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Eli's Hospice Insider

Audits: 5 Hospice Audit Reports Show Medical Review Challenges Hospices Face

Problems abound with OIG review processes, audited hospices charge.

If an OIG medical reviewer comes knocking on your door, the result could be tens of millions in estimated overpayments. Take a look at five audit reports targeting hospices the HHS Office of Inspector General has released in recent weeks.

Read on for audit details:

1. Alive Hospice Inc. From October 2015 to September 2017, nonprofit Alive billed nearly 12,000 claims resulting in $45.8 million in Medicare reimbursement. The OIG contractor reviewed 100 claims from the period and found 24 non-compliant - 16 for failing to support the six-month prognosis and eight for not supporting a General Inpatient (GIP) level of care. Using extrapolation, the OIG estimates Alive owes Medicare $7.3 million for the time period.

The Albuquerque, New Mexico-based hospice admits that two of the 24 claims "arguably could be viewed as lacking sufficient documentation to support the beneficiary's terminal prognosis. But it disputes the findings on the other 22 claims in a 17-page letter via its attorney. The hospice takes aim at reviewer qualifications, elevating "the OIG reviewer's judgment above that of the certifying physician's judgment," incorrectly using Local Coverage Determination guidelines as requirements, confusing GIP and Continuous Home Care (CHC) requirements, and much more. Alive also takes issue with the OIG's sampling and extrapolation processes, noting that "the OIG's sample is flawed because it is not representative of the broader universe of Alive's claims nor is it large enough to produce a standard precision and confidence level." Alive plans to appeal "and is confident those findings will be overturned," the response letter says.

Unlike in its recent string of home health agency audits, the OIG sticks by its original findings and doesn't walk back any of the determinations. "After reviewing Alive's comments, we maintain that our findings and recommendations are valid," says the report at https://oig.hhs.gov/oas/reports/region9/91803016.asp.

2. Ambercare Hospice Inc. From January 2016 to December 2017, Ambercare submitted about 13,380 claims resulting in about $53.8 million in Medicare payments. The OIG contractor reviewed 100 claims from the period and found 52 noncompliant based on six-month prognosis. Using extrapolation, the OIG estimates Ambercare owes Medicare $24.6 million for the time period.

"Ambercare acknowledges that 4 of the 100 audited claims arguably could be viewed as lacking sufficient documentation to support the beneficiary's terminal prognosis," according to its 14-page response letter to the report via its attorney. But it disagrees on the other 48 claims, noting that "the patients' medical records actually do support the terminal prognosis for those claims." Like Alive, Ambercare takes aim at everything from reviewer qualifications to "cherry pick[ing] selective portions of the patient's medical record while either ignoring or discounting other portions that clearly support a terminal prognosis." And it challenges the OIG's sampling and extrapolation as well.

Also like Alive, "after reviewing Ambercare's comments, we maintain that our findings and recommendations are valid," the OIG says in the report at https://oig.hhs.gov/oas/reports/region9/91803017.asp.

3. Suncoast Hospice Inc. From July 2015 to June 2017, Clearwater, Florida-based Suncoast submitted nearly 39,000 claims resulting in $148.5 million in Medicare payments. The OIG contractor reviewed 100 claims from the period and found 49 claims noncompliant based on six-month prognosis, failure to support care levels for 23 GIP claims and three CHC claims, and incorrect Service Intensity Add-on billing. Using extrapolation, the OIG estimates the nonprofit owes

Medicare $47.4 million for the time period.

The findings are "fundamentally flawed" and show a "clear lack of understanding of hospice eligibility reflected in the OIG's Medical Review Contractor's decisions," Suncoast charges in a letter from its attorney, **Bryan Nowicki** with law firm Husch Blackwell. "The Contractor's summaries are misleading, incomplete, focus on irrelevant data points, and, most importantly, fail to provide any explanation regarding how those data points relate to each patient's prognosis," the letter charges. The reviewer "cherry-picked discrete bits of information to rationalize its decisions while ignoring the patients' overall medical condition," the letter criticizes. The reviewer "failed to give any deference to the certifying hospice physicians, resulting in the unsupported conclusion that the clinical determinations made by more than 50 different physicians, many of whom have over a decade of hospice experience and are Board-certified in Hospice and Palliative Care Medicine, were wrong," it adds. Suncoast also takes on the OIG's sampling and extrapolation procedures.

Once again, the OIG sticks by its findings, notes the report at https://oig.hhs.gov/oas/reports/region2/21801001.asp.

4. Franciscan Hospice. The OIG asserts that 21 of 100 reviewed claims from Franciscan Hospice in University Place, Washington, are "noncompliant." Specifically, "for 19 claims, the clinical record did not support the beneficiary's terminal prognosis, and for the remaining 2 claims, there was no documentation to support the hospice services that Franciscan billed to Medicare," the OIG says in the report.

In its audit period of 2016 and 2017, nonprofit Franciscan had a universe of 21,537 claims and $101.5 million in Medicare payment. Using statistical sampling and extrapolation, the OIG figures that Franciscan owes "at least $13 million" to Medicare for "unallowable Medicare reimbursement for hospice services," it says in the report.

In a nine-page response letter to the OIG, Franciscan allows that the audit was correct on seven of its claims. But the Catholic health system-based hospice disputes the other 12 claims, "particularly those challenging the existence of a terminal prognosis." Franciscan lists multiple case examples where the OIG reviewer claimed the record lacked support for the terminal prognosis, but the hospice's expert reviewer did not agree.

Franciscan also challenges the OIG's extrapolation methodology, noting that its "nominal error rate is not suggestive of a systemic error requiring extrapolation." In fact, "under CMS standards, medical reviewers are directed to extrapolate only in the event of 'sustained or high level payment error' rate, meaning 50 percent or more," the hospice says. "While these standards apply directly to Medicare review contractors (e.g., UPICs, RACs, the SMRC, and MACs), they should not be ignored in the context of an OIG audit recommending extrapolation," the letter urges.

"Certain inaccuracies in the OIG's audit findings produced an inflated error rate and resulted in incorrect conclusions," the hospice concludes in its letter in the report at https://oig.hhs.gov/oas/reports/region9/92003034.pdf.

5. New York Medicaid. The fourth audit report is a bit different. It covers a New York state audit of hospice claims that chalks up $50 million in illegitimate Medicaid payments based on relatedness and dual-eligibles.

New York state "identified approximately $50 million in actual and potential Medicaid overpayments, cost-saving opportunities, and questionable payments for services provided to dually eligible individuals receiving Medicare-covered hospice care," says an Office of the New York State Comptroller's audit report, which the OIG issued on April 21.

The breakdown: For the period Jan. 1, 2015 through July 31, 2019, the Comptroller identified $35.7 million in questionable payments for personal care services; $4.3 million in "actual and potential overpayments" for services not allowed in conjunction with hospice or that overlap with hospice-covered benefits; $1.2 million in potential overpayments for services that likely should have been covered by hospice providers; $370,506 for unnecessary personal care services; $4.1 million in questionable payments for durable medical equipment and supplies; and $4.3 million in unnecessary payments for nursing home room and board under managed care, according to the report.

CMS says "services unrelated to the terminal illness should be exceptional, unusual, and rare," the audit report points out. "Medicare requires non-hospice providers who bill Medicare for services to document the diagnoses or conditions the hospice provider has determined are unrelated to the terminal illness. However, Medicaid does not specifically require

providers to document why services are provided outside of the hospice benefit."

Plus: The New York Department of Health "does not have a process to identify, track, or monitor dual-eligibles who elect the Medicare hospice benefit," the audit report adds.

The NYDOH says it will pursue the overpayments, although on its own terms. It "pulled its own data to include the … identified overpayments" and "will pursue recovery of any payments it determines to be inappropriate as a result of that analysis," according to the NYDOH's report response letter.

The state also says it is "establishing a roster of hospice care recipients" enrolled in Medicaid and making other system changes to identify affected dual-eligibles.

Watch for: "The Department is clarifying which services should be covered by hospice and issue comprehensive guidance to hospice providers via a Medicaid Update … and updates to the Hospice Billing and Program Policy Guidelines," NYDOH says.

"The state is also formally reminding long-term care providers, managed care plans, and hospices themselves that they must coordinate services and coverage. That task includes a 'Dear Administrator Letter' (DAL) … to all hospice providers reminding them of the Medicare Conditions of Participation requirement to coordinate all services provided to individuals electing the hospice benefit," according to the report.

And NYDOH "is working with the [Medicaid Managed Long-Term Care plans] to ensure that Person Center Service Plans accurately document what is covered by the MLTC as opposed to hospice and is expanding its survey process to include a sample review of said documentation," says the report at https://oig.hhs.gov/oas/reports/region2/22101008.pdf.

Up next: Don't be surprised to see this sort of scrutiny and resulting actions take place in other states, experts warn.