State of New Jersey
Office of the State Comptroller
Medicaid Fraud Division

AUDIT REPORT
CARE ALTERNATIVES OF NEW JERSEY, LLC

PHILIP JAMES DEGNAN
STATE COMPTROLLER

March 16, 2017

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I. Executive Summary

The Office of the State Comptroller's Medicaid Fraud Division (OSC) engaged in an audit of Care Alternatives of New Jersey, LLC[1] (Care Alternatives) to determine whether hospice claims it submitted for the operative period were in compliance with applicable state regulations. OSC performed the audit as part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid). The audit entailed a review of clinical files for a sample of 11 Medicaid-only recipients[2] to determine whether the hospice services billed by Care Alternatives for these recipients were supported by medical records and whether Care Alternatives satisfied the applicable Medicaid documentation requirements.

Based on its audit findings, OSC seeks to recover payments for 53 hospice claims for 7 recipients totaling $153,095.[3] This recovery is based on a combination of documentation failures, all of which constitute violations of applicable regulations. The issues found include Care Alternatives': a) failure to maintain physician certifications that satisfied Medicaid regulations; b) improper submission of claims for both routine and continuous hospice services provided on the same day for the same recipient; c) billing for hospice services after such services were terminated; and d) submission of claims for a recipient who, during the period of such claims, was withdrawn (revoked) from hospice services.

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[1] In July 2014, Care Alternatives, LLC was renamed Ascend Hospice.

[2] 61 recipients were originally selected for review. 50 of those 61 recipients were eligible to receive both Medicare and Medicaid benefits (dual eligible). Only 11 of the 61 sampled recipients who received hospice services during the audit period were solely Medicaid eligible, which is why this audit involves the clinical files for only those 11 recipients.

[3] Although the audit identified $155,168 in claims attributable to documentation failures, because $2,073 of that amount was not paid to Care Alternatives, the overpayment amount sought from Care Alternatives has been reduced by $2,073.

OSC provided a draft copy of this report to Care Alternatives for review and comment. Their comments are attached as Appendix B.

II. Background

Care Alternatives is a hospice provider located in Cranford, New Jersey. The facility enrolled in the Medicaid program effective July 1, 1995. Care Alternatives provides hospice services to recipients in nursing facilities, private residences, assisted living facilities, and hospitals, with the vast majority of services provided to recipients in nursing facilities.

III. Objective

The objective of the audit was to evaluate hospice claims billed by Care Alternatives to determine whether Care Alternatives complied with applicable Medicaid documentation requirements as prescribed under state regulations.

IV. Scope

OSC reviewed Care Alternatives' claims for Medicaid recipients to determine whether the hospice services billed by Care Alternatives were supported by the appropriate documentation for the operative period from January 1, 2008 through December 31, 2010. To achieve the audit objective, OSC attempted to ascertain whether Care Alternatives billed Medicaid in compliance with applicable Medicaid documentation requirements prescribed by state regulations. The specific regulations can be found as Appendix A to this report. The audit was conducted under the authority of *N.J.S.A.* 52:15C-1 *et seq.* and the Medicaid Program Integrity and Protection Act, *N.J.S.A.* 30:4D-53 *et seq.*

V. Audit Methodology

OSC's audit methodology consisted of the following:

- Sampled selection of hospice recipients;
- Reviewed Care Alternatives' clinical records to determine that hospice services were rendered;
- Evaluated the timeliness of hospice physician certifications and corresponding billing;
- Reviewed hospice billings for services that were withdrawn and reinstated in the same benefit period;
- Reviewed hospice billings for services for periods beyond the hospice termination date;
- Reviewed hospice billings for prohibited, overlapping hospice services such as routine and continuous care; and
- Reviewed file documentation to ascertain the existence and completeness of required hospice medical record forms (*e.g.*, FD-380 - Representative Statement for the Election of Hospice Benefits, FD-381 - Revocation of Hospice Benefits, FD-385 - Physician Certification/Recertification for Hospice Benefits).

VI. Audit Findings

A. Review of Physician Certifications – Missing and Late Certifications

OSC identified 4 Medicaid recipients, with 39 claims totaling $150,585, where Care Alternatives was paid for hospice care and/or room and board but a "Physician Certification/Recertification for Hospice Benefits Form" (Form FD-385) was either missing or submitted late. Of the 39 claims, 26 claims totaling $105,688, did not have a Form FD-385 on file and the remaining 13 claims, totaling $44,896, had Form FD-385 that was signed beyond the grace period when the form is required to be completed. The applicable regulation, *N.J.A.C.* 10:53A-3.1, referencing *N.J.A.C.* 10:53A-2.3, requires the completion of Form FD-385 within two days after

hospice service is initiated and allows a grace period of up to eight days for a written certification. *N.J.A.C.* 10:53A-2.3 requires hospice providers to retain Forms FD-385.

Due to the missing and late certifications noted above, OSC is seeking the recovery of $150,585 for 39 claims for 4 recipients.

B. Inappropriate Billing of Routine and Continuous Care on the Same Day

OSC identified one recipient for whom Care Alternatives improperly billed Medicaid simultaneously for both routine care and continuous care for 10 claims during a 9-day period. Pursuant to *N.J.A.C.* 10:53A-4.2(b)(1)(i), a hospice is not permitted to bill for different levels of hospice care with different intensities and durations, for the same recipient, for the same days. Consequently, OSC seeks to recover $1,497 for these claims.

C. Inappropriate Billing Beyond the Hospice Termination Date

OSC identified two recipients with two paid claims totaling $1,013 where Care Alternatives billed Medicaid for hospice room and board for dates that extended beyond the termination dates of hospice services. OSC seeks to recover $1,013 because these recipients were either deceased or terminated from hospice services during the periods covered by these claims. Thus, the claims billed were not consistent with *N.J.A.C.* 10:53A-2.5, which disallows hospice reimbursement for claim dates after the termination of such services.

D. Revocation and Reinstatement of Hospice Services Not in Compliance with Regulations

OSC identified one recipient, with two paid claims totaling $2,073, who had withdrawn from and subsequently reinstated hospice services before the end of the same benefit period. OSC seeks to recover these claims because they are inconsistent with *N.J.A.C.* 10:53A-3.3(d), which prohibits payments for hospice services when a recipient chooses to withdraw from hospice services

or decides that hospice services are no longer required for the remainder of a given benefit period. Because OSC seeks a recovery for this recipient for the same claims already included under Audit Finding A above, no additional recovery is being sought in this instance.

VII. Recommendations

A. Care Alternatives must repay $153,095 to the Medicaid program for claims that did not comply with state regulations.

B. Care Alternatives must strengthen its processes for billing hospice services rendered to Medicaid recipients by developing procedures that will:

1. Ensure that physician certifications are completed as required by Medicaid regulations and maintained on file;

2. Discontinue billing routine and continuous care for the same recipient on the same dates;

3. Discontinue billing for room and board services beyond the hospice termination date; and

4. Discontinue billing for any portion of time that a recipient has withdrawn from hospice care, in the event that recipient later reinstates hospice services during the same benefit period.

Office of the State Comptroller – Medicaid Fraud Division

Hospice Regulations - New Jersey Administrative Code

***N.J.A.C.* 10:49-9.8, Provider certification and recordkeeping, providing, in part:**

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of 5 years from the date the service was rendered;
2. To furnish information for such services as the program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;
4. That the services billed on any claim and the amount charged therefore, is in accordance with the requirements of the New Jersey Medicaid and/or NJ FamilyCare programs;
5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and
6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

***N.J.A.C.* 10:53A-2.6, Recordkeeping, providing, in part:**

(a) The medical record of the hospice beneficiary maintained by the hospice shall be complete and accurate and reflect the services provided. The medical record shall include, at a minimum, the following information:

1. Identification information;
2. Certification/recertification documents;
3. Informed consent documents;
4. Election forms;
5. Hospice eligibility forms;
6. Pertinent medical history and physical examination data;
7. Test results;
8. Initial and subsequent assessments;
9. Plan of care and updates; and
10. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

(b) All medical records shall be signed and dated by the professional staff person providing the service.

(c) The medical record shall be maintained and made available, as necessary, to the Division of Medical Assistance and Health Services or its agent for audit and review purposes in accordance with State law (see N.J.S.A. 30:4D-12 and N.J.A.C. 10:49-13.1)

***N.J.A.C.* 10:53A-3.3, Benefit periods, providing, in part:**

(d) Revocation of election of hospice services shall be as follows:

1. The beneficiary may choose at any time to institute a "break" (a time period when care other than hospice care is given) between benefit periods or by a revocation of hospice services.
2. The Election of Hospice Benefits Statement, FD-378 shall be considered to be valid through subsequent benefit periods if there is no "break" in care.
3. A new Election of Hospice Benefits Statement, FD-378 is required to be filed following a break or revocation of hospice service.
    i. The beneficiary or his or her representative shall file a signed statement with the hospice provider that indicates the beneficiary revokes the election for Medicaid/NJ FamilyCare FFS coverage of hospice services for the remainder of the election period with the date that the revocation is to be effective.
    ii. When revoked, the beneficiary forfeits hospice services for any remaining days in the benefit period. A beneficiary may not receive hospice services later than the effective date that the revocation is signed.
    iii. The hospice shall immediately notify the agency that determined hospice eligibility (either CBOSS, DYFS or the MACC) of the revocation of hospice, verbally if possible, and also by filling out and submitting the Hospice Eligibility Form, FD-383 (5/01) to the eligibility source (CBOSS, MACC or DYFS, as applicable) so that the beneficiary's hospice eligibility may be terminated. The hospice shall also fill out the Termination of Hospice Benefits, FD-382 (Form #5 in the Appendix, incorporated herein by reference) and retain this form in the beneficiary's medical record.

***N.J.A.C.* 10:53A-2.5, Administrative policy for admission and discharge from room and board services in a nursing facility, providing, in part:**

(b) If the beneficiary residing in an NF chooses hospice benefits, the NF shall submit to the fiscal agent, a completed Long Term Care Turnaround Document (TAD) (MCNH-117) (Form #11 in the Appendix herein incorporated by reference) to remove the beneficiary from the Long-Term Care Facility billing system. The following information shall be placed on the MCNH-117 in the REMARKS column (Field #38 on the bottom):

"DISCHARGED FROM NURSING FACILITY TO HOSPICE"

1. The hospice beneficiary is removed from the Long Term Care Facility billing system effective on the date the Election of Hospice Benefits Statement, FD-378 (Appendix Form #1) is signed. On that date and thereafter, the Medicaid/NJ FamilyCare fiscal agent will directly reimburse the hospice for services rendered to the hospice beneficiary and the NF will no longer be reimbursed for care beginning this date. The hospice shall be responsible for reimbursing the NF for room and board services provided under contract with the hospice.

2. If the beneficiary revokes hospice and returns to NF care, the NF Shall complete and submit the Long Term Care Turnaround Document (TAD) (MCNH-117) form to the fiscal agent. The following information shall be placed on the MCNH-117 in the REMARKS column (Field #38 on the bottom):

"ADMITTED TO NURSING FACILITY AND DISCHARGED FROM HOSPICE"

3. The effective date of the change from hospice care to NF care is the Date the Revocation of Hospice Benefits, FD-381 (Form #4 in the Appendix incorporated herein by reference) is signed. The NF will be reimbursed for care provided on this date and thereafter, and the hospice will no longer be reimbursed for care beginning on this date.

***N.J.A.C.* 10:53A-4.2, Basis of Payment – Hospice Services, providing, in part:**

b) The rules regarding the reimbursement for each level of care related to the per diem are described below:
    1. The hospice is reimbursed at the routine home care rate for routine nursing services, social work, counseling services, durable medical equipment, medical supplies and equipment, drugs, biologicals, home health aide/homemaker services, physical therapy, occupational therapy, and speech-language pathology services. The "routine home care rate" is also reimbursed to the hospice for home care provided continuously that is not predominately nursing care and includes respite care delivered in the home.
        i. The "routine home care rate" is reimbursed when the beneficiary is not receiving "continuous home care rate" regardless of the volume and intensity of routine home care services.

***N.J.A.C.* 10:53A-3.1, Eligibility for covered hospice services, providing, in part:**

(c) In addition to financial eligibility, the individual applying for Medicaid/NJ FamilyCare FFS hospice eligibility shall meet the following conditions:
    1. He or she shall voluntarily elect the hospice services (see N.J.A.C. 10:53A-3.2);
    2. If eligible for Medicare, he or she shall elect his or her Medicare Part A Benefits for hospice care. For dually eligible Medicare and Medicaid hospice beneficiaries, the hospice benefits election applies simultaneously under both the Medicare and Medicaid programs. Thus, Medicare is responsible for the payment of claims for services provided, as first payer of the hospice benefit. Medicaid is responsible for payment for services not covered under the Medicare hospice benefit when those services are Medicaid covered services, such as any co-payment, co-insurance deductibles, if applicable, and those Medicaid covered services listed in N.J.A.C. 10:53A-3.4(g).
    3. He or she shall be certified or recertified as terminally ill by the Attending physician (see N.J.A.C. 10:53A-2.3) and be certified by the attending physician that hospice services are reasonable and necessary for the palliation or management of the terminal illness or related conditions by the completion of the Physician Certification/Recertification for Hospice Benefits Form FD-385 (6/92). A copy of this form shall be part of the medical record at

the hospice agency;

***N.J.A.C.* 10:53A-2.3, Physician certification and recertification**

(a) The hospice shall follow these policies and procedures to obtain physician certification of the applicant's terminal illness and to certify that hospice services are reasonable and necessary for the palliation and management of the terminal illness or related conditions.

1. The attending physician, who must be a doctor of medicine (M.D.) or osteopathy (D.O.), is the one identified by the Medicaid/NJ FamilyCare FFS beneficiary at the time the beneficiary elects to receive hospice services as the primary physician in the determination and the delivery of the beneficiary's medical care.
2. The written Physician Certification/Recertification for Hospice Benefits Form, FD-385 (Form #8 in the Appendix incorporated herein by reference) shall be obtained within two calendar days after hospice care is initiated for the first period of hospice coverage.
    i. If the hospice does not obtain written certification within two Days after the initiation of hospice care, a verbal certification may be obtained within these two days and a written certification no later than eight calendar days after care is initiated. If these requirements are not met, no payment can be made for any days prior to the certification.
    ii. The signing of the written form shall be done by the hospice Medical Director, or physician of the interdisciplinary team and the attending physician (if the applicant has an attending physician), and shall include the statement that the applicant's medical prognosis is such that the life expectancy is six months or less.
3. If the hospice beneficiary revokes the hospice benefit package and then reenters the hospice in any subsequent period, the hospice shall obtain, no later than seven calendar days after the beginning of that period, a written Physician Certification/Recertification for Hospice Benefits Form, FD-385 prepared by the Medical Director of the hospice or the physician member of the hospice's interdisciplinary group.
4. For subsequent recertifications, a written recertification must be obtained no later than two business days after the period begins (after the first 90-day benefit period, after the next 90-day benefit period, and after each subsequent 60-day period). The Medical Director of the hospice or physician member of the interdisciplinary team shall recertify that the individual is terminally ill and that hospice services are reasonable and necessary for the palliation and management of the terminal illness or related condition, and, in addition, recertify the necessity of the continuing need for hospice services.
5. In addition, the individual's attending physician is required to recertify the terminal illness for each subsequent 60-day benefit period, as described below:
    i. An additional Physician Certification/Recertification for Hospice Benefits Form, FD-385 must be obtained prior to each subsequent 60-day period but no later than two days after the period begins.
6. The hospice must retain the Physician Certification/Recertification for Hospice Benefits Form(s), FD-385 on file for review by the Division in the beneficiary's medical record.

Ascend Hospice

January 25, 2017

Mr. Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division
Trenton, NJ 08625-0025

Re: Care Alternatives of New Jersey, LLC
Response to Draft Audit Report

Dear Mr. Lichtblau:

Care Alternatives of New Jersey d/b/a Ascend Hospice ("Ascend Hospice") has reviewed the Draft Audit Report from your office, which was dated December 22, 2016.

Ascend is committed to compliance. As you know, this audit began in May 2014. The claims at issue were for dates of service ranging from December 2007 to November 2010. Ascends compliance program proactively made a number of changes to its procedures and policies in the past 6-7 years to ensure compliance with all Medicaid regulations. While Ascend strongly disagrees with the findings in the Draft Audit Report, in order to avoid further proceedings, Ascend agrees to repay $153,095 identified in the draft audit report.

Attached please find the Plan of Correction which addresses the recommendations in the Draft Audit Report. We note that these many of these processes have been in place for several years.

If you have any questions regarding this response, please call me at 508-229-8390 or by email at janet.bahl@ascendhealth.com.

Sincerely,

Janet Bahl, VP Clinical Operations

cc: Michael Morgese, Audit Supervisor
Dawnmarie R. Matlock, Esq., Alston & Bird

APPENDIX B

Ascend Hospice New Jersey

RE: Draft Audit Report, Compliance with Applicable Medicaid Regulations

January 23,2017

Plan of Correction

Area of Deficiency- details/ regulations potentially to be cited	Plan of Correction with outcomes expected	Responsible party for ensuring implementation	Dates of expected/ anticipated completion
Missing and late "Physician Certification/Recertification for Hospice Benefits Form" FD-385	Until 100% compliance is achieved the agency will: Review all admission documents for completeness inclusive of FD-385 Once faxed/submitted, the 385 will be scanned into EMR Clinical Director to participate with billing department on weekly review of compliance documents necessary for billing.	New Jersey Ascend agency Executive Director/Clinical Director	Anticipated completion by 2/28/17 & ongoing

Area of Deficiency- details/ regulations potentially to be cited	Plan of Correction with outcomes expected	Responsible party for ensuring implementation	Dates of expected/ anticipated completion

APPENDIX B

Simultaneously billing for routine and continuous care on the same dates	Clinical Director/Clinical managers alert billing department when a change in LOC is ordered. Clinical Director attends weekly billing errors report call with the billing department to review all paperwork for compliance prior to billing	New Jersey Ascend agency Clinical Director/ Executive Director/ Billing department	**Implemented 12/2016 & completed & ongoing**

Area of Deficiency- details/ regulations potentially to be cited	Plan of Correction with outcomes expected	Responsible party for ensuring implementation	Dates of expected/ anticipated completion
Billing beyond the hospice termination date	All departments are notified when hospice patient expires and Suncoast EMR is updated with the correct date of death 100 % of all death records are audited monthly for compliance re billing and documentation	NJ agency Clinical Director/ Executive Director	**Implemented 12/2016 & completed & ongoing**

APPENDIX B

Area of Deficiency- details/ regulations potentially to be cited	Plan of Correction with outcomes expected	Responsible party for ensuring implementation	Dates of expected/ anticipated completion
Revocation 7 Reinstatement of hospice services	The agency will promptly submit FD-382: Termination of Hospice Benefits & retain the form by scanning into the EMR Form FD-383 will be promptly be submitted so the beneficiary's hospice eligibility will be terminated The hospice agency will promptly notify the billing department of the date of revocation	Agency Clinical Director/designee	Implemented & completed 12/2016 & ongoing

State of New Jersey

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Appendix C

AUDIT REPORT OF CARE ALTERNATIVES OF NEW JERSEY, LLC

Comptroller's Notes on Care Alternatives' Response

Care Alternatives' Response: In its written response, Care Alternatives (d/b/a Ascend Hospice) stated that "[t]he claims at issue were for dates of service from December 2007 to November 2010. Ascend[']s compliance program proactively made a number of changes to its procedures and policies in the past 6-7 years to ensure compliance with all Medicaid regulations. While Ascend strongly disagrees with the findings in the Draft Audit Report, in order to avoid further proceedings, Ascend agrees to repay $153,095 identified in the draft audit report."

Care Alternatives' response also included as an attachment a Corrective Action Plan "which addresses the recommendations in the Draft Audit Report." Care Alternatives noted "that many of these processes have been in place for several years."

Comptroller's Comments: Although Care Alternatives/Ascend stated that it strongly disagreed with the audit findings, it did not provide any documentation or other information to support its disagreement. Instead, Care Alternatives/Ascend agreed to repay the Medicaid program the full amount cited in the audit report, $153,095, and described the steps it has taken or will take to implement all of the recommendations made in this audit report. Given that Care

Alternatives/Ascend has agreed to repay the Medicaid program the entire amount identified in the audit and has addressed all of the recommendations in the audit report, there is no further action that needs to be taken with respect to this audit.