

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HOSPICE PROVIDER
COMPLIANCE AUDIT:
HOSPICE COMPASSUS, INC.,
OF PAYSON, ARIZONA**

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Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

Report in Brief

Date: November 2020

Report No. A-02-16-01023

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 and who have elected hospice care. Previous OIG reviews found that Medicare inappropriately paid for hospice services that did not meet Medicare requirements.

Our objective was to determine whether hospice services provided by Hospice Compassus, Inc., of Payson, Arizona (Payson), complied with Medicare requirements.

How OIG Did This Audit

Our audit covered 2,150 claims for which Payson received Medicare reimbursement totaling \$8 million for hospice services provided during the period January 2014 through March 2016. We reviewed a random sample of 100 claims. We evaluated the services for compliance with Medicare requirements and submitted records associated with them to a medical review contractor.

Medicare Hospice Provider Compliance Audit: Hospice Compassus, Inc., of Payson, Arizona

What OIG Found

Payson did not comply with Medicare requirements for 39 of the 100 claims in our sample. For these claims, Payson claimed Medicare reimbursement for hospice services: (1) for which the associated beneficiary did not meet eligibility requirements, (2) that were not documented, and (3) at a reimbursement rate associated with a level of care higher than what the associated beneficiary required.

These improper payments occurred because Payson's policies and procedures for ensuring that claims for hospice service met Medicare requirements were not always effective. On the basis of our sample results, we estimated that Payson received at least \$1.8 million in Medicare reimbursement for hospice services that did not comply with Medicare requirements.

What OIG Recommends and Payson Comments

We recommend that Payson exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule, and based on the results of our audit, identify, report, and return any additional overpayments as having been made in accordance with our recommendations. We also recommended that Payson strengthen its procedures to ensure that hospice services comply with Medicare requirements.

In written comments on our draft report, Payson, through its attorneys, generally disagreed with our findings and recommendations. Specifically, Payson disagreed with all but 2 of the 70 claims questioned in our draft report. Payson asserted that the medical review contractor misunderstood or misapplied coverage criteria related to the Medicare hospice benefit and downplayed the significance of the physician's certification of terminal illness. Additionally, Payson believes that the records it provided supported the certifying physician's prognosis of terminal illness.

Based on the independent medical review contractor's reassessment of the cases disputed by Payson, as well as an evaluation of Payson's comments, we revised our determinations for 32 claims. This resulted in 31 claims being allowable because 1 of the 32 claims remains unallowable for another reason. We revised our report and related recommendations accordingly. We maintain that our findings and recommendations, as revised, are valid.

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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) reviews found that Medicare inappropriately paid for hospice services that did not meet certain Medicare requirements.¹

OBJECTIVE

Our objective was to determine whether hospice services provided by Hospice Compassus, Inc., of Payson, Arizona (Payson), complied with Medicare requirements.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Part A, also known as hospital insurance, provides for the coverage of various types of services, including hospice services.² CMS contracts with four Home Health and Hospice Medicare Administrative Contractors (MACs) to process and pay Medicare hospice claims.

The Medicare Hospice Benefit

To be eligible to elect hospice care, a beneficiary must be entitled to Medicare Part A and certified by a physician as being terminally ill (i.e., as having a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal course).³ Hospice care is palliative (supportive), rather than curative, and includes, among other things, nursing care, medical social services, hospice aide services, medical supplies, and physician services. The Medicare hospice benefit has four levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient (GIP) care. Each level has an all-inclusive daily rate.⁴

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

² The Act §§ 1812(a)(4) and (5).

³ The Act §§ 1814(a)(7)(A) and 1861(dd)(3)(A) and 42 CFR §§ 418.20 and 418.3.

⁴ 42 CFR § 418.302.

Beneficiaries eligible for the Medicare hospice benefit may elect hospice care by filing a signed notice of election (NOE) with a hospice.⁵ Upon election, the hospice assumes the responsibility for medical care of the beneficiary's terminal illness, and the beneficiary waives all rights to Medicare payment for services that are related to the treatment of the terminal condition or related conditions.⁶ The hospice must submit the NOE to its MAC within 5 calendar days after the effective date of election. If the hospice does not submit the NOE to its MAC within the required timeframe, Medicare will not cover and pay for days of hospice care from the effective date of election to the date that the NOE was submitted to the MAC.⁷

Beneficiaries are entitled to receive hospice care for two 90-day periods, followed by an unlimited number of 60-day periods.⁸ At the start of the initial 90-day period of care, the hospice must obtain written certification of the beneficiary's terminal illness from the hospice medical director or the physician member of the hospice interdisciplinary group⁹ and the beneficiary's attending physician, if any. For subsequent periods, a written certification by only the hospice medical director or the physician member of the hospice interdisciplinary group is required.¹⁰ The initial certification and all subsequent recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less.¹¹ The written certification may be completed no more than 15 calendar days prior to the effective date of election or the start of the subsequent benefit period.¹²

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice beneficiary whose total stay across all hospices is anticipated to reach a third benefit period. 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.¹³

⁵ 42 CFR § 418.24(a)(1).

⁶ The Act § 1812(d)(2)(A) and 42 CFR § 418.24(d).

⁷ 42 CFR §§ 418.24(a)(2) and (a)(3).

⁸ 42 CFR § 418.21(a).

⁹ A hospice interdisciplinary group consists of individuals who together formulate the hospice plan of care for terminally ill beneficiaries. The interdisciplinary group must include a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor, and may include others, such as hospice aides, therapists, and trained volunteers (42 CFR § 418.56).

¹⁰ 42 CFR § 418.22(c).

¹¹ 42 CFR § 418.22(b)(3).

¹² 42 CFR § 418.22(a)(3).

¹³ 42 CFR §§ 418.22(a)(4), (b)(3)(v), and (b)(4).

Hospice providers must establish and maintain a clinical record for each hospice patient.¹⁴ The record must include all services, whether furnished directly or under arrangements made by the hospice. Records should contain enough clinical factors and descriptive notes to show the illness is terminal and progressing in a manner that a physician would reasonably have concluded that the beneficiary's life expectancy was 6 months or less.¹⁵

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.¹⁶

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 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.¹⁷

Hospice Compassus, Inc., of Payson, Arizona

Payson, located in Payson, Arizona, is 1 of more than 140 healthcare programs operated by Hospice Compassus in 30 States across the United States.¹⁸ Payson operates a freestanding hospice care center that provides services to terminally ill beneficiaries residing in Gila and Coconino Counties, as well as support for their families. Services offered by Payson under its hospice benefit include physician, nursing, home health aide, counseling, medical social services, medical supplies, physical and occupational therapy, short-term inpatient care, and speech pathology. During the period January 1, 2014, through March 31, 2016 (audit period), Payson provided hospice services to approximately 500 beneficiaries and received Medicare

¹⁴ 42 CFR §§ 418.104 and 418.310.

¹⁵ 42 CFR §§ 418.22(b)(2) and (d)(2) and 418.104(a).

¹⁶ The Act § 1128J(d); 42 CFR §§ 401.301 to 401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

¹⁷ 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, Provider Reimbursement Manual – Part 1, Pub. 15-1, § 2931.2; and 81 Fed. Reg. 7654, 7670 (Feb. 12, 2016).

¹⁸ Hospice Compassus is a nationwide network of community-based hospice, palliative, and home health care services.

reimbursement of almost \$8 million.¹⁹ National Government Services, Inc. (NGS), serves as the MAC for Payson.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$7,964,432 in Medicare reimbursement for 2,150 claims for hospice services provided by Payson during the audit period. We reviewed a random sample of 100 of these claims to determine whether hospice services complied with Medicare requirements. We provided the associated medical records to an independent medical review contractor who determined whether there was sufficient documentation to support that (1) the associated beneficiaries were terminally ill, (2) hospice services provided were reasonable and necessary, and (3) Medicare requirements were met.

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

FINDINGS

Payson received Medicare reimbursement for claims for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in our sample, 61 claims complied with Medicare requirements, but 39 did not. Specifically:

- For 30 claims, hospice eligibility requirements were not met.
- For six claims, Payson submitted claims for Medicare reimbursement for services that were not documented in the beneficiary's clinical record.
- For four claims, the beneficiary's case record did not support the level of care claimed for Medicare reimbursement.

The total exceeds 39 because 1 claim contained more than 1 of the above errors.

Improper payment of these claims occurred because Payson's policies and procedures were not effective to ensure that hospice eligibility requirements were met and that the appropriate

¹⁹ Claims data for the period January 1, 2014, through March 31, 2016, was the most current data available when we started our audit.

level of care was provided. In addition, Payson submitted claims to Medicare for services for which it did not provide supporting documentation.

On the basis of our sample results, we estimated that Payson received at least \$1,872,291 in unallowable Medicare reimbursement for hospice services that did not comply with Medicare requirements.²⁰ As of the publication of this report, all unallowable claims in the sample are outside the 4-year claims reopening period.²¹ Notwithstanding, Payson 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 claims reopening period.²²

HOSPICE ELIGIBILITY REQUIREMENTS NOT MET

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 periods, followed by an unlimited number of 60-day periods. At the start of the initial 90-day period of care, the hospice must obtain written certification of the beneficiary's terminal illness from the hospice medical director or the physician member of the hospice interdisciplinary group and the individual's attending physician, if any.²³ For subsequent periods, a written certification from the hospice's physician is required. The written certification may be completed no more than 15 calendar days prior to the effective date of election or the start of the subsequent benefit period. Finally, a hospice physician or hospice nurse practitioner must perform a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the third benefit period to gather clinical findings to determine continued eligibility for hospice care.²⁴ The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the third benefit period recertification, and every benefit period recertification thereafter.²⁵

²⁰ To be conservative, we estimate 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 95 percent of the time.

²¹ 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).

²² 42 CFR § 405.980(c)(4).

²³ Clinical information and other documentation that supports the beneficiary's terminal prognosis must accompany the physician's certification and be filed in the medical record with the written certification (42 CFR § 418.22(b)(2)).

²⁴ The physician or nurse practitioner who performs the face-to-face encounter must attest in writing that such an encounter occurred (42 CFR §§ 418.22(a)(4) and (b)(4)).

²⁵ 42 CFR § 418.22(a)(4).

For 30 of the 100 sample claims, Payson claimed Medicare reimbursement for hospice services provided to beneficiaries who did not meet the eligibility requirements to receive such services.²⁶ Specifically:

- For 28 sample claims, the clinical record provided by Payson did not support the associated beneficiary's terminal illness diagnosis. Specifically, the records for these claims did not contain sufficient clinical factors and descriptive notes to indicate that the associated beneficiary's illness was terminal and progressing in a manner that a physician would have reasonably concluded that the beneficiary's life expectancy was 6 months or less.
- For six sample claims, the physician's certification of terminal illness covering our sample claim did not comply with Medicare requirements. Specifically, for three claims, Payson did not provide the physician's recertification of terminal illness, and for three other claims, the physician completed the recertification of terminal illness more than 15 days prior to the beginning of the recertification benefit period.²⁷
- For two sample claims, face-to-face encounter requirements were not met. Specifically, for two claims, the medical record for the associated beneficiary did not contain evidence that the hospice physician or hospice nurse practitioner completed a face-to-face encounter.

SERVICES NOT DOCUMENTED

No Medicare payment shall be made to any provider unless it has furnished the information necessary to determine the amount due (the Act § 1815(a)).

For 6 of the 100 sample claims, there was no documentation to support some of the hospice services billed to Medicare. Specifically:

- For five sample claims, Payson submitted claims for Medicare reimbursement that included social work and nursing services ordered by a physician and included in the associated beneficiary's care plan that were not documented in the beneficiary's clinical record.²⁸

²⁶ The total exceeds 30 because 4 claims contained more than 1 reason as to why hospice eligibility requirements were not met.

²⁷ The recertifications were completed 19 to 22 days prior to the beginning of the recertification benefit period.

²⁸ These undocumented services did not impact the Medicare reimbursement Payson received because they were not paid separately. Rather, they were included in an all-inclusive daily rate paid to the hospice.

- For one sample claim, Payson claimed and received Medicare reimbursement for physician services that were not documented in the associated beneficiary’s clinical record.²⁹

LEVEL OF CARE NOT SUPPORTED

Medicare reimbursement for hospice services is made at one of four predetermined rates—based on the level of care provided—for each day that a beneficiary is under the hospice’s care. The four levels are (1) routine home care, (2) continuous home care, (3) inpatient respite care, and (4) GIP care.³⁰ GIP care is for pain control or acute or chronic symptom management that cannot be managed in other settings, such as the beneficiary’s home, and is intended to be short-term.³¹

For 4 of the 100 sample claims, Payson claimed Medicare reimbursement at the GIP level of care; however, the associated beneficiary’s clinical record did not support the need for that level of care. Specifically, Payson billed for GIP care even though the beneficiary did not have uncontrolled pain or unmanaged symptoms, or the beneficiary received care that could have been provided at home. For all four sample claims, the associated beneficiaries’ hospice care needs could have been met at the less expensive routine level of care.³²

RECOMMENDATIONS

We recommend that Hospice Compassus, Inc., of Payson, Arizona:

- exercise reasonable diligence to identify, report, and return the estimated \$1,872,291 for hospice services that did not comply with Medicare requirements in accordance with the 60-day rule, and identify any of those returned overpayments as having been made in accordance with this recommendation;

²⁹ Payment for these physician services was based on the physician fee schedule and not included in the all-inclusive daily rate paid to a hospice (42 CFR § 418.304(b)).

³⁰ Definitions and payment procedures for specific level-of-care categories are codified at 42 CFR § 418.302.

³¹ 42 CFR §§ 418.302(b)(4) and 418.202(e) and CMS’s *Medicare Benefit Policy Manual*, Pub.100-02, chapter 9, § 40.1.5.

³² For three of these claims, we questioned the difference between the GIP and routine levels of care. The other claim had more than one error and was questioned in its entirety.

- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any additional overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation;³³ and
- strengthen its procedures to ensure that hospice services comply with Medicare requirements.

HOSPICE COMPASSUS, INC., OF PAYSON, ARIZONA, COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Payson, through its attorneys, generally disagreed with our findings and recommendations.^{34, 35} Specifically, Payson disagreed with all but 2 of the 70 sample claims questioned in our draft report and provided specific responses for each. Payson agreed to return overpayments for the two claims it agreed were in error and to repay any related claims identified outside of our audit period. However, Payson did not agree with our recommendation to strengthen its procedures, as it believes its procedures are sufficiently strong to ensure that hospice services comply with Medicare requirements.

Payson asserted that the medical review contractor misunderstood or misapplied the relevant coverage criteria related to the Medicare hospice benefit and downplayed the significance of the physician's certification of terminal illness. Payson stated that, because relevant regulations only require that clinical information and other documentation support the terminal prognosis, it is wrong to conclude that such supporting documentation must prove the validity of a physician's clinical judgement. Payson stated that it and its own hospice experts believe that the hospice records provided during the audit supported the certifying physician's prognosis of terminal illness. Therefore, according to Payson, no hospice claim should be denied because the hospice records indeed support the certifying physicians' prognosis of terminal illness such that they made informed judgments on clinical eligibility. Lastly, Payson indicated that OIG should not extrapolate the results of the audit since OIG's findings do not contain a sustained or high level of payment error and Payson was not subject to Medicare

³³ 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.

³⁴ In a cover letter accompanying Payson's attorney's comments, Payson disagreed with the draft report findings.

³⁵ The draft report had four recommendations, which we have revised to three. In the draft report, we recommended that Payson refund to the Medicare program the portion of the estimated overpayment for claims incorrectly billed that are within the reopening period. We removed this recommendation because all of the incorrectly billed claims will be outside of the reopening period when this report is issued.

audits prior to this audit, thus making the use of extrapolation inappropriate. Payson's comments are included as Appendix E.³⁶

Based on the results of the independent medical review contractor's reassessment of cases disputed by Payson, as well as an evaluation of Payson's written comments, we revised our determinations for 32 claims. This resulted in 31 claims being allowable because 1 of 32 claims for which we revised our determinations (sample claim 41), remains unallowable for another reason. Specifically, we are no longer questioning 30 claims for noncompliance with Medicare hospice eligibility requirements, 1 claim for which we originally determined the level of care was not supported, and the 2 claims for which we originally determined the NOE was not filed timely. The total exceeds 32 because 1 claim (sample claim 38) contained more than 1 error that we are no longer questioning. As detailed below, we revised our report and related recommendations accordingly. We maintain that our findings and recommendations, as revised, are valid.

Additionally, we considered Payson's comments on the use of estimation in this audit and maintain that our statistical approach resulted in a legally valid and reasonably conservative estimate of the amount overpaid by Medicare to Payson. Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.³⁷ We also note that the requirement that a determination of a sustained or high level of payment error must be made before extrapolation applies only to Medicare contractors.³⁸

³⁶ Payson included attachments to its comments that contained a claim-by-claim rebuttal to the medical review findings in our draft report, Hospice Compassus' current clinical eligibility policy, and résumés and curriculum vitae of the external reviewers it hired to review the records of the patients that OIG's medical review contractor determined were ineligible. These documents contain proprietary and personally identifiable information and have been excluded from this report but will be provided separately in their entirety to CMS.

³⁷ See *Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), adopted by 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

³⁸ See Social Security Act § 1893(f)(3); CMS Medicare Program Integrity Manual, Pub. No. 100-08, ch. 8, § 8.4 (effective January 2, 2019).

HOSPICE ELIGIBILITY REQUIREMENTS NOT MET

Payson Comments

Payson disagreed with our determinations for 58 of the 60 claims identified in our draft report as not meeting hospice eligibility requirements.³⁹ Specifically, Payson disagreed that the clinical record did not support the terminal illness diagnosis for 56 claims, that physician's certification of terminal illness did not comply with Medicare requirements for 6 claims, and that face-to-face encounter requirements were not met for 2 claims.⁴⁰ Payson argued that there were inconsistencies in the independent medical review contractor's analysis. In addition, Payson stated that the contractor applied erroneous standards when determining whether documentation supported a terminal prognosis and downplayed the legal significance of the physician's certification of terminal illness. Lastly, Payson contended that the medical review contractor did not use a reasonable approach when deciding clinical eligibility for hospice services.

Office of Inspector General Response

The independent medical review contractor reassessed all 56 claims for which Payson disagreed with the determination that the clinical record did not support the associated beneficiary's terminal illness diagnosis. The other two claims that Payson disagreed with did not involve a medical review determination and therefore were not included in the contractor's review of cases disputed by Payson. For this review, the medical review contractor considered Payson's comments on our draft report and its attachments, the previously reviewed medical records, as well as its original determinations. Upon consideration of the independent medical review contractor's review results, we revised the determinations for 30 claims. We maintain that the remaining 28 claims did not meet hospice eligibility requirements because (1) the clinical record did not support the terminal illness diagnosis (26 claims), (2) the physician's certification of terminal illness covering our sample claim did not comply with Medicare requirements (6 claims), and (3) face-to-face encounter requirements were not met (2 claims).⁴¹

Payson's assertions that there were inconsistencies in the independent medical review contractor's analysis, that the contractor misunderstood or misapplied hospice coverage criteria when determining whether documentation supported a terminal prognosis, and that the contractor did not use a reasonable approach when deciding clinical eligibility for hospice services are not correct. We also disagree that the contractor downplayed the legal significance of a physician's certification of terminal illness. The independent medical review

³⁹ Payson has initiated repayments for the two claims that it agreed with.

⁴⁰ The total exceeds 58 because 4 claims contained more than 1 reason for why hospice eligibility requirements were not met.

⁴¹ The total exceeds 28 because 4 claims contained more than 1 reason as to why hospice eligibility requirements were not met.

contractor properly used the appropriate statutory and regulatory hospice criteria, as well as applicable Local Coverage Determination (LCD) guidelines, as the framework for its determination of terminal status. Specifically, the 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 certification and be filed in the medical record.⁴² In addition, the independent medical review contractor did not downplay the significance of the hospice physician's certification. Rather, the contractor acknowledged the physician's terminal diagnosis and evaluated the medical records for each hospice claim, 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 factors supported the physician's medical prognosis, a determination that hospice eligibility criteria were met was made.

SERVICES NOT DOCUMENTED

Payson Comments

Payson disagreed with our determination that, for six claims, there was no documentation to support some of the hospice services billed to Medicare. Specifically, for the services identified in our draft report as missing supporting documentation, Payson stated that the independent medical review contractor may have misunderstood that Medicare pays for hospice services on a per diem rate, irrespective of whether services are provided on a particular day, and missing records for a single service do not render any portion of the claim unallowable. In addition, for the one claim for which physician services were not documented in the associated beneficiary's clinical record, Payson agreed that there was no documentation to support those services; however, it stated that hospice services were still appropriate.

Office of Inspector General Response

After reviewing Payson's comments, we maintain that our findings related to these six claims are valid. We agree that some of the undocumented services did not impact the Medicare reimbursement Payson received. As noted in our report, these services were not paid separately. Rather, they were included in the all-inclusive daily rate paid to Payson. Accordingly, we did not calculate an overpayment for those services but still reported them as services that did not comply with Medicare requirements. We also agree with Payson that hospice services were appropriate for the beneficiary whose claim included physician services that were not documented. However, we did not question that claim because the beneficiary did not have a life expectancy of 6 months or less. Rather, we questioned it

⁴² The standard is further elaborated on in LCD guidelines that state that the documentation must contain enough information to support terminal illness upon review and that the documentation should "paint a picture" for a reviewer to clearly see why the patient is appropriate for hospice care.

because there was no documentation to support two physician services that resulted in an overpayment of \$195.⁴³

LEVEL OF CARE NOT SUPPORTED

Payson Comments

Payson disagreed with our determinations that, for five claims, it claimed Medicare reimbursement at the GIP level of care when the associated beneficiary's clinical record did not support the need for that level of care. Payson contended that, for each of these claims, the beneficiary was suffering from acute exacerbations of symptoms that could not have been effectively managed outside of a facility setting and, as such, the GIP level of care was appropriate.

Office of Inspector General Response

Based on the results of the independent medical review contractor's reassessment of the five claims, we revised our determination for one claim because the associated beneficiary's clinical record supported the need for the GIP level of care. For the remaining four claims, the independent medical review contractor determined that the associated beneficiary's clinical record did not support the need for the GIP level of care. Specifically, the medical records for these claims indicated that the pain management provided was not at an intensity that needed to be provided in an inpatient hospital setting and could have been managed in other settings.

⁴³ We allowed the remainder of the claim.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 2,150 hospice claims for which Payson received Medicare reimbursement totaling \$7,964,432 for services provided from January 1, 2014, through March 31, 2016. These claims were extracted from CMS's National Claims History (NCH) file.

We did not assess Payson'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 Payson's office in Payson, Arizona.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidelines;
- met with CMS officials to gain an understanding of the Medicare hospice benefit;
- met with NGS officials to gain an understanding of the Medicare requirements related to hospice services;
- met with Payson officials to gain an understanding of Payson's policies and procedures related to providing and billing Medicare for hospice services and reviewed those policies and procedures;
- obtained from the CMS NCH file a sampling frame of 2,150 hospice claims, totaling \$7,964,432, for the audit period;
- selected a random sample of 100 hospice claims from the sampling frame;
- reviewed data from CMS's Common Working File and other available data for the sample claims to determine whether the claims had been canceled or adjusted;
- worked with NGS to identify the date the NOEs were submitted for each sample claim and determined the timeliness of the submission;

- obtained medical records for the 100 sample claims and provided them to a medical review contractor, who determined whether the hospice services complied with Medicare requirements;
- reviewed the medical review contractor's results and summarized the reason(s) 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 Payson for hospice services; and
- discussed the results of our audit with Payson officials.

See Appendix C for our statistical sampling methodology and Appendix D for our sample results and estimates.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries From Harm</i>	<u>OEI-02-17-00021</u>	7/3/2019
<i>Hospice Deficiencies Pose Risks to Medicare Beneficiaries</i>	<u>OEI-02-17-00020</u>	7/3/2019
<i>Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio</i>	<u>OEI-02-16-00570</u>	7/30/2018
<i>Hospices Should Improve Their Election Statements and Certifications of Terminal Illness</i>	<u>OEI-02-10-00492</u>	9/15/2016
<i>Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care</i>	<u>OEI-02-10-00491</u>	3/30/2016
<i>Hospice of New York, LLC, Improperly Claimed Medicare Reimbursement for Some Hospice Services</i>	<u>A-02-13-01001</u>	6/26/2015
<i>Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities</i>	<u>OEI-02-14-00070</u>	1/31/2015
<i>The Community Hospice, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services</i>	<u>A-02-11-01016</u>	9/23/2014
<i>Servicios Suplementarios de Salud, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services</i>	<u>A-02-11-01017</u>	8/7/2014

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of all Medicare Part A reimbursed claims for hospice services provided by Payson from January 1, 2014, through March 31, 2016.

SAMPLING FRAME

The sampling frame was an Access database containing 2,150 claims totaling \$7,964,432.⁴⁴ The data was 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 FOR SELECTING SAMPLE ITEMS

We consecutively numbered the hospice claims in our sampling frame from 1 to 2,150. 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 Payson 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 improper payment total 95 percent of the time.

⁴⁴ The sampling frame excludes hospice services that were identifiable in the Recovery Audit Contractor data warehouse as having been reviewed by another party and zero paid claims.

We also used the software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Number of Claims in Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Claims	Value of Unallowable Claims
2,150	\$7,964,432	100	\$358,579	39 ⁴⁵	\$117,482

Estimated Value of Unallowable Claims
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$2,525,872
Lower limit	1,872,291
Upper limit	3,179,453

⁴⁵ Thirty-four of these thirty-nine claims had errors that affected Medicare reimbursement.

APPENDIX E: HOSPICE COMPASSUS, INC., OF PAYSON, ARIZONA, COMMENTS



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September 10, 2019

Brenda M. Tierney
Regional Inspector General for Audit Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Re: Report Number: A-02-16-01023

Dear Ms. Tierney,

On behalf of Compassus, thank you for the opportunity to provide comments to the HHS Office of Inspector General's ("OIG") draft report on the Compassus hospice program in Payson, Arizona that focused on Medicare hospice services provided from January 2014 through March 2016.

Compassus is a provider of hospice and palliative care services, furnishing care and support to individuals in their last phase of life. Last year, Compassus cared for over 37,570 patients and their families in 140 locations across the United States. Our Payson, AZ hospice program has cared for over 800 patients since 2016 and we have been serving that community since 2007. Our core tenets include delivering high-quality patient-centric care, expanding access to qualified individuals, and putting compliance at the forefront every day. We operate in a highly regulated environment and are acutely aware of our responsibility to ensure that patients who meet Medicare's clinical eligibility standards, as determined by physicians, receive our hospice services. To that end, we have in place a highly-developed process for conducting clinical eligibility assessments. Our admissions practices include a certification of terminal illness from two physicians (if the beneficiary designates an attending physician), and the comprehensive clinical assessment of a registered nurse who is trained in hospice and palliative care.



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As part of our planning around OIG's audit of our Payson program, we engaged independent hospice experts and external legal counsel to evaluate those Medicare claims that OIG identified as unsupported. Our legal counsel's response, which incorporates the findings of the independent hospice experts, is included with this letter and sets forth specific reasons for Compassus' nonconcurrency with OIG's findings and any alternative corrective action planned or taken. As that response describes, Compassus' independent hospice experts disagree for the most part with OIG's initial clinical review findings.

We take the OIG's audit of our Payson program very seriously. Since OIG first notified us of the preliminary audit findings in September 2018, we have worked with reasonable diligence to identify the issues that could lead to a potential overpayment. With regard to one of the OIG draft reports observations, we disagree that Compassus' policies and procedures are ineffective or require substantive modification. Our clinical operations team works diligently to ensure that our policies are best in class and fully reflect the values of Compassus and our legal obligations. Our team also ensures that our policies evolve over time to reflect the current regulatory requirements and procedural best practices that help us care for our patients in the best way we can. Providing end of life care for patients consistent with the Medicare hospice benefit requirements is a responsibility we embrace with the utmost care and diligence.

Throughout this process, Compassus has provided sufficient information to demonstrate its compliance with Medicare's requirements for hospice care. As OIG knows, just because a hospice patient does not pass away within six months of being certified as terminally ill does not mean that the patient did not qualify for hospice care or that the certifying physicians were wrong. CMS has long recognized that issues of life and death do not always follow an exact trajectory or timeline. Based on the independent review conducted, we believe that OIG's draft report contains numerous incorrect and inaccurate conclusions and that the certifying physicians were correct to certify and recertify eligibility for all but one of the patients in OIG's sample.



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We do not have information on the physician reviewers the OIG used in connection with its audit of the clinical records, as that information was not made available to us. The independent experts Compassus engaged, including a nationally known hospice clinical consultant team and a board certified hospice and palliative care physician who runs a hospice program for a top academic medical center, reviewed these records and determined that there was adequate record support for the terminal condition of each of the claims for the patients in the sample except for one. Consistent with its obligations under the Sixty Day Rule, Compassus has effectuated a refund for the amount at issue. The expert review determined that just one of the one hundred sampled claims did not demonstrate sufficient clinical eligibility – that level of accuracy, 99%, is substantially higher than that of the industry. This not only affirms that our processes, policies, and procedures are effective at the Payson hospice program, but also that our clinicians are making clinically appropriate decisions around prognosis and that the clinical records sufficiently support those determinations. Above all, we are caring for our end-of-life patients and their families and caregivers with compassion and appropriate goals of care.

Simply put, while we embrace OIG’s audits of health care entities participating in the Medicare program, here we disagree with OIG’s draft audit findings. The detailed rationale for this is included in the attached report and we hope that OIG will duly consider this information as it finalizes its findings.

Sincerely,

Jim Deal
Chief Executive Officer
Compassus

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September 10, 2019

BY FEDERAL EXPRESS AND ELECTRONIC MAIL

Brenda M. Tierney
Regional Inspector General for Audit Services
U.S. Dep't. of Health & Human Services, Office of Audit Services Region II
Jacob K. Javitz Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Re: Hospice Compassus Inc. of Payson, AZ; A-02-16-01023

Dear Ms. Tierney:

Hospice Compassus, Inc. of Payson, AZ ("Compassus"), through its counsel, submits this letter in response to the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General's ("OIG") draft audit report (A-02-16-01023) dated August 2, 2019 (the "Draft Report"). Compassus thanks OIG for allowing an extension through September 11, 2019 to provide comments to the Draft Report.

Compassus appreciates the opportunity to provide comments to OIG's Draft Report. In general, Compassus fundamentally disagrees with the OIG's independent medical review contractor ("IMRC") findings inasmuch as the medical reviewers appear to have misunderstood or misapplied the relevant coverage criteria related to the Medicare hospice benefit and downplayed the legal significance of the hospice physicians' certifications of terminal illness with their corresponding clinical belief that the beneficiaries served had a terminal prognosis at that time. As described in greater detail below, the Medicare hospice benefit is based on subjective clinical determinations by one or more certifying physicians as to whether an individual is terminally ill, meaning that individual has a life expectancy of six months or less if the illness runs its normal course. The Centers for Medicare & Medicaid Services ("CMS") has specifically noted that terminal prognostication is not an exact science and made clear that hospice claims should not be denied when a certifying physician has a good faith clinical belief that a patient will pass away in six (6) months or less. Importantly, physicians are not required to prognosticate with 100% certainty. As the Eleventh Circuit just decided and clarified in the *AseraCare* opinion, under the Medicare hospice benefit the

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certifying physician's certification of terminal illness ("CTI") must be given great weight and that:

[T]he relevant regulations require only that "clinical information and other documentation that support the prognosis . . . accompany the certification" and "be filed in the medical record." This "medical prognosis" is, itself, "based on the physician's . . . clinical judgment." 42 C.F.R. § 418.22(b). To conclude that the supporting documentation must, standing alone, prove the validity of the physician's initial clinical judgment would read more into the legal framework [of the Medicare statute] than its language allows. . . [t]hat is, the [certifying] physician's clinical judgment dictates eligibility as long as it represents a reasonable interpretation of the relevant medical records."¹

In sum, the OIG's IMRC reviewers, and by extension the OIG, applied the wrong legal documentation standard as to what the Medicare hospice benefit requires to support a terminal prognosis and support a claim for hospice services that were indeed furnished. OIG's Draft Report does not contend services were not furnished; nor does the Draft Report contend, because it cannot, that the hospice physicians failed to certify in good faith that each patient had a terminal prognosis for each hospice benefit period under review.

The *AseraCare* opinion is instructive insofar as it is the most complete explication by a court of the Medicare hospice benefit's legal requirements on the documentation that supports a terminal prognosis and the role of that documentation in support of a physician's CTI. That decision spends seven (7) pages discussing the Medicare hospice benefit legal requirements,² outside the context of False Claims Act liability, as to how the Medicare statute must be interpreted. Importantly for purposes of the OIG's reconsideration of its Draft Report findings and the legally flawed findings of its IMRC physician reviewers, the Court notes that:

[H]ad Congress or CMS intended the patient's medical records to objectively demonstrate terminal illness, it could have said so. Yet Congress said nothing to indicate that the medical documentation presented with a claim must prove the veracity of the clinical judgment on an after-the-fact review. And CMS's own choice of the word "support" – instead of, for example, "demonstrate" or "prove" – does not imply the level of certitude the Government wishes to attribute to it.³

¹ *U.S. v. AseraCare, Inc.*, No 2:12-cv-00245, slip op. at 32-33 (11th Cir. September 9, 2019) (https://ecf.alnd.uscourts.gov/cgi-bin/DktRpt.pl?113698504560242-L_1_0-1).

² *Id.* at 26-32.

³ *Id.* at 33.

Hospice Compassus Inc. of Payson, AZ
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The Court goes on to observe “[m]ore broadly, CMS’s rulemaking commentary signals that well-founded clinical judgments should be granted deference.”⁴ The Court of Appeals in *AseraCare* has it right. Compassus respectfully requests that OIG reconsider its medical review findings with the court’s interpretive findings squarely in mind. To fail to do so will not protect the Medicare hospice benefit, but rather will do it (and our client Compassus) an injustice by further embracing a legally faulty medical documentation standard under the Medicare hospice benefit. That is not to say that hospice physician judgments warrant unfettered deference under the Medicare hospice benefit. Compassus believes, to the contrary, those clinical judgments should be reasonable. To that very point, and Compassus believes critical to OIG’s consideration of these comments to the Draft Report,

[W]hile there is no question that clinical judgments must be tethered to a patient’s valid medical records, it is equally clear that the law is designed to give physicians meaningful latitude to make informed judgments without fear that those judgments will be second-guessed after the fact by laymen in a liability proceeding.⁵

For the reasons offered in the balance of this response letter, and in the detailed, claim-by-claim response in the confidential attachment (which contains protected health information and which Compassus presumes will not be publicly posted by OIG), Compassus strongly believes, as do the hospice experts it hired to review OIG’s claim denial determinations, that the hospice records indeed support the certifying physicians’ prognosis of terminal illness such that they made informed judgments on clinical eligibility.

Compassus disagrees with the Draft Report’s determination on fifty-eight (58) of the sixty (60) claims where OIG determined hospice eligibility requirements were not met. Compassus’s fundamental disagreement relates to the conclusions of the IMRC reviewers, which are inaccurate or divergent from the clinical facts present and unsupported by a reasonable clinical review of the record. In addition, Compassus further disagrees with the substance and import of the finding that six (6) claims purportedly did not contain documentation in support of services. Compassus disagrees with the finding that the level of care furnished with respect to five (5) claims was not supported. Compassus also disagrees that it failed to comply with the Notice of Election filing requirements alleged by OIG in two (2) instances.

The specific responses to each clinical denial are contained in the attached appendix. **Attachment A.** In addition, several examples of when the IMRC reviewers arrived at incorrect clinical conclusions are set forth below.

⁴ *Id.* at 33.

⁵ *Id.* at 34.

OFFICIAL RESPONSE TO OIG DRAFT REPORT A-02-16-01023

I. INTRODUCTION: OVERVIEW OF COMPASSUS AND HOSPICE CARE

Compassus is a nationwide network of community-based hospice, palliative and home health care services. Founded in 2006, Compassus has grown to become the third-largest hospice provider in the nation with more than one hundred and forty (140) locations in over thirty (30) states. As a large provider of hospice care, Compassus is acutely aware that its hospice programs operate in a highly regulated environment. While high quality end-of-life care is its highest priority, Compassus programs also have a keen focus on appropriately documenting those services.

Compassus operates a freestanding hospice care center in Payson, Arizona ("Payson"). Payson serves hospice beneficiaries in Gila County, as well as a portion of Coconino County. At its Payson location, Compassus offers hospice and palliative care, including general inpatient care, respite care, spiritual care, physical and occupational therapy, dietary counseling, grief counseling, and hospice aides among other services. Payson employs two (2) hospice physicians (including its primary Medical Director) and a nurse practitioner, in addition to a full contingent of nursing staff, aides, social workers, chaplains, and volunteers.

Hospice care is a comprehensive suite of services identified and coordinated by a patient's attending physician (if the patient has elected one), hospice physician, and interdisciplinary group ("IDG") to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and their family members. As required by law, Payson has a valid Medicare provider agreement with CMS and meets the required hospice Conditions of Participation. According to CMS regulations, "terminally ill individuals" are patients with a medical prognosis including a life expectancy of six (6) months or less, if the disease runs its normal course. In order to be eligible for the hospice benefit under Medicare, a patient must be eligible for Part A benefits and be certified as terminally ill by a physician. Each patient is assessed by a hospice medical director for hospice eligibility, in consultation with the patient's attending physician (if the patient has one). When considering admission, medical directors assess the patient's terminal condition, other health conditions, and the clinically relevant information supporting each diagnosis. A medical director may obtain clinically relevant information directly or indirectly from the patient's attending physician and/or through hospice nurses' assessment of the patient and the patient's medical history, as well as other pertinent sources. For the initial ninety (90)-day certification period, the medical director (or a physician member of the IDG) and attending physician must both sign the written CTI ("CTI"); for each subsequent certification period the medical director (or a physician member of the IDG) may certify a patient's terminal status without conferring with the attending physician. Each CTI must be supported by the patient's condition as reflected in their medical records.

To satisfy these requirements, Compassus has implemented a comprehensive set of policies and procedures for determining clinical eligibility for hospice and effectuating admissions. For example, Compassus has developed a thorough process for conducting eligibility assessments that includes 1) receiving and processing a referral from a healthcare provider, patient, or patient's family/friend; 2) obtaining relevant medical records related to the certification of its physicians, 3) the physical assessment by a registered nurse and 4) the concurrence by the patient that they are terminally ill. Compassus's current clinical eligibility policy is set forth in **Attachment B**.

II. SUMMARY OF DRAFT REPORT FINDINGS

OIG selected claims submitted by Payson between January 1, 2014 and March 31, 2016 for its review. During this time, Payson submitted two thousand one hundred and fifty (2,150) claims for reimbursement for hospice care provided to five hundred (500) Medicare beneficiaries, for which Payson received a total of \$7,964,432. From these claims, OIG directed its physician contractors to review 100 random claims, seventy (70) of which the contractor asserted did not comply with one or more Medicare requirements. OIG then extrapolated the results of this sample, notwithstanding the individualized care and conditions of each patient, and estimated by extrapolation that Payson received \$4,447,426 to which it was not entitled.

OIG identified four (4) primary issues among Payson's claims:

- 1) Beneficiaries did not meet eligibility requirements (sixty (60) claims);
- 2) Claims were not supported by proper documentation (six (6) claims);
- 3) Reimbursement rates claimed were higher than beneficiaries required (five (5) claims); and
- 4) Notices of election were not timely filed with Payson's Medicare Administrative Contractor ("MAC"), National Government Services, Inc. ("NGS") (two (2) claims).

Three (3) of the claims were alleged to have more than one error. OIG asserted that while Payson had policies and procedures related to determining eligibility, they were not effective to ensure that the requirements were met and the appropriate level of care was provided. Moreover, although Payson had policies pertaining to Notices of Election, those policies did not specifically address the timely filing of these notices with the MAC. Finally, OIG asserts that Payson submitted claims without supporting documentation.

To remedy these issues, OIG made several recommendations. OIG recommended that Payson return overpayments received within the four (4)-year claims reopening period, use reasonable diligence to identify and return improper payments falling outside of the four (4)-year reopening period and the audit period in accordance with the "sixty (60)-day rule," and strengthen its procedures to ensure that Payson's hospice services comply with Medicare requirements.

III. ANALYSIS OF DRAFT REPORT

Compassus and its external advisors have reviewed the Draft Report. In addition, Compassus engaged two (2) separate independent reviews – one performed by a nationally recognized hospice consulting firm and the other by the Medical Director of a hospice program of an Ivy League university medical center. Compassus also evaluated its own policies and procedures related to the issues identified by OIG.

Compassus respectfully asks the OIG to consider the following related to its Draft Report findings:

- 1) Inconsistencies in analysis and approach of the IMRC Reviewers;
- 2) Compassus's Expert Review Methodology;
- 3) Compassus's Expert Review Findings;
- 4) OIG's Review and Credible Information;
- 5) Compliance Enhancements and Training;
- 6) Technical Documentation Issues; and
- 7) Use of Extrapolation.

1. Inconsistencies in the IMRC Reviewers Used by OIG

OIG furnished Compassus with confidential clinical summaries setting forth the determinations made by one or more Independent Medical Review Contractor ("IMRC") physicians, as well as coders in certain instances, of the one hundred (100) claims reviewed. Based on its own review, Compassus believes that the OIG's IMRC physicians applied inconsistent and erroneous clinical standards when deciding whether documentation supported a terminal prognosis.

Compassus was not provided with the OIG's IMRC physicians' curricula vitae or other biographical information. Compassus cannot, therefore, ascertain which of the available board certifications the IMRC physicians held in hospice and palliative medicine. Compassus' experts' review suggests, however, that the IMRC reviewers did not apply a reasonable approach to determine clinical eligibility for hospice services consistent with the legal requirements of the Medicare hospice benefit.⁶ The IMRC clinical review findings

⁶ See discussion *supra* at pp. 2-3.

also demonstrated a lack of consistency from summary to summary. As discussed in more depth below, the reviewers appeared to appropriately summarize the salient facts and medical conditions reflected each sampled record, but did not synthesize them into appropriate clinical conclusions. Accordingly, Compassus believes that OIG should consider the findings of Compassus's hospice clinical review experts included within the attachment hereto. Compassus believes its experts' opinions evidence a well-founded, "whole patient" approach to determining clinical eligibility from a desk-audit record review, and Compassus asks that OIG apply these findings to its final report.

2. Compassus Experts' Review Methodology

Compassus received initial information related to the OIG's audit findings in September 2018. [REDACTED], a nationally-recognized hospice auditing and consulting organization, was engaged at that time to review the pertinent hospice records. [REDACTED] utilizes a team of clinicians with substantial hospice-specific experience to review medical records and compare the contents of those records to applicable local coverage determinations ("LCDs") and other established hospice documentation guidelines. For this matter, the relevant records were reviewed by [REDACTED], RN, [REDACTED], RN, and [REDACTED], RN ("[REDACTED]"), whose resumes are included as **Attachment C**.

Compassus provided the reviewers access to the identical set of records submitted to the OIG. Thereafter, the [REDACTED] evaluated these records from two (2) perspectives: 1) whether the records contained appropriate documentation to meet the technical regulatory conditions of payment for Medicare hospice services and 2) whether the records contained appropriate documentation evidencing a patient's clinical eligibility for Medicare hospice services.

In addition, Compassus engaged [REDACTED], M.D., MBA, HMDC, FAAHPM, a physician and professor who specializes in hospice and palliative medicine at the Hospital of the University of Pennsylvania. [REDACTED] has substantial experience in both an academic setting and a practical setting related to hospice care. Since 2010, [REDACTED] has been both a practitioner and a professor of clinical and palliative medicine at various institutions, including Duke University and the University of Pennsylvania. In those roles, [REDACTED] was not only engaged in the day-to-day assessment of patients for determining terminal prognosis, but also undertook substantive clinical research projects as well as assessment of the Medicare program's coverage criteria for hospice care. Through these engagements, [REDACTED] has developed a strong understanding of Medicare's eligibility requirements for the terminally ill. [REDACTED] CV is included as **Attachment D**.

[REDACTED] conducted an independent clinical review of each of the patient's medical records for each of the claims that the IMRC reviewers determined was ineligible. [REDACTED] did not adopt [REDACTED] determinations, but rather conducted a separate independent

*** OIG Note:** The name of the organization hired by Payson to review hospice records, as well as the names of the individuals that reviewed the records have been redacted because they are personally identifiable information.

review of the clinical eligibility of each patient based on the documentation available. [REDACTED] determined whether the certification or recertification related to each claim at issue was reasonably supported by the documented clinical indicators.

3. Compassus Expert Review Findings

Both [REDACTED] and the [REDACTED] reviewed each of the claims that the IMRC reviewers determined did not qualify for Medicare payment. Importantly, for the two (2) claims (Patient 5 and Patient 76) for which the Compassus independent clinical reviewers determined did not support Medicare hospice clinical eligibility, Compassus effectuated a refund related to not only the claims under review, but additional periods outside of the review period. Compassus understands its obligations under the sixty (60)-Day Rule and after exercising reasonable diligence, it has or will appropriately refund identified overpayments.

Compassus hospice experts' findings illustrate that the substantial majority of the patients determined by the IMRC physicians to be not terminally ill were indeed eligible for the Medicare hospice benefit. Eighteen (18) of the patients met the requirements of the applicable LCD issued by National Government Services ("NGS"), Payson's Medicare Administrative Contractor ("MAC"). Moreover, although forty (40) patients did not squarely meet the applicable LCD, they each nevertheless exhibited a terminal prognosis that qualified them for the Medicare hospice benefit. LCDs in the hospice context are merely guidelines; patients can be (and often are) terminally ill without fully meeting corresponding hospice LCD elements.

[REDACTED] reviewed each of the sixty (60) claims at issue and determined that, for fifty-eight (58) out of the sixty (60), the certifying physician's prognostication that the individual was terminally ill was appropriate. This stands in stark contrast to the IMRC reviewers' determinations and several of their disagreements stood out, as summarized below.

- Patient 12 – Review Period in April 2014 - This was a seventy-nine (79) year old male patient with chronic obstructive pulmonary disorder (COPD), renal failure, dementia, and a significant number of falls. The patient was admitted to the Payson program in March 2014 and passed away less than 6 weeks later (on the last day of the review period) for a total hospice stay of forty-two (42) days. The IMRC reviewer detailed the relevant facts with accuracy, including that the patient scored a 50% on the Palliative Performance Scale ("PPS"), had an oxygen saturation level of 83% to 88% on room air, had shortness of breath at rest, disabling shortness of breath when walking more than ten (10) feet, and had increasing weakness, skin breakdown, and anxiety.

However, rather inexplicably, the IMRC reviewer concluded:

Review of the records indicated the patient did not meet criteria for end stage COPD and was receiving dialysis for his ESRD. Therefore, a less than six month prognosis was not established. The patient did have anxiety and depression that required intervention and assessment. However, there are a variety of services available to treat anxiety and depression for patients who do not meet criteria for hospice.

It appears that there is a significant disconnect between the IMRC reviewer's findings and his or her conclusions. To be clear, this patient was admitted to hospice care one and a half (1.5) months before his death, which was directly the result of his primary diagnosis. The patient's hospice eligibility and terminal condition is unrelated to anxiety and depression. The IMRC reviewer's suggestion that "there are a variety of services available to treat anxiety and depression" for non-hospice patients is an irrelevant statement and in no way justifies that IMRC doctor's conclusion that this patient was not eligible for the Medicare hospice benefit. The IMRC reviewer reviewed the record entries for the *very last day of this patient's life* and yet still somehow concluded that a "less than six month prognosis was not established."

This is not a case that [REDACTED] or, in all likelihood, any credible hospice physician conducting a careful review would be ambivalent about. [REDACTED] agreed with the IMRC reviewer's findings and further noted that the patient's Body Mass Index ("BMI") was a 17, which suggests frailty in a patient of this age and condition. The patient's COPD was advanced and increasing daily and it was appropriate for Compassus to admit the patient and furnish end of life hospice care.

Finally, should a MAC ultimately decide to reopen any of Payson's claims, this claim falls outside of the four (4)-year reopening period.

- Patient 23 – Review Period in June 2014 – This was an eighty-six (86) year old male with a primary diagnosis of end-stage heart disease. The patient was classified as a New York Heart Association ("NYHA") Stage IV, with significant weight loss (eight (8) pounds) from one recertification period to the next. The patient reported significant pain and a decrease in PPS to 40% with symptoms at rest. Notably, the patient passed away just twenty-seven (27) days after the period at issue.

Again, the IMRC reviewer identified with accuracy the patient's relevant clinical conditions, including the fact that the patient passed away soon after the review period, but came to an unsupported conclusion the patient was not terminally ill:

Review of the records indicated the patient did not meet the criteria for end stage heart disease. The patient was classified as end stage heart disease but did not use continuous oxygen, had a PPS of 50-60% throughout the hospice services and had little change in status from each certification period. The patient's pain and shortness of breath were well controlled and did not require frequent interventions or medication changes. The patient's symptoms were well managed. Hospice was not medically reasonable.

The fact that the hospice managed the patient's symptoms well does not vitiate that the patient was terminally ill. The IMRC reviewer references a clinical requirement of "continuous oxygen," but this is not part of the LCD guidelines and is not a primary indicator for terminality in congestive heart failure patients. Even if it were, this patient was in fact on supplemental oxygen – when the supplemental oxygen was removed, the patient's oxygen saturation level decreased to 95% within twenty (20) minutes. Similar to Patient 12's analysis, the IMRC reviewer's factual summary clearly supports a terminal prognosis, but his or her conclusion wildly contradicts those factual findings. [REDACTED] identified that the patient was appropriately classified as NYHA IV with substantial weight loss and worsening shortness of breath. These clinical indicators support a terminal prognosis, which ultimately turned out to be accurate one month later.

Finally, should a MAC ultimately decide to reopen any of Payson's claims, this claim falls outside of the four-year reopening period.

- Patient 26 – Review Period in July 2014 – This was a female patient aged 90 or older with a primary diagnosis of metastatic lung cancer. She was admitted to hospice in April 2014 after meeting with her oncologist, who indicated that the patient's chemotherapy treatment was no longer effective and the patient was suffering from worsening symptoms of shortness of breath, fatigue and cough secondary to lung cancer. The patient lost thirty-two (32) pounds from her admission weight during the certification period, reported pain in her ribs and chest, and had blood-tinged sputum with her cough. By all accounts, including that of the IMRC reviewer, the patient was on a rapidly declining trajectory. Nevertheless, the IMRC reviewer asserted that:

Review of the records indicated the patient had a stable course and did not have a prognosis of six months or less. The patient should not have been recertified to hospice services. She remained a 60% to 70% on the PPS and required minimal assistance with ADLs. She was not declining and there were not any symptom management issues in the documentation provided. Hospice care was not medically necessary.

This is factually untrue. The patient's course was not stable but rather continually worsened during the period under review, including a 24% weight loss. While her PPS was 70% on admission, this is standard in cancer patients except when they are imminently dying. In fact, the LCD issued by NGS suggests clear eligibility for terminal cancers when a patient has a PPS of 70% or less, the cancer has progressed to a metastatic phase, and the patient declines further intervention. In addition, the patient's PPS declined to 60% during the second certification period, which was in the middle of the review period. [REDACTED] determined that the patient continued to lose weight and was increasingly unable to perform Activities of Daily Living (ADLs). Though the patient did not ultimately pass away until 10 months from the period under review, her condition squarely met the relevant LCD guidelines from her admission until her passing. The certifying physician believed the patient was terminally ill, [the patient's oncologist believed the patient was terminally ill and qualified for hospice, the hospice IDG team who cared for the patient believed that the patient was terminally ill, but the IMRC physician, based upon a narrow and legally unsupported view that a precipitous clinical decline is necessary to qualify for hospice, somehow concluded hospice care was not medically necessary. The OIG should not credit such a clearly erroneous conclusion.

Finally, should a Medicare Administrative Contractor ultimately decide to reopen any of Payson's claims, this claim falls outside of the four-year reopening period.

- Patient 81 – Review Period in October 2015 – This was an eighty-four (84) year old woman with end-stage heart disease, as well as several strokes (cardiovascular accidents) before and during the time of hospice care. She was admitted in July 2015 and passed away in November 2015, one month after the review period. The patient was on hospice for a total of four (4) months.

The patient was an NYHA Class IV with a PPS of 40%. She slept 95% of the time, used significant supplemental oxygen, and needed assistance with all ADLs. Even with the additional oxygen, her oxygen saturation level was typically around 80%, indicating a severely hypoxic condition. The patient had a stroke prior to hospice care, which caused her to be effectively non-verbal and suffer from dysphagia. She had another stroke during the review period, which caused right-sided limpness, slurred speech, and an inability to ambulate whatsoever. Despite this clinical presentation, the IMRC reviewer concluded:

Review of the records indicated that the patient did not require hospice level of care. While the patient had a PPS score of 40%, her weight remained stable. The patient was eating meals when fed and had no aspiration events. Her prognosis reasonably was not six (6) months or less.

Aspiration is an irrelevant factor in end-stage heart disease patients and, though the patient was not losing weight, other clinical indicators of terminality were accelerating. The IMRC reviewer's use of a single element of the patient's presentation (one which is not part of the LCD) is misleading and does not invalidate the patient's terminal condition. The relevant NGS LCD states that the terminal stage of heart disease is identified by the patient having already been treated for heart disease and are NYHA Class IV. Supporting symptoms include arrhythmias, history of cardiac arrest, history of "unexplained syncope," or brain embolism of cardiac origin. Importantly, the IMRC reviewer specifically summarized that the patient was NYHA Class IV and had "unexplained syncope." [REDACTED] concurred with the IMRC reviewer's findings about the patient's status, but disagreed that these did not suggest a terminal prognosis. As noted, the patient passed away in November 2015, less than a month following the end of the review period.

This is another instance where the IMRC reviewer appears to find the relevant clinical factors that would make a patient terminally ill, but then concludes based on the presence or absence of wholly unrelated factors that the patient is not terminally ill. Whether this is due to clerical error or clinical misunderstanding, it results in highly erroneous conclusions that the OIG should not adopt in its final report.

- Patient 99 – Review Period in March 2016 – This was a male aged 90 years or older admitted for congestive heart failure. The patient was on hospice services for only ten (10) days before passing away in early April 2016. The patient had previously been admitted to a hospital in March 2016 for congestive heart failure. Upon admission, the patient was a NYHA Class IV, had mild to moderate dyspnea on exertion, with significant pitting edema in both legs. Although the patient could ambulate, he was largely chair-bound and had supplemental oxygen as needed. During the period, the patient exhibited increasing shortness of breath. Despite the patient's significant symptoms and limited time on hospice service, the IMRC reviewer asserted that:

Review of the records indicated the patient was not eligible for hospice care and received routine treatment for chronic illness. His illness did not follow a terminal arc. The patient had an ejection fraction of 45%. This does not carry a prognosis of six (6) months or less. The PPS was 50% and FAST score was only 3. The patient had only mild dyspnea with exertion. There was no evidence of other major co-morbidity. Symptom management did not require hospice care.

The IMRC reviewer's assessment that the illness did not follow a terminal arc is not only undermined by the fact that the patient passed away in ten (10) days from

hospice admission, but also that the patient's clinical presentation in March 2016 clearly supported terminal prognosis. The IMRC reviewer concedes that the patient was an NYHA Class IV and had significant comorbidities. He had just been admitted to the hospital for congestive heart failure and exhibited signs of cardiopulmonary dysfunction, including shortness of breath, low oxygen saturation, and pitting edema (which demonstrates that the heart was not pumping forcefully enough to move fluid throughout the patient's body). A FAST score is entirely irrelevant in a congestive heart failure patient and a specific PPS is not included in the LCD guidelines. While the patient's ejection fraction of 40-50% was higher than the 20% anticipated in the LCD, that is not the only indicator of heart function – the patient's significant pitting edema, in addition to the patient's recent admission related to heart pain and shortness of breath, fully demonstrates the inability of this patient's heart to function properly. Additionally, although not mentioned by the IMRC reviewer, the patient had an irregular heartbeat (arrhythmia), which is a supporting clinical indicator in the LCD. Again, ██████████ agreed with many of the IMRC reviewer's clinical indicators, but not his or her conclusion as to the patient's terminal illness.

The IMRC's approach to these and other patients in the sample is concerning to Compassus. The OIG has asserted significant liability against the Payson program as a result of this review. These IMRC reviewers' errors are exaggerated by OIG's potential use of extrapolation. The OIG should closely scrutinize the work of the IMRCs because it appears that there are significant misunderstandings of hospice eligibility or misapplications of the hospice clinical guidelines. In either case, the OIG should substantially revise its Draft Report to reflect that, in all but two instances, the patients at issue were clinically eligible for the Medicare hospice benefit.

Additionally, Compassus experts' reviews disagreed with each instance where the IMRC reviewers asserted that Compassus provided a higher level of care than was warranted by the patient's condition. In each of these instances, the patients were suffering from acute exacerbations of symptoms that could not have been effectively managed outside of a facility setting. When the patients' symptoms were resolved and it was safe and medically appropriate to change the patients' level of care, Compassus did so. Accordingly, OIG should revise its findings in the Draft Report that there were instances where the services provided exceeded the level of care necessary.

4. OIG's Review and Credible Information

As noted above, Compassus is keenly aware of the requirements under the 60-Day Rule, which generally require a provider to report and return any identified overpayment within 60 days of identification and calculation. As further expanded by CMS regulations in 2016, the 60-Day Rule directs that providers with credible information of a potential overpayment should engage in reasonable diligence to determine if an overpayment exists. Determinations from the Federal government, such as MAC reviews or the OIG's pending

audit here, may constitute “credible information” that gives rise to a provider’s obligation to engage in reasonable diligence. The Payson OIG review results have prompted Compassus to do just that with a careful review of the Payson program’s technical documentation, policies and procedures, as well as a detailed clinical review conducted by several independent hospice experts. For the reasons noted above, Compassus fundamentally disagrees with the findings of the IMRC physicians, but finds its own expert reviewers’ findings compelling, especially now in light of the *AseraCare* decision.

5. Compliance Enhancements and Training

Although Compassus did not uncover any systemic compliance issues at its Payson program from either a clinical or technical documentation standpoint, Compassus engages in regular compliance program assessment, with enhancements developed as appropriate. These include regular compliance training, internal audits, and corrective actions for detected compliance shortcomings.

6. Technical Issues

OIG identified limited technical documentation deficiencies during the course of its review. Specifically, OIG asserted two (2) instances where a patient’s Notice of Election (“NOE”) form was not timely submitted in accordance with regulations.

The regulation requiring the submission of the NOE within five (5) days of the patient’s admission went into effect on October 1, 2014, which is in the middle of the OIG’s audit review period. This requirement was originally scheduled to be effective April 1, 2014, but CMS permitted hospices until October 1, 2014 to effectively implement this requirement. It appears that the IMRC reviewers misunderstood, as they denied a number of claims on the basis that an NOE was not timely uploaded and filed:

- 1) Patient 14 (4/22/14 – 4/30/13);
- 2) Patient 24 (6/2/14 – 6/30/14);
- 3) Patient 27 (7/1/14);
- 4) Patient 38 (9/28/14 – 9/30/14);
- 5) Patient 39 (9/10/14); and
- 6) Patient 41 (10/1/14 – 10/31/14).

In five (5) of these six (6) instances, the review period is before the NOE filing requirement was enforced. It is unclear to us why OIG Draft Report asserted that only two of these instances were non-compliant. Compassus presumes that OIG identified two instances because those services spanned the NOE regulation effective date (October 1, 2014). However, in both instances, the patients were admitted to hospice prior to the NOE regulation effective date. Patient 38 was admitted on September 28, 2014 and died on October 6, 2014. Patient 41 was admitted to hospice on September 26, 2014. In both cases, the admission was completed prior to the NOE rule effective date and, therefore, there is no basis for Payson to have filed the additional form. Subsequent to the NOE effective date, Compassus had no instances of admissions with late NOE filing. Compassus investigation into this issue did not reveal a systemic concern about the timely filing of the NOE.

7. Extrapolation

OIG appeared to use its standard methodology to extrapolate the results of the clinical audit to all of the claims submitted by Payson within the time period under review. Though Compassus has not reviewed and are not commenting on the legitimacy and accuracy of OIG's extrapolation methodology, OIG should forgo extrapolation for two (2) reasons.

First, in accordance with CMS's recent revisions to its extrapolation procedures in the case of Medicare audits, the clinical review findings do not reflect a high or sustained level of payment error for which extrapolation is justified. And second, Payson was not subject to Medicare audits prior to the OIG audit and thus extrapolation is not appropriate.

IV. **RESPONSE TO RECOMMENDATIONS**

In the Draft Report, OIG gave four (4) recommendations. Compassus concurs in part with two (2) of the recommendations and disagrees with two (2) recommendations. Compassus's specific concurrence or nonconcurrence is set out below.

1. *Compassus should refund to the Federal Government the portion of the estimated \$4,447,426 for hospice services that did not comply with Medicare requirements and that are within the 4-year claims reopening period.*

Compassus disagrees insofar as it does not believe it was overpaid for hospice services that are within the four (4)-year claims reopening period (except for the limited instances where a refund has already been initiated). Compassus disagrees with OIG's outside IMRC in virtually every instance where the outside contractor determined that the services did not comply with Medicare requirements.

2. *Compassus should exercise reasonable diligence to identify and return improper payments in accordance with the 60-day-rule for the remaining portion of the*

estimated \$4,447,427, which is outside of the 4-year claims reopening period, and identify any returned improper payments as having been made in accordance with this recommendation.

Compassus concurs with this recommendation insofar as exercising reasonable diligence to identify and return improper payments identified for the claims reviewed by OIG's external consultant. Compassus has effectuated repayments for any claims that, as a result of its external review, were determined to be overpayments, irrespective of whether they were within or outside of the four (4)-year claims reopening period. Although Compassus did determine that certain limited claims were not eligible for Medicare payment, Compassus did not identify any systemic issues that would compel Compassus to conduct additional reviews at its Payson hospice program.

3. *Compassus should exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.*

Compassus concurs with this recommendation insofar as it has ongoing responsibilities to repay identified overpayments in accordance with statutory and regulatory requirements. As noted above, Compassus has exercised reasonable diligence with respect to the issues raised by OIG and has not identified any additional Medicare overpayments or systemic issues arising from the OIG audit. Compassus continues to conduct frequent auditing at its Payson program in accordance with its compliance policies and procedures.

4. *Compassus should strengthen its procedures to ensure that hospice services comply with Medicare requirements.*

Compassus disagrees with this recommendation because it believes its procedures are sufficiently strong to ensure that hospice services comply with Medicare requirements. As the independent expert's review demonstrated, the vast majority of the claims reviewed by OIG complied with Medicare requirements. Compassus Payson's procedures are consistent, timely and appropriate both with regard to the initial admission process and recertifications. However, Compassus reviews and updates its policies and procedures from time to time to ensure compliance with regulatory requirements and appropriate clinical standards. Compassus has a dedicated team of hospice and compliance professionals to develop, implement, and train staff on its compliance and clinical operations.

V. CONCLUSION

Compassus, through its counsel, appreciates the opportunity to provide the comments to the OIG for its consideration and inclusion in its final audit report. Compassus respectfully

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requests that OIG consider the information contained in the comments herein and the corresponding appendices and modify its Final Report findings accordingly.

Sincerely,

/Howard J. Young/

Howard J. Young

Enclosures