Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HOSPICE PROVIDER COMPLIANCE AUDIT: AMBERCARE HOSPICE, 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: May 2021
Report No. A-09-18-03017

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

Medicare Hospice Provider Compliance Audit: Ambercare Hospice, 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 Ambercare Hospice, Inc. (Ambercare), complied with Medicare requirements.

How OIG Did This Audit

Our audit covered 13,382 claims for which Ambercare (located in Albuquerque, New Mexico) received Medicare reimbursement of $53.8 million for hospice services provided from January 1, 2016, through December 31, 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

Ambercare received Medicare reimbursement for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in our sample, 48 claims complied with Medicare requirements. However, for the remaining 52 claims, the clinical record did not support the beneficiary's terminal prognosis.

Improper payment of these claims occurred because Ambercare's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis. On the basis of our sample results, we estimated that Ambercare received at least $24.6 million in unallowable Medicare reimbursement for hospice services.

What OIG Recommends and Ambercare Comments

We recommend that Ambercare: (1) refund to the Federal Government the portion of the estimated $24.6 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.

In written comments on our draft report, Ambercare, through its attorney, stated that it disputed nearly all of our findings and did not concur with our recommendations. However, Ambercare agreed to refund any overpayments for the four claims it agreed were in error. Ambercare stated that our independent medical review contractor did not apply the correct standard to determine whether the beneficiary's clinical record supported a terminal prognosis and the beneficiary's eligibility to receive hospice services. In addition, Ambercare's statistical expert challenged the validity of our statistical sampling methodology and the resulting extrapolation.

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

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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 Ambercare Hospice, Inc. (Ambercare), 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 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. 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 (January 1, 2016, through December 31, 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]

Ambercare Hospice, Inc.

Ambercare, located in Albuquerque, New Mexico, is a for-profit provider that furnishes hospice care, home health services, and personal care services to beneficiaries who live in New Mexico. From January 1, 2016, through December 31, 2017 (audit period), Ambercare provided hospice services to approximately 3,000 beneficiaries and received Medicare reimbursement of about $55 million.[19] Palmetto GBA, LLC (Palmetto), serves as the MAC for Ambercare.

HOW WE CONDUCTED THIS AUDIT

Ambercare received Medicare Part A reimbursement of $55,482,172 for hospice services provided during our audit period, representing 14,873 paid claims. After we excluded 1,491 claims, totaling $1,636,568, our audit covered 13,382 claims totaling $53,845,604.[20] We reviewed a random sample of 100 of these claims, totaling $397,050, 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 January 1, 2016, through December 31, 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 (1,183 claims), had compromised beneficiary numbers (303 claims), or were identified in the Recovery Audit Contractor data warehouse as having been reviewed by another party (5 claims).

FINDING

Ambercare received Medicare reimbursement for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in our sample, 48 claims complied with Medicare requirements. However, for the remaining 52 claims, the clinical record did not support the beneficiary's terminal prognosis. Improper payment of these claims occurred because Ambercare's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis.

On the basis of our sample results, we estimated that Ambercare received at least $24.6 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, Ambercare 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]

TERMINAL PROGNOSIS NOT SUPPORTED

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 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]

For 52 of the 100 sampled claims, the clinical record provided by Ambercare 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 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.

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[21] The statistical lower limit is $24,665,520. 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).

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

RECOMMENDATIONS

We recommend that Ambercare Hospice, Inc.:

- refund to the Federal Government the portion of the estimated $24,665,520 for hospice services that did not comply with Medicare requirements and that are within the 4-year reopening period;[25]

- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule[26] 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.

AMBERCARE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Ambercare, through its attorney, stated that it disputed nearly all of our findings and did not concur with our recommendations. Ambercare disagreed with our determinations for all but 4 of the 52 sampled claims questioned in our draft report and provided specific responses for each of the 52 claims. Ambercare agreed to refund or repay any overpayments for the four claims it agreed were in error.

Ambercare stated that OIG's independent medical review contractor did not apply the correct standard to determine whether the beneficiary's clinical record supported a terminal prognosis and the beneficiary's eligibility to receive hospice services. Furthermore, Ambercare stated that our independent medical review contractor repeatedly found that documentation was insufficient because it did not satisfy Local Coverage Determination (LCD) criteria. Ambercare stated that LCD guidelines are not mandatory and that failure to meet those guidelines cannot support a claim denial. In addition, Ambercare stated that our independent medical review contractor repeatedly failed to consider the totality of each patient's circumstances and each patient's individualized clinical condition and needs.

[25] 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.

[26] 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.

Ambercare engaged a statistical expert, who analyzed our statistical sampling methodology and, based on that analysis, stated that our methodology is not statistically valid and should not be used as a basis to calculate an extrapolated overpayment. Ambercare's comments are included as Appendix E.[27]

After reviewing Ambercare's comments, we maintain that our findings and recommendations are valid. We also reviewed the report prepared by Ambercare's statistical expert and 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 Ambercare. The following sections summarize Ambercare's comments and our responses.

NONCONCURRENCE WITH RECOMMENDATIONS

Ambercare Comments

Ambercare did not concur with our three recommendations as follows:

- Regarding our first recommendation, Ambercare stated that based on a review by a third-party expert, 48 of the 52 sampled claims were supported by the patient's clinical record and billed appropriately. Ambercare agreed to refund or repay any overpayments associated with the remaining four sampled claims. In addition, Ambercare stated that our sampling methodology was not statistically valid and should not be used as a basis to calculate an extrapolated overpayment. Ambercare stated that it intends to vigorously challenge our findings for the 48 sampled claims and any sampling methodology used to calculate and extrapolate overpayments by exercising its rights to appeal any adverse findings through the Medicare administrative appeals process.

- Regarding our second recommendation, Ambercare acknowledged its legal obligation to exercise reasonable diligence to identify potential overpayments within the preceding 6 years based on receipt of credible information that an overpayment may exist. However, Ambercare stated that it disagreed with our findings and believes that the vast majority of the sampled claims are supported by the patients' clinical records and were billed appropriately.

- Regarding our third recommendation, Ambercare disagreed that its procedures allowed any systemic issues to occur. Ambercare stated that OIG has not identified any

[27] Ambercare attached four exhibits to its comments, which contained resumes and curricula vitae of the external consultants it hired to review the beneficiary clinical records that our independent medical review contractor determined were not supported, those external consultants' rebuttal statements for our findings, supplemental beneficiary clinical records, and the Ambercare statistical expert's review of our statistical sampling methodology. Because these documents contain proprietary and personally identifiable information, we have excluded them from this report, but we are providing Ambercare's comments separately in their entirety to CMS.

particular policies or procedures that it believes to be lacking or insufficient and that the findings reflect a largely effective compliance program.

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 a potential 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 52 sampled claims occurred because Ambercare's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis.

CONCERNS RELATED TO AUDIT PROCESS

Ambercare Comments

Ambercare stated that it has numerous concerns with OIG's audit process. Ambercare stated that the draft report does not provide a single reason why Ambercare specifically was selected for audit.

Ambercare stated that it has serious concerns about the qualifications of our independent medical review contractor, and OIG has not provided any substantive information by which Ambercare can assess the contractor. Ambercare also stated that without receiving information about our contractor, Ambercare can assess the reviewer only through his or her individual medical determinations of the audited claims.

Ambercare stated that our independent medical review contractor repeatedly found that documentation was insufficient because it did not satisfy LCD criteria. Ambercare also stated that LCD guidelines are not mandatory and that failure to meet those guidelines cannot support a claim denial.

Office of Inspector General Response

We selected Ambercare for a compliance audit through the use of computer matching, data mining, and data analysis techniques that identified hospice claims that were at risk for noncompliance with Medicare billing requirements.

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. In conducting the medical review, our contractor properly used the appropriate statutory and regulatory hospice criteria, as well as applicable LCD guidelines, as the framework for determining terminal status. 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.[28]

We acknowledge that some beneficiaries who did not meet the guidelines in the hospice LCDs may still be 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. 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.

CLINICAL JUDGMENT AND SUPPORT FOR TERMINAL PROGNOSIS

Ambercare Comments

Ambercare stated that the findings in our draft report are based entirely on a subjective difference in clinical opinion and that our independent medical review contractor determined in his or her own medical opinion that the portion of the patient's clinical records assessed did not support the terminal prognosis. Ambercare cited several court cases and stated that a difference in clinical judgment cannot render the physician's certification false or invalid for billing purposes.

Ambercare disagreed with our determinations for 48 of the 52 sampled claims in our draft report for which our independent medical review contractor found that the associated beneficiaries' clinical records did not support the terminal illness prognosis. Ambercare stated that our contractor consistently failed to apply the appropriate standard for assessing whether the clinical record supported the terminal prognosis. Ambercare also stated that our independent medical review contractor's analysis was limited to a "snapshot" of the patient's medical condition at a particular point in time, as illustrated by only a portion of the patient medical record.

Office of Inspector General Response

As previously mentioned, 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. In conducting the medical review, our contractor properly used the appropriate statutory and regulatory hospice criteria, as well as applicable LCD

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

guidelines, as the framework for its determinations. Our contractor acknowledged the physician's terminal diagnosis and evaluated the medical records for each hospice claim (including necessary historical clinical records), guided by questions rooted in the Medicare requirements, to determine whether the certified terminal prognosis was supported. When the medical 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. In addition, the decisions in the court cases that Ambercare referenced addressed whether a difference in clinical judgment can render a physician certification false for purposes of False Claims Act liability and therefore are inapplicable to OIG audit recommendations and CMS recoveries arising from OIG audits.

Based on our review of Ambercare's comments, including its external consultants' analyses, we maintain that the clinical records for each of the 52 sampled claims did not support the associated beneficiary's terminal prognosis. For the reasons stated above, we disagree with Ambercare's statement that our independent medical review contractor failed to apply the appropriate standard for assessing whether the clinical record supported the terminal prognosis. We also disagree that our contractor's analysis was limited to a "snapshot" of the patient's medical condition at a particular point in time.

OFFICE OF INSPECTOR GENERAL SAMPLING METHODOLOGY

Ambercare Comments

Ambercare challenged the validity of our statistical sampling methodology, engaged a statistical expert to review our sampling methodology, and provided a copy of the statistical expert's report. The statistical expert stated that our sample and extrapolation are not statistically valid and should not be used as a basis to calculate an extrapolated overpayment because: (1) the audit findings did not meet the high-error-rate criteria in the Social Security Act and CMS's *Medicare Program Integrity Manual* (MPIM) to justify the use of extrapolation, (2) the audit findings did not meet the error rate criteria in OIG's corporate integrity agreement (CIA) to justify the use of extrapolation, (3) OIG ignored statistical principles by excluding underpayments or unpaid (i.e., zero-paid) claims from the universe of claims, (4) OIG's sample is not sufficient to achieve the standard precision and confidence level for this type of statistical estimate, (5) OIG did not provide information sufficient to re-create the sampling frame and sample or OIG's overpayment estimate, (6) OIG did not state the sort order of the sampling frame, and (7) OIG failed to provide information connecting claims to overpaid amounts.

Office of Inspector General Response

After reviewing the statistical expert's report, 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.[29] 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.

The statutory and manual requirement that a determination of a sustained or high level of payment errors must be made before extrapolation can be used applies only to Medicare contractors.[30] In addition, OIG no longer uses the 5-percent error-rate threshold in its CIAs. Moreover, even in prior CIAs that used the 5-percent error-rate threshold, the threshold was used to determine when an additional claims sample (referred to as a "full sample") needed to be selected and reviewed based on the results of a probe sample (referred to as a "discovery sample"). The entity under the CIA was required to extrapolate the results of the full sample, regardless of the error rate.[31]

Ambercare relies heavily on the MPIM in its arguments that the removal of zero-paid claims ignored statistical principles. The MPIM does not apply to OIG. Even if this manual applied to OIG, it expressly allows for the removal of "claims/claim lines [that] are attributed to sample units for which there was no payment."[32] More generally, OIG may perform a statistical or nonstatistical review of a provider without covering all claims from that provider.

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.[33] Ambercare focuses on the 5 percent of cases when a provider may have to pay more to the Government; however, these cases are inherently rare, and the disadvantage to the provider in such cases tends to be small given the precision in this audit. If we had selected a larger sample size, the average effect and the most likely effect would have

[29] *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).

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

[31] Furthermore, the 5-percent error-rate threshold is a contractual term of the CIA and therefore applies only to the party to the CIA.

[32] MPIM, Pub. No. 100-08, chapter 8, § 8.4.3.2.

[33] 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).

been that we would have recommended that Ambercare refund a larger amount to the Government.

We provided Ambercare with sufficient information to re-create the statistical sample and to calculate our estimate given the overpayments amounts in our sample. The sampling frame was sorted by the FI_DOC_CLM_CNTL_NUM (a claim identification number) field and then numbered before we generated the random numbers for the sample. There is no legal or technical requirement that the sort order of the sampling frame be declared in writing in advance of generating the random numbers.

We also provided Ambercare with the medical review determinations underlying the errors identified in our audit. Because Ambercare stated that it does not have sufficient information to connect the sample overpayment amounts to the medical review determinations, we will work with Ambercare to ensure that it has the necessary information to make this connection.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 13,382 hospice claims for which Ambercare received Medicare reimbursement totaling $53,845,604 for services provided from January 1, 2016, through December 31, 2017 (audit period). These claims were extracted from CMS's National Claims History (NCH) file.

We did not assess Ambercare'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 Ambercare's office in Albuquerque, New Mexico.

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 Palmetto officials to gain an understanding of the Medicare requirements related to hospice services;
- met with Ambercare officials to gain an understanding of Ambercare'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 14,873 hospice claims, totaling $55,482,172,[34] for the audit period;
- excluded 1,183 claims, totaling $615,592, that had a payment amount of less than $1,000; 303 claims, totaling $1,004,598, that had compromised beneficiary numbers; and 5 claims, totaling $16,378, that were identified in the Recovery Audit Contractor data warehouse as having been reviewed by another party;
- created a sampling frame consisting of 13,382 hospice claims, totaling $53,845,604;
- selected a simple random sample of 100 hospice claims from the sampling frame;

[34] 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 Ambercare for hospice services; and

- discussed the results of our audit with Ambercare 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: 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 Ambercare provided during our audit period, representing 14,873 paid claims totaling $55,482,172. We excluded 1,183 claims, totaling $615,592, that had a payment amount of less than $1,000; 303 claims, totaling $1,004,598, that had compromised beneficiary numbers; and 5 claims, totaling $16,378, 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 13,382 claims totaling $53,845,604. 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 by the FI_DOC_CLM_CNTL_NUM (a claim identification number) field, and we consecutively numbered the hospice claims in our sampling frame from 1 to 13,382. 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 Ambercare 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
13,382	$53,845,604	100	$397,050	52	$220,324

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

Point estimate	$29,483,817
Lower limit	24,665,520
Upper limit	34,302,113