enrollee's hospice election statement addendum is available on request, and educate hospices to provide the addendum if requested to help an acute-care hospital assess whether an outpatient service palliated or managed an enrollee's terminal illness and related conditions.

- Continue to educate hospices that they should be providing to enrollees virtually all necessary services that palliate or manage terminal illnesses and related conditions either directly or through arrangements.

- Educate acute-care hospitals to analyze not only whether outpatient services palliated or managed enrollees' terminal illnesses but also whether outpatient services palliated or managed a condition related to a terminal illness.

- Clarify the language in the Manual (chapter 11, section 50), and in other CMS or MAC guidance documents or educational initiatives, if necessary, to specifically mention "related conditions" so that the language is consistent with Federal regulations and the *Federal Register* in stating that services not related to enrollees' terminal illnesses and related conditions may be billed to Medicare with condition code 07.

- Direct MACs or other appropriate contractors, such as Recovery Audit Contractors, to: (1) analyze Medicare claims data to identify acute-care hospitals that have aberrant billing patterns for condition code 07, and conduct Targeted Probe and Educate reviews of these acute-care hospitals; and (2) conduct prepayment or postpayment reviews of acute-care hospital claims for outpatient services provided to hospice enrollees and billed with condition code 07.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our second through sixth recommendations and provided information on actions that it had taken or planned to take to address these recommendations. However, CMS did not concur with our first recommendation. CMS's comments are included in their entirety as Appendix D.

After reviewing CMS's comments, we refined the wording of our first recommendation. Our summaries of CMS's comments on the recommendations and our response to CMS's nonconcurrence with the first recommendation are in the following sections.

CMS COMMENTS

- **First recommendation.** CMS did not concur with this recommendation. CMS stated that it has concerns about the feasibility and effectiveness of the type of modifications to the system edits described in our report. CMS stated that it is the hospice's responsibility to identify an individual's terminal illness and related conditions upon election of the hospice benefit. CMS also stated that determining whether outpatient services are related to an individual's terminal illness and related conditions requires clinical judgment and is best suited for complex medical review. CMS stated, however, that it will take our findings and all other recommendations into consideration.

- **Second recommendation.** CMS concurred and stated that information on the hospice election statement addendum, including timeframes for hospices to furnish the addendum, is outlined in chapter 9, section 20.2.1.2, of the Medicare Benefit Policy Manual. CMS stated that it will continue to educate hospices and nonhospice providers about the hospice election statement addendum.

- **Third recommendation.** CMS concurred and stated that the comprehensive nature of the services covered under the Medicare hospice benefit was structured so that hospice enrollees would not have to routinely seek items, services, and medications beyond those provided by a hospice. CMS stated that it will continue to educate hospices that they should be providing Medicare enrollees virtually all necessary services that palliate or manage terminal illnesses and related conditions either directly or through arrangements.

- **Fourth recommendation.** CMS concurred and stated that it will educate nonhospice providers, such as acute-care hospitals, that hospices are responsible for not only the terminal condition but also those conditions related to the terminal condition and that this should be taken into account before submitting a claim with condition code 07.

- **Fifth recommendation.** CMS concurred and stated that it will review the language in the Manual, and other documents as necessary, to ensure that the language is consistent with Federal regulations and the *Federal Register.*

- **Sixth recommendation.** CMS concurred and stated that it uses a robust program integrity strategy to reduce and prevent Medicare improper payments. CMS also stated that it will take our findings and recommendation into consideration when determining any appropriate next steps.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding our first recommendation, we refined the wording to recommend that CMS improve its system edit processes to help reduce (instead of to prevent) improper payments for outpatient services provided by acute-care hospitals to hospice enrollees. Improving system edit processes may help identify claims that merit additional review. The issues we identified in our audit are longstanding. A prior OIG audit found that Medicare paid $6.6 billion to nonhospice providers from 2010 through 2019 for items and services provided to hospice enrollees during a hospice period of care.[31] In that audit, we identified a potential risk for inappropriate payments of Part B nonhospice items and services during a hospice period of care. Another OIG audit found that Medicare Part B improperly paid $117 million to suppliers for DMEPOS items provided to hospice enrollees.[32] In this audit, we found that Medicare improperly paid $190.1 million to acute-care hospitals for outpatient services provided to hospice enrollees from calendar years 2017 through 2021. The improper payments identified in our audits could have been reduced with an effective system edit process to detect improper payments to nonhospice providers.

Although we acknowledge the importance of clinical judgment in determining whether a specific outpatient service is related to a terminal illness and related conditions, improving system edit processes could help identify improper claims and claims that require further scrutiny. Such improvements will assist MACs or other appropriate contractors, such as Recovery Audit Contractors, in identifying claims that require medical review and will lead to timely reviews of these claims and recovery of improper payments. Improving CMS's system edit processes could help reduce improper payments going forward.

[31] See footnote 1.

[32] See footnote 2.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nationwide audit covered $283,732,214 in Medicare Part B payments to acute-care hospitals for 1,275,600 outpatient services billed with condition code 07 and provided to hospice enrollees from January 1, 2017, through December 31, 2021. To identify these services, we first identified hospice claims with dates of service during our audit period. We then used enrollees' information and service dates from those claims to identify outpatient services that had service dates within the hospice claims' dates of service, excluding the first and last days of each enrollee's hospice services.

We selected a stratified random sample consisting of 100 outpatient service line items, totaling $120,059. For each sample item, we contacted the hospice and the acute-care hospital that provided care to an enrollee to obtain the enrollee's medical records and requested that the hospice and acute-care hospital assess whether the outpatient services palliated or managed the enrollee's terminal illness and related conditions. After analyzing their responses, we provided the medical records to an independent medical review contractor to determine whether the outpatient services: (1) met coverage, medical necessity, and coding requirements; and (2) palliated or managed the enrollee's terminal illness and related conditions.

We focused on Medicare Part B payments to acute-care hospitals for outpatient services billed with condition code 07. We did not conduct medical review to determine whether hospices' Medicare Part A services were medically necessary.

We did not perform an overall assessment of the internal control structures of CMS, MACs, or hospice MACs. Rather, we limited our review to those internal controls (i.e., program safeguards) related to Medicare payment requirements. To assess internal controls, we interviewed CMS officials to obtain an understanding of the CWF edit process. In addition, we reviewed policies and procedures governing the processing and payment of Medicare Part B claims billed with condition code 07 for outpatient services provided to enrollees receiving hospice care. As part of that review, we interviewed hospice and acute-care hospitals officials and MACs to confirm our understanding of their policies and procedures. Furthermore, we interviewed and obtained written responses to our questionnaires from hospices and acute-care hospitals to understand their processes in billing for outpatient services provided to hospice enrollees. Lastly, we analyzed the claims data for our audit period to determine the potential impact of the weaknesses we identified in the processes for preventing and detecting improper Part B payments for outpatient services.

Our audit procedures enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the data.

We conducted our audit from July 2022 through May 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and CMS guidance;

- interviewed and obtained written responses to our questionnaires from hospices and acute-care hospitals to understand their processes in billing for outpatient services provided to hospice enrollees;

- used CMS's NCH file to identify Medicare Part A hospice claims with dates of service during our audit period;

- used CMS's NCH file to create a sampling frame of 1,275,600 Medicare Part B outpatient services billed with condition code 07 that had service dates during our audit period and within the hospices' dates of service, excluding the first and last day of each enrollee's hospice services;[33]

- selected a stratified random sample of 100 outpatient services billed with condition code 07 (see Appendix B);

- reviewed available data from CMS's CWF for the 100 sample items to determine whether the claims had been canceled or adjusted;

- interviewed CMS officials and reviewed documentation they provided to understand how the CWF prepayment edit process works;

- requested from hospices and acute-care hospitals associated with the 100 sample items the enrollees' medical records and the clinical assessments of whether the outpatient services palliated or managed the enrollees' terminal illnesses and related conditions;[34]

- provided the medical records to an independent medical review contractor to determine whether the outpatient services: (1) met coverage, medical necessity, and coding requirements; and (2) palliated or managed the enrollees' terminal illnesses and related conditions;

- estimated the total amount that Medicare improperly paid acute-care hospitals for outpatient services provided to hospice enrollees that palliated or managed terminal illnesses and related conditions (see Appendix C);

[33] The outpatient services had paid amounts of $10 or more and totaled $283,732,214.

[34] See footnote 26.

- estimated the total amount in deductibles and coinsurance that may have been incorrectly collected from hospice enrollees or from someone on their behalf for outpatient services that palliated or managed terminal illnesses and related conditions (see Appendix C); and

- discussed the results of our audit with CMS officials.

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: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of Medicare Part B outpatient services provided to hospice enrollees during our audit period. The sampling frame comprised 1,275,600 outpatient service line items billed with condition code 07 for which acute-care hospitals received Medicare payments of $283,732,214. The sampling frame contained line items with payment amounts of $10 or more.

SAMPLE UNIT

The sample unit was an outpatient service line item.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing six strata (see Table 2). We stratified the sampling frame based on the dollar amount of the payment for the outpatient services and the effective date of the hospice election addendum requirement (October. 1, 2020).

Table 2: Strata for Outpatient Service Line Items

Stratum	Outpatient Category	No. of Outpatient Service Line Items in Sampling Frame	Value of Frame	Sample Size
1	Hospice admission date on or after 10/1/2020 ($10 to $493.98)	227,381	$32,013,874	25
2	Hospice admission date on or after 10/1/2020 ($493.99 or greater)	18,410	32,013,084	25
3	Hospice admission date before 10/1/2020 ($10 to $215.23)	765,408	54,926,346	15
4	Hospice admission date before 10/1/2020 ($215.24 to $407.17)	183,888	54,932,288	10
5	Hospice admission date before 10/1/2020 ($407.18 to $1,802.01)	65,062	54,938,814	10
6	Hospice admission date before 10/1/2020 ($1,802.02 or greater)	15,451	54,907,808	15
Total		**1,275,600**	**$283,732,214**	**100**

SOURCE OF RANDOM NUMBERS

The source of the random numbers for our sample was the OIG, Office of Audit Services (OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sample items in each stratum by a unique CMS claim line field (IDR_LINK_LINE_NUM) and then consecutively numbered the sample items in each stratum in the sampling frame. After generating the random numbers for our sample according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate: (1) the amount that Medicare improperly paid acute-care hospitals for outpatient services billed with condition code 07 and (2) the amount in deductibles and coinsurance that may have been incorrectly collected from hospice enrollees or from someone on their behalf for outpatient services billed with condition code 07. These estimates apply only to items listed in our sampling frame.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results for Medicare Payments*

Stratum	No. of Outpatient Service Line Items in Sampling Frame	Value of Frame	Sample Size	Value of Sample	No. of Improperly Billed Outpatient Services in Sample	Value of Improperly Billed Outpatient Services in Sample
1	227,381	$32,013,874	25	$4,042	17	$2,679
2	18,410	32,013,084	25	34,134	19	21,427
3	765,408	54,926,346	15	941	12	743
4	183,888	54,932,288	10	3,194	8	2,490
5	65,062	54,938,814	10	8,413	8	7,478
6	15,451	54,907,808	15	69,335	6	17,098
Total	**1,275,600**	**$283,732,214**	**100**	**$120,059**	**70**	**$51,915**

*Strata 1 and 2 consist of outpatient services provided to hospice enrollees with hospice admission dates on or after October 1, 2020. Strata 3 through 6 consist of outpatient services provided to hospice enrollees with hospice admission dates before October 1, 2020.

Table 4: Sample Results for Enrollee Payments (Deductibles and Coinsurance)

Stratum	No. of Outpatient Service Line Items in Sampling Frame	Value of Enrollee Payments in Frame	Sample Size	Value of Enrollee Payments in Sample	No. of Improperly Billed Outpatient Services in Sample	Value of Improper Enrollee Payments in Sample
1	227,381	$8,017,376	25	$823	17	$609
2	18,410	6,052,045	25	6,576	19	3,399
3	765,408	14,231,861	15	227	12	180
4	183,888	14,288,135	10	811	8	632
5	65,062	13,944,373	10	1,923	8	1,668
6	15,451	10,568,185	15	10,786	6	3,786
Total	**1,275,600**	**$67,101,975**	**100**	**$21,146**	**70**	**$10,274**

Table 5: Estimated Improper Medicare Payments for Outpatient Services in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$190,110,930
Lower limit	153,704,474
Upper limit	226,517,385

Table 6: Estimated Improper Enrollee Payments for Outpatient Services in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$43,622,535
Lower limit	34,160,760
Upper limit	53,084,310

APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: July 30, 2024

TO: Juliet T. Hodgkins
Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Acute-Care Hospitals an Estimated $190 Million Over 5 Years for Outpatient Services Provided to Hospice Enrollees (A-09-23-03024)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to high quality hospice care while protecting taxpayer and beneficiary dollars by preventing improper payments. CMS has made significant changes in hospice payment policy in recent years to better align payments with the cost of care and to provide beneficiaries with more transparency about what items and services are the responsibility of the hospice to provide versus those that the hospice has determined are unrelated to the palliation and management of the beneficiary's terminal condition.

CMS has also focused on the integrity of the hospice benefit and strengthened its monitoring of hospice claims to reduce improper payments. CMS has initiated prepayment medical review, including targeted probe and educate reviews, of hospice services from certain providers. Further, CMS has taken action to reduce and prevent improper Medicare payments for items and services unrelated to the terminal condition of the beneficiary (i.e., the beneficiary's terminal illness and related conditions) that are paid separate from the hospice service. For example, CMS's Recovery Audit Contractors were approved to begin reviewing durable medical equipment billed after the admission date and before the discharge date of a hospice election in October 2018.[1] As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

Hospices are required to educate each patient and their primary caregiver(s) on the palliative versus curative nature of the Medicare hospice benefit and outline the services needed for the palliation and management of the patient's terminal illness and related conditions on the plan of care and document the patient's or representatives' level of understanding, involvement, and agreement with the plan of care. To promote greater transparency regarding coverage under the Medicare hospice benefit and potentially reduce the need for beneficiaries to seek care outside of the hospice benefit for services related to their terminal illness, CMS modified the hospice

[1] Information regarding the Recovery Audit Contractors' reviews is available online at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics-Items/0114-DME-while-in-Hospice

election statement content requirements in the FY 2020 Hospice Payment Rate Update and Final Rule (CMS-1714-F).[2] Effective for hospice elections beginning on or after October 1, 2020, the hospice election statement must include, among other requirements, information about the holistic, comprehensive nature of the Medicare hospice benefit, as well as a statement that, although it would be rare, there could be some necessary items, drugs, or services that would not be covered by the hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions.

Also for hospice elections beginning on or after October 1, 2020, hospices are required, upon request, to provide the beneficiary (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors an addendum to the hospice election statement with a written list and rationale for any conditions, items, services, or drugs that the hospice has determined are unrelated to the individual's terminal illness and related conditions. The election statement addendum must include, among other requirements, a list of the individual's conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions. It must also include a written clinical explanation as to why the identified conditions, items, services, and drugs are considered unrelated to the individual's terminal illness and related conditions and not needed for pain or symptom management. CMS believes this is necessary information for patients and their families to make informed care decisions and to anticipate any financial liability associated with needed items, services, and drugs not provided under the Medicare hospice benefit.

Additionally, CMS has taken action to educate health care providers on the proper billing of hospice services.[3, 4] CMS has also taken steps to educate health care providers regarding the recent changes to the hospice election statement and addendum. For example, CMS published a Medicare Learning Network article regarding the manual updates related to the hospice election statement and the implementation of the election statement addendum and released a hospice election statement example.[5]

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services improve system edit processes to prevent improper payments for outpatient services provided by acute-care hospitals to hospice enrollees.

CMS Response

CMS does not concur with this recommendation. CMS has concerns about the feasibility and effectiveness of the type of modifications to the system edits presented by OIG in this report. It is the hospice's responsibility to identify an individual's terminal illness and related conditions

[2] Medicare Program Fiscal Year 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule (August 6, 2019) https://www.govinfo.gov/content/pkg/FR-2019-08-06/pdf/2019-16583.pdf

[3] Information about the Hospice Prospective Payment System is available online at: https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice

[4] Information about the hospice payment system and coverage is available online at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Hospice

[5] MLN Matters Manual Updates Related to the Hospice Election Statement and the Implementation of the Election Statement Addendum (November 6, 2020) https://www.cms.gov/files/document/mm12015.pdf; Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" (Updated March 2023) https://www.cms.gov/files/document/model-hospice-election-statement-addendum-march-2024.pdf

upon election of the hospice benefit. The determination of whether the outpatient services are related to an individual's terminal illness and related conditions requires clinical judgement and is best suited for complex medical review. However, CMS will take OIG's findings and all other recommendations into consideration as we determine appropriate next steps.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services educate acute-care hospitals to understand that each hospice enrollee's hospice election statement addendum is available on request, and educate hospices to provide the addendum if requested to help an acute-care hospital assess whether an outpatient service palliated or managed an enrollee's terminal illness and related conditions.

CMS Response

CMS concurs with this recommendation. Information regarding the hospice election statement addendum, including the ability for individuals (or representatives), non-hospice providers furnishing items, services, or drugs, or Medicare contractors to request the addendum, as well as timeframes for hospices to furnish the addendum, are outlined in Chapter 9, Section 20.2.1.2 of the Medicare Benefit Policy Manual.[6] CMS will continue to educate hospices and non-hospice providers regarding the hospice election statement addendum.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services continue to educate hospices that they should be providing to enrollees virtually all necessary services that palliate or manage terminal illnesses and related conditions either directly or through arrangements.

CMS Response

CMS concurs with this recommendation. The comprehensive nature of the services covered under the Medicare hospice benefit is structured so that hospice beneficiaries would not have to routinely seek items, services, and medications beyond those provided by hospice. We believe that it would be unusual and exceptional to see services related to the treatment of the terminal condition for which hospice care was elected or a related condition provided outside of hospice for those individuals who are approaching the end of life and we have reiterated since 1983 that ''virtually all'' care needed by the terminally ill individual should be provided by the hospice. CMS will continue to educate hospices that they should be providing people with Medicare virtually all necessary services that palliate or manage terminal illnesses and related conditions either directly or through arrangements.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services educate acute-care hospitals to analyze not only whether outpatient services palliated or managed enrollees' terminal illnesses but also whether outpatient services palliated or managed a condition related to a terminal illness.

CMS Response

CMS concurs with this recommendation. CMS will educate non-hospice providers, such as acute-care hospitals, that hospices are responsible for not only the terminal condition but also those conditions related to the terminal condition and that this should be taken into account before submitting a claim with condition code 07.

---

[6] Chapter 9 of the Medicare Benefit Policy Manual is available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c09.pdf

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services clarify the language in the Medicare Claims Processing Manual (chapter 11, section 50), and in other CMS or MAC guidance documents or educational initiatives, if necessary, to specifically mention "related conditions" so that the language is consistent with Federal regulations and the Federal Register in stating that services not related to an individual' terminal illnesses and related conditions may be billed to Medicare with condition code 07.

CMS Response

CMS concurs with this recommendation. CMS will review the language in the Medicare Claims Processing Manual, and other documents as necessary, to ensure that the language is consistent with Federal regulations and the Federal Register.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the MACs or other appropriate contactors, such as Recovery Audit Contractors, to: (1) analyze Medicare claims data to identify acute-care hospitals that have aberrant billing patterns for condition code 07, and conduct Targeted Probe and Educate reviews of these acute-care hospitals; and (2) conduct prepayment or postpayment reviews of acute-care hospital claims for outpatient services provided to hospice enrollees and billed with condition code 07.

CMS Response

CMS concurs with this recommendation. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments. CMS will take the OIG's findings and recommendation into consideration when determining any appropriate next steps.

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does it Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Stay In Touch

Follow HHS-OIG for up to date news and publications.

 OIGatHHS

 HHS Office of Inspector General

Subscribe To Our Newsletter

OIG.HHS.GOV

Contact Us

For specific contact information, please visit us online.

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov