Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE COMMUNITY HOSPICE, INC., IMPROPERLY CLAIMED MEDICARE REIMBURSEMENT FOR SOME HOSPICE SERVICES

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

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for Audit Services

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Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

The Community Hospice, Inc., improperly claimed at least $447,000 in Medicare reimbursement for hospice services.

WHY WE DID THIS REVIEW

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

Our objective was to determine whether hospice services claimed for Medicare reimbursement by The Community Hospice, Inc. (Community) complied with Medicare requirements.

BACKGROUND

Federal regulations provide the Medicare hospice benefit to eligible beneficiaries. To be eligible for the Medicare hospice benefit, a beneficiary must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course. Inclusion in the Medicare hospice program is voluntary and can be revoked at any time by the beneficiary. Medicare reimbursement for hospice services is made at one of four predetermined rates—based on the level of care provided—for each day that a beneficiary is under the hospice's care.

HOW WE CONDUCTED THIS REVIEW

Our review covered 9,147 beneficiary-months for which Community received Medicare reimbursement totaling $28,396,090 for hospice services provided during calendar year 2010. A beneficiary-month includes all hospice services provided to a beneficiary during 1 month. We reviewed all Medicare payments for hospice services related to our random sample of 100 beneficiary-months.

WHAT WE FOUND

Community claimed Medicare reimbursement for some hospice services that did not comply with certain Medicare requirements. Of the 100 beneficiary-months in our random sample for which Community claimed Medicare reimbursement, 93 beneficiary-months complied with Medicare requirements, but 7 did not.

The improper payments occurred because Community did not always (1) maintain adequate documentation to support a beneficiary's eligibility for hospice services or (2) ensure that it billed Medicare for the appropriate level of hospice care.

On the basis of our sample results, we estimated that Community improperly received at least $447,467 in Medicare reimbursement for hospice services that did not comply with certain Medicare requirements.

WHAT WE RECOMMEND

We recommend that Community:

- refund $447,467 to the Federal Government and
- strengthen its procedures to ensure that it complies with Medicare requirements for claiming hospice services.

THE COMMUNITY HOSPICE, INC., COMMENTS AND OUR RESPONSE

In written comments on our draft report, Community generally disagreed with our first recommendation (financial disallowance) and agreed with our second recommendation. Specifically, Community agreed to refund the Medicare payments associated with 4 of the 7 beneficiary-months for which we determined that services did not comply with Medicare requirements. Community stated that, for the claims associated with the remaining 3 beneficiary-months, it believed that there was ample documentation to support the associated beneficiary's terminal prognosis. Finally, Community contested the extrapolation of the audit results to arrive at an estimated repayment amount.

After reviewing Community's comments, we maintain that our findings and recommendations are valid. Specifically, the hospice services in question did not comply with Medicare requirements.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

OBJECTIVE

Our objective was to determine whether hospice services claimed for Medicare reimbursement by The Community Hospice, Inc. (Community) complied with Medicare requirements.

BACKGROUND

The Medicare Program

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

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

The Medicare Hospice Benefit

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

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

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[1] 42 CFR § 418.302.

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

Upon a beneficiary's election of hospice care, the hospice assumes the responsibility for medical care for the beneficiary's terminal illness. The beneficiary waives all rights to Medicare payment for services related to the curative treatment of the terminal condition or a related condition.[3] Inclusion in the Medicare hospice program is voluntary and can be revoked at any time by the beneficiary.[4]

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

The Community Hospice, Inc.

Community is a nonprofit hospice located in Rensselaer, New York, that provides hospice services to those who are seriously ill as well as support for their families. During calendar year (CY) 2010, Community provided hospice services to beneficiaries residing in seven upstate New York State counties.

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

HOW WE CONDUCTED THIS REVIEW

Our review covered 9,147 beneficiary-months for which Community received Medicare reimbursement totaling $28,396,090 for hospice services provided during CY 2010. A beneficiary-month includes all hospice services provided to a beneficiary during 1 month. We reviewed all Medicare payments for hospice services related to our random sample of 100 beneficiary-months. For certain sample items, we sought NGS's assistance in determining whether the associated hospice services met Medicare requirements.

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

[3] Sections 1812(d)(2)(A) and 1861(dd)(1) of the Act.

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

[5] 42 CFR § 418.21(a).

[6] 42 CFR § 418.22(c).

[7] 42 CFR § 418.22(b)(3).

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

FINDINGS

Community claimed Medicare reimbursement for some hospice services that did not comply with certain Medicare requirements. Of the 100 beneficiary-months in our random sample for which Community claimed Medicare reimbursement, 93 beneficiary-months complied with Medicare requirements, but 7 did not. Specifically, for 5 beneficiary-months, the associated beneficiary's eligibility for hospice services was not adequately documented and for 2 beneficiary-months, the associated beneficiary's case records did not support the level of care claimed for reimbursement.

The improper payments occurred because Community did not always (1) maintain adequate documentation to support a beneficiary's eligibility for hospice services or (2) ensure that it billed Medicare for the appropriate level of hospice care.

On the basis of our sample results, we estimated that Community improperly received at least $447,467 in Medicare reimbursement for hospice services that did not meet Medicare requirements.

BENEFICIARY ELIGIBILITY NOT ADEQUATELY DOCUMENTED

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

For 5 beneficiary-months, Community claimed Medicare reimbursement for services provided to beneficiaries whose eligibility for the Medicare hospice benefit was not adequately documented.[11] Specifically:

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

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

[10] 42 CFR § 418.22.

[11] The medical review staff of NGS made these determinations.

- For 3 beneficiary-months, the clinical documentation provided by Community did not support the associated beneficiary's terminal illness diagnosis.

- For 1 beneficiary-month, the clinical documentation provided by Community did not support the associated beneficiary's terminal prognosis (i.e., the documentation did not indicate that the beneficiary had 6 months or less to live).

- For 1 beneficiary-month, there was no physician's written certification in the associated beneficiary's case record.

LEVEL-OF-CARE NOT SUPPORTED

Medicare reimbursement for hospice services is made at one of four predetermined rates—based on the level of care provided—for each day that a beneficiary is under the hospice's care. The four levels are (1) routine home care, (2) continuous home care, (3) inpatient respite care,[12] and (4) general inpatient care.[13, 14] The inpatient rate (general or respite) is paid for the date the beneficiary is admitted to the hospice and all subsequent inpatient days, except the day on which the patient is discharged. For the date of discharge, the appropriate home care rate (routine or continuous) is paid.[15]

For 2 beneficiary-months, Community claimed Medicare reimbursement for some services for which the associated beneficiary's case records did not support the level-of-care claimed. Specifically, Community claimed the general inpatient level of care; however the beneficiaries' case records supported the inpatient respite level of care.[16] In addition, for one of these beneficiary-months, Community claimed the beneficiary's date of discharge at the general inpatient care rate rather than the appropriate routine home care rate.[17]

RECOMMENDATIONS

We recommend that Community:

- refund $447,467 to the Federal Government and

[12] Inpatient respite care is provided only when necessary to relieve family members or other persons caring for the beneficiary at home.

[13] General inpatient care is for pain control or acute or chronic symptom management that cannot be managed in other settings.

[14] Definitions and payment procedures for specific level-of-care categories are codified at 42 CFR § 418.302.

[15] 42 CFR § 418.302(e)(5).

[16] The medical review staff of NGS made these determinations.

[17] For these services, we questioned the difference between the level-of-care claimed and level-of-care provided.

- strengthen its procedures to ensure that it complies with Medicare requirements for claiming hospice services.

THE COMMUNITY HOSPICE, INC. COMMENTS

In written comments on our draft report, Community generally disagreed with our first recommendation (financial disallowance) and agreed with our second recommendation. Specifically, Community agreed to refund the Medicare payments associated with 4 of the 7 beneficiary-months for which we determined that services did not comply with Medicare requirements. Community stated that, for the claims associated with the remaining 3 beneficiary-months, it believed there was ample documentation to support the beneficiary's terminal prognosis.

Community also stated that if NGS–the Home Health and Hospice MAC for hospice providers in Jurisdiction 6–reopens the claims for the 3 beneficiary-months for which Community disagreed with our determinations, Community intends to invoke Federal requirements that limits a provider's liability and the time period during which a paid claim can be reopened by a MAC. Specifically, Community cited section 1870 of the Act, which prohibits recovery of any paid claims subsequent to the third year following the year the original payment was made if the provider was "without fault." Community stated that all of the claims we reviewed were made in 2010 and therefore, any findings by OIG or NGS would be made after the third year of the original payment. Community also cited section 1879 of the Act, which limits the liability of a Medicare provider if the provider did not know, and could not reasonably been expected to know, that payment would not be made. According to Community, a denial of coverage for hospice services based on a determination that the beneficiary is not terminally ill is included among the situations where liability may be limited. Finally, Community cited 42 CFR § 405.980(b), which prohibits a Medicare contractor from reopening an initial determination more than 4 years after the date of the initial determination unless there is reliable evidence of fraud or similar fault.

Community also contested the extrapolation of the audit results to arrive at an estimated repayment amount. Community cited section 1893(f)(3) of the Act, which prohibits Medicare contractors from using an extrapolation to determine overpayments unless there is a sustained or high level of payment error. Additionally, Community stated that OIG guidance supports the use of statistical sampling in cases of providers subject to a Corporate Integrity Agreement (CIA) and since Community was not the subject of a CIA, there was no basis for extrapolation. Finally, Community noted that OIG failed to net small underpayments discovered during the course of the audit against overpayments and that the amount Community already refunded should be deducted from the recommended financial disallowance.

Community's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Community's comments, we maintain that our findings and recommendations are valid.

First, we maintain that Community claimed Medicare reimbursement for services provided to beneficiaries whose eligibility for the Medicare hospice benefit was not adequately documented. We made our determinations based on recommendations made by NGS medical review staff with extensive knowledge of Medicare requirements related to hospice care. NGS medical review staff concluded that Community's records did not contain sufficient evidence to support the beneficiary's terminal prognosis.

Second, regarding Community's assertion that claims for the period we reviewed are time-barred from being reopened because Community was "without fault" and because there was no evidence of similar fault, we note that CMS (the action official) will reexamine all cases that we have recommended disallowing and determine whether an overpayment exists and if the limitation of liability provisions apply.

Lastly, we disagree with Community's objections to our use of statistical sampling and to extrapolating the sample results to arrive at an estimated financial disallowance. Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare.[18] It should also be noted that Community's argument that Medicare contractors are prohibited from using extrapolation to determine overpayment amounts is not applicable as OIG is not a Medicare contractor. We did not consider the underpayments identified during the course of our review as we had no assurance that NGS would pay these claims. However, Community is aware of what claims are affected and can resubmit these claims if it so chooses. Finally, CMS will make the final determination as to the total amount to be refunded and will take into consideration any amounts Community has already refunded.

[18] See Anghel v. Sebelius, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 9,147 beneficiary-months for which Community received Medicare reimbursement totaling $28,396,090 for hospice services provided during CY 2010. A beneficiary-month includes all hospice services provided to a beneficiary during 1 month.

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

We performed our fieldwork at Community's office in Rensselaer, New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidelines;
- met with CMS officials to gain an understanding of the Medicare hospice benefit;
- met with NGS officials to gain an understanding of the Medicare requirements related to hospice services;
- met with Community officials to gain an understanding of its policies and procedures related to providing and billing Medicare for hospice services;
- obtained from the CMS National Claims History file a sampling frame of 9,147 beneficiary-months, totaling $28,396,090, for CY 2010;
- selected a simple random sample of 100 beneficiary-months from the sampling frame;
- obtained and reviewed case records and claim payment data for each of the sampled beneficiary-months to determine whether:
    - the associated beneficiary was eligible for hospice services and
    - the services provided met Medicare requirements;
- submitted case records for certain sample items to NGS for their assistance in determining whether the associated hospice services met Medicare requirements; and
- estimated the total unallowable Medicare reimbursement paid in the population of 9,147 beneficiary-months.

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

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all Medicare Part A payments made to Community for a beneficiary-month during CY 2010. A beneficiary-month is defined as all hospice services Community provided to a beneficiary during 1 month.

SAMPLING FRAME

The sampling frame was an Access database containing 9,147 beneficiary-months, totaling $28,396,090. The data was extracted from the CMS National Claims History file.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiary-months.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

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

ESTIMATION METHODOLOGY

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

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Beneficiary-Months in Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Beneficiary-Months	Value of Unallowable Beneficiary-Months
9,147	$28,396,090	100	$303,078	7	$17,059

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

Point Estimate	$1,560,350
Lower Limit	$447,467
Upper Limit	$2,673,233

APPENDIX D: THE COMMUNITY HOSPICE, INC. COMMENTS

THE COMMUNITY HOSPICE

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July 10, 2014

Via U.S. Mail and Email

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Re: Report Number A-02-11-01016

Dear Mr. Edert:

Thank you for the opportunity to comment on draft report Number A-02-11-01016. The Community Hospice, Inc., is committed to compliance with all regulations and standards governing its participation in the Medicare program, and we welcome the opportunity that was afforded by this audit to improve our internal controls and processes to better ensure compliance.

Our responses to the OIG's two recommendations are set forth below.

Recommendation #1: Refund $447,467 to the Federal Government

We strongly object to the OIG's first recommendation for the following reasons.

First, while we have conceded four of the seven sample beneficiary months and have repaid the associated Medicare payments, we continue to believe that there was ample documentation to support the beneficiary's terminal prognosis in the three remaining sample beneficiary-months (samples #30, #35, and #63). Should our Medicare Administrative Carrier (MAC), NGS, seek to reopen these three claims, we intend to exercise our hearing and appeal rights. Because the medical reviews in this audit were conducted by NGS and relayed with only brief written explanations, without an opportunity to discuss them directly with NGS, the precise basis for

their findings is not entirely clear to us. In one instance (#30), for example, it appears that NGS concluded that the beneficiary was ineligible because the principal terminal diagnosis (aortic stenosis) was not documented in the patient's record by a copy of an echocardiogram report that demonstrated severe/critical aortic stenosis. While we have since obtained a copy of that report from the hospital where the patient was an inpatient at the time of hospice admission, physician notes that were included in the documentation provided to OIG listed multiple medical co-morbidities, including severe aortic stenosis, coronary artery disease, peripheral vascular disease, chronic hypertension, atrial fibrillation, congestive heart failure, cardiomyopathy with left ventricular hypertrophy, diabetes mellitus, and chronic kidney disease. Additional health conditions were reflected in other documentation provided, and the hospital discharge summary reflected that four physicians, including a Community Hospice medical director and the patient's attending physician, concurred in the hospice admission. In another case (#63), it appears that the NGS reviewer applied the Local Coverage Determination for Hospice – Determining Terminal Status (L25678), relating to the patient's terminal diagnosis of acute renal failure, like a checklist, denying eligibility solely because the patient's serum creatinine level did not, strictly speaking, meet LCD criteria for end-stage renal disease. As noted in the LCD at page 2: "Some patients may not meet these guidelines, yet still have a life expectancy of six months or less." In the case of patient #63, a 90 year-old, our medical director noted that it is well-recognized in the medical community that serum creatinine overestimates renal function in the very old and three physicians concurred in the assessment of hospice eligibility. Because we believe that the documentation available to and reviewed by these three patients' certifying hospice medical directors was sufficient to support their eligibility, we will vigorously exercise our appeal rights.

Second, if NGS seeks to re-open the three samples at issue, Community Hospice intends to invoke to the extent applicable provisions of the Social Security Act and Medicare regulations that limit the time period in which a Medicare contractor may reopen a paid claim and limit a provider's liability under certain circumstances. These include:

- 42 C.F.R. Section 405.980(b), which prohibits a Medicare contractor from reopening an initial determination more than four years after the date of the initial determination unless "there exists reliable evidence as defined in §405.902 that the initial determination was procured by fraud or similar fault as defined in §405.902." Section 405.902 defines "reliable evidence" as "evidence that is relevant, credible, and material." Section 405.902 defines "similar fault" as "to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought or received is not legally entitled." We respectfully submit that the small number of errors in this audit (if one accepts the audit report findings, at most 7% in raw numbers and only 5.62% if one looks at the financial error rate) is evidence in itself that there was neither fraud nor "similar fault."

- Section 1870 of the Social Security Act, which prohibits recovery of an overpayment to a provider if such provider was "without fault" with respect to the overpayment. Section 1870(b) (as applicable to the claim year involved here, calendar year 2010) establishes a presumption that a provider "shall, in the absence of evidence to the contrary, be deemed to be without fault" if the Secretary's determination that there was an overpayment is

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made after the third year following the year in which the payment was originally made.[1] All of the claims payments in this audit were made in 2010, and thus any final findings by the OIG or NGS will be made after the third year after the year payment was made. To overcome the presumption, there would have to be actual evidence of "fault" on the part of Community Hospice. We respectfully submit that the very occasional instances when the professional clinical judgment of a Community Hospice certifying physician have been found to be at odds with the determination of the NGS medical reviewers in this audit do not constitute evidence of "fault" sufficient to overcome the presumption. The same can be said for the instances of inadequate documentation of the hospice level of care or a single missing recertification.

- Section 1879 of the Social Security Act, which limits the liability of both the Medicare beneficiary and the provider of services for an overpayment, if both the beneficiary and the provider "did not know, and could not reasonably have been expected to know" that payment would not be made for such items or services. A denial of coverage for hospice services based on a determination that the beficiary is not terminally ill is specifically included as among the situations where liability may be limited. Social Security Act §1879(g)(2). While we acknowledge that a hospice provider should reasonably be expected to know that payment will be denied if a certification of terminal illness is missing (as in the case of sample #2) or if the day of discharge from inpatient hospice care is mistakenly billed at the inpatient level of care (as in the case of sample #75), we respectfully submit that close cases involving the exercise of professional judgment and experience in determining the existence of a terminal condition are precisely the kind of situation to which the limitation of liability provision of Section 1879 applies.

Third, we strongly contest the proposed extrapolation of the results of the audit of 100 sample beneficiary-months to arrive at an estimated repayment amount. Section 1893(f)(3) of the Social Security Act, added by Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-17) prohibits Medicare contractors from using an extrapolation to determine overpayment amounts unless the Secretary determines that "there is a sustained or high level of payment error" or "documented educational intervention has failed to correct the payment error." See also CMS, Medicare Program Integrity Manual, IOM 100-08, Chapter 8, Section 8.4.1.2.

CMS has not issued regulations or other guidance specifically defining what a sustained or high level of payment error rate might be, but other guidance from CMS clearly suggests that a financial error rate of only 5.62% (or just 2.68% if we prevail on an appeal of the three contested sample beneficiary-months) does not provide a basis for extrapolation. In Section 3.7.1.1 of Chapter 3 of the Medicare Program Integrity Manual, CMS notes that if a MAC identifies a provider-specific problem, the MAC should conduct a review (on either a pre-payment or post-payment basis) to determine the provider's specific error rate. In the case of post-payment review, the error rate is calculated using the following formula: dollar amount of services paid in error as determined by medical review/dollar amount of services medically reviewed. In making

[1] The American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 §638(a), 126 Stat. 2357, extended this time limit from the third year after the claim was initially paid to the fifth year after payment was made. The law was effective January 2, 2013. *Id.* §638(b).

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the computation, the MAC is directed to net out (subtract) the dollar amount of charges under-billed. In Section 3.7.1.2 of the Manual, CMS provides seven different vignettes to provide guidance to MACs in characterizing and responding to varying levels of confirmed error rates. In the first vignette, 20 claims are reviewed. One claim is denied because a physician signature is lacking a plan of care. The denial reflects 7% of the dollar amount of the claims reviewed. In this situation, CMS concludes that no further review is necessary at that time. In another vignette, 40 claims are reviewed and a 25% error rate (by dollars) leads to notification of the provider about the specific error and the initiation of a moderate amount (e.g., 30%) of prepayment medical review to ensure proper billing. In the one vignette that results in a decision to conduct a post-payment review utilizing statistical sampling and extrapolation, the provider error rate on an initial review of 35 claims was 75%, a far cry from the 5.62% error rate that the OIG has determined.

The OIG's own guidance relative to the use of statistical sampling also does not support the use of statistical sampling in the case of Community Hospice. The OIG has posted "FAQs" applicable to providers who are subject to Corporate Integrity Agreements. Those providers are, almost by definition, providers who have been determined to have "a sustained or high level of payment error," and thus with respect to whom the use of statistical sampling and extrapolation would be permitted by Section 1893. In the FAQs (http://oig.hhs/faqs/corporate-integrity-agreements-faq.asp), at section 4, CIA Claims Reviews, the OIG discusses the use of discovery samples of 50 sampling units, to determine a "net financial error rate" (i.e., netting underpayments against overpayments to arrive at the error rate). If the net financial error rate in the discovery sample equals or exceeds 5%, then the discovery sample is used to determine the size of a full sample, which would then be reviewed and the results extrapolated. But if the discovery sample's net financial error rate is less than 5%, the review is complete. See Q 4.14. In that case, any identified overpayments would be repaid, but no full sample would be generated or extrapolated. Given that Community Hospice is not the subject of a Corporate Integrity Agreement, there is no basis for extrapolation based on an error rate of 5.62%, let alone 2.68%.

In this connection, we note that the OIG has failed to net the small underpayments that were discovered during the course of the audit against the overpayments. See samples #28, #66, #70, and #86.

Finally, in recommending that Community Hospice repay $447,467, the OIG has overlooked that we have already repaid a total of $72,169.64 to NGS, $35,981.85 of which is attributable to payments received in calendar year 2010. This $35,981.85 should be deducted from the recommended repayment amount.

Recommendation #2: Community should strengthen its procedures to ensure that it complies with Medicare requirements for claiming hospice services.

We concur with this recommendation. Since the conduct of the audit, Community Hospice has tightened its procedures to ensure that copies of original documentation from hospitals, nursing homes and other health care providers who were involved in a prospective hospice beneficiary's care, and which are relied upon by the hospice medical director in certifying the beneficiary's terminal prognosis, are obtained and placed in the hospice medical record in a timely manner.

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We have also continued to refine our existing policies and procedures for ensuring that recertifications are obtained in a timely manner.

In closing, I would like to thank Mr. Jacobs and all of the members of the OIG's audit team for the professionalism, courtesy and cooperation that they extended to us throughout the audit.

Sincerely,

Laurie Mante

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