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Administrator  
Centers for Medicare & Medicaid Services

**FROM:** Stuart Wright /S/  
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**SUBJECT:** Memorandum Report: *Questionable Billing for Physician Services for Hospice Beneficiaries*, OEI-02-06-00224

This memorandum report determines the extent of questionable billing for physician services under both Medicare Part A and Medicare Part B for hospice beneficiaries in 2009. The Medicare hospice benefit allows a beneficiary with a terminal illness to forgo curative treatment for the illness and instead receive palliative care, which is the relief of pain and other uncomfortable symptoms. The number of Medicare beneficiaries receiving hospice care has increased significantly in recent years, from 729,000 in 2003 to over 1 million in 2008.<sup>1</sup> In addition, concerns about the benefit have been raised, including a recent Office of Inspector General (OIG) report that found that 82 percent of hospice claims for beneficiaries residing in nursing facilities did not meet Medicare coverage requirements.<sup>2</sup>

In addition, during meetings with OIG, CMS raised concerns specifically about physician billing for hospice beneficiaries. It listed Part B billing for physician services as one of the top hospice issues that should be addressed. CMS noted that physician billing for hospice services is a potential vulnerability, given that Medicare pays for physician services through Part A or Part B, depending on the physician's relationship with the hospice. CMS also noted that physicians may be billing for services related to the terminal illness under Part B that hospices are also billing for under Part A.

We found that questionable billing for Part B physician services provided to hospice beneficiaries amounted to nearly \$566,000 in 2009. This means that Medicare paid this amount to physicians directly through Part B for services related to a beneficiary's terminal illness, while

<sup>1</sup> Centers for Medicare & Medicaid Services (CMS) analysis of Medicare Health Care Information System data for 2008 claims. Accessed at <http://www.cms.hhs.gov/center/hospice.asp> on July 16, 2010. At the time of the writing of this report, the most recent available data were for 2008.

<sup>2</sup> OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance With Medicare Coverage Requirements*, OEI-02-06-00221, September 2009.

Medicare also paid for services from the same physician for the terminal illness under Part A. One-third of these questionable claims were from Florida.

Although we did not find that this problem is widespread, billing for physician services for hospice care is a potential program vulnerability given that Medicare may be billed under Part A and Part B. As such, we encourage CMS to continue to monitor this issue. In addition, we will refer all of the questionable claims to CMS for appropriate action. We will provide this information in a separate memorandum.

## **BACKGROUND**

The goals of hospice care are to help terminally ill beneficiaries continue life with minimal disruption and to support beneficiaries' families and other caregivers throughout the process. The care may be provided to individuals and their families in the home or other places of residence, such as a skilled or other nursing facility. In 2008, over 1 million beneficiaries received Medicare hospice care at a cost of \$11.2 billion.<sup>3</sup>

To be eligible for Medicare hospice care, a beneficiary must be entitled to Part A of Medicare and be certified as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course. Upon a beneficiary's election of hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. This care is palliative, rather than curative. It includes, among other things, nursing care, medical social services, home health aide (sometimes referred to as hospice aide) services, medical supplies, and physician services. The beneficiary waives all rights to Medicare payment for services related to the curative treatment of the terminal condition or a related condition but retains rights to Medicare payment for services to treat conditions unrelated to the terminal illness.<sup>4</sup>

The Medicare hospice benefit has four levels of care, and each level has an all-inclusive, daily rate that is paid through Part A. The rate is paid to the hospice for each day that a beneficiary is in hospice care, regardless of the number of services furnished. The four levels of care are routine home care, continuous home care, inpatient respite care, and general inpatient care. Routine home care is the most common level of care. Appendix A provides detailed information on hospice services, the four levels of care, and the payment rates.

Some physician services relating to the terminal illness are paid separately, in addition to the daily rate.<sup>5</sup> Medicare pays for these services through Part A or Part B, depending on the

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<sup>3</sup> CMS analysis of Medicare Health Care Information System data for 2008 claims. Accessed at <http://www.cms.hhs.gov/center/hospice.asp> on July 16, 2010. At the time of the writing of this report, the most recent available data were for 2008.

<sup>4</sup> 42 CFR § 418.24(d).

<sup>5</sup> 42 CFR § 418.304. While the daily rate includes hospice medical director supervisory services and plan of care services performed by the physician member of the hospice's interdisciplinary group, other physician services are billed separately.

physician's relationship with the hospice. If the beneficiary's attending physician is an employee of or under contract with the hospice provider, Medicare pays the hospice for physician services under Part A, and the hospice compensates the physician through salary or some other arrangement. In these instances, the Part A hospice claim will include a code for physician services in a line item separate from the daily rate.

If the beneficiary's attending physician is not an employee of or under contract with the hospice provider, Medicare pays the physician for physician services under Part B.<sup>6</sup> In these instances, the physician bills Medicare Part B directly for the physician services provided to the hospice beneficiary. Physicians can include modifiers on their Part B claims. The GV modifier indicates that the attending physician is not employed or paid under agreement by the patient's hospice provider. The GW modifier indicates that the service is not related to the hospice patient's terminal condition.<sup>7</sup> In 2009, Medicare paid \$165 million for Part B physician services for hospice beneficiaries.<sup>8</sup>

This memorandum report is part of OIG's continuing work on Medicare hospice care. A series of previous OIG reports have focused on hospice care for beneficiaries residing in nursing facilities. OIG found that 31 percent of Medicare hospice beneficiaries resided in nursing facilities in 2006 and that 82 percent of hospice claims for these beneficiaries did not meet Medicare coverage requirements.<sup>9</sup> OIG also found that hospices most commonly provided nursing, home health aide, and medical social services to beneficiaries in nursing facilities, furnishing an average of 4.2 visits per week for these 3 services combined.<sup>10</sup> Another report found that, on average, beneficiaries in nursing facilities spent more time in hospice and were associated with higher Medicare reimbursements than beneficiaries in other settings.<sup>11</sup> Lastly, a fourth OIG report found a number of cases in which the use of respite care for beneficiaries in nursing facilities may have been inappropriate; these cases were referred to CMS for corrective action.<sup>12</sup>

## METHODOLOGY

We based this memorandum report on an analysis of Part A and Part B claims for physician services provided to hospice beneficiaries. To accomplish this, we extracted all Medicare Part A

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<sup>6</sup> 42 CFR § 418.304(c).

<sup>7</sup> CMS, *Medicare Claims Processing Manual, ch. 11 - Processing Hospice Claims*, sections 40.1.3 and 50. Accessed at <https://www.cms.gov/manuals/downloads/clm104c11.pdf> on August 31, 2010.

<sup>8</sup> OIG analysis of 2009 Part B physician service claims for hospice beneficiaries. This amount includes reimbursements for Part B physician services unrelated to hospice beneficiaries' terminal diagnoses.

<sup>9</sup> OIG, *Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities*, OEI-02-06-00223, September 2009; OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance With Medicare Coverage Requirements*, OEI-02-06-00221, September 2009.

<sup>10</sup> OIG, *Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities*, OEI-02-06-00223, September 2009.

<sup>11</sup> OIG, *Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings*, OEI-02-06-00220, December 2007.

<sup>12</sup> OIG, *Hospice Beneficiaries' Use of Respite Care*, OEI-02-06-00222, March 2008.

hospice claims from CMS's National Claims History file (NCH) that included physician service dates in 2009. These services were provided by a physician who was an employee or under contract with the hospice provider. The services were indicated by a code on the claim that was listed separately from the daily hospice rate. Part A hospice claims typically cover a 1-month period but could be for shorter periods of time.

We identified the beneficiaries' Health Insurance Claim Numbers for each Part A claim and extracted these beneficiaries' Part B physician claims for 2009 from the NCH. For each beneficiary, we compared the dates of service on the Part B claims to the time periods covered by the Part A hospice claims. We included in our analysis Part B claims with a date of service that fell within the time period covered by a Part A hospice claim. We excluded from our analysis any Part B claims that occurred on the beneficiary's first day in hospice care because the services on these Part B claims may have been provided before the beneficiary's election of hospice care. For instance, a beneficiary may receive Part B physician services for a terminal illness in the morning, elect hospice care in the afternoon, and receive physician services under the Part A hospice benefit later in the day. In this case, both physician services may be appropriate.

We then compared the physician and diagnosis of each Part B physician claim and its corresponding Part A hospice claim by using the National Provider Identifiers and diagnosis codes included on the claims. We excluded from our analysis claims in which the physician used the GW modifier indicating that the service provided was not related to the hospice beneficiary's terminal condition *and* provided a diagnosis specific to the service billed which differed from the beneficiary's terminal diagnosis. We excluded these claims because physicians are allowed to bill Part B for services that are not related to a hospice beneficiary's terminal condition.<sup>13</sup>

We identified instances in which a physician billed Part B for services provided to a hospice beneficiary for his or her terminal illness while a hospice billed Part A for services by that same physician for the same beneficiary and illness. In other words, the service date on the Part B claim fell within the time period covered by the Part A claim and the physician and diagnosis on the Part B physician claim matched the physician and diagnosis on the Part A claim. We considered these claims to be questionable.<sup>14</sup>

We identified the physicians and hospices associated with these questionable claims. We also determined how often physicians included a GV modifier on the questionable claims. This modifier is used to indicate that the attending physician is not employed or paid under agreement by the patient's hospice provider. In addition, we determined the reimbursement amounts of the

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<sup>13</sup> We also excluded claims that had a Q5 or Q6 modifier, which indicates that the service was provided by a physician substituting for the beneficiary's attending physician.

<sup>14</sup> Note that we considered Part B claims to be questionable when they fell within the same time period covered by the Part A claim, not just the same date of the Part A line item. Physicians bill Part A or Part B based on their relationship with the hospice, which is unlikely to change during the claim period.

questionable claims. We analyzed the claims to identify any discernable patterns in terms of geography and diagnosis.

### **Limitations**

For a given beneficiary, we considered Part B claims to be questionable if they were from the same physician, during the same time period, and for the same diagnosis as Part A claims. Based on our analysis, we could not determine whether the questionable billing was the result of the physician inappropriately billing Part B or the hospice inappropriately billing Part A. We based our results on the Part B claims, as this is the more conservative approach. Part B claims are for one date of service while Part A claims usually cover a 1-month period. Part A claims often include more than one physician service per claim and therefore have higher reimbursement totals per claim than Part B claims. We did not conduct a medical record review and did not determine whether services provided were medically necessary.

## **RESULTS**

### **Questionable Billing for Physician Services Provided to Hospice Beneficiaries Amounted to Nearly \$566,000 in 2009**

We identified 9,272 questionable Part B claims for physician services provided to hospice beneficiaries in 2009. These Part B claims are for services provided by the same physician for the same time period as billed on the Part A claims. In addition, the Part B services are for the same diagnosis, which is the terminal diagnosis on the corresponding Part A claim. Medicare pays for physician services through Part A or Part B, depending on the physician's relationship with the hospice. Medicare, however, should not pay a physician for services related to a hospice beneficiary's terminal diagnosis through Part A and Part B at the same time. In almost 70 percent of the questionable claims, the physician indicated that he or she was not employed or paid under agreement by the patient's hospice provider. It is not clear in these cases whether the physician used the modifier incorrectly or the hospice billed inappropriately.

In 2009, questionable Part B claims totaled \$565,666 for 4,280 Medicare beneficiaries. The most common diagnoses for these questionable claims were lung cancer, followed by chronic airway obstruction and congestive heart failure. The most common services were for patient evaluation and management. Notably, one-third of the questionable claims were from Florida. Florida claims amounted to \$199,613, which is 35 percent of the total reimbursement for questionable Part B claims in 2009. North Carolina had the next highest amount, with \$63,027 in questionable claims, which is 11 percent of the total. In 2008, 9 percent of hospice beneficiaries lived in Florida and 3 percent lived in North Carolina.<sup>15</sup>

The questionable Part B claims were submitted by 3,116 physicians in 2009. The 10 physicians with the highest questionable Part B billing each received more than \$3,700 from such claims in

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<sup>15</sup> CMS, *Number of Hospices, Number of Persons, Covered Days of Care, Total Charges, and Program Payments for Hospice Services Used by Medicare Beneficiaries, by Area of Residence: Calendar Year 2008*, Table 8.3, data from the Medicare Data Extract System. Accessed at [www.cms.gov/Medicaremedicaidstatsupp/downloads/09hospices.zip](http://www.cms.gov/Medicaremedicaidstatsupp/downloads/09hospices.zip) on August 31, 2010.

2009. Six of the ten physicians resided in Florida. Three of the ten had the same mailing address. These three physicians were reimbursed a total of \$22,916 for the questionable Part B claims. Another 2 of the 10 also shared a billing address. They were reimbursed a total of \$15,505 for questionable Part B claims. A total of 664 hospices were associated with Part B questionable claims for physician services. Of the 10 hospices associated with the highest questionable Part B billing, 8 were in Florida.

## **CONCLUSION**

We found that questionable billing for Part B physician services provided to hospice beneficiaries amounted to nearly \$566,000 in 2009. This means that Medicare paid this amount to physicians directly through Part B for services related to a beneficiary's terminal illness, while Medicare also paid for services from the same physician for the terminal illness under Part A. One-third of these questionable claims were from Florida.

Although we did not find that this problem is widespread, billing for physician services for hospice care is a potential program vulnerability given that Medicare may be billed under Part A and Part B. As such, we encourage CMS to continue to monitor this issue. In addition, we will refer all of the questionable claims to CMS for appropriate action. We will provide this information in a separate memorandum.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-02-06-00224 in all correspondence.

## APPENDIX A

### HOSPICE SERVICES, LEVELS OF CARE, AND PAYMENT RATES

The Medicare hospice benefit covers nursing care, medical social services, hospice aide and homemaker services, physician services, counseling, physical therapy, occupational therapy, and speech-language pathology services. It also includes short-term inpatient care, medical supplies (including drugs and biologicals), and the use of medical appliances. In addition, the hospice benefit covers any other service that is specified in the plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions and for which payment may otherwise be made under Medicare.<sup>16</sup>

The Centers for Medicare & Medicaid Services (CMS) publishes general hospice payment rates annually to be used for each level of care.<sup>17</sup> The rates are adjusted based on the beneficiary's geographic location. The levels of care and the fiscal year 2009 Medicare unadjusted daily rates for each are as follows:

- Routine Home Care (\$139.97): The routine home care rate is paid to the hospice for each day that the beneficiary is under the care of the hospice and is not receiving one of the other categories of care. Routine home care includes, but is not limited to, nursing and hospice aide services. Routine home care may be provided in the home or other places of residence, such as a nursing facility.
- Continuous Home Care (\$816.94): Continuous home care is allowed only during periods of crisis in which a beneficiary requires continuous care to achieve palliation or management of acute medical symptoms. It is covered only as necessary to maintain the terminally ill beneficiary at home. The care must be predominantly nursing care. Continuous home care may be provided in the home or other places of residence, such as a nursing facility. The continuous home care rate is divided by 24 hours to determine an hourly rate. A minimum of 8 hours must be provided.
- Inpatient Respite Care (\$144.79): Respite care is short-term inpatient care provided to the beneficiary when necessary to relieve the beneficiary's caregiver(s). Respite care may be provided only on an occasional basis and is not reimbursed for more than 5 consecutive days. Respite care may be provided in a Medicare- or Medicaid-certified hospice inpatient facility, hospital, skilled nursing facility, or nursing facility.

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<sup>16</sup> 42 CFR § 418.202(i).

<sup>17</sup> CMS, *Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice Pricer for FY 2009*, Transmittal 1570, Change Request 6155. Accessed at <http://www.cms.gov/transmittals/downloads/R1570CP.pdf> on July 15, 2010.

- General Inpatient Care (\$622.66): General inpatient care is for pain control and symptom management that cannot feasibly be provided in other settings. General inpatient care may be provided in a Medicare- or Medicaid-certified hospice inpatient facility, hospital, or skilled nursing facility.