Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HOSPICE PROVIDER COMPLIANCE AUDIT: NORTHWEST HOSPICE, LLC

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June 2021
A-09-20-03035

Office of Inspector General

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Report in Brief
Date: June 2021
Report No. A-09-20-03035

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

Medicare Hospice Provider Compliance Audit: Northwest Hospice, LLC

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 Northwest Hospice, LLC (NW Hospice), complied with Medicare requirements.

How OIG Did This Audit

Our audit covered 6,864 claims for which NW Hospice (located in Tigard, Oregon) received Medicare reimbursement of $31.5 million for hospice services provided from June 1, 2016, through May 31, 2018. 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

NW Hospice received Medicare reimbursement for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in our sample, 81 claims complied with Medicare requirements. However, for the remaining 19 claims, the clinical record did not support the beneficiary's terminal prognosis. Improper payment of these claims occurred because NW Hospice'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 NW Hospice received at least $3.9 million in unallowable Medicare reimbursement for hospice services.

What OIG Recommends and NW Hospice Comments

We recommend that NW Hospice: (1) refund to the Federal Government the portion of the estimated $3.9 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, NW Hospice, through its attorney, stated that it concurred with the conclusion of our independent medical review contractor with respect to 7 of the 19 sampled claims we questioned but disagreed with our contractor's determinations for the remaining 12 sampled claims. Specifically, NW Hospice stated that: (1) the beneficiaries were discharged from hospice the same month or the month following our contractor's determination of ineligibility (six claims) and (2) the licensed physician it hired determined that the beneficiaries were eligible for hospice services (six claims). NW Hospice did not explicitly concur or nonconcur with our recommendations; however, regarding our first recommendation, it agreed to take appropriate action to refund payments for services determined not to have complied with Medicare requirements and provided information on actions that it had taken or planned to take to address our second and third recommendations.

After reviewing NW Hospice's comments, we maintain that our finding and recommendations are valid. We maintain that the medical records for each of the 19 sampled claims we questioned did not support the associated beneficiary's terminal prognosis.

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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 Northwest Hospice, LLC (NW Hospice), 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 (June 1, 2016, through May 31, 2018), 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]

Northwest Hospice, LLC

NW Hospice, doing business as Signature Hospice or Signature Healthcare at Home, is a for-profit provider that furnishes hospice care in Tigard, Oregon. From June 1, 2016, through May 31, 2018 (audit period), NW Hospice provided hospice services to approximately 2,000 beneficiaries and received Medicare reimbursement of about $32 million.[19] National Government Services, Inc. (NGS), serves as the MAC for NW Hospice.

HOW WE CONDUCTED THIS AUDIT

NW Hospice received Medicare Part A reimbursement of $32,281,383 for hospice services provided during our audit period, representing 7,687 paid claims. After we excluded 823 claims, totaling $748,588, our audit covered 6,864 claims totaling $31,532,795.[20] We reviewed a random sample of 100 of these claims, totaling $439,518, 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 June 1, 2016, through May 31, 2018, 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 (741 claims), were identified in the Recovery Audit Contractor data warehouse as having been reviewed by another party (74 claims), or had compromised beneficiary numbers (8 claims).

FINDING

NW Hospice received Medicare reimbursement for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in our sample, 81 claims complied with Medicare requirements. However, for the remaining 19 claims, the clinical record did not support the beneficiary's terminal prognosis. Improper payment of these claims occurred because NW Hospice'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 NW Hospice received at least $3.9 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, NW Hospice 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 19 of the 100 sampled claims, the clinical record provided by NW Hospice 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 $3,902,337. 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 Northwest Hospice, LLC:

- refund to the Federal Government the portion of the estimated $3,902,337 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.

NW HOSPICE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, NW Hospice, through its attorney, stated that it concurred with the conclusion of our independent medical review contractor with respect to 7 of the 19 sampled claims we questioned but disagreed with our contractor's determinations for the remaining 12 sampled claims. NW Hospice did not explicitly concur or nonconcur with our recommendations; however, regarding our first recommendation, it agreed to take appropriate action to refund payments for services determined not to have complied with Medicare requirements and provided information on actions that it had taken or planned to take to address our second and third recommendations.

With respect to the 12 sampled claims for which NW Hospice disagreed with our independent medical review contractor's determinations, for 6 claims, NW Hospice strongly urged OIG to find that the 6 patients discharged from hospice the same month or the month immediately following our contractor's determination of ineligibility were discharged in a timely and entirely appropriate manner. For the remaining six claims, NW Hospice, through a licensed physician (hospice expert), stated that the beneficiaries were eligible for hospice services and provided

[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.

specific responses for each of these claims. NW Hospice's comments are included as Appendix E.[27]

After reviewing NW Hospice's comments, we maintain that our finding and recommendations are valid. We maintain that the medical records for each of the 19 sampled claims we questioned did not support the associated beneficiary's terminal prognosis. The following sections summarize NW Hospice's comments and our responses.

HOSPICE DISCHARGES WITHIN THE MARGIN FOR REASONABLE CLINICAL JUDGMENT AND SUPPORT FOR TERMINAL PROGNOSIS

NW Hospice Comments

NW Hospice stated that for 6 of the 19 sampled claims we questioned, it discharged the beneficiaries from hospice either the same month or the month immediately following our independent medical review contractor's retrospective determination that the patient's terminal illness prognosis was no longer supported. NW Hospice stated that in each of these six cases, its clinical team reached the same conclusion as our contractor—i.e., that the course of the beneficiary's disease was not following the expected trajectory and, therefore, the beneficiary was no longer eligible for Medicare reimbursement of hospice services.
NW Hospice stated that it should not and reasonably cannot be faulted when its clinicians and professional staff reached the same conclusion as our independent medical review contractor within "literally a matter of days."

NW Hospice cited decisions in several court cases and stated that CMS has explicitly recognized that the "central inquiry" for determining hospice care eligibility—predicting a beneficiary's life expectancy—is not an exact science but is subject to a certifying physician's best clinical judgment supported by the beneficiary medical records.

In addition, NW Hospice stated it engaged a hospice expert to review the medical records that were provided to OIG. The hospice expert determined that another 6 of the 19 sampled claims involved beneficiaries who were eligible for hospice services. NW Hospice provided the hospice expert's findings for each of the six claims.

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. In conducting the medical review, our contractor properly used the appropriate

[27] NW Hospice attached a Supplemental Appendix to its comments, which contained supplemental clinical records for the six claims reviewed and determined appropriately paid by the hospice expert it hired; the hospice expert's curriculum vitae; and a letter of affirmation by the hospice expert. Although these documents are not included as appendices in our final report, we considered the entirety of these documents in preparing our final report and are providing NW Hospice's comments in their entirety to CMS.

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 clinical information and other documentation that support the medical prognosis to accompany the physician's written certification of terminal illness and be filed in the medical record.[28] 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.

The decisions in the court cases that NW Hospice 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.

We maintain that the medical records for each of the 19 sampled claims we questioned did not support the associated beneficiary's terminal prognosis. For the first six sampled claims mentioned in NW Hospice's comments, we disagree with NW Hospice's statement that its clinical team reached the same conclusion as our independent medical review contractor that the six beneficiaries were no longer eligible for Medicare reimbursement of hospice services. Although it is true that the six beneficiaries were discharged within the same month or the month following the claim service dates selected (i.e., our sampled claims' dates of service), our contractor evaluated the medical records and found that from the most recent certification, the medical prognoses of the six beneficiaries were not supported; therefore, the beneficiaries should have been discharged before the claim service dates selected. If NW Hospice's clinical team had reached the same conclusion as our contractor, these beneficiaries would have been discharged when the certifications were due. However, these six beneficiaries were discharged at least 1 month or up to 3 months after their latest certifications. Our independent medical review contractor considered each beneficiary's clinical picture and found that the medical 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.

For the next six sampled claims (for which NW Hospice's expert determined that the beneficiaries were eligible for hospice services) and for the seven sampled claims for which NW Hospice concurred with our independent medical review contractor's determinations, our contractor considered each beneficiary's clinical picture and found that the medical records for these claims did not contain sufficient clinical information and other documentation to support

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

the medical prognosis of a life expectancy of 6 months or less if the terminal illness ran its normal course.

THE 60-DAY RULE AND RETURN OF MEDICARE OVERPAYMENTS

NW Hospice Comments

NW Hospice stated that it is fully cognizant of its obligations pursuant to Medicare's 60-day rule. NW Hospice also stated that to comply with such obligations, it is currently in the process of "gathering information on hospice claims submitted during the period of January 1, 2015 through May 31, 2016. This period precedes the audit period of June 1, 2016 through May 31, 2018 and extends back six years prior to the date of the Draft Report." NW Hospice stated that hospice claims submitted to and paid by Medicare during both the 2-year preaudit and 2-year audit periods are not representative of hospice claims submitted to Medicare during the 2-year postaudit period (June 1, 2018, through December 31, 2020) covered by the 60-day rule's presumptive lookback period. NW Hospice provided information on actions that it is taking to comply with the 60-day rule.

Office of Inspector General Response

The 60-day rule (42 CFR §§ 401.301–401.305) requires that, 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. The 60-day rule is CMS's rule; therefore, NW Hospice should address to CMS any questions it may have about the time period covered by the 60-day rule, including any preaudit or postaudit period.

RECOMMENDATIONS

NW Hospice Comments

NW Hospice provided comments on our three recommendations as follows:

- Regarding our first recommendation, NW Hospice stated that it will take appropriate action to refund payments for services determined not to have complied with Medicare requirements after OIG has considered the information and arguments in NW Hospice's comments and upon OIG's issuance of a final audit report.

- Regarding our second recommendation, NW Hospice stated that it is aware of its obligations pursuant to Medicare's 60-day rule and referenced its specific comments on the 60-day rule (summarized in the prior section). NW Hospice stated that it will act consistently with those obligations and will reference the fact that the return of any overpayments is in accordance with this recommendation. NW Hospice provided information on actions that it had taken to address this recommendation.

- Regarding our third recommendation, NW Hospice stated that it had implemented a number of substantive, significant, and costly improvements and enhancements to its daily operations, which have facilitated and resulted in improved compliance with NW Hospice's already compliant policies and procedures.

Office of Inspector General Response

We maintain that improper payment of the 19 sampled claims occurred because NW Hospice's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis. 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.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 6,864 hospice claims for which NW Hospice received Medicare reimbursement totaling $31,532,795 for services provided from June 1, 2016, through May 31, 2018 (audit period). These claims were extracted from CMS's National Claims History (NCH) file.

We did not assess NW Hospice'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 NW Hospice's facility in Tigard, Oregon.

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 NW Hospice officials to gain an understanding of NW Hospice'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 7,687 hospice claims, totaling $32,281,383,[29] for the audit period;
- excluded 741 claims, totaling $383,095, that had a payment amount of less than $1,000; 74 claims, totaling $338,275, that were identified in the Recovery Audit Contractor data warehouse as having been reviewed by another party; and 8 claims, totaling $27,218, that had compromised beneficiary numbers;
- created a sampling frame consisting of 6,864 hospice claims, totaling $31,532,795;
- selected a simple random sample of 100 hospice claims from the sampling frame;

[29] 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 NW Hospice for hospice services; and

- discussed the results of our audit with NW Hospice 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: 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 NW Hospice provided during our audit period, representing 7,687 paid claims totaling $32,281,383. We excluded 741 claims, totaling $383,095, that had a payment amount of less than $1,000; 74 claims, totaling $338,275, that were identified in the Recovery Audit Contractor data warehouse as having been reviewed by another party; and 8 claims, totaling $27,218, that had compromised beneficiary numbers. As a result, the sampling frame consisted of 6,864 claims totaling $31,532,795. 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, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sampling frame by the field FI_DOC_CLM_CNTL_NUM (a claim identification number), and we consecutively numbered the hospice claims in our sampling frame from 1 to 6,864. 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 NW Hospice 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
6,864	$31,532,795	100	$439,518	19	$88,112

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

Point estimate	$6,048,022
Lower limit	3,902,337
Upper limit	8,193,707