OIG Audit: Medicare Improperly Paid Acute-Care Hospitals for Outpatient Services Provided to Hospice Enrollees

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The findings of a Health and Human Services (HHS) Office of the Inspector General (OIG) audit revealed that Medicare improperly paid acute-care hospitals an estimated $190 million for outpatient services provided to hospice enrollees. The OIG reviewed a random sample of 100 acute-care hospital claims that were paid while a beneficiary was also enrolled in the Medicare hospice benefit. The audit was conducted from 2017 through 2021and found that 70 of the sample claims did not comply with Medicare requirements.

In a recently released report on this audit, the OIG estimates that in addition to Medicare potentially saving $190 million during the audit timeframe if the acute-care hospital claims had complied with requirements, hospice 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.

In this most recent audit report, the OIG stated that the hospitals were paid 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. The OIG cited four causes for the improper acute-care hospital payments for hospice enrollees and made six recommendations to CMS:

Causes:

1. the claims 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.

Recommendations:

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 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.
3. 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.

4. 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.

5. Clarify the language in the Manual (chapter 11, section 50), and in other CMS or MAC (Medicare Administrative Contractor) 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.

6. 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 concurred with five of the six recommendations but did not concur with the first recommendation. CMS stated that it has concerns about the feasibility and effectiveness of the type of modifications to the system edits described in the report. CMS further 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.

Medicare payments for items and services provided to Medicare beneficiaries outside the Medicare hospice benefit during a hospice period of care (referred to as "nonhospice payments") have been a concern for the OIG as well as the Centers for Medicare & Medicaid Services (CMS) for some time. CMS continues to reiterate its 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 and "virtually all" care needed for a hospice enrollee should be provided by the hospice. As the Alliance has shared in written comments to CMS on the subject of nonhospice payments, and as the causes the OIG cited in its report highlight, hospices are not fully to blame for nonhospice payments.

In some of the cases the OIG reviewed for this audit it was noted that the acute care hospital and the beneficiary/caregiver had the right to request a Medicare hospice election statement addendum, but neither did. If they had, the claims may have been properly billed. Effective for Medicare hospice elections on or after October 1, 2020, hospice beneficiaries (or their representative) and non-hospice suppliers and providers caring for the hospice beneficiary may request that the hospice provide them an election statement addendum which identifies, 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. The OIG made some recommendations to CMS relative to the addendum which CMS concurred with.

After reviewing CMS's comments to recommendations resulting from this recent audit, the OIG refined its first recommendation to recommend that CMS improve its system edit processes to help reduce (instead of to prevent) improper payments.

The Alliance recommends that hospices review their processes and communications with patients (or their representatives) to ensure that:

- Notice of the right to request the addendum meets requirements as outlined in Section 20.2.1.2 of Chapter Nine of the Medicare Benefit Policy Manual.
- Processes for providing the addendum are in place and meet requirements for content and timeframe.
- Communication processes with patients includes routinely asking what non-hospice providers or suppliers the patient may be receiving services, items or drugs from. This allows the hospice to reach out to these non-hospice providers or suppliers for coordination of care and coverage.