

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE HOSPICE PROVIDER  
COMPLIANCE AUDIT:  
NORTHWEST HOSPICE, LLC**

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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**



### 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.

## Medicare Hospice Provider Compliance Audit: Northwest Hospice, LLC

### 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.<sup>1</sup>

### 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.<sup>2</sup> 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).<sup>3</sup> 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,

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<sup>1</sup> See Appendix B for a list of related OIG reports on Medicare hospice services.

<sup>2</sup> The Act §§ 1812(a)(4) and (5).

<sup>3</sup> 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.<sup>4</sup>

Beneficiaries eligible for the Medicare hospice benefit may elect hospice care by filing a signed election statement with a hospice.<sup>5</sup> 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.<sup>6</sup>

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.<sup>7</sup>

Beneficiaries are entitled to receive hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods.<sup>8</sup> 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<sup>9</sup> 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.<sup>10</sup> The initial certification and all subsequent recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy

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<sup>4</sup> 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).

<sup>5</sup> 42 CFR § 418.24(a)(1).

<sup>6</sup> 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).

<sup>7</sup> 42 CFR §§ 418.24(a)(2) and (a)(3).

<sup>8</sup> 42 CFR § 418.21(a).

<sup>9</sup> 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).

<sup>10</sup> 42 CFR § 418.22(c).



of 6 months or less.<sup>11</sup> 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.<sup>12</sup>

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.<sup>13</sup> 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.<sup>14</sup>

Hospice providers must establish and maintain a clinical record for each hospice patient.<sup>15</sup> 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.<sup>16</sup>

### **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.<sup>17</sup>

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

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<sup>11</sup> 42 CFR § 418.22(b)(3).

<sup>12</sup> 42 CFR § 418.22(a)(3).

<sup>13</sup> 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).

<sup>14</sup> 42 CFR §§ 418.22(a)(4), (b)(3)(v), and (b)(4).

<sup>15</sup> 42 CFR §§ 418.104 and 418.310.

<sup>16</sup> 42 CFR §§ 418.22(b)(2) and (d)(2).

<sup>17</sup> 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.<sup>18</sup>

## **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.<sup>19</sup> 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.<sup>20</sup> 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.

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<sup>18</sup> 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.

<sup>19</sup> Claims data for the period June 1, 2016, through May 31, 2018, were the most current data available when we started our audit.

<sup>20</sup> 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.<sup>21</sup> As of the publication of this report, these overpayments include claims outside of the 4-year reopening period.<sup>22</sup> 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.<sup>23</sup>

### 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.<sup>24</sup>

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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<sup>21</sup> 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.

<sup>22</sup> 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).

<sup>23</sup> 42 CFR § 405.980(c)(4).

<sup>24</sup> 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;<sup>25</sup>
- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule<sup>26</sup> 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

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<sup>25</sup> 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.

<sup>26</sup> 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.<sup>27</sup>

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

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<sup>27</sup> 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.<sup>28</sup> 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

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<sup>28</sup> 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,<sup>29</sup> 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;

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<sup>29</sup> 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**

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

<b>Number of Claims in Sampling Frame</b>	<b>Value of Sampling Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Unallowable Claims</b>	<b>Value of Overpayments in Sample</b>
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

## APPENDIX E: NW HOSPICE COMMENTS<sup>30</sup>



Northwest Hospice, LLC  
Signature Healthcare at Home  
25117 SW Parkway, Suite F  
Wilsonville, OR 97070  
877-744-2200

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Lori A. Ahlstrand  
Regional Inspector General for Audit Services  
U.S. Department of Health and Human Services  
Office of Audit Services, Region IX  
90 Seventh Street, Suite 3-650  
San Francisco, CA 94103

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Re: Northwest Hospice, LLC, Response to OIG Draft Report A-09-20-03035

Dear Ms. Ahlstrand,

Northwest Hospice, LLC d/b/a Signature Healthcare at Home appreciates the opportunity to respond and provide comments to the above-referenced Office of Inspector General's ("OIG") draft audit, which Northwest Hospice received on January 26, 2021. We also appreciate the extension of time we received from your office to compose and submit our response..

Our mission is to "enhance the life of every person we serve." It is in this service that we demonstrate our deep commitment to compliance and the duties we have to do no harm and provide high quality end-of-life care to those who have been given a prognosis by two separate physicians that physical and terminal illness is upon them. Ensuring that Medicare-eligible patients who are deemed terminal and qualify for hospice benefits have access to and receive services that are medically necessary to address their specific symptoms, illnesses, and holistic needs at the end-of-life is a responsibility of which we are keenly aware, and Northwest Hospice has had, and continues to have, policies and procedures in place that reflect Medicare's rules, regulations and guidelines. Further, we periodically revisit our internal processes to keep up with changes in eligibility criteria, allowable services, and recommended best evidence-based practices. When occasionally presented with information suggesting we may need to tighten, train, or improve our compliance and practices we evaluate the information and make any appropriate adjustments.

To assist Northwest Hospice in responding to the draft audit covering the period June 1, 2016 through May 31, 2018, we engaged outside legal counsel, Calfo Eakes, to review the sample claims that OIG's contract medical reviewer determined to be unsupported. Outside counsel, in turn, retained a highly-qualified medical expert with clinical expertise in geriatric medicine and a decade of experience as Associate Medical Director for the largest hospice agency in the Seattle metropolitan area. The response of our outside counsel, which incorporates the conclusions and supporting rationales of our independent medical expert along with supplemental hospice and external facility documentation, is submitted with this letter for your consideration and review.

In short, OIG's draft audit looked at a sample of 100 claims for hospice benefits and determined 19 to be unsupported. For the reasons explained in detail and carefully documented in the attached letter, Northwest Hospice *disagrees* with the determinations reached by OIG's reviewer regarding 12 of the 19 claims. In the case of the remaining 7 claims, Northwest

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<sup>30</sup> OIG Note: We redacted text in selected places in this appendix because it is personally identifiable information.

Hospice concurs that the documentation in the relevant medical records and time frame evaluated does not adequately support the claims, but does not concede either that the patient was ineligible to receive/continue to receive hospice benefits or that the services provided were not medically necessary. Accordingly, we respectfully request that OIG review, reconsider and reverse the determination of its medical reviewer in those 12 instances we have disputed after thoughtful independent examination and analysis.

Again, Northwest Hospice is thankful for this opportunity to provide the draft audit response submitted contemporaneously with this letter and remains available to answer any questions you or your staff may have concerning the claim-by-claim rebuttals provided in the response.

Sincerely,

[REDACTED]

[REDACTED] APRN, MSN, FNP-BC  
Division President  
Signature Healthcare at Home

Attachment



March 22, 2021

*Transmitted Electronically and Via Fed Ex*

Lori A. Ahlstrand  
Regional Inspector General for Audit Services  
U.S. Department of Health and Human Services  
Office of Audit Services, Region IX  
90 Seventh Street, Suite 3-650  
San Francisco, CA 94103

Re: Northwest Hospice, LLC, Response to OIG Draft Report A-09-20-03035

Dear Ms. Ahlstrand,

Northwest Hospice, LLC d/b/a Signature Healthcare at Home ("Northwest Hospice"), through its counsel, submits this letter in response to the U.S. Department of Health and Human Services Office of Inspector General's ("OIG") draft audit report, A-09-20-03035 (the "Draft Report"). After receiving the Draft Report on January 6, 2021, Northwest Hospice has worked diligently, with the assistance of a consulting physician specializing in geriatric medicine who served for a decade as Associate Medical Director for the largest hospice services provider in the metropolitan Seattle area, to complete a thorough review of the claims at issue. Northwest Hospice now submits this comprehensive written Response, consistent with the extension OIG provided through March 22, 2021. In short, Northwest Hospice concurs with the conclusion of OIG's contract medical reviewer with respect to seven of the 19 claims questioned (Sample Claims 23, 26, 39, 44, 50, 71 and 95) due to the insufficiency of the documentation present in the medical record. However, for the reasons explained in detail below, Northwest Hospice disagrees with the determination of OIG's reviewer as to the remaining 12 questioned claims.

#### Introduction

By way of historical background, Northwest Hospice, LLC d/b/a Signature Hospice started in 2009 in Portland, Oregon. In September 2019, Northwest Hospice, LLC changed its d/b/a to Signature Healthcare at Home, and currently offers hospice services to patients in Oregon, Utah and Idaho. In 2020, the company served 1,816 hospice patients. At all times relevant to OIG's audit and





subsequently, Northwest Hospice has strived to operate as a responsible, ethical, and compliant Medicare service provider and has embraced opportunities presented to it, including two recent Targeted Probe and Educate ("TPE") reviews, discussed in greater detail below, to update and enhance (1) its policies and procedures, (2) the quality of its documentation and medical record-keeping, and (3) adherence by its clinical staff to applicable Medicare rules and regulations.

Moreover, a review of the most current Program for Evaluating Payment Patterns Electronic Report ("PEPPER report") for Northwest Hospice's parent organization, which is designed to identify indicators of payment errors, reveals that Signature Healthcare at Home's PEPPER data (which includes Northwest Hospice) consistently reflects a high performing organization below the National 80th Percentile. Among other things, the data demonstrate appropriate admission decisions for patients eligible for hospice care and, accordingly, policies and procedures that are effective in making clinically appropriate admission decisions regarding end-of-life prognoses.

#### Discussion

With respect to the matter at hand, Northwest Hospice understands that OIG's Draft Report is based on a universe of 6,864 claims for Medicare reimbursement for hospice services provided from June 1, 2016 through May 31, 2018. As detailed in the Draft Report, OIG retained a medical contractor to review a random sample of 100 of these 6,864 claims. That analysis identified 19 instances where OIG's reviewer found that the clinical record did not support the beneficiary's continuing terminal prognosis or the associated payments for hospice services. Conversely, OIG's review resulted in a determination of compliance for the vast majority, 81, of the 100 sampled claims.

As noted above and discussed in detail below, Northwest Hospice's own analysis of the 19 claims questioned by OIG's contract reviewer concluded that Northwest Hospice achieved an even higher rate of compliance with Medicare requirements for hospice eligibility and care. Specifically, following consultation with and review by its own physician reviewer with expertise in geriatric medicine and experience as a hospice medical director for a large Seattle-based hospice services, it is Northwest Hospice's position that 12 of the 19 claims questioned by the draft audit are, in fact, supportable claims for hospice services and that the Medicare reimbursement associated with those claims is entirely appropriate. Accordingly, in the event OIG concurs in the analysis set forth in the remainder of this Response, 93 of the 100 claims reviewed as part of the sample audit of Northwest Hospice would meet applicable Medicare criteria.

In regard to the seven claims with which Northwest Hospice does not take issue due to the insufficiency of the supporting documentation (not due to flawed clinical judgment), Northwest Hospice intends to refund the associated payments once OIG issues a final audit report and will, likewise, comply with its obligations to identify, report and return overpayments pursuant to Medicare's 60-Day Rule. Northwest Hospice does not believe that the issues raised by those seven claims present systemic concerns for the post-audit period, given the significant operational and other changes implemented by Northwest Hospice in mid-2018, which are discussed in detail later in this submission.

*A. Discharges by Northwest Hospice Clearly Within the Margin for Reasonable Clinical Judgment*

As an initial matter and before proceeding on a claim-by-claim basis to discuss the claims questioned by OIG's reviewer with which Northwest Hospice disagrees, six of the 19 claims questioned in the Draft Report involve a patient discharged from hospice by Northwest Hospice either the *same month* (Sample Claims 69 and 77) or the *month immediately following* (Sample Claims 1, 33, 36, and 37) the OIG reviewer's retrospective determination that the patient's terminal illness prognosis was no longer supported. In each of these six cases, and as part of their ongoing evaluation of hospice patients, Northwest Hospice's clinical team reached the same conclusion as did OIG's reviewer—that the course of the patient's disease was not following the expected trajectory and, therefore, that the patient was no longer eligible for Medicare reimbursement of hospice services. Northwest Hospice not only reached that same conclusion, but completed its methodical, multi-step discharge process to ensure a safe transition from hospice, within the same month or the month immediately following the claim period questioned by the contract reviewer's *ex post* review. Accordingly, Northwest Hospice respectfully submits that OIG should reject its reviewer's determination that these six claims are unsupported and remove them from its overpayment analysis for the following reasons.

First, Northwest Hospice should not and reasonably cannot be faulted where, as here, its clinicians and professional staff reached the same conclusion as OIG's reviewer within literally a matter of days. A patient's eligibility for hospice care under the Medicare program is a significant determination and the product of a subjective, multi-factor analysis that Northwest Hospice undertakes with utmost care and seriousness and maintains documentation to support. Whether in connection with an initial eligibility certification or a periodic recertification, a certifying physician must carefully evaluate whether a patient is terminally ill, meaning the individual has a life expectancy of six months or less if the illness with which the patient has been diagnosed were to run its normal course.

Importantly, as noted recently by several Circuit Court decisions, the Centers for Medicare & Medicaid Services ("CMS") has explicitly recognized that this central inquiry for hospice care eligibility—predicting a patient's life expectancy—is not (nor could it possibly be) an exact science, but is subject to a certifying physician's best clinical judgment supported by the patient's medical records. *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1293-95 (11th Cir. 2019) (citing 75 Fed. Reg. 70372, 70448 (Nov. 17, 2010); 79 Fed. Reg. 50452, 50470 (Aug. 22, 2014)); accord *United States v. Care Alternatives*, 952 F.3d 89, 93 (3rd Cir. 2020); *Winter ex rel. United States v. Gardens Reg'l Hosp. and Med. Ctr., Inc.*, 953 F.3d 1108, 1119 & n.8 (9th Cir. 2020).

For patients already receiving hospice care, the determination of a continuing terminal diagnosis can be particularly challenging as symptoms and conditions worsen, improve and appear to stabilize over a period of time. Hospice patients often experience plateaus and even temporary improvements that do not, in and of themselves, warrant, let alone require, discharge from hospice. Northwest Hospice physicians continually and collaboratively monitored each of the six at-issue patients to determine if Medicare's hospice eligibility criteria continued to be met—that is, if the

prior prognosis of terminal illness remained accurate or if, instead, unexpected stabilization and/or improvement was sufficient to warrant discharge.

Even setting to one side the "meaningful latitude" physicians are understandably and appropriately afforded when making informed decisions as to each patient's terminal status, *AseraCare*, 938 F.3d at 1295, the precise timing of such judgment calls within the span of a month or less can be particularly subjective. This is especially the case where, as here, Northwest Hospice's clinicians and Inter-Disciplinary Team members were treating, interacting with, and observing the six patients in real-time, whereas OIG's reviewer had access only to medical records and progress notes, which, by their nature, do not always capture each and every relevant nuance present in a patient's day-to-day condition. Indeed, as noted by the Court of Appeals in *AseraCare*, "[w]hile there is no question that clinical judgments must be tethered to a patient's valid medical records," the documentation presented need not "prove the veracity of the clinical judgment on an after-the-fact review." *Id.* at 1294-95. Rather, a "physician's clinical judgment dictates eligibility as long as it represents a reasonable interpretation of the relevant medical records." *Id.* at 1294.

Second, and critically, Northwest Hospice's responsibilities to its patients do not abruptly terminate once the conclusion is reached that the patient is no longer eligible for hospice services. To the contrary, it is Northwest Hospice's responsibility to ensure that the patient has an appropriate living arrangement and care plan in place upon discharge. These considerations may, and often do, include: (1) coordinating with the patient's family and caregivers to ensure that they are ready to resume care, (2) assisting with placement of the patient in an appropriate chronic care facility, (3) helping arrange a private duty agency to help with the patient's activities of daily living, (4) ensuring that the patient has a primary care provider and coordinating care with that provider, (5) obtaining required documentation and information for any needed durable medical equipment, and (6) planning for the patient's psychosocial and spiritual needs. In short, properly discharging a patient involves a multi-dimensional process. Attending to and complying with that process in a responsible manner cannot be achieved overnight.

Northwest Hospice strongly urges OIG to find that the six patients (Sample Claims 1, 33, 36, 37, 69 and 77) discharged from hospice the same month or the month immediately following OIG's reviewer's determination of ineligibility were discharged in a timely and entirely appropriate manner. Each discharge indisputably occurred within sufficient proximity to when OIG's reviewer determined the patient was no longer eligible for hospice that the discharge should be deemed (1) timely—i.e., well within the margin of acceptable clinical judgment—and (2) free from overpayment liability. To conclude otherwise would be to ignore the accepted understanding that a determination that a patient has improved or stabilized to the point that his/her prognosis no longer appears to be terminal requires the application of clinical judgment to a multitude of complex and frequently fluid variables (just as a prognosis of terminal illness does) and to pretend instead that such a determination is, or should be, susceptible to objective certainty at a specific moment in time. That, of course, is not the case as a matter of fact or of law, and no credible clinician, particularly one with hospice experience, would (or could) seriously suggest that it is.

*B. Northwest Hospice's Medical Reviewer and Review Methodology*

Northwest Hospice was fortunate to engage ██████████ a licensed physician in Washington State and Associate Professor of Medicine in the Division of Gerontology and Geriatrics at the University of Washington, to serve as a consultant for purposes of assisting Northwest Hospice to respond to OIG's Draft Report. A copy of ██████████ Curriculum Vitae is submitted as **Attachment A** to Northwest Hospice's **Supplemental Appendix**, which is provided under separate cover.

██████████ background is particularly well-suited to a review of the claims at issue in this matter as the focus of his post-graduate medical education and professional experience has been in the field of geriatrics where, on a daily basis, he has studied and observed disease progression in the elderly. In addition to his Board Certification in Internal Medicine, ██████████ holds a subspecialty certification in Geriatric Medicine; he lectures and writes frequently on topics involving the care of elderly patients, including hospice care at home; and spent a decade—from 2009 to 2019—as Associate Medical Director at Providence Hospice of Seattle, the largest hospice agency in the Seattle metropolitan area and a leading educational site for medical students, residents and fellows.

██████████ has conducted clinical research under numerous federally-sponsored grants for the National Institutes of Health, the Agency for Health Care Research and Quality, and the Health Resources & Services Administration (from which he received a Geriatrics Academic Career Award). He is a member of the American College of Physicians, American Geriatric Society, and Society for Post-Acute and Long Term Care.

In regard to his review of the 13 claims questioned by OIG's medical reviewer (and not discussed in Section A, above), ██████████ was provided the same medical records as were requested by and provided to OIG. He also requested and, where available, was provided certain additional records from the facilities from which the patients at issue received care prior to their certification for hospice eligibility and hospice care by Northwest Hospice.<sup>1</sup> ██████████ conducted an independent review of both the OIG reviewer's determinations and the documentation supporting the hospice care provided by Northwest Hospice and billed to Medicare.

*C. Claims Where Clinical Documentation Adequately Supports Terminal Prognosis*

Based on a thorough review of available, relevant medical and facility documentation, ██████████ determined that six of the 13 claims he reviewed involved patients who were eligible for hospice services. ██████████ findings are summarized below and he has provided a letter, attached as **Attachment C** to the **Supplemental Appendix**, stating (1) that the summaries provided in this Response accurately represent his conclusions and (2) that he fully subscribes to the argument made in Section A, above, regarding the claims of the six patients whose discharge from hospice occurred, for all practical purposes, contemporaneously with OIG's reviewer's determination of ineligibility.

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<sup>1</sup> Supplemental hospice and/or facility (skilled nursing or congregate assisted living) documentation for the six remaining claims Northwest Hospice disputes is included separately as **Attachment B** to the **Supplemental Appendix** submitted contemporaneously herewith, in order to protect Protected Health Information. That additional documentation is provided in its entirety, rather than only via selected excerpts.

#### Sample Claim # 14

Date of Hospice Election: 9/6/2017  
Dates of Service: 11/1/2017 - 11/30/2017  
Length on Service: 2 months

Following an independent record review by Northwest Hospice's consulting physician and a holistic assessment of the patient's comorbidities, symptoms, and course of treatment prior to and during the period under audit, Northwest Hospice submits that this claim is appropriately documented and, thus, supportable as explained below:

This 96-year-old female was admitted to hospice services on 9/6/2017, two months prior to the claim in question. She was hospitalized from 8/31/17 through 9/5/17 for heart failure exacerbation and admitted for congestive heart failure (CHF). She was noted to have bilateral moderate pleural effusions during her hospitalization, which is consistent with disease progression. The submitted hospital records referenced an EF of 25%, which was obtained from a transthoracic echocardiogram (TTE) from 3/29/17. The difference between an EF of 20% versus 25% is clinically insignificant compared to the presence of moderate bilateral pleural effusions indicating the current severity of her heart failure. The TTE report from 3/29/17 indicates not only an EF of  $25\% \pm 5$ , but, more importantly, akinetic walls (inferior and inferolateral) and hypokinetic ventricular walls.

During her hospice episode of care, the patient continued to exhibit clinically significant signs and symptoms that indicated decline consistent with LCD guidelines. Her comorbidities include hypertension, coronary artery disease (including a history of a coronary artery bypass graft). It was noted that her CHF is secondary to ischemic dilated cardiomyopathy, which is a result of coronary artery disease and a diagnosis of atrial fibrillation, which is a consequence of hypertension that leads to diastolic CHF.

Skilled nursing visits indicate:

1. Decline in systolic blood pressure to below 90 (LCD signs of progression of disease);
2. Inability to tolerate maximal medication doses due to hypotension;
3. Presence of edema and dyspnea with minimal exertion despite maximally tolerated medication;
4. Progressive inanition (decline in mid-arm circumference); and
5. Need for frequent medication adjustments and medications being held due to hypotension and/or bradycardia.

The below table summarizes excerpts of the patient's hospice course from her admission through the audited time period and clearly documents the progression of her declining condition. To the extent any of this information was not previously provided OIG, it is included in Northwest Hospice's **Supplemental Appendix**.

Date	Documentation Type	Exam findings and Intervention
9/6/17	Hospice Admit	PPS score 50% MAC: 7.2 inches Medications at time of hospice admission: Lasix 40 mg bid; Lisinopril 2.5 mg q day; Metoprolol succinate 100 mg q day.
9/8/17	SN	BP 78/54
9/9/17	SN*	BP 86/58, HR 62
9/13/17	SN	BP 92/58, discontinued lisinopril
9/15/17	SN	Metoprolol held by assisted living facility due to breaching holding parameters
9/18/17	SN*	BP 116/80, HR 68; Lasix reduced to 20mg q day
9/20/17	SN	BP 98/58
9/25/17	SN*	BP 102/98, HR 73
10/3/17	SN*	BP 108/62, HR 80; 1+ edema
10/24/17	SN*	BP 110/78, HR 78; 2+ edema
11/8/17	SN*	HR 64; 2+ edema, dyspnea with minimal exertion, 2 minutes to recover
11/15/17	SN-	Spironolactone 25mg q day added
11/21/17	SN*	BP 108/64, HR 68
11/29/17	IDT	MAC 6.8 inches; sleeping in more, increase in edema

(SN: Skilled Nursing; \*Vital signs obtained from supplemental documentation.)

The aggregate documentation available reflects a patient with end stage heart failure, who, at the time of the claim at issue and despite maximally tolerated medical management, exhibits clinically significant signs and symptoms which, in the reasonable clinical judgment of Northwest Hospice personnel, met the hospice LCD guidelines for clinical progression of disease.

Based on the above clinical information, Northwest Hospice submits that the patient qualified for hospice services during the period audited.

#### Sample Claim # 28

Date of Hospice Election: 7/27/2017  
 Dates of Service: 9/1/2017 – 9/30/2017  
 Length on Service: 3 months

Following an independent record review by Northwest Hospice's consulting physician and a holistic assessment of the patient's comorbidities, symptoms, and course of treatment prior to and during the period under audit, Northwest Hospice submits that this claim is appropriately documented and, thus, supportable as explained below:

This 79-year-old-female was admitted to hospice on 7/27/17 with peripheral vascular disease (PVD). Her PVD was exacerbated and deemed terminal due to repeated hospitalizations,

functional decline, and patient declination for definitive amputation for non-healing foot wound on the right plantar first metatarsal head. Notable co-morbid conditions included:

1. Prior toe amputations and refusal for physician recommended additional amputations to assist with wound healing;
2. Rheumatoid arthritis refractory to disease-modifying antirheumatic drugs and on chronic steroids<sup>2</sup>;
3. Chronic pain;
4. Fall with hip fracture; and
5. Paroxysmal atrial fibrillation.

At the time of hospice admission, the patient's PPS was 40-50%, and she required assistance with 3/6 ADLs including bathing, dressing, and grooming. The patient's weight was 135 lbs.

The patient has a clearly documented arc of decline as called for by the LCD. This patient was admitted to hospice after prior conservative therapy and interventions failed with the patient consistently declining definite treatment (surgical amputation). The documentation highlights the patient's prior home health episode of care, hospitalization, and resumption of home health with continued decline as evidenced by worsening wounds, repeated infections, and increasing lethargy requiring pharmacologic modifications.

Identified below is supplemental documentation from the patient's record prior to hospice election, which is included in the **Supplemental Appendix**:

Date	Event
6/9/2017	On antibiotics, "taking antibiotics at this time"
6/16/2017	Olanzapine reduced to 2.5mg qhs from prior dosing of 2.5mg in the morning and 5mg in the evening (total daily dose 7.5mg), representing a 66% dose decrease. Despite these changes fatigue continues.
6/19/2017	Wound bed measurement 1.5 x 1.0 x 0.1cm
6/21/2017	Hole measurement 0.2 x 0.4cm, "moderate amount of serosanguineous fluid"
6/29-7/2/17	Hospitalization
7/3/2017	Home health resumes, R foot wound 1.3 x 0.9 x 0.1 cm, no drainage

The patient was ultimately referred to hospice due to continued worsening of her wound, lethargy, and continued declination of definitive treatment. The arc of decline in the patient's condition clearly continued during her audited hospice course as characterized by the following list of

<sup>2</sup> Patients with rheumatoid arthritis are at increased risk for atherosclerotic peripheral vascular disease, including elevated inflammatory markers, extra-articular disease, and glucocorticoid use. The patient failed multiple disease modifying anti-rheumatic drugs (DMARDs), including sulfasalazine, methotrexate, and infliximab.

clinical symptoms and related contemporaneous documentation set forth below and provided in the Supplemental Appendix.

Symptoms:

1. Wound growing larger and drainage increasing;
2. Signs of reinfection and need for antibiotics;
3. Increasing lethargy that requires further dosage reduction of medication; and
4. Increasing loss of function.

Date	Document Type	Observation and Intervention
7/31/17	SNV	"DTI with 2x1cm", "scant clear yellow drainage"
8/2/17	SNV	"wound bed...2x1cm"; scant clear yellow drainage; "Calcified subdermal wound approx. 4x4cm"
8/11/17	SNV	Increasing somnolence leading to decrease of gabapentin from 400 mg tid to 300 mg tid (25% dose reduction).
8/16/17	SNV	"almost closed", wound bed 3x3cm
8/18/17	SNV	"requiring 2-person max assist", use of bed side commode
8/30/17	SNV	Purulent drainage, foul odor, increase in pain, started clindamycin 300 mg tid.
9/7/17	SNV	"recent ABX treatment [Bactrim 5-day course]"; "small amount of green drainage, 3x3cm area calloused with pin-sized opening, foul order noted. Pain associated with palpation"
9/11/17	SNV	"Small, clear drainage"
9/13/17	SNV	"Moderate, clear drainage"; "Opening in circumferential callous is larger"
9/21/17	IDT	"Bactrim appeared effective as drainage now is clear"

PVD is the correct life-limiting, end stage condition for this patient and the documentation is supportive of progressive worsening of the condition. Amputation was the only option for this patient to have definitive source control from her worsening wound due to PVD. Short of amputation, all other options merely maintained the status quo, but did not improve the patient's prognosis or reverse her continuing decline.

There is no Disease Specific LCD guideline for PVD. However, this patient's trajectory indicates hospice appropriateness at the time of hospice admission and exhibits signs and symptoms consistent with LCD decline in clinical status guidelines (e.g., recurrent infections, weakness/lethargy, dependence with ADLs).

Finally, the OIG reviewer did not accurately consider all of this patient's comorbidities. The OIG reviewer stated that a "history of CVA" was considered as a comorbidity. However, this patient did not have a history of cerebral vascular accident (CVA). Instead, the comorbid conditions that significantly and negatively impacted this patient's prognosis are rheumatoid arthritis refractory to



disease-modifying antirheumatic drugs and chronic steroids (LCD guideline of refractory severe autoimmune disease). The patient's refractory severe autoimmune disease significantly reduced the chances of healing and increased risk of infection from her wound.

Based on the above clinical information, Northwest Hospice submits that the patient qualified for hospice services during the period audited.

#### Sample Claim # 29

Date of Hospice Election: 6/9/2016  
Dates of Service: 2/1/2017 – 2/28/2017  
Length on Service: 8 months

Following an independent record review by Northwest Hospice's consulting physician and a holistic assessment of the patient's comorbidities, symptoms, and course of treatment prior to and during the period under audit, Northwest Hospice submits that this claim is appropriately documented and, thus, supportable as explained below:

The patient is a 92-year-old woman residing in a congregate assisted living facility (ALF) memory unit, admitted to hospice for Alzheimer's dementia due to weight loss, inanition, repeated falls, and functional loss.

At time of hospice admission, she had the following functional descriptive scores:

1. FAST 6E, PPS 30%;
2. Dependent in 5/6 ADLs; and
3. Weight was 112 pounds.

The patient's comorbid conditions included congestive heart failure (CHF), hypertension, atrial fibrillation, valvular heart disease (aortic regurgitation), and bronchiectasis/COPD. In addition, she had risk factors for cerebrovascular disease. The patient was taking Breo Ellipta inhaler daily for her COPD, used nitroglycerin and was on fentanyl transdermal every 72 hours for back pain. The patient's Life Alert was activated in the period under audit and she was noted to be ashen and required nitro and lorazepam.

The usual descriptors of the severity of cognitive impairment such as FAST and PSS scores did not adequately capture this patient's prognosis. Available medical records, however, clearly document an arc of decline that captures her hospice appropriateness. The patient's cognitive impairment severely impacted her memory, causing her to forget whether she had eaten (visit 12/1/16), and manifested a progressive, clinically significant weight loss of 18% after admission (satisfying the LCD decline in clinical status and weight loss guidelines).

The patient's medical record on hospice notes the following:

Date	Event
6/22/2016	IDT note: "only eating bites despite constant cueing" according to ALF staff
12/1/2016	Skilled nursing visit: documents patient forgetting that she had not eaten and asks to be returned to her room without having eaten.
12/27/2016	Skilled Nursing Visit: "25-50% oral intake"

The OIG reviewer questioned this claim based, in part, upon the fact that the patient had a total weight loss of 8.8%. That conclusion was based upon a reported weight of 102 pounds in the IDT meeting on 2/1/17. However, the weight reported in the 2/1/17 IDT meeting was obtained from an SNV conducted on 1/19/17. The patient had a subsequent SNV on 2/1/17. That visit documented that the patient's weight had decreased to 92 pounds—a loss of 10 pounds (9%) since the visit on 1/19/17 less than two weeks earlier. The patient's weight of 92 pounds represents a total weight loss of 20 pounds (17.8%) since admission. The OIG reviewer's analysis neither referenced nor utilized the significant SNV information from 2/1/17 in reaching a final determination.

This is a patient whose continuing terminal prognosis is clearly supported by numerous clinical symptoms. She had severe cognitive impairment with poor safety awareness. Medical documentation reflects repeated falls with and without injuries and an arc of decline of functional loss with a weight loss of 18% subsequent to admission. By August 2016 (8/31/16 IDT note), she was dependent in 6/6 ADLS, clearly satisfying the LCD decline in clinical status guideline.

The patient experienced repeated falls, eventually leading to the need for a lowered bed in the assisted living facility by the end of December 2016 (ordered 12/21/16) and had an injury fall noted in the IDT documentation on 2/1/17. In mid-winter, she also developed a viral pulmonary infection in the congregate living facility at which she resided that left her more lethargic (2/9/17 SNV) (documenting recovery from a pulmonary infection and "sleeps more and tires easily").

The OIG reviewer does not appear to have considered bronchiectasis/COPD as an important comorbidity for this patient relative to her prognosis and hospice needs. Anorexia is often a manifestation of end stage COPD. The medical records indicate extensive muscle wasting and descriptors that are consistent with someone with COPD (clavicles prominent in skilled nursing visits of 1/19/17). Pulmonary cachexia and anorexia coupled with severe cognitive impairment from dementia (causing the patient to not recall if she had eaten) had a clinically significant impact on this patient's prognosis, but are not always necessarily captured by functional descriptors such as PPS or FAST scores on which the LCD guideline place particular emphasis.

Based on the above clinical information, Northwest Hospice submits that the patient qualified for hospice services during the period audited.

**Sample Claim # 55**

Date of Hospice Election: 7/21/2015  
Dates of Service: 6/1/2016 – 6/30/2016  
Length of Service 11 months

Following an independent record review by Northwest Hospice's consulting physician and a holistic assessment of the patient's comorbidities, symptoms, and course of treatment prior to and during the period under audit, Northwest Hospice submits that this claim is appropriately documented and, thus, supportable as explained below:

The patient is a 92-year-old female admitted to hospice services on 7/21/2015 for Alzheimer's disease with recurrent falls, functional decline, clinically significant weight loss, and recurrent hospitalizations with the most recent hospitalization prior to hospice admission for focal neurological deficits of right sided weakness. The patient also exhibited symptoms of cerebrovascular disease/vascular dementia dominant.

At the time of the hospice admission, the patient's PPS was 30%, she required assistance for 6/6 ADLs, her FAST was 7A, and her weight was 152.2 pounds. Per the admission note, her weight on 6/29/15 was 165 pounds. Her admission weight represents a weight loss of 13 pounds or a loss of 7.9% total body weight loss prior to admission. Pertinent comorbid conditions included: atrial fibrillation, hypertension, type 2 diabetes with insulin use, a history of intracerebral hemorrhage with right hemiparesis, right facial droop and dysphagia.

The patient had documented weight loss and falls (supportive of the LCD decline in clinical status guidelines) and an ongoing arc of decline throughout her hospice admission. The patient also had documented acute changes in her clinical condition in September and October 2015. As documented in the facility records on 9/13/2015, the patient had had new onset of left sided weakness and left facial droop. The patient continued to decline and her condition worsened and was assessed as FAST 7C. Contrary to the OIG reviewer's observation, this decline was documented in the skilled nursing note on 10/14/15.

Over a period of several months, the patient was reassessed as FAST 7A on 3/16/16 in the IDT note. The neurological deficit mirrored the initial hospitalization that prompted hospice referral and in the clinical context likely represented another vascular neurological insult. The patient suffered falls with facility notes confirming neurologic checks following a fall on 3/26/16. According to skilled nursing notes on 5/6/2016, her "bed was in lowest position and fall mats."

By March 2016, the patient appears to return to FAST 7A, as her weight loss, per the table below, was apparent. She continued a declining trajectory in her weight up to the audited claim and certification period of 05/16/2016 - 07/14/2016. Nursing notes during the review period document "temporal wasting" and "ill-fitting clothing."

Date	Weight (lbs.)	Documentation Source
6/29/2015	165.2	Facility weight
8/19/2015	152	IDT note 08/19/15
9/2/2015	150	IDT note 09/02/15
10/14/2015	142	SN visit 10/14/15
01/06/2016	136.2	IDT note 01/06/2016
3/4/2016	122	IDT note 3/16/16
5/10/2016	136.4	Not included in documentation initially provided OIG, the facility documentation included a noted by an RN chart review: "Weight increase may be due to different scales"
7/6/2016	135.2	IDT note: "increased daytime somnolence, decrease meal intake"

The patient's declining oral intake is further supported by the need for reducing her insulin regimen as her oral intake declined:

1. Humalog insulin 6 units TID (three times a day) schedule was stopped on 4/2/2016;
2. IDT note on 7/16/16 documents, "increased daytime somnolence, decreased meal intake"; and
3. Glargine insulin 30 units daily was reduced to 20 units daily on 8/8/2016.

In the span of four months, the patient's total insulin daily dose went from 48 to 20 units, representing a decline of 58% of glycemic needs. Similarly, the patient's declining oral intake led to widely fluctuating INR results (per facility INR results in March 2016) that lead her attending provider to transition to apixaban as of 4/2/2016. On 3/26/2016, the day of one of her falls, her INR was documented as 5.5.

Based on the above clinical information, Northwest Hospice submits that the patient qualified for hospice services during the period audited.

#### Sample Claim # 62

Date of Hospice Election: 3/3/2017  
 Dates of Service: 7/1/2017 – 7/31/2017  
 Length of Service 4 months

Following an independent record review by Northwest Hospice's consulting physician and a holistic assessment of the patient's comorbidities, symptoms, and course of treatment prior to and during the period under audit, Northwest Hospice submits that this claim is appropriately documented and, thus, supportable as explained below:

This patient is a 92-year-old woman admitted to hospice with Alzheimer's disease with anorexia, weight loss, lethargy and functional loss after an emergency room (ER) evaluation. Following her

acute ER event, the clinical picture supports hospice services given the severity of hypoxia (81% on room air) with a UTI, refusing food and medication as well a depressed level of consciousness.

She was noted to be newly in need of a Hoyer Lift and had previously been sit-to-stand. The patient's initial hospice assessment of a PPS of 20% and FAST scale of 7 supported this and although she survived the initial acute event, her PPS score and FAST remained severe.

All relevant and available documentation may not have been provided initially to OIG for review, but is included in the **Supplemental Appendix**. The facility documentation supports progressive lethargy leading to decrease in oral intake, and weight loss (supporting the LCD for decline in clinical status guidelines). An arc of decline for this patient is documented.

Date	Event
7/7/2017	Weight 191.8 pounds
7/12/2017	Lethargy on ARNP examination, resting heart rate 98
7/13/2017	"Resident refused breakfast and only had a few bites for lunch."
7/14/2017	"Resident only ate a few bites for each meal", "Resident has been sleeping most of this shift."
7/21/2017	"Patient opened eyes briefly and resume sleeping."
7/24/2017	"Resident kept falling asleep during dinner. Staff was only able to give her a few bites."
7/25/2017	"Resident is coughing and sleeping a lot" and only ate "Resident ate 25% for both meals"
7/25/2017	Skilled Nursing Visit "today very sleepy and did not want much".

It appears OIG's reviewer may not have considered all of the comorbidities of the patient, including heart failure that was not included in the Advanced Dementia Prognostic Tool (ADEPT), a risk score to estimate survival in nursing home residents with advanced dementia. The patient also had evidence of severe edema and hypoxia on examination, an elevated brain natriuretic peptide, and evidence of cardiomegaly on chest radiographs, and treated with diuretics - all findings consistent with heart failure.

The patient also had evidence of insufficient oral intake that satisfied ADEPT scoring (defined as not consuming almost all liquids in previous 3 days or at least 25% of food uneaten at most meals) in the audited month as documented above. Recalculating ADEPT scoring with the addition of the above (1.5 for heart failure and 2 for insufficient oral intake), a more accurate ADEPT score is 15.6, yielding a six-month mortality of 34-43%.

Based on the above clinical information, Northwest Hospice submits that the patient qualified for hospice services during the period audited.

**Sample Claim # 100**

Date of Hospice Election: 4/13/2017  
Dates of Service: 2/1/2018 – 2/28/2018  
Length on Service: 10 months

Following an independent record review by Northwest Hospice's consulting physician and a holistic assessment of the patient's comorbidities, symptoms, and course of treatment prior to and during the period under audit, Northwest Hospice submits that this claim is appropriately documented and, thus, supportable as explained below:

This patient is a 94-year-old female who was admitted to hospice on 4/13/2017 with a diagnosis of Alzheimer's dementia from the Memory Unit of an assisted living facility. In addition to advanced Alzheimer's, the patient had the following notable comorbidities: Type 2 diabetes, aortic stenosis, coronary artery disease, a history of cerebrovascular accidents with hemiplegia, hypertension and a 25-pound weight loss over a month. In addition, the patient had repeated falls, some with injuries requiring hospital visits, with progressive functional decline. Upon admission she was dependent on 4/6 ADLs and at the time of the claim in question she was dependent on all ADLs with the exception of feeding. At time of hospice admit, FAST was 6E, PPS score was 40% which is consistent with LCD requirements.

This patient lived in a congregate setting and was treated with oseltamivir because of influenzae in the facility. As explained below, prominent to the decision to recertify the patient for hospice was the fact that the patient exhibited complications related to her viral infection. The infection was not asymptomatic and documentation supports the fact that it evolved to cause lethargy and acute weight loss for the patient. The chronological events leading up to the decision to recertify are outlined below and appear not to have been reviewed by OIG's reviewer, but is included in the **Supplemental Appendix**:

1. IDT documentation on O 1/10/18 (made one day after Tamiflu was started for this patient) describes the then-present situation as asymptomatic;
2. Documentation supports that the patient developed a wet cough and flu like symptoms and that the patient was sleeping 20 hours a day. In addition, the SNV identified a 7-pound weight loss.

Given the contemporaneous information of an acute respiratory viral infection and the above sequela, the fact that the patient was living in a congregate setting, her advanced age, and associated co-morbidities (including Type 2 diabetes, aortic stenosis, coronary artery disease, a history of cerebrovascular accidents with hemiplegia, hypertension and weight loss), it was a clinically sound and reasonable exercise of medical judgment to predict that this patient's trajectory and prognosis would indicate a 6-month life expectancy at the time of her evaluation and recertification for hospice eligibility. Notably, her acute weight loss and lethargy are objective symptoms consistent with the LCD guidelines for a progressing decline in clinical status.

Based on the above clinical information, Northwest Hospice submits that the patient qualified for hospice services during the period audited.

*D. 60-Day Rule and Return of Medicare Overpayments*

Northwest Hospice is fully cognizant of its obligations, triggered by receipt of the Draft Report, pursuant to Medicare's 60-Day Rule. In order to comply with those obligations, Northwest Hospice is currently in the process of gathering information regarding hospice claims submitted during the period of January 1, 2015 through May 31, 2016. This period immediately 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.

Hospice claims submitted to and paid by Medicare during both the two-year pre-audit and two-year audit periods are not, however, representative of hospice claims submitted to Medicare by Northwest Hospice during the two-year post-audit period covered by the 60-Day Rule's presumptive lookback period. With respect to the post-audit period (June 1, 2018 through December 31, 2020), Northwest Hospice is confident that claims submitted during that period *were* submitted with appropriate documentation and, therefore, *were* properly paid. As outlined below and independent of OIG's retrospective audit, Northwest Hospice implemented significant, substantive post-audit changes to its: (1) Quality Assurance staffing levels, (2) quality assurance audits, (3) policies and procedures, (4) staff training, (5) medical records/documentation, and (6) key personnel which, separately and together, resulted in material improvements to the accuracy of claims submitted to Medicare and to the documentation supporting those claims.

Specifically, in October 2017 and March 2018, Northwest Hospice underwent separate Target Probe and Educate (TPE) reviews by Noridian, the Supplemental Medical Review Contractor for CMS. As a result of the lessons internalized from those reviews, Northwest Hospice identified a number of opportunities to strengthen various aspects of its daily operations and promptly instituted measures to address those operational shortcomings. The most relevant changes and improvements, all of which were substantially completed prior to the post-audit period, are summarized below:

1. Northwest Hospice created a centralized Quality Assurance department in June 2018. That department provides consistency and uniformity across all hospice locations. The new department developed and implemented a centralized auditing process which includes an audit of 10% of all hospice claims from all locations each quarter. As part of reorganizing the department, QA staff was increased from 1.5 to three FTEs.
2. The QA department provided additional education and training to staff, which resulted in consistent standards and procedures across all locations.
3. Regular, external, continuing education training programs were provided through the End-of-Life Nursing Education Consortium to all IDT members, as well as training on palliative care through the National Hospice and Palliative Care Organization. Targeted training was also provided to the then-Medical Director in order for her to obtain her Hospice and Palliative Medicine Certification.

4. In May 2018, Northwest Hospice transitioned to a new point of care electronic medical record system (Homecare Homebase) specially designed for hospice care providers, which facilitated and has resulted in more accurate and comprehensive patient documentation. This upgrade—from start to finish—cost nearly \$2M to deploy.
5. Development and implementation of updated and improved operating policies and procedures.
6. The Agency Annual Report to the Governing Body template was formalized to include regulatory elements and best practices.

With regard to personnel changes, Northwest Hospice made a number of significant changes based on the results of the above-referenced TPE reviews, including the replacement of both its Medical Director and Administrator. [REDACTED] was named the new Medical Director. [REDACTED] is a hospice and palliative medicine specialist with over 20 years of experience in hospice and palliative medicine. [REDACTED] was hired as the new Hospice Administrator, bringing more than 10 years of hospice and palliative care experience to Northwest Hospice. Finally, but importantly, [REDACTED] APRN, MSN, FNP-BC, the former VP of Clinical Operations, was put in charge of QA and Performance Improvement program development after the first TPE review and began the planning, identification and acquisition of additional resources necessary to implement many of the quality/process improvements identified above. She subsequently was promoted to Division President of Signature Healthcare at Home in December 2018 and continues to oversee Northwest Hospice.

As a result of the foregoing substantive changes made in direct response to Northwest Hospice's 2017 and 2018 TPE reviews, which includes a rigorous self-audit protocol, Northwest Hospice is confident that its claims submitted during the two-year, post-audit time frame—June 1, 2018 through December 31, 2020—do not present the same documentation issues identified in the seven claims questioned in the Draft Report that Northwest Hospice has elected not to dispute.

#### *E. Response to Recommendations*

The Draft Report proposes three recommendations for Northwest Hospice's consideration. Northwest Hospice's position as to each is set forth below.

1. 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.

Northwest Hospice 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 made in this submission and upon issuance by OIG of a final audit report.

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 identify any of those returned overpayments as having been made in accordance with this recommendation.



Per Section D of this Response, Northwest Hospice is aware of its obligations pursuant to Medicare's 60-Day Rule, will act consistently with those obligations, and will reference the fact that the return of any overpayments is in accordance with this recommendation. In light of the substantive and significant changes and enhancements to its daily operations since its 2018 TPE review, which includes ongoing, regular audits of its hospice claims to Medicare, Northwest Hospice does not believe that additional diligence is necessary or required to address the issues raised by the Draft Report in the post-audit period.

3. Strengthen [internal] policies and procedures to ensure that hospice services comply with Medicare requirements.

As noted above, in the aftermath of its 2018 TPE review, Northwest Hospice implemented a number of substantive, significant and costly improvements and enhancements to its daily operations, including a new EMR system and increased professional training and continuing education/annual competencies, that have both facilitated and resulted in improved compliance with Northwest Hospice's already compliant policies and procedures. Those policies and procedures are periodically revisited and updated, as necessary, by compliance personnel and Division leadership to ensure that they keep up with changes in applicable Medicare rules and regulations.

#### Conclusion

Northwest Hospice, through its counsel in this matter, is grateful for the opportunity to submit this detailed rebuttal to OIG's Draft Report for inclusion in the final audit report. Northwest Hospice is confident that a fair and objective reconsideration of 12 of the OIG reviewer's 19 adverse determinations, in light of the comments, observations, and supplemental information/documentation provided here and, separately, in the **Supplemental Appendix**, will result in a favorable revision of the Draft Report that recognizes the many, often complex, medical variables and considerations—including some that are psychological, emotional, spiritual, and logistical in nature, but still necessarily part of the decision-making calculus for hospice care providers—that together comprise the full clinical picture of a hospice patient and must ultimately and appropriately inform clinical judgments regarding hospice eligibility and hospice services.

Such a revision is especially appropriate here, where six of the 19 sample claims questioned (Sample Claims 1, 33, 36, 37, 69, and 77) involve patients discharged from hospice by Northwest Hospice the *same month* or the *month immediately following* OIG reviewer's subjective determination that hospice eligibility had ceased. Similarly, six additional claims questioned by OIG's reviewer (Sample Claims 14, 28, 29, 55, 62 and 100) should stand as submitted because sufficient medical documentation—whether produced originally to OIG or as provided in the **Supplemental Appendix**—exists to support the reasonable clinical judgment of Northwest Hospice personnel that the symptoms; multiple, serious, difficult-to-manage comorbidities; and probable prognosis of the six patients, all but one of whom was 92 years old or older, continued to render them eligible and appropriate for hospice care during the audited period.

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March 22, 2021  
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Thank you for your careful consideration of this comprehensive Response to OIG's Draft Report.

Sincerely,

A black rectangular redaction box covering the signature and name of the sender.

Attachment (Supplemental Appendix)