Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HOSPICE PROVIDER COMPLIANCE AUDIT: MISSION HOSPICE & HOME CARE, INC.

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

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Office of Inspector General

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Report in Brief
Date: July 2021
Report No. A-09-18-03009

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

Medicare Hospice Provider Compliance Audit: Mission Hospice & Home Care, Inc.

Why OIG Did This Audit

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 who have elected hospice care. Previous OIG audits and evaluations found that Medicare inappropriately paid for hospice services that did not meet certain Medicare requirements.

Our objective was to determine whether hospice services provided by Mission Hospice & Home Care, Inc. (Mission), complied with Medicare requirements.

How OIG Did This Audit

Our audit covered 6,142 claims for which Mission (located in San Mateo, California) received Medicare reimbursement of about $37 million for hospice services provided from October 1, 2015, through September 30, 2017. We reviewed a random sample of 100 claims. We evaluated compliance with selected Medicare billing requirements and submitted these sampled claims and the associated medical records to an independent medical review contractor to determine whether the services met coverage, medical necessity, and coding requirements.

What OIG Found

Mission received Medicare reimbursement for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in our sample, 66 claims complied with Medicare requirements. However, the remaining 34 claims did not comply with the requirements. Specifically, for 33 claims, the clinical record did not support the beneficiary's terminal prognosis, and for 1 claim, the clinical record did not support the level of care billed to Medicare. In addition, for a few claims, there was no evidence that beneficiaries elected hospice care before the periods covered by the sampled claims, or there was no support for physician services billed to Medicare.

Improper payment of these claims occurred because Mission's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis, election statements were signed before the periods covered by the sampled claims, the appropriate level of care was billed, and physician services were supported. On the basis of our sample results, we estimated that Mission received at least $10.5 million in unallowable Medicare reimbursement for hospice services.

What OIG Recommends and Mission Comments

We recommend that Mission: (1) refund to the Federal Government the portion of the estimated $10.5 million for hospice services that did not comply with Medicare requirements and that are within the 4-year reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Mission, through its attorney, disagreed with our determinations for all but 7 of the 34 sampled claims we questioned. Mission concurred in part with our first and second recommendations and disagreed with our third recommendation. Mission stated that it had made inquiries with its Medicare contractor to refund Medicare for the seven claims it agreed were in error. In addition, Mission challenged the validity of our statistical sampling methodology and the resulting extrapolation.

After reviewing Mission's comments, we maintain that our findings and recommendations are valid. We also maintain that our sampling methodology and extrapolation were statistically valid and resulted in a legally valid and reasonably conservative estimate of the amount Medicare overpaid to Mission.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/91803009.asp.

TABLE OF CONTENTS

APPENDICES

INTRODUCTION

WHY WE DID THIS AUDIT

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 who have elected hospice care. Previous Office of Inspector General (OIG) audits and evaluations found that Medicare inappropriately paid for hospice services that did not meet certain Medicare requirements.[1]

OBJECTIVE

Our objective was to determine whether hospice services provided by Mission Hospice & Home Care, Inc. (Mission), 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.[2] CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Medicare hospice claims in four home health and hospice jurisdictions.

The Medicare Hospice Benefit

To be eligible to elect Medicare hospice care, a beneficiary must be entitled to Medicare Part A and certified by a physician as being terminally ill (i.e., as having a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal course).[3] Hospice 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. The Medicare hospice benefit has four levels of care: (1) routine home care, (2) general inpatient (GIP) care,

[1] See Appendix B for a list of related OIG reports on Medicare hospice services.

[2] The Act §§ 1812(a)(4) and (5).

[3] The Act §§ 1814(a)(7)(A) and 1861(dd)(3)(A) and 42 CFR §§ 418.20 and 418.3.

(3) inpatient respite care, and (4) continuous home care (CHC). Medicare provides an all-inclusive daily payment based on the level of care.[4]

Beneficiaries eligible for the Medicare hospice benefit may elect hospice care by filing a signed election statement with a hospice.[5] Upon election, the hospice assumes the responsibility for medical care of the beneficiary's terminal illness, and the beneficiary waives all rights to Medicare payment for services that are related to the treatment of the terminal condition or related conditions for the duration of the election, except for services provided by the designated hospice directly or under arrangements or services of the beneficiary's attending physician if the physician is not employed by or receiving compensation from the designated hospice.[6]

The hospice must submit a notice of election (NOE) to its MAC within 5 calendar days after the effective date of election. If the hospice does not submit the NOE to its MAC within the required timeframe, Medicare will not cover and pay for days of hospice care from the effective date of election to the date that the NOE was submitted to the MAC.[7]

Beneficiaries are entitled to receive hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods.[8] At the start of the initial 90-day benefit 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[9] and the beneficiary's attending physician, if any. For subsequent benefit periods, a written certification by only the hospice medical director or the physician member of the hospice interdisciplinary group is required.[10] The initial certification and all subsequent recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy

[4] 42 CFR § 418.302. For dates of service on or after January 1, 2016, there are two daily payment rates for routine home care: a higher rate for the first 60 days and a lower rate for days 61 and beyond. 80 Fed. Reg. 47142, 47172 (Aug. 6, 2015).

[5] 42 CFR § 418.24(a)(1).

[6] The Act § 1812(d)(2)(A) and 42 CFR § 418.24(d). After our audit period (October 1, 2015, through September 30, 2017), the text of 42 CFR § 418.24(d) was moved to 42 CFR § 418.24(e), effective October 1, 2019. 84 Fed. Reg. 38484, 38544 (Aug. 6, 2019).

[7] 42 CFR §§ 418.24(a)(2) and (a)(3).

[8] 42 CFR § 418.21(a).

[9] A hospice interdisciplinary group consists of individuals who together formulate the hospice plan of care for terminally ill beneficiaries. The interdisciplinary group must include a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor, and may include others, such as hospice aides, therapists, and trained volunteers (42 CFR § 418.56).

[10] 42 CFR § 418.22(c).

of 6 months or less.[11] The written certification may be completed no more than 15 calendar days before the effective date of election or the start of the subsequent benefit period.[12]

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice beneficiary whose total stay across all hospices is anticipated to reach a third benefit period.[13] The physician or nurse practitioner conducting the face-to-face encounter must gather and document clinical findings to support a life expectancy of 6 months or less.[14]

Hospice providers must establish and maintain a clinical record for each hospice patient.[15] The record must include all services, whether furnished directly or under arrangements made by the hospice. Clinical information and other documentation that support the medical prognosis of a life expectancy of 6 months or less if the terminal illness runs its normal course must be filed in the medical record with the written certification of terminal illness.[16]

Medicare Requirements To Identify and Return Overpayments

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of: (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[17]

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments

[11] 42 CFR § 418.22(b)(3).

[12] 42 CFR § 418.22(a)(3).

[13] Hospices that admit a patient who previously received hospice services (from the admitting hospice or from another hospice) must consider the patient's entire Medicare hospice stay to determine in which benefit period the patient is being served and whether a face-to-face visit will be required for recertification. 75 Fed. Reg. 70372, 70435 (Nov. 17, 2010).

[14] 42 CFR §§ 418.22(a)(4), (b)(3)(v), and (b)(4).

[15] 42 CFR §§ 418.104 and 418.310.

[16] 42 CFR §§ 418.22(b)(2) and (d)(2).

[17] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.[18]

Mission Hospice & Home Care, Inc.

Mission is a nonprofit provider located in San Mateo, California, that furnishes hospice care to beneficiaries who live in California. From October 1, 2015, through September 30, 2017 (audit period), Mission provided hospice services to approximately 1,500 beneficiaries and received Medicare reimbursement of about $37.3 million.[19] National Government Services, Inc. (NGS), serves as the MAC for Mission.

HOW WE CONDUCTED THIS AUDIT

Mission received Medicare Part A reimbursement of $37,329,352 for hospice services provided during our audit period, representing 6,466 paid claims. After we excluded 324 claims, totaling $217,646, our audit covered 6,142 claims totaling $37,111,706.[20] We reviewed a random sample of 100 of these claims, totaling $605,507, to determine whether hospice services complied with Medicare requirements. Specifically, we evaluated compliance with selected billing requirements and submitted these sampled claims and the associated medical records to an independent medical review contractor to determine whether the services met coverage, medical necessity, and coding 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 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 C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

[18] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

[19] Claims data for the period October 1, 2015, through September 30, 2017, were the most current data available when we started our audit.

[20] We excluded hospice claims that had a payment amount of less than $1,000 (316 claims), had compromised beneficiary numbers (4 claims), or were identified in the Recovery Audit Contractor data warehouse as having been reviewed by another party (4 claims).

FINDINGS

Mission received Medicare reimbursement for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in our sample, 66 claims complied with Medicare requirements. However, the remaining 34 claims did not comply with the requirements:

- For 33 claims, the clinical record did not support the beneficiary's terminal prognosis. In addition, for 2 of these 33 claims, there was no evidence that either beneficiary elected hospice care by signing an election statement before the period covered by the sampled claim, and for 1 of these 33 claims, Mission provided documentation that did not support the physician service billed to Medicare.

- For one claim, the clinical record did not support the level of care and some physician services billed to Medicare.

Improper payment of these claims occurred because Mission's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis, election statements were signed before the periods covered by the sampled claims, the appropriate level of care was billed, and physician services were supported.

On the basis of our sample results, we estimated that Mission received at least $10.5 million in unallowable Medicare reimbursement for hospice services.[21] As of the publication of this report, these overpayments include claims outside of the 4-year reopening period.[22] Notwithstanding, Mission can request that a Medicare contractor reopen the initial determinations for those claims for the purpose of reporting and returning overpayments under the 60-day rule without being limited by the 4-year reopening period.[23]

MEDICARE REQUIREMENTS

To be eligible for the Medicare hospice benefit, a beneficiary must be certified as being terminally ill. Beneficiaries are entitled to receive hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods. At the start of the initial 90-day benefit 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 benefit

[21] The statistical lower limit is $10,564,396. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total at least 95 percent of the time.

[22] 42 CFR § 405.980(b)(2) (permitting a contractor to reopen within 4 years for good cause) and 42 CFR § 405.980(c)(2) (permitting a party to request that a contractor reopen within 4 years for good cause).

[23] 42 CFR § 405.980(c)(4).

periods, a written certification from the hospice medical director or the physician member of the hospice interdisciplinary group is required. Clinical information and other documentation that support the beneficiary's medical prognosis must accompany the physician's certification and be filed in the medical record with the written certification of terminal illness.[24]

Payment may be made for hospice care provided to an individual if the individual makes an election to receive hospice care.[25] Beneficiaries eligible for the Medicare hospice benefit may elect hospice care by filing a signed election statement with a hospice. The election statement must include: (1) the individual's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care and (2) the effective date of hospice care, which may be no earlier than the date of the election statement.[26] Hospices must maintain clinical records for each beneficiary, such as a signed copy of the election statement.[27]

No Medicare payment shall be made to any provider unless it has furnished the information necessary to determine the amount due (the Act § 1815(a)).

Medicare reimbursement for hospice services is made at predetermined payment 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) GIP care, (3) inpatient respite care, and (4) CHC.[28] GIP care is provided in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings, such as the beneficiary's home, and is intended to be short-term.[29] Routine home care is the least expensive level of hospice care, followed by inpatient respite care, GIP care, and CHC, which is the most expensive level of hospice care.

TERMINAL PROGNOSIS NOT SUPPORTED

For 33 of the 100 sampled claims, the clinical record provided by Mission did not support the associated beneficiary's terminal prognosis. Specifically, the independent medical review contractor determined that the records for these claims did not contain sufficient clinical

[24] 42 CFR §§ 418.22(b)(2) and 418.104(a).

[25] The Act § 1812(d)(1) and 42 CFR § 418.200.

[26] 42 CFR §§ 418.24(a)(1), (b)(2), and (b)(4).

[27] 42 CFR § 418.104(a)(2).

[28] Definitions and payment procedures for specific level-of-care categories are codified at 42 CFR § 418.302. For dates of service on or after January 1, 2016, there are two daily payment rates for routine home care: a higher rate for the first 60 days and a lower rate for days 61 and beyond. 80 Fed. Reg. 47142, 47172 (Aug. 6, 2015).

[29] 42 CFR §§ 418.302(b)(4) and 418.202(e).

information and other documentation to support the medical prognosis of a life expectancy of 6 months or less if the terminal illness ran its normal course.

In addition, for 2 of these 33 claims, there was no evidence that either beneficiary elected hospice care by signing an election statement before the period covered by the sampled claim. For the first claim, Mission stated that it could not locate the election statement. For the second claim, Mission provided an election statement that was signed and dated approximately 16 months after the period covered by the sampled claim. Furthermore, for 1 of these 33 claims, Mission billed Medicare for a physician service that was not supported by the beneficiary's clinical record.[30]

LEVEL OF CARE NOT SUPPORTED

Our sample contained one claim for which Mission billed Medicare at the GIP level of care, which has a higher payment rate. However, the beneficiary's clinical record did not support the need for the level of care billed. The independent medical review contractor determined that the beneficiary did not have pain or symptoms that required the GIP level of care. The beneficiary's hospice care needs could have been met if Mission had provided services at the less expensive routine level of care.[31] For the same sampled claim, Mission billed Medicare for some physician services that were not supported by the beneficiary's clinical record.

RECOMMENDATIONS

We recommend that Mission Hospice & Home Care, Inc.:

- refund to the Federal Government the portion of the estimated $10,564,396 for hospice services that did not comply with Medicare requirements and that are within the 4-year reopening period;[32]

[30] Payment for the physician service was based on the physician fee schedule for those physician services furnished by hospice employees or under arrangements with the hospice and was not included in the all-inclusive daily payment made to the hospice (42 CFR § 418.304(b)).

[31] For the one claim, we used the applicable payment rates and questioned the difference in payment amounts between the GIP and routine levels of care.

[32] OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule[33] and identify any of those returned overpayments as having been made in accordance with this recommendation; and

- strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

MISSION COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Mission, through its attorney, disagreed with our determinations for all but 7 of the 34 sampled claims questioned in our draft report and provided specific responses for each of the 34 claims. Mission did not comment on our finding that Mission billed Medicare for some physician services that were not supported by the beneficiary's clinical record. Mission concurred in part with our first and second recommendations and disagreed with our third recommendation. Mission stated that it had made inquiries with NGS to effectuate a refund to Medicare for the seven claims it agreed were in error. Mission also stated that NGS has instructed it not to make those refunds at this time but to wait for an overpayment demand.

Mission stated that our independent medical review contractor "used a rigid, post-hoc approach" to determine hospice eligibility under the Medicare benefit and largely ignored the critical role of the hospice physicians' reasonable clinical belief that the beneficiaries were terminally ill at the time the physicians completed the certifications of terminal illness. Mission cited a Federal court decision that noted: "Congress said nothing to indicate that the medical documentation presented with a claim must prove the veracity of the clinical judgment on an after-the-fact review." Mission also stated that it engaged two highly experienced independent hospice and palliative care physicians (hospice experts) to review our sampled claims and that they disagreed with a significant majority of our findings. In addition, Mission reviewed our statistical sampling methodology and stated that our methodology and resulting extrapolation were not statistically valid. Mission's written comments are included as Appendix E.[34]

After reviewing Mission's comments, we maintain that our findings and recommendations are valid. Our independent medical review contractor acknowledged the physician's terminal diagnosis and evaluated the clinical records provided by the hospice for each sampled claim

[33] This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

[34] Mission attached four exhibits to its comments, which contained the attorney's authorization to release information, the hospice experts' authorization to release information, the hospice experts' rebuttal statements for our findings, and the curricula vitae of the hospice experts. Although the exhibits are not included as appendices in our final report, we considered the entirety of these documents in preparing our final report and will provide Mission's comments in their entirety to CMS.

(including necessary historical clinical records), guided by questions rooted in the Medicare requirements, for its determinations.

The Federal court decision that Mission referenced addressed whether a difference in clinical judgment can render a physician certification false for purposes of False Claims Act liability and therefore is inapplicable to OIG audit recommendations and CMS recoveries arising from OIG audits. Our independent medical review contractor did not require that documentation *prove* the medical prognosis. Instead, our contractor considered each beneficiary's clinical picture and found that the records for these claims did not contain sufficient clinical information and other documentation to *support* the medical prognosis of a life expectancy of 6 months or less if the terminal illness ran its normal course.

We also maintain that our statistical sampling methodology and extrapolation were statistically valid and resulted in a legally valid and reasonably conservative estimate of the amount that Medicare overpaid to Mission.

The following sections summarize Mission's comments and our responses.

INDEPENDENT MEDICAL REVIEW CONTRACTOR

Mission Comments

Mission stated that it was not provided with our independent medical review contractor physicians' curricula vitae or other biographical information. Mission stated that it cannot, therefore, ascertain the physicians' qualifications, board certifications (if any), or perspective and experience with hospice and palliative medicine. Mission also stated that its hospice experts found that our independent medical review contractor applied an inconsistent approach to determine clinical eligibility for hospice services and the need for higher levels of care consistent with the legal requirements of the Medicare hospice benefit. In addition, Mission stated that our contractor appeared in most instances to appropriately summarize the salient facts and medical conditions reflected in each sampled claim, but did not synthesize these facts or the patients' comorbidities and other clinical conditions into appropriate clinical conclusions.

Office of Inspector General Response

We used an independent medical review contractor that is a licensed physician who specializes in hospice and palliative medicine and is familiar with Medicare hospice guidelines and protocols. The contractor properly used the appropriate statutory and regulatory hospice criteria, as well as applicable Local Coverage Determination (LCD) guidelines, as the framework for its determinations. Specifically, our independent medical review contractor applied standards set out in 42 CFR § 418.22(b)(2), which requires that clinical information and other documentation that support the medical prognosis accompany the physician's written

certification of terminal illness and be filed in the medical record.[35] As previously mentioned, our contractor acknowledged the physician's terminal diagnosis and evaluated the clinical records provided by the hospice for each sampled claim (including necessary historical clinical records), guided by questions rooted in the Medicare requirements, to determine whether the certified terminal prognosis was supported. The contractor evaluated all clinical conditions presented in the medical records collectively to obtain an overall clinical picture of the beneficiary, and based on information that was *available* and *known* at the time of certification or recertification, the contractor determined whether hospice eligibility requirements were met. When the clinical records and other available clinical information supported the physician's medical prognosis of a life expectancy of 6 months or less if the terminal illness runs its normal course, a determination that hospice eligibility criteria were met was made.

MISSION HOSPICE EXPERTS' REVIEW FINDINGS

Mission Comments

Mission stated that its hospice experts found record support for hospice eligibility and the higher level of care (as applicable) in 27 of the 34 sampled claims that our independent medical review contractor determined did not comply with Medicare requirements. Mission stated that for those beneficiaries who only partially met the applicable LCD guidelines, they each nevertheless exhibited a terminal prognosis that qualified them for the Medicare hospice benefit. Mission stated that LCDs in the hospice context are merely guidelines; patients can be (and often are) terminally ill without fully meeting corresponding hospice LCD elements. In addition, Mission stated that the NGS hospice LCD specifically notes: "Some patients may not meet these guidelines, yet still have a life expectancy of six months or less. Coverage for these patients may be approved if documentation otherwise supporting a less than six-month life expectancy is provided." Mission also stated that our independent medical review contractor misapplied the Advanced Dementia Prognostic Tool (ADEPT). Finally, Mission stated that, for one beneficiary for which our contractor asserted a level-of-care concern, the level of care that Mission provided was reasonable and necessary given the beneficiary's clinical condition and need at that time.

Office of Inspector General Response

After reviewing Mission's comments, including its hospice experts' analyses, we maintain that the clinical records for each of the 27 sampled claims did not support the associated beneficiary's terminal prognosis or the need for the claimed GIP level of care. Although our independent medical review contractor referenced the ADEPT in conducting the medical review, the contractor properly used the appropriate statutory and regulatory hospice criteria, as well as applicable LCD guidelines, as the framework for its determinations. We acknowledge that some beneficiaries who did not meet the guidelines in the hospice LCDs may still be

[35] Applicable LCD guidelines also state that the documentation must contain enough information to support terminal illness upon review.

appropriate for hospice care based upon an individual assessment of the beneficiary's health status. Accordingly, our independent medical review contractor merely used LCD guidelines as a tool to evaluate the terminal prognosis. In conclusion, it was the opinion of our contractor that the documentation in the clinical records did not support the terminal prognosis. Therefore, we maintain that our independent medical review contractor consistently and appropriately applied Medicare hospice eligibility requirements when it determined whether the certified terminal prognosis was supported.

For the one sampled claim for which Mission billed Medicare at the GIP level of care, our independent medical review contractor determined that the associated beneficiary did not have pain or symptoms that required that level of care. The beneficiary's hospice care needs could have been met if Mission had provided services at the less expensive routine level of care.

OFFICE OF INSPECTOR GENERAL SAMPLING METHODOLOGY

Mission Comments

Mission challenged the validity of our statistical sampling methodology and extrapolation. Mission stated that although OIG engages in a standardized sampling plan for its provider compliance audits, Mission observes that the representativeness of OIG's sample and reliability of the overall estimate is questionable because: (1) OIG's exclusion of claims that had a payment amount of less than $1,000 inappropriately skews the representativeness of the sample and (2) the use of a 100-claim sample was simply too small. Furthermore, Mission stated that OIG should forgo extrapolation because the clinical review findings do not reflect a high or sustained level of payment error for which extrapolation is justified according to CMS extrapolation procedures. Finally, Mission stated that the extrapolation is defective because it "failed to account for Medicare repayments related to the OIG audit time period that were already made by Mission as a result of its 'hospice aggregate cap.' "

Office of Inspector General Response

After reviewing Mission's comments, we maintain that our sampling methodology and extrapolation are statistically valid. The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[36] We properly executed our statistical sampling methodology in that we defined our sampling frame and sample unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., the OIG, Office of Audit Services (OAS), statistical software RAT-STATS) to apply the correct formulas for the extrapolation.

[36] *See John Balko & Assoc. v. Sebelius*, 2012 WL 6738246 at *12 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff'd*, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

OIG may perform a statistical or nonstatistical review of a provider without covering all claims from that provider. Furthermore, OIG's statistical estimates are applied only to the sampling frame from which the sample was drawn.

Although Mission takes issue with our sample size of 100 claims, sample sizes smaller than 100 have routinely been upheld by the Departmental Appeals Board and Federal courts.[37] To account for the precision of our estimate, we recommend recovery at the statistical lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total in the sampling frame 95 percent of the time. The use of the lower limit accounts for the precision of our estimate in a manner that generally favors the auditee.[38] If we had selected a larger sample size, the average effect and the most likely effect would have been that we would have recommended that Mission refund a larger amount to the Government.

The Social Security Act and *Medicare Program Integrity Manual* (MPIM) requirement that a determination of a sustained or high level of payment error must be made before extrapolation can be used applies only to Medicare contractors—not OIG.[39]

The aggregate cap limits the total aggregate payments that any individual hospice may receive in a cap year to an allowable amount based on an annual per-beneficiary cap amount and the number of beneficiaries served. The aggregate cap ensures that hospice care does not exceed the cost of conventional medical care at the end of life. Any amount paid to a hospice for its claims in excess of the aggregate cap is considered an overpayment and must be repaid to Medicare. If a provider's covered days of hospice care or Medicare payments are adjusted through an audit or other review, the MAC may recalculate the aggregate cap if the amount is material.[40] A hospice that believes its payments have not been properly determined may request a review from the MAC or the Provider Reimbursement Review Board.[41]

[37] *See Anghel v. Sebelius*, 912 F. Supp. 2d 4, 10 (E.D.N.Y. 2012) (upholding a sample size of 95 claims); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *30-31 (S.D. Tex. 2012) (upholding a sample size of 30 claims).

[38] E.g., see *Puerto Rico Dep't of Health*, DAB No. 2385, at 10 (2011); *Oklahoma Dep't of Human Servs.*, DAB No. 1436, at 8 (1993) (stating that the calculation of the disallowance using the lower limit of the confidence interval gave the State the "benefit of any doubt" raised by use of a smaller sample size).

[39] See the Act § 1893(f)(3); MPIM, Pub. No. 100-08, chapter 8, § 8.4.

[40] See CMS's *Medicare Benefit Policy Manual* (MBPM), Pub. No. 100-02, chapter 9, § 90.2.5.

[41] 42 CFR § 418.311; MBPM, Pub. 100-02, chapter 9, § 90.3.

RECOMMENDATIONS

Mission Comments

Mission concurred in part with our first and second recommendations and disagreed with our third recommendation, as follows:

- Regarding our first recommendation, Mission disagreed insofar as it does not believe it was overpaid the recommended refund amount for hospice services that are within the 4-year reopening period. Mission stated that it disagreed with our independent medical review contractor in most instances in which the contractor determined that patients were not eligible for hospice services. Mission stated that it concurred regarding certain claims referred to in its comments (i.e., the seven sampled claims it agreed were in error), but also stated that, per NGS's instruction, it is awaiting instruction on effectuating refunds of those claims.

- Regarding our second recommendation, Mission concurred only insofar as exercising reasonable diligence to identify and return improper payments upon having credible evidence of a potential Medicare overpayment is a statutory and regulatory obligation. Mission stated that it has already attempted to effectuate repayments for any Medicare payments that, in Mission's determination, were determined to be overpayments (i.e., for the seven sampled claims it agreed were in error). Mission stated that it did not identify any systemic hospice service billing issues that would compel Mission to conduct additional reviews at this time.

- Regarding our third recommendation, Mission stated that it believes its currently existing procedures are sufficiently strong to ensure that hospice services reasonably comply with Medicare requirements. Mission also stated that its compliance policies and procedures have evolved over time and are appropriate both with regard to the initial admission process and recertifications. Mission stated that it reviews and updates its policies and procedures from time to time to ensure compliance with regulatory requirements and appropriate clinical standards. In addition, Mission stated that it has a dedicated team of hospice and compliance professionals to develop, implement, and train staff on its compliance and clinical operations.

Office of Inspector General Response

We clarified in the footnote to our first recommendation that OIG audit recommendations do not represent final determinations by Medicare. Action officials at CMS, acting through a MAC or other contractor, will determine whether an overpayment exists and will recoup any overpayments consistent with CMS's policies and procedures. If a disallowance is taken, a provider has the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

We maintain that improper payment of the 34 sampled claims occurred because Mission's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis and that the appropriate level of care was provided.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 6,142 hospice claims for which Mission received Medicare reimbursement totaling $37,111,706 for services provided from October 1, 2015, through September 30, 2017 (audit period). These claims were extracted from CMS's National Claims History (NCH) file.

We did not assess Mission's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our objective. Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the NCH file, but we did not assess the completeness of the file.

We performed fieldwork at Mission's office in San Mateo, California.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- 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 Mission officials to gain an understanding of Mission's policies and procedures related to providing and billing Medicare for hospice services and reviewed those policies and procedures;
- obtained from CMS's NCH file 6,466 hospice claims, totaling $37,329,352,[42] for the audit period;
- excluded 316 claims, totaling $184,888, that had a payment amount of less than $1,000; 4 claims, totaling $17,026, that had compromised beneficiary numbers; and 4 claims, totaling $15,732, that were identified in the Recovery Audit Contractor data warehouse as having been reviewed by another party;
- created a sampling frame consisting of 6,142 hospice claims, totaling $37,111,706;
- selected a simple random sample of 100 hospice claims from the sampling frame;

[42] We excluded claims that were zero-paid; however, an individual claim line can have a zero payment.

- reviewed data from CMS's Common Working File and other available data for the sampled claims to determine whether the claims had been canceled or adjusted;

- obtained medical records for the 100 sampled claims and provided them to an independent medical review contractor, which determined whether the hospice services complied with Medicare requirements;

- reviewed the independent medical review contractor's results and summarized the reason or reasons a claim was determined to be improperly reimbursed;

- used the results of the sample to estimate the amount of the improper Medicare payments made to Mission for hospice services; and

- discussed the results of our audit with Mission officials.

See Appendix C for our statistical sampling methodology and Appendix D 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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Hospice Provider Compliance Audit: Northwest Hospice, LLC	A-09-20-03035	6/23/2021
Medicare Hospice Provider Compliance Audit: Professional Healthcare at Home, LLC	A-09-18-03028	6/10/2021
Medicare Hospice Provider Compliance Audit: Franciscan Hospice	A-09-20-03034	5/18/2021
Medicare Hospice Provider Compliance Audit: Alive Hospice, Inc.	A-09-18-03016	5/14/2021
Medicare Hospice Provider Compliance Audit: Ambercare Hospice, Inc.	A-09-18-03017	5/14/2021
Medicare Hospice Provider Compliance Audit: Suncoast Hospice	A-02-18-01001	5/7/2021
Medicare Hospice Provider Compliance Audit: Tidewell Hospice, Inc.	A-02-18-01024	2/22/2021
Medicare Hospice Provider Compliance Audit: Hospice Compassus, Inc., of Tullahoma, Tennessee	A-02-16-01024	12/16/2020
Medicare Hospice Provider Compliance Audit: Hospice Compassus, Inc., of Payson, Arizona	A-02-16-01023	11/19/2020
Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm	OEI-02-17-00021	7/3/2019
Hospice Deficiencies Pose Risks to Medicare Beneficiaries	OEI-02-17-00020	7/3/2019
Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	OEI-02-16-00570	7/30/2018
Hospices Should Improve Their Election Statements and Certifications of Terminal Illness	OEI-02-10-00492	9/15/2016
Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care	OEI-02-10-00491	3/30/2016
Hospice of New York, LLC, Improperly Claimed Medicare Reimbursement for Some Hospice Services	A-02-13-01001	6/26/2015
Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities	OEI-02-14-00070	1/13/2015
The Community Hospice, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services	A-02-11-01016	9/23/2014
Servicios Suplementarios de Salud, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services	A-02-11-01017	8/7/2014

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We obtained Medicare Part A claims data for hospice services that Mission provided during our audit period, representing 6,466 paid claims totaling $37,329,352. We excluded 316 claims, totaling $184,888, that had a payment amount of less than $1,000; 4 claims, totaling $17,026, that had compromised beneficiary numbers; and 4 claims, totaling $15,732, that were identified in the Recovery Audit Contractor data warehouse as having been reviewed by another party. As a result, the sampling frame consisted of 6,142 claims totaling $37,111,706. The data were extracted from the CMS NCH file.

SAMPLE UNIT

The sample unit was a Medicare Part A hospice claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 Medicare Part A hospice claims.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG, OAS, statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sampling frame using a field in OIG's copy of CMS's NCH file that uniquely identifies claims. We consecutively numbered the hospice claims in our sampling frame from 1 to 6,142. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to calculate our estimates. We estimated the total amount of improper Medicare payments made to Mission for unallowable hospice services at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results

Number of Claims in Sampling Frame	Value of Sampling Frame	Sample Size	Value of Sample	Number of Unallowable Claims	Value of Overpayments in Sample
6,142	$37,111,706	100	$605,507	34	$225,166

Table 2: Estimated Value of Overpayments in the Sampling Frame (*Limits Calculated for a 90-Percent Confidence Interval*)

Point estimate	$13,829,680
Lower limit	10,564,396
Upper limit	17,094,964