Moreover, the compliance programs should address the ramifications of failing to cease and correct any conduct criticized in a Special Fraud Alert, if applicable to hospices, or to take reasonable action to prevent such conduct from reoccurring in the future. If appropriate, a hospice should take the steps described in section II.G. regarding investigations, reporting, and correction of identified problems. [ Although the OIG concluded in a 1998 report that the Medicare hospice program seems to be working as intended,\(^{(20)}\) compliance programs for hospices should still address areas of OIG concern that include: \(^{(21)}\) Hospices may also want to consult the OIG’s Work Plan when conducting the risk assessment. The OIG Work Plan details the various projects the OIG intends to address in the applicable fiscal year. It should be noted that the priorities in the Work Plan are subject to modification and revision as the year progresses and it does not represent a complete or final list of areas of concern to the OIG. The Work Plan is currently available on the Internet at http://www.dhhs.gov/progorg/oig. ]

- uninformed consent to elect the Medicare Hospice Benefit; \(^{(22)}\) [A hospice must ensure that an individual (or authorized representative) is informed about the palliative nature of the care and services that may be provided if the individual desires to elect the Medicare Hospice Benefit. 42 CFR 418.62. The decision to elect the Medicare Hospice Benefit has significant consequences because the patient waives the right to receive standard Medicare benefits related to the terminal illness, including all treatment for the purposes of curing the terminal illness. See 42 U.S.C. 1395d(d). A patient’s hospice election statement must include the following items of information: (1) identification of the particular hospice that will provide care to the individual; (2) the individual’s or representative’s acknowledgment that he or she has been given a full understanding of hospice care; (3) the individual’s or representative’s acknowledgment that he or she understands that certain Medicare services are waived by the election; (4) the effective date of the election; and (5) the signature of the individual or representative. See Medicare Hospice Manual ¶ 210. ]

- admitting patients to hospice care who are not terminally ill; \(^{(23)}\) [ For a hospice patient to receive reimbursement for hospice services under Medicare, the patient must be "terminally ill." See 42 U.S.C. 1395d(a). An individual is considered to be "terminally ill" if the individual has a medical prognosis that the individual’s life expectancy is six months or less if the illness runs its normal course. 42 CFR 418.3. In March 1995, Operation Restore Trust (ORT), a joint initiative, was established between the OIG, HCFA, and Administration on Aging. Among its projects, ORT assessed the medical eligibility for hospice services in the five largest States in terms of Medicare spending (New York, Florida, Illinois, Texas and California). Through ORT activities, it was discovered that many beneficiaries receiving Medicare hospice benefits did not have a terminal illness as defined by Medicare. See OIG report A-05-96-00023 - “Enhanced
Controls Needed to Assure Validity of Medicare Hospice Enrollments." See also section II.A.3.a. and accompanying notes.]

• arrangement with another health care provider who a hospice knows is submitting claims for services already covered by the Medicare Hospice Benefit;[24]

[When an individual makes an election to receive services covered by the Medicare Hospice Benefit, that individual waives the right to receive Medicare reimbursement for any treatment related to his or her terminal illness. Accordingly, a hospice should ensure it is not involved with a health care provider who the hospice knows submits claims for the following services that are unallowable for reimbursement under the Medicare Hospice Benefit: (1) standard Medicare benefits for treatment of the terminal illness; (2) treatment by another hospice not arranged for by the patient’s hospice; and (3) care from another provider that duplicates care the hospice is required to furnish. See 42 U.S.C. 1395d(d). It is expected that the hospice provider will work with other providers to coordinate care and ensure appropriate billing if these situations occur. Where a single episode of care culminates in an inpatient admission and also involves services by two different providers, the need for a clear record from both providers is critical.]

• under-utilization;[25]

[In other words, knowing denial of needed care in order to keep costs low. A hospice is accountable for the appropriate allocation and utilization of its resources in order to provide optimal care consistent with the needs of a patient, family and/or lawful representative. When a patient is receiving hospice care, the hospice is paid a predetermined fee for each day during the length of care, no matter how much care the hospice actually provides. This means that a hospice may have a financial incentive to reduce the number of services provided to each patient, because the hospice will get paid the same amount regardless of the number of services provided. The OIG has received complaints about hospices neglecting patient needs and ignoring reasonable requests for treatment, including complaints about limited availability of durable medical equipment for patients as their medical condition decreases and failure to provide continuous care for periods of crisis due to staff shortages. The OIG has also been alerted to improper utilization of services that occurs when a hospice encourages a patient to revoke the Medicare Hospice Benefit for the purpose of obtaining expensive care under the standard Medicare benefits, only to re-elect the Medicare Hospice Benefit when expensive care is no longer necessary.]

• falsified medical records or plans of care;[26]

[OIG investigations have revealed that certain hospices have falsified patient medical records and plans of care to exaggerate the negative
aspects regarding a hospice patient's condition to justify reimbursement. See section II.A.3.b. and accompanying notes.

- untimely and/or forged physician certifications on plans of care;
- inadequate or incomplete services rendered by the Interdisciplinary Group; (27) Each hospice is required to have an "Interdisciplinary Group" of personnel. See 42 U.S.C. 1395x(dd)(2)(B). See note 16. Failure of the Interdisciplinary Group to meet its responsibilities may result in substandard care. In addition, inadequate review of a hospice patient may result in improper reimbursement for services provided to a patient who fails to continue to be eligible for the Medicare Hospice Benefit.

- insufficient oversight of patients, in particular, those patients receiving more than six consecutive months of hospice care; (28) Since the enactment of the Balanced Budget Act of 1997, the Medicare Hospice Benefit is divided into the following benefit periods: (1) initial 90-day; (2) subsequent 90-day; and (3) unlimited number of 60-day benefit periods as long as the patient continues to meet program eligibility requirements. See 42 U.S.C. 1395d. At the beginning of each subsequent 60-day benefit period, the hospice physician must recertify that the patient is terminally ill. See 42 U.S.C. 1395f(a)(7). If the necessary oversight is not performed during the unlimited periods of care, a hospice may receive improper reimbursement for services provided to a patient who fails to continue to be eligible for the Medicare Hospice Benefit.

- hospice incentives to actual or potential referral sources (e.g., physicians, nursing homes, hospitals, patients, etc.) that may violate the anti-kickback statute or other similar Federal or State statute or regulation; (29) Examples of arrangements that may run afoul of the anti-kickback statute include practices in which a hospice pays a fee to a physician for each certification of terminal illness, or provides nursing, administrative, and other services for free or below fair market value to physicians, nursing homes, hospitals and other potential referral sources with the intent to influence referrals. See 42 U.S.C. 1320a-7b; 60 FR 40847 (1995). See also discussion in section II.A.4. and accompanying notes. In addition, a hospice that offers an incentive to an individual that such hospice knows or should know is likely to influence the individual to use a particular hospice may be subject to civil money penalties. See 42 U.S.C. 1320a-7a(5). Including improper arrangements with nursing homes; (30) The OIG has observed instances of potential kickbacks between hospices and nursing homes to unlawfully influence the referral of patients. In general, payments by a hospice to a nursing home for "room and board" provided to a Medicaid hospice patient should not exceed what the nursing home otherwise would have received directly from Medicaid if the patient
had not been enrolled in hospice. (If a patient receiving Medicare hospice benefits in a nursing home is also eligible for Medicaid, Medicaid will pay the hospice at least 95 percent of the State’s daily nursing home rate, and the hospice is then responsible for paying the nursing home for the patient’s room and board.) See Hospice Medicare Manual o 204.2. See also section II.A.4. and accompanying notes.)

- overlap in the services that a nursing home provides, which results in insufficient care provided by a hospice to a nursing home resident;[31] [There may be some overlap in the services that the nursing homes and hospices provide, thereby providing one or the other the opportunity to reduce services and costs. Recent OIG reports found that residents of certain nursing homes receive fewer services from their hospice than patients who receive hospice services in their own homes. Upon review, it was found that many nursing home hospice patients were receiving only basic nursing and aide visits that were provided by nursing home staff as part of room and board when hospice staff were not present. Other additional treatments provided by hospice staff, such as nursing and aide visits, were often clearly within the professional skills possessed by nursing home staff. The reports found that the nature of services provided by hospice staff, while appropriate and efficacious, appeared to differ little from services a nursing home would have provided if the patient was not enrolled in hospice. See OIE report OIE-05-95-00250 - "Hospice Patients in Nursing Homes;" see also OIG report A-05-96-00023 - "Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments." Since hospices receive a fixed daily payment regardless of the number of services provided or the location of the patient, fewer services may result in higher profits per patient. See also section II.A.3.e. and accompanying notes.)

- improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers and privately-paid professionals;[32] [Certain of the hospice services (i.e., "core services" such as nursing, medical, social, and counseling services) must be provided directly to the patient by employees of the hospice, while other non-core hospice services may be provided at fair market value in accordance with contracts with other providers. However, the hospice must retain professional management for all contracted services. See 42 CFR 418.80.)

- providing hospice services in a nursing home before a written agreement has been finalized, if required;[33] [A patient who resides in a skilled nursing facility or nursing facility may elect the Medicare Hospice Benefit if: (1) the residential care is paid for by (a) the beneficiary or private insurance, or (b) Medicaid (if the beneficiary is dual eligible); and (2) the hospice and facility have a written agreement under which the hospice takes full responsibility for the professional
management of the individual's hospice care and the facility agrees to provide room and board. Hospice Medicare Manual § 204.2.]

- billing for a higher level of care than was necessary; (34)  
  [Billing for unnecessary services involves knowingly seeking reimbursement for services that "are not reasonable and necessary for the palliation or management of terminal illness." See 42 U.S.C. 1395y(a)(1)(C). Because HCFA establishes different payment amounts for specific categories of covered hospice care, a hospice must ensure that it provides services to hospice patients that are reasonable and necessary. Otherwise, the hospice may be reimbursed for a higher level of care than was necessary, e.g., a hospice that provides and bills for continuous care where only routine home care is necessary. See also section II.A.3.d. and accompanying notes.]

- knowingly billing for inadequate or substandard care;

- pressure on a patient to revoke the Medicare Hospice Benefit when the patient is still eligible for and desires care, but the care has become too expensive for the hospice to deliver; (35)  
  [Fiscal intermediaries have informed the OIG that hospices rarely offer the reasons supporting the revocation of a patient's Medicare Hospice Benefit. Although a hospice may discharge a patient if it discovers that the patient is not terminally ill, hospices should not encourage a patient to revoke the benefit merely to avoid the obligation to pay for hospice services that have become too costly. See 42 CFR 418.28; Hospice Medicare Manual § 210.]

- billing for hospice care provided by unqualified or unlicensed clinical personnel; (36)  
  [Medicare conditions of participation require that hospices and all hospice employees must be licensed in accordance with applicable Federal, State and local laws and regulations. 42 CFR 418.72.]

- false dating of amendments to medical records; (37)  
  [If additions or corrections need to be made to medical records, hospices should make such entries according to standards of practice and applicable State law. For example, hospices might correct a medical record by drawing a single line through the erroneous entry, writing "error" next to the entry, initialing and dating the correction and writing the correct information near the entry or writing where the correct information could be found.]

- high-pressure marketing of hospice care to ineligible beneficiaries; (38)
Hospices should not utilize prohibited or inappropriate conduct (e.g., offer free gifts or services to patients), designed to maximize business growth and patient retention, to carry out their initiatives and activities. Also, any marketing information offered by hospices should be clear, correct, non-deceptive, and fully informative. Through ORT, it was discovered that hospice marketing materials had placed considerable emphasis on the availability of hospice benefits for long term care patients, while downplaying or ignoring the terminal illness eligibility requirement. See OIG report A-05-96-00023 - "Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments." Hospices should not engage in marketing and sales strategies that offer incomplete or inadequate information about Medicare entitlement under the Medicare Hospice Benefit to induce beneficiaries to elect hospice and thereby waive aggressive treatment options that Medicare would otherwise cover. Marketing statements should not create the perception that the initial terminal prognosis is of limited importance and that hospice benefits may almost routinely be provided over an indefinite time period. Marketing materials should prominently feature the eligibility requirements for the Medicare Hospice Benefit.

• improper patient solicitation activities, such as "patient charting;" (39)

An example of an improper review of patient records is when a hospice arranges with the administration of a nursing facility to review patient records without the patients' permission, solely to determine if the patients are eligible for hospice care and to solicit hospice referrals. Hospices should not review medical records of nursing home patients in an attempt to recruit patients for hospice services based on their diagnoses. For instance, see OIG report A-05-96-00023 - "Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments."

• inadequate management and oversight of subcontracted services, which results in improper billing; (40)

The Balanced Budget Act of 1997, Pub.L. 105-33, amended the Social Security Act so that hospices will no longer be required to routinely provide all physician services directly by employing a physician. See 42 U.S.C. 1395x(dd)(2). Because the OIG has received reports of limited involvement displayed by contracted physicians, as opposed to hospice-employed physicians, hospices should consider having oversight mechanisms in place to ensure that hospice physicians are thoroughly reviewing re-certification documentation.

• sales commissions based upon length of stay in hospice; (41)

Through ORT activities, it was discovered that hospice sales staff often were paid on commission based on the length of a patient's stay in hospice. For example, commission amounts were determined by multiplying the total number of days of hospice patient care (patient days)
within a sales representative's territory by a factor that reflected the level of achievement of assigned sales performance objectives. Such marketing tactics encouraged the recruitment of long-term patients, many of whom the review found ineligible for the Medicare Hospice Benefit. The OIG recommends that hospices monitor sales commissions for potential vulnerabilities associated with improper patient recruiting. See OIG report A-05-96-00023 - "Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments."

- deficient coordination of volunteers:[42]
  [ Hospices rely heavily on volunteer support. In fact, the Medicare Hospice Benefit is the only Federally funded program that mandates the provision of volunteer services. Appropriately, hospices need to recognize and attend to compliance issues associated with volunteers (i.e., screening, training, disciplining, monitoring, etc.). ]

- improper indication of the location where hospice services were delivered:[43]
  [ Medicare payments for hospice services are made on a prospective basis and adjusted by an area wage index. Hospices must submit claims based on the geographic location at which the service is furnished and not the location of the hospice. Incorrect designation of the place of service for revenue codes 651 and 652 of the hospice claim may significantly alter reimbursement and result in overpayment for services performed (e.g., hospice office in a metropolitan area may be reimbursed more than a rural home where the services were performed). ]

- failure to comply with applicable requirements for verbal orders for hospice services:[44]
  [ Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive a verbal certification of terminal illness and file written certifications in the medical record. See 42 CFR 418.22(d). State regulations may require that verbal and telephone orders from physicians should only be accepted by individuals authorized by State law to accept such orders. The OIG recommends that those authorized individuals accepting verbal and telephone orders should record, date and sign these orders and the physician(s) who ordered the service or treatment should countersign them no later than the time period required by State regulations.]

- non-response to late hospice referrals by physicians:[45]
  [ We have received comments expressing concern over late hospice referrals by physicians. While the onus of a timely hospice referral may be on a physician, a hospice should identify untimely referrals and provide adequate follow-up to the physicians. When hospice referrals are late, terminally ill patients may be unnecessarily denied access to the Medicare... ]
Hospice Benefit, hospices may have to admit a patient at the costliest stage of terminal illness, and quality of care may be affected because of patients being too far along to receive the optimum benefits of hospice care. Hospices need to work closely with physicians to educate and remind them as to the sensitivities and risks associated with untimely referrals. The OIG supports appropriate efforts to increase access to hospice care for eligible individuals.

- knowing misuse of provider certification numbers, which results in improper billing;\(^{46}\)(E.g., transfer of a patient from one hospice to another hospice owned by the same company to circumvent applicable reimbursement caps.)

- failure to adhere to hospice licensing requirements and Medicare conditions of participation;\(^{47}\) and
  [See 42 CFR 418.50-418.100 for the Medicare conditions of participation that apply to hospices.]

- knowing failure to return overpayments made by Federal health care programs.\(^{48}\)
  [An overpayment is the amount of money a hospice may have received in excess of the amount due and payable under a health care program. Examples of overpayments include, but are not limited to, instances where a hospice is: (1) paid twice for the same service either by Medicare or by Medicare and another insurer; or (2) paid for care rendered to patients who are not terminally ill or are otherwise ineligible for the Medicare Hospice Benefit. For instance, see Hospice Medicare Manual § 307. The OIG strongly recommends that the hospice institute procedures to detect overpayments and to promptly remit such overpayments to the affected payor. See 42 U.S.C. 1320a-7b(a)(3), which provides criminal penalties for failure to disclose an overpayment. See also 18 U.S.C. 669.]

A hospice’s prior history of noncompliance with applicable statutes, regulations and Federal health care program requirements may indicate additional types of risk areas where the hospice may be vulnerable and that may require policies and procedures to prevent recurrence.\(^{49}\)

[“Recurrence of misconduct similar to that which an organization has previously committed casts doubt on whether it took all reasonable steps to prevent such misconduct” and is a significant factor in the assessment of whether a compliance program is effective. See United States Sentencing Commission Guidelines, Guidelines Manual, 8AT.2, Application Note 3(k)(iii).] Additional risk areas should be assessed by hospices as well and incorporated into the written policies and procedures and training elements developed as part of their compliance programs.