

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HOSPICE OF NEW YORK, LLC,
IMPROPERLY CLAIMED MEDICARE
REIMBURSEMENT FOR SOME
HOSPICE SERVICES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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**James P. Edert
Regional Inspector General
for Audit Services**

June 2015
A-02-13-01001

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

Hospice of New York, LLC improperly claimed at least \$1.2 million in Medicare reimbursement for hospice services.

WHY WE DID THIS REVIEW

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

Our objective was to determine whether hospice services claimed for Medicare reimbursement by Hospice of New York, LLC (the Hospice) complied with Medicare requirements.

BACKGROUND

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

HOW WE CONDUCTED THIS REVIEW

Our review covered 4,369 beneficiary-months for which the Hospice received Medicare reimbursement totaling \$19,528,997 for hospice services provided during calendar year (CY) 2011 and paid during CYs 2011 through 2012. We reviewed all Medicare payments for hospice services related to our random sample of 100 beneficiary-months. A beneficiary-month included all hospice services provided to a beneficiary during 1 month.

WHAT WE FOUND

The Hospice claimed Medicare reimbursement for some hospice services that did not comply with certain Medicare requirements. Of the 100 beneficiary-months in our random sample for which the Hospice claimed Medicare reimbursement, 79 beneficiary-months complied with Medicare requirements, but 21 did not.

The improper payments occurred because the Hospice did not always obtain the required physician’s certifications or sufficient clinical documentation to support a beneficiary’s eligibility for hospice services. The Hospice also claimed Medicare reimbursement for services for which it did not provide supporting documentation and for services with a date of service after a beneficiary’s death.

On the basis of our sample results, we estimated that the Hospice improperly received at least \$1,266,517 in Medicare reimbursement for hospice services that did not comply with certain Medicare requirements. This overpayment includes claims paid outside of the 3-year recovery period. Of the estimated overpayment, at least \$226,744 was paid within the 3-year recovery period.

WHAT WE RECOMMEND

We recommend that the Hospice:

- refund \$226,744 to the Federal Government for hospice services that did not comply with Medicare requirements and that are within the 3-year claims recovery period;
- work with the Medicare Administrative Contractor (MAC) to return overpayments outside of the 3-year claims recovery period in accordance with the 60-day repayment rule; and
- strengthen its procedures to ensure that it complies with Medicare requirements for claiming hospice services.

HOSPICE OF NEW YORK, LLC COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospice partially agreed with our first recommendation (financial disallowance) and agreed with our remaining recommendations. Specifically, of the 21 beneficiary-months that we questioned in our draft report, the Hospice agreed that 3 did not comply with Medicare requirements and agreed to refund the Medicare payments associated with these beneficiary-months. The Hospice disagreed with our determination that it did not obtain timely verbal certifications of the beneficiary's terminal prognosis for the remaining 18 beneficiary-months and described why records provided during our review documented that verbal certifications were properly obtained and present. The Hospice also submitted several attachments to its comments that it believes supports its claim that the Hospice is in full compliance with Medicare verbal certification requirements.

After reviewing the Hospice's comments, we maintain that our findings and recommendations are valid. Specifically, for the 18 beneficiary-months that the Hospice disagreed with our determinations, the associated beneficiary's medical records did not contain sufficient evidence that the Hospice obtained timely verbal certifications of the beneficiary's terminal illness.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

OBJECTIVE

Our objective was to determine whether hospice services claimed for Medicare reimbursement by Hospice of New York, LLC (the 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. CMS contracts with four Home Health and Hospice Medicare Administrative Contractors (MAC) to process and pay Medicare hospice claims.

The Medicare Hospice Benefit

Medicare Part A covers hospice services provided to eligible beneficiaries.¹ The Medicare hospice benefit has four levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care. Each level has an all-inclusive daily rate.² The goals of hospice care are to help terminally ill beneficiaries continue life with minimal disruption and to support beneficiaries' families and other caregivers throughout the process. This care is palliative (supportive), rather than curative, and includes, among other things, nursing care, medical social services, hospice aide services, medical supplies, and physician services.

To be eligible for hospice care, a beneficiary must be entitled to Medicare Part A and certified by a physician as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course.³

¹ Sections 1812(a)(4) and (5) of the Act.

² 42 CFR § 418.302.

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

Upon a beneficiary's election of hospice care, the hospice assumes the responsibility for medical care for the beneficiary's terminal illness. The beneficiary waives all rights to Medicare payment for services related to the curative treatment of the terminal condition or a related condition.⁴ Inclusion in the Medicare hospice program is voluntary and can be revoked at any time by the beneficiary.⁵

Beneficiaries are entitled to receive hospice care for two 90-day periods, followed by an unlimited number of 60-day periods.⁶ At the start of the initial 90-day period of care, the hospice must obtain written certification of the beneficiary's terminal illness from the hospice medical director or the physician member of the hospice interdisciplinary group and the individual's attending physician, if any. For subsequent periods, a written certification by a hospice physician is required.⁷ The initial certification and all subsequent re-certifications must include a brief narrative of the clinical findings that supports a life expectancy of 6 months or less.⁸

Hospice of New York, LLC

The Hospice, located in the Long Island City section of Queens, New York, provides hospice services to those who are seriously ill, as well as support for their families. During calendar year (CY) 2011, the Hospice provided hospice services to beneficiaries residing in the New York City metropolitan area. Palmetto, Inc. (Palmetto) serves as the Home Health and Hospice MAC for the Hospice.

HOW WE CONDUCTED THIS REVIEW

Our review covered 4,369 beneficiary-months for which the Hospice received Medicare reimbursement totaling \$19,528,997 for hospice services provided during CY 2011 and paid during CYs 2011 through 2012. We reviewed all Medicare payments for hospice services related to our random sample of 100 beneficiary-months. A beneficiary-month included all hospice services provided to a beneficiary during 1 month. For certain sample items, we sought Palmetto's assistance in determining whether the associated hospice services met Medicare requirements.

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

⁴ Sections 1812(d)(2)(A) and 1861(dd)(1) of the Act.

⁵ Section 1812(d)(2)(B) of the Act.

⁶ 42 CFR § 418.21(a).

⁷ 42 CFR § 418.22(c).

⁸ 42 CFR § 418.22(b)(3).

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

FINDINGS

The Hospice claimed Medicare reimbursement for some hospice services that did not comply with certain Medicare requirements. Of the 100 beneficiary-months in our random sample for which the Hospice claimed Medicare reimbursement, 79 beneficiary-months complied with Medicare requirements, but 21 did not. Specifically:

- For 19 beneficiary-months, hospice eligibility requirements were not met.
- For 1 beneficiary-month, the Hospice did not provide documentation to support a service claimed for Medicare reimbursement.
- For 1 beneficiary-month, the Hospice claimed Medicare reimbursement for services that were not provided.

These improper payments occurred because the Hospice did not always obtain the required physician's certifications or sufficient clinical documentation to support a beneficiary's eligibility for hospice services. The Hospice also claimed Medicare reimbursement for services for which it did not provide supporting documentation and for services with a date of service after a beneficiary's death.

On the basis of our sample results, we estimated that the Hospice improperly received at least \$1,266,517 in Medicare reimbursement for hospice services that did not comply with certain Medicare requirements. This overpayment includes claims paid outside of the 3-year recovery period.⁹ Of the estimated overpayment, at least \$226,744 was paid within the 3-year recovery period.¹⁰

HOSPICE ELIGIBILITY REQUIREMENTS NOT MET

⁹ Our audit report represents the results for all claims within CY 2011. Section 1870(b) of the Act governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, the Hospice is responsible for reporting and returning overpayments they identified to their Medicare administrative contractor. The 2010 Patient Protection and Affordable Care Act requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

¹⁰ 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 will be less than the actual overpayment total at least 95 percent of the time.

To be eligible for the Medicare hospice benefit, a beneficiary must be entitled to Part A and certified as being terminally ill.¹¹ For the initial period of care, the hospice must obtain from the hospice's physician and the beneficiary's attending physician (if any), a written certification of the terminal illness that specifies the beneficiary's prognosis is for a life expectancy of 6 months or less if the illness runs its normal course.¹² The certification must be accompanied by clinical information and other documentation that supports the medical prognosis and must be signed and dated by the physician(s). If the hospice cannot obtain the written certification within 2 days, after a benefit period begins, it must obtain an oral certification within 2 days and the written certification before the hospice submits a claim for payment.¹³

For 19 beneficiary-months, the Hospice claimed Medicare reimbursement for services provided to beneficiaries for whom hospice eligibility requirements were not met. Specifically:

- For 18 beneficiary-months, the Hospice did not obtain a verbal certification of the beneficiary's terminal illness from the hospice's physician and/or the beneficiary's attending physician, when a written certification was not obtained within 2 days of the start of the benefit period.¹⁴
- For 1 beneficiary-month, clinical documentation provided by the Hospice did not support the associated beneficiary's terminal prognosis (i.e., the documentation did not indicate that the beneficiary's life expectancy was 6 months or less).¹⁵

SERVICES NOT DOCUMENTED

Payments to Medicare providers should not be made unless the provider has furnished information necessary to determine the amounts due the provider.¹⁶

For 1 beneficiary-month, the Hospice claimed Medicare reimbursement for a physician's visit for which there was no progress note in the associated beneficiary's case record.

SERVICES NOT PROVIDED

For 1 beneficiary-month, the Hospice claimed Medicare reimbursement for services not provided. Specifically, the Hospice billed continuous home care services with dates of service after the beneficiary's death.

¹¹ Sections 1814(a)(7)(A) and 1861(dd)(3)(A) of the Act and 42 CFR § 418.20.

¹² For subsequent periods of care, only a written certification from the hospice's physician is required.

¹³ 42 CFR § 418.22.

¹⁴ All 18 beneficiary-months were within the initial period of care. We questioned only those services provided from the start of the beneficiary-month until the date of when the Hospice obtained the written certification.

¹⁵ Palmetto's medical review staff assisted with this determination.

¹⁶ Section 1815(a) of the Act.

RECOMMENDATIONS

We recommend that the Hospice:

- refund \$226,744 to the Federal Government for hospice services that did not comply with Medicare requirements and that are within the 3-year claims recovery period;
- work with the Medicare Administrative Contractor to return overpayments outside of the 3-year claims recovery period in accordance with the 60-day repayment rule; and
- strengthen its procedures to ensure that it complies with Medicare requirements for claiming hospice services.

HOSPICE OF NEW YORK, LLC COMMENTS

In written comments on our draft report, the Hospice partially agreed with our first recommendation (financial disallowance) and agreed with our remaining recommendations. Specifically, of the 21 beneficiary-months we questioned in our draft report, the Hospice agreed that 3 beneficiary-months did not comply with Medicare requirements and agreed to refund the Medicare payments associated with these beneficiary-months. The Hospice disagreed with our determination that it did not obtain timely verbal certifications of the beneficiary's terminal prognosis for the remaining 18 beneficiary-months. For each of these beneficiary-months, the Hospice contended that the initial plan of care contained the verbal certifications.

According to the Hospice, when a beneficiary is admitted to its program, a nurse calls the beneficiary's physician to verify the physician's medical orders and obtain verbal certification. This information, along with evidence of team collaboration and the initial plan of care are entered into an electronic medical record, which is then signed by the nurse and sent to the physician for signature. The Hospice stated that items appearing on the initial plan of care above the nurse's signature are evidence of communication between the physician and nurse and represent the verbal certification. The Hospice included several attachments to its comments that, according to the Hospice, support its claim that it is in full compliance with Medicare verbal certification requirements.¹⁷

The Hospice's comments are included as Appendix D.¹⁸

¹⁷ Among other information, the attachments included a case-by-case verification that the initial plans of care for the 18 disallowed beneficiary-months contained required verbal certifications, signed statements from Hospice staff detailing the procedures they follow to obtain verbal certifications, and the opinion of a Hospice-paid consulting firm indicating that the Hospice's initial plans of care were adequate evidence of a timely verbal physician certification.

¹⁸ Attachments to the Hospice's comments are not included because they were too voluminous.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospice's comments, we maintain that our findings and recommendations are valid. Specifically, for each of the 18 beneficiary-months that the Hospice disagreed with our determinations, the associated beneficiary's medical record did not contain sufficient evidence that the Hospice obtained a timely verbal certification of the beneficiary's terminal illness.

As part of our review, we sought Palmetto's assistance in determining whether the Hospice's documentation met Medicare verbal certification requirements. We provided Palmetto officials who have extensive knowledge of Medicare requirements related to hospice care, the initial plans of care for the beneficiaries in question and described the Hospice's processes for when a beneficiary is admitted to the Hospice. On the basis of its review, Palmetto agreed with our determinations that the Hospice did not obtain verbal certifications as required. According to Palmetto officials, there should be a notation in the beneficiary's record indicating that a nurse spoke with the beneficiary's physician on a specific date and that, on that date, the physician verbally certified that the patient was terminally ill and required hospice care. The documentation that the Hospice provided for the 18 beneficiary-months in question did not contain this information.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 4,369 beneficiary-months for which the Hospice received Medicare reimbursement totaling \$19,528,997 for hospice services provided during CY 2011. A beneficiary-month included all hospice services provided to a beneficiary during 1 month. The claims for these hospice services were extracted from CMS's National Claims History file.

We did not assess the Hospice's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of the Hospice's policies and procedures related to hospice services. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We performed fieldwork from December 2012 through April 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidelines;
- met with CMS officials to gain an understanding of the Medicare hospice benefit;
- met with Palmetto officials to gain an understanding of the Medicare requirements related to hospice services;
- met with Hospice officials to gain an understanding of its policies and procedures related to providing and billing Medicare for hospice services;
- obtained from the CMS National Claims History file a sampling frame of 4,369 beneficiary-months, totaling \$19,528,997, for CY 2011;
- selected a simple random sample of 100 beneficiary-months from the sampling frame;
- reviewed data from CMS's Common Working File and other available data for the sample claims to determine whether the claims had been canceled or adjusted;
- obtained and reviewed case records and claim payment data for each of the sample beneficiary-months to determine whether:
 - the associated beneficiary was eligible for hospice services and
 - the services provided met Medicare requirements;

- submitted case records for certain sample items to Palmetto medical review staff for their assistance in determining whether the associated hospice services met Medicare requirements;
- estimated the total unallowable Medicare reimbursement paid in the sampling frame of 4,369 beneficiary-months;
- estimated the unallowable Medicare reimbursement paid in the sampling frame of 4,369 beneficiary-months that is within the 3-year recovery period; and
- discussed the results of our review with Hospice officials.

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

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all Medicare Part A payments made to the Hospice for a beneficiary-month during CY 2011. A beneficiary-month is defined as all hospice services the Hospice provided to a beneficiary during 1 month.

SAMPLING FRAME

The sampling frame was an Access database containing 4,369 beneficiary-months, totaling \$19,528,997. The data was extracted from the CMS National Claims History file.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiary-months.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

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

ESTIMATION METHODOLOGY

We used the OAS statistical software to calculate our estimates. We estimated (1) the total amount of improper Medicare payments for unallowable hospice services during CY 2011, and (2) the amount of overpayments for claims paid to the Hospice within the 3-year recovery period, at the lower limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

TOTAL MEDICARE OVERPAYMENTS FOR CY 2011

Sample Details and Results

Beneficiary-Months in Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Beneficiary-Months	Value of Unallowable Beneficiary-Months
4,369	\$19,528,997	100	\$425,623	21	\$53,720

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

Point Estimate	\$2,347,024
Lower Limit	\$1,266,517
Upper Limit	\$3,427,531

MEDICARE OVERPAYMENTS FOR CLAIMS PAID WITHIN 3-YEAR RECOVERY PERIOD

Sample Details and Results

Beneficiary-Months in Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Beneficiary-Months	Value of Unallowable Beneficiary-Months
4,369	\$19,528,997	100	\$425,623	7	\$25,576

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

Point Estimate	\$1,117,423
Lower Limit	\$226,744
Upper Limit	\$2,008,103

APPENDIX D: HOSPICE OF NEW YORK, LLC COMMENTS

Hospice of New York

April 28, 2015

RE: Report Number A-02-13-01001

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Dear Mr. Edert:

Thank you for your letter of April 2, 2015. I have reviewed the draft report and am prepared to provide you with our comments, as requested.

Of the total 21 beneficiary month errors cited in the draft report, Hospice of New York concurs with three and does not concur with 18. We agree that for one beneficiary month the clinical documentation we provided did not support the associated beneficiary's terminal prognosis, that for one beneficiary month there was no progress note in the associated beneficiary's case record reflecting a physician's visit, and that for one beneficiary month continuous care services were billed for a half hour after the death of the beneficiary.

However, we do not agree with your finding that for 18 beneficiary months we did not obtain timely verbal certification of the beneficiary's terminal prognosis. In fact, we did obtain these verbal certifications and did properly document them.

After reviewing all the correspondence and meeting notes related to these cases, it is clear to me that the issue comes down to the validity of the procedure we used to document the verbal certifications. We have previously explained, on a case-by-case basis, that the documents we used to show properly obtained verbal certifications are present, with valid dates and signatures in all 18 cases. I refer you to our letter of March 19, 2014, which is attached as Exhibit 1. Your finding must therefore be based on your belief that these documents are somehow inadequate proof of verbal certification. Because of this, I wish to focus our comments on why the form we use and the way we use it is, in fact, evidence of properly and timely obtained verbal certifications.

To Comfort Always...

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In the early 1980's I served as administrator of a Florida not for profit, hospital-based hospice and was active in the pursuit of Medicare coverage for hospices. As part of this effort I testified before Congress on hospice coverage issues and, subsequent to the passage of hospice Medicare coverage in 1982, I served as chair of the National Hospice Organization (now the National Hospice and Palliative Care Organization) Committee on Licensure and Reimbursement. In this capacity, I was the hospice movement's principal liaison with the then Health Care Financing Administration (HCFA) in the development of the hospice regulations. I subsequently published a comprehensive history of the development of hospice coverage under Medicare as a chapter to the book "Hospice Handbook: A Guide for Managers and Planners" (Aspen Systems, 1985). I mention these to illustrate that I have a long-term knowledge of the verbal certification and other regulatory requirements for hospices.

I recall, for example, that the option to obtain a verbal certification within two days of patient admission was not part of the original Conditions of Participation (CoP) for hospices dating from 1983. The requirement at that time was to obtain a written certification within two days. This created many difficulties for hospices, and the requirement was changed in 1989 by Section 6005(b) of the Omnibus Budget Reconciliation Act (OBRA) of 1989. The new option for verbal certifications was added to the CoP in 1990 as Section 418.22(a)(3) and has remained unchanged since then. It was at that point in time that hospices began to design various procedures and forms to obtain and document verbal certifications.

In 1991, I formed the nation's first hospice management firm to provide planning and management support to developing hospice programs across the country. Between 1991 and 2004 that firm had management services contracts with more than a dozen hospices in Arizona, Illinois, Missouri, Delaware, Virginia, Minnesota, New Jersey, New York, Pennsylvania, Texas, Maryland and Oklahoma. As part of this effort, I designed all the forms and policies under which these hospices operated, including the form now known as the Initial Plan of Care at Hospice of New York. Of course, at first these forms were all hard copy as there was no electronic medical record (EMR) software for hospices available at that time. However, the format and concept of this form has essentially been unchanged since the early 1990's and used at many hospices since then. To my knowledge, at no time during all those years up to the present has any accrediting body, government agency or fiscal intermediary found this form to be out of compliance with the requirements of 418.22(a)(3) as documentary proof of the timely obtaining of verbal certifications.

The idea behind this form was to cover several regulatory requirements on one form in order to achieve efficiency and better compliance. The form contains 1) an initial care plan including legal medical orders from the physician; 2) verbal certification of terminal illness by both the attending physician and hospice medical director; 3) evidence of team collaboration in the development of the care plan; and 4) when subsequently signed by the attending physician, written evidence of his/her certification of terminal illness. I knew at the time that many hospices met these requirements through the use of multiple forms, but I felt strongly that combining them in one form was preferable. Therefore, I developed a single form to be used

essentially as what is known generally as a telephone (or verbal) order (TO), obtained through direct communication between the nurse and the physician, signed by the nurse and subsequently countersigned by the physician. As a process, at the time patients are admitted to our program, the nurse will call the physician to verify his/her medical orders and obtain the verbal certification. These items, along with the evidence of team collaboration and the initial plan of care, are entered into our EMR and electronically (previously in ink) signed by the nurse. TO's are a typical and common procedure in many healthcare settings such as hospitals and nursing homes. In our case, the items on the form which appear above the nurse's signature, including the certification, are TO's. We then print the form and send it out (by mail, fax or electronically) for the physician to sign prior to billing.

This process ensures a verifiable, trackable system to confirm that we have met all these applicable regulatory requirements. I have always been aware of the need for verbal certifications, and this requirement was specifically considered in the development of the "Initial Plan of Care" form. There is no specific mandated form or format in the CoP for the hospice to obtain the verbal certification; it is left up to individual hospices to determine how they wish to document the verbal certification. Some hospices have a separate, specific form for this; others document it as part of a clinical note; yet others use various sections of their electronic medical record to do this documentation. We use the Initial Plan of Care. This form is unambiguous evidence of communication between the physician and the nurse and should not be discounted simply because other hospices may have different ways of achieving the same result.

To further support this position and to explain our process, I asked several of our nurses and attending physicians to tell you how this works and to confirm that they routinely get/give verbal certifications in a timely way and document it properly on our Initial Plan of Care form. I have included these statements as Exhibit 2.

Also, to provide evidence that this is indeed a valid process in not just my opinion and that of our staff at Hospice of New York, I have attached the following additional exhibits, which I trust will provide authoritative validation of our position.

Exhibit 3: The National Hospice and Palliative Care Organization has published a series of "Compliance Guides" for hospices to assist in meeting regulatory requirements. This exhibit is their Compliance Guide entitled "Components of Medicare Hospice Certification and Recertification Form." In part, it reads, "The hospice staff member documenting the verbal certification from the physician should print, sign, and date their name under the verbal certification statement....The verbal certification can be documented separately or on the written certification form." This is precisely what happens on our Initial Plan of Care form, which is also our written certification form. The certification statement appears above the nurse's signature, which is printed and dated. I understand that the date appears at the top of the form, but this location is controlled by our EMR system.

Exhibit 4: We are accredited by the Community Health Accreditation Program (CHAP). We have been surveyed multiple times by CHAP. These are comprehensive surveys that examine all aspects of our program, including compliance issues such as certification. The CHAP standard that covers verbal certifications is HI.5. CHAP has never cited the process by which we obtain and document verbal certifications as a deficiency under this or any of their other standards. This exhibit is the certificate of accreditation issued to us indicating compliance with CHAP standards for the period of your sampling frame.

Exhibit 5: On January 27, 2011, we responded to a request from the Medicare Comprehensive Error Rate Testing (CERT) Documentation Contractor for additional information regarding, among other unrelated items, our method of obtaining and documenting verbal certifications. This exhibit is the letter we send them. The CERT contractor accepted this explanation and we were not cited as being deficient.

Exhibit 6: This month, we engaged the services of Simone Healthcare Consultants, a highly reputable, independent and experienced consulting firm with expertise in hospice. We asked them to review the Initial Plan of Care form (both in general and in reference to the specific cases covered in your draft report) and opine on whether it constitutes legitimate evidence of a timely verbal certification. Their conclusion is that it does. Their opinion is presented in this exhibit.

Exhibit 1: Our letter of March 19, 2014. This letter, referenced above, contains the specific case-by-case verification that the properly and timely completed Initial Plans of Care documenting the verbal certifications appear in the case records of all 18 of these cases.

You asked that we respond specifically to your three recommendations.

- Hospice of New York is prepared to refund to the Federal Government the amount of \$4,261.88, which represents the amount covered in the three beneficiary months for which we accept your findings. We do not believe we should be required to refund any amounts related to the other 18 beneficiary months since we consider these to be in compliance, as we have presented in this letter. Further, we understand that a total of three beneficiary month errors does not qualify the OIG to extrapolate a repayment amount over all 4,369 Medicare claims for the sampling frame, but only to require repayment of the actual amounts covered under these three errors.
- Hospice of New York will work with the Medicare Administrative Contractor with respect to any improper payments received at any time. It has always been our policy to do so and we have made appropriate adjustments as necessary, including both prior to and subsequent to Medicare billings. I assure you we are committed to billing only for those services that are fully proper and properly documented.
- Hospice of New York constantly works to strengthen our procedures in order to ensure compliance with all regulatory and billing requirements. We have active quality

assurance and compliance functions at Hospice of New York that work diligently to ensure that we admit and continue to care for only those Medicare beneficiaries who meet all the appropriate requirements for hospice care. In the three cases in which we accept your findings: We will work to ensure that all billed physician visits have notes in the record. I believe this one case involved us relying on the note being left in the nursing home chart by the physician. We will no longer make this assumption without verification. We have worked with our continuous care staff to ensure that they understand that while they may remain with the family for a reasonable time after the death of a patient for support, such time is not properly billed to Medicare. And in the case of the individual who was deemed not to be qualified for hospice services, while we recognize that this is often a professional judgment call on the part of our staff, we know we must properly document positive eligibility. This is an ongoing process.

In conclusion, we respect the work of the Office of Inspector General in protecting the integrity of the hospice Medicare benefit. Personally, having been involved in hospice since the 1970's I am particularly distressed when I read about hospices that have abused the benefit, often for financial gain. We also appreciate the professional approach taken by your auditors in our audit. We are willing to admit when we have erred, although I can assure you it was not intentional. We also feel strongly that the issue of the verbal certifications in our audit does not represent errors but rather a simple misunderstanding of our process. I hope that we have supplied sufficient background information and professional corroboration for you to reverse your finding of errors in these 18 cases and we respectfully request this outcome.

We are certainly available to discuss these issues further with you and to answer any questions or concerns you may have.

I am also transmitting to Ms. Griffis an electronic copy of this letter and its exhibits, as you requested.

Sincerely,



Michael Rosen
Administrator

cc: Marlyn J. Griffis

Exhibits