RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

IN THE MATTER OF:

MAHS Docket No.: 16-003072

[redacted]

Agency Case No.: [redacted]

Case Type: **PR**

v

[redacted]

_____/

Issued and entered
this 15th day of March, 2017
by:
Steven Kibit
Administrative Law Judge

PROPOSAL FOR DECISION

This matter is before the Michigan Administrative Hearing System pursuant to the provisions of Section 6411 of the Patient Protection and Affordability Care Act of 2010, as well as the Michigan Medicaid State Plan, The Social Welfare Act, MCL 400.1 *et seq.*, The Administrative Procedures Act, MCL 24.271 *et seq*. and Administrative Rules 400.3401 *et seq.* and 792.10101 *et seq.*

PROCEDURAL HISTORY

This is an appeal of a decision by the Respondent Michigan Department of Health and Human Services to recover payments made to Petitioner [redacted] (Petitioner or [redacted]) for a Medicaid beneficiary's [redacted] through [redacted] hospice stay, following an audit by [redacted]. (HMS), the Recovery Audit Contractor (RAC) for the Department.

On May 18, 2016, Petitioner requested an Administrative Hearing. A Prehearing Conference was held on May 3, 2016 and a hearing was held on June 6, 2016.

[redacted] Officer Administrator, appeared on Petitioner's behalf. [redacted] Director of Professional Services, testified as a witness for Petitioner. [redacted]-[redacted] Hospice Consultant, was also present during the hearing for Petitioner.

[redacted], Appeals Review Officer, represented the Respondent Department. Dr. [redacted], M.D. and HMS Medical Director, testified as a witness for the Department. [redacted], Contract Manager with the Department; [redacted], a Manager in the Office of Inspector General; and [redacted] Program Director for HMS; were also present during the hearing for the Department.

During the hearing, Petitioner offered one exhibit that was entered into the record as Exhibit 1. Respondent also offered one exhibit that was entered into the record as Exhibit A.

ISSUE

Was the Department's decision to recover payment for the [redacted] through [redacted] hospice stay of a Medicaid beneficiary with the initials J.L. (JL) proper?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is an enrolled provider in the State of Michigan's Medicaid program.

2. On [redacted], JL, a fifty-nine-year-old male Medicaid beneficiary, was enrolled in hospice services through Petitioner with peripheral artery disease; multiple ischemic ulcers, some Stage IV and some unable to be staged; chronic osteomyelitis unresolved by antibiotic therapy; amputation of digits secondary to gangrene and critical ischemia/infarction; coronary artery disease (CAD); chronic obstructive pulmonary disease (COPD); and hypertension (HTN). (Exhibit 1, page 1; Testimony of Respondent's witness).

3. JL was also found to have a Karnofsky Performance Status (KPS) score and a Palliative Performance Score (PPS) of 30 at the time of admission. (Exhibit A, page 27).

4. Around that time, on [redacted], a physician for Petitioner also certified that JL's life expectancy was six months or less given his terminal illness and the anticipated course of treatment. (Exhibit 1, page 1).

5. JL continued to receive hospice services through Petitioner at all times relevant to this matter, with Petitioner regularly recertifying JL's need for

such services as required. (Testimony of Petitioner's witness; Testimony of Respondent's witness).

6. In a Certification Evaluation dated February 25, 2014, Petitioner noted that JL's KFS and PPS remained unchanged at 30; JL was slowly decreasing his narcotics and wanted to wean himself off them if he could tolerate it; and there was a noted increased phantom pains and wound pains. (Exhibit A, page 27).

7. The physician completing the Recertification Evaluation Addendum that accompanied that certification also stated that JL had been worse in the last month according to caregivers; he had ongoing neuropathic, spastic and phantom limb pain; his weight was at 84 pounds, which was 16 pounds less than at admission, and further weighing was not possible due to technical reasons; his mid-upper arm circumference (MAC) was at 18 cm, which was up 1 cm from October of 2013, but down 1 cm from February of 2013; JL had ongoing cachexia; his severe pain is better controlled with Baclofen, Gabapentin, and high-does opioids; and JL's comorbid CAD, COPD, HTN and deep vein thrombosis (DVT) all contributed to a life expectancy was six months or less given his terminal illness and the anticipated course of treatment. (Exhibit A, page 30).

8. In the Certification Evaluation signed April 29, 2014, Petitioner indicated that JL's KFS and PPS remained unchanged at 30; JL continued to wean himself off narcotics; he was tolerating withdrawal sensations and pain rating a 4-7; and he was now only on four Norco per day. (Exhibit 1, pages 2-4; Exhibit A, pages 19-21).

9. The physician completing the Recertification Evaluation Addendum that accompanied that certification also stated that JL's non-compliance with the recommended plan of care complicated his clinical course; his MAC was the same; he still had ongoing cachexia; and his comorbid COPD contributed to a likely prognosis of a life expectancy of less than six month with the anticipated course of JL's severe PAD and chronic osteomyelitis. (Exhibit 1, page 5; Exhibit A, pages 17, 69, 119).

10. On May 29, 2014, JL was approved for one week of physical therapy (PT) with the goal of performing transferring between his bed and wheelchair and back with minimal physical assistance. (Exhibit 1, page 55).

11. One session of PT subsequently to be pushed back a week because JL was ill. (Exhibit 1, page 55).

12. On June 10, 2014, JL's physician ordered a daily dose of Bactrim DS to treat an infection. (Exhibit 1, page 54; Testimony of Petitioner's witness).

13. A [redacted] Clinical Note – Nursing provided that JL's pain was controlled with four Norco per day, but still had persistence headaches; he required persistent wound care as his wounds were healing very slowly; and JL had reported how PT had helped him. (Exhibit 1, pages 76-78; Exhibit A, pages 54-55, 104-105).

14. Similarly, a [redacted] Clinical Note – Nursing provided that JL continued to have headaches and sensitive wound pain, but that he was taking pain pills to remain off narcotics and was still only on Norco four times a day. (Petitioner's Exhibit 1, pages 73-75).

15. In the Certification Evaluation signed [redacted], Petitioner indicated that JL's KFS and PPS remained unchanged at 30; his MAC remained the same as before; and he had weaned himself off long acting narcotics, but was still on Norco. (Exhibit 1, pages 7-9; Exhibit A, pages 10-12, 62-64, 77-79, 112-114)

16. The physician completing the Recertification Evaluation Addendum that accompanied that certification noted the same, while also adding that:

> Comorbid COPD contributes to likely prognosis < 6 six months with anticipated course of severe PAD and chronic osteomyelitis. Above confirmed on FTF assessment done by hospice NP done 6/11/14.
>
> Non-hospice/non-related conditions include:
>
> COPD is stable of medications, does not require oxygen, and is not advanced to the point of limiting his prognosis.
> GERD
> Prostate cancer is remote and not an active condition.
> CAD is quiescent, asymptomatic, and not contributing to his terminal prognosis at this time.
> HTN I stable off of medications and is not contributing to his decline at present.
> BPH is stable and not contributing to his terminal decline at this time.

Exhibit 1, page 10

17. On July 1, 2014, Petitioner also completed a Local Coverage Determination (LCD) for non-disease specific baseline guidelines with

respect to JL. (Petitioner's Exhibit 1, pages 17-18; Respondent's Exhibit A, pages 15-16, 67-68, 117-118).

18. In a [redacted] Clinical Note – Nursing, it was noted that JL had received the Bactrim DS that was ordered, but was declining to take it. (Exhibit 1, pages 69-71; Exhibit A, pages 47-49, 59-61, 97-99, 109-111).

19. He was taking Gabapentin and Norco four times a day. (Exhibit 1, pages 69-71; Exhibit A, pages 47-49, 59-61, 97-99, 109-111).

20. JL canceled an RN visit for [redacted] because he had no new changes or concerns. (Exhibit 1, page 68; Exhibit A, pages 46, 58, 96, 108).

21. A July 15, 2014 Interdisciplinary Team Plan of Care Update & Review of Comprehensive Assessment also provided that JL continued to have wounds and headaches; he was using Gabapentin and Norco; and he did not want to change his pain medications. (Exhibit 1, pages 50-51).

22. Clinical notes dated [redacted] and [redacted] were similar to previous notes, though it was also noted that JL had some chest and abdominal pain at one point and that he caught poison ivy from his grandson. (Exhibit 1, pages 62-67; Exhibit A, pages 40-45, 56-57, 90-95, 106-107).

23. In an [redacted] Hospice Face to Face Encounter Findings for Medical Practitioners report, Petitioner noted that JL was on Doxycycline for chronic osteomyelitis and had sloughing skin. (Exhibit 1, pages 25-27; Exhibit A, pages 127-129).

24. JL then cancelled RN visits on [redacted] and [redacted], with a specific notation that the first visit was cancelled because JL was doing okay. (Exhibit A, pages 37-38, 87-88).

25. In an [redacted] Clinical Note – Nursing, it was noted that JL's symptoms were continuing with no new changes; he was taking 4-5 Norco per day and Gabapentin routinely; and that he did not have any muscle spasms. (Exhibit 1, pages 59-61; Exhibit A, pages 34-36, 84-86).

26. Similarly, an [redacted] Interdisciplinary Team Plan of Care Update & Review of Comprehensive Assessment noted that J: had no new symptoms, but continued to have phantom pain, headaches, and wounds. (Exhibit 1, page 28).

27. On August 26, 2014, Petitioner also completed an LCD for non-disease specific baseline guidelines with respect to JL. (Exhibit 1, pages 15-16).

28. In an [redacted] Clinical Note – Nursing, it was noted that JL takes Norco 4-5 times a day and Gabapentin routinely, and that his pain is controlled. (Exhibit 1, pages 56-58; Exhibit A, pages 31-33, 81-83).

29. In 2015, HMS conducted an audit on the Department's behalf and determined both that JL did not meet the criteria for hospice services for the time period of [redacted] through [redacted] and that payments made to Petitioner for those services should be recovered. (Exhibit 1, page 80; Testimony of Respondent's representative.)

30. In a letter dated August 27, 2015, Petitioner appealed that decision. (Exhibit 1, pages 80-81).

31. Specifically, Petitioner argued that, based on a review of the total person, JL met the criteria for hospice services during the service dates of [redacted] to [redacted]. (Exhibit 1, pages 80-81).

32. In January of 2016, the Department conducted a preliminary conference, after which it upheld HMS' findings and decision. (Exhibit 1, pages 82; Testimony of Petitioner's witness).

33. On March 18, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, pages 82-85; Exhibit A, pages 134-136).

34. In that request, Petitioner noted that it had received the preliminary conference decision and that, upon its review, it still feels that JL met eligibility criteria during the disputed dates. (Exhibit 1, pages 82-85; Exhibit A, pages 134-136).

35. Petitioner also cited the LCDs found in the record; commented on the Preliminary Conference Decision Findings of Fact; discussed the applicable recertification evaluation addendum prepared by a hospice physician; and responded to the testimony provided by an HMS physician during the conference. (Exhibit 1, pages 82-85; Exhibit A, pages 134-136).

36. On April 27, 2016, [redacted] completed a Michigan RAC Audit Reconsideration Physician Review. (Exhibit A, page 6).

37. In that review, [redacted] concluded that the documentation provided for the certification period in question did not support JL's terminal diagnosis as JL continued to exhibit multiple non-healing wounds, without signs of active infection; he was receiving physical therapy, transferring to a wheelchair, and performing activities of daily living with nursing assistance. (Exhibit A, page 6).

CONCLUSIONS OF LAW

The Michigan Department of Health and Human Services is the single state agency responsible for health policy, the purchase of health care services, and accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population or paid for by the Department.

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that State Medicaid Agencies provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure payments are consistent with "efficiency, economy and quality of care . . ." Under section 1902(d), a State can contract with an entity that meets the requirements of section 1152 of the Act to perform medical or utilization review functions requires under the Act.

Section 6411 of the Affordable Care Act (ACA) expands the Recovery Audit Contractor Program (RAC) to the Medicaid program. Section 6411 provides, in pertinent part:

> SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC)
> PROGRAM.
>
> (a) EXPANSION TO MEDICAID.—
>
> (1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—(A) by striking ''that the records'' and inserting ''that— ''(A) the records''; (B) by inserting ''and'' after the semicolon; and (C) by adding at the end the following: ''(B) not later than December 31, 2010, the State shall— ''(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and ''(ii) provide assurances satisfactory to the Secretary that— ''(I) under such contracts, payment shall be made to such a contractor only from amounts recovered; ''(II) from such amounts recovered, payment— ''(aa) shall be made on a contingent basis for collecting overpayments; and ''(bb) may be made in such amounts as the State may specify for identifying

> underpayments; ‘‘(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and ‘‘(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including— ‘‘(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan; ‘‘(bb) that section 1903(d) shall apply to amounts recovered under the program; and ‘‘(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State Medicaid fraud control unit; and’’. H. R. 3590—657
>
> (2) COORDINATION; REGULATIONS.— (A) IN GENERAL.— The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State’s Medicaid program prior to December 31, 2010. (B) REGULATIONS.— The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.

The Code of Federal Regulations requires that appeals rights be given to providers who have received notice of adverse Medicaid RAC determinations. 42 CFR 455.512 provides, in pertinent part:

> 455.512 Medicaid RAC provider appeals.
>
> States must provide appeal rights under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination.

Health Management Systems (HMS) is the Michigan Department of Health and Human Services' Recovery Audit Contractor (RAC). Pursuant to Section 6411 of the Patient Protection and Affordability Care Act of 2010, HMS is authorized to audit provider payments and associated financial records for fee-for-service and managed care Medicaid populations. The purpose is to ensure services are medically necessary and billed correctly by the provider.

The Social Welfare Act, MCL 400.1 *et seq*., provides that as a condition of participation in the Medicaid program a provider must meet all the requirements listed in MCL 400.111b:

> Requirements as condition of participation by provider.
>
> Sec. 111b.
>
> (1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27). . .

The Director of the Michigan Department of Health and Human Services may develop Medicaid Program policy and procedures and must notify enrolled Medicaid Providers of any changes.

> Sec. 111a.
>
> (1) The director, after appropriate consultation with affected providers and the medical care advisory council established pursuant to federal regulations, may establish policies and procedures that he or she considers appropriate, relating to the conditions of participation and requirements for providers established by section 111b and to applicable federal law and regulations, to assure that the implementation and enforcement of state and federal laws are all of the following:
>
> (a) Reasonable, fair, effective, and efficient.
> (b) In conformance with law.
> (c) In conformance with the state plan for medical assistance adopted pursuant to section 10 and approved by the United States department of Health and Human Services.
>
> *MCL 400.111a(1)*

A Medicaid provider must comply with all Department policies and procedures related to the conditions of participation in the Medicaid program, requirements for Medicaid providers, and with all applicable federal laws and regulations:

> (18) A provider shall comply with all requirements established under section 111a (1), (2), and (3).
>
> *MCL 400.111b(18)*

Medicaid providers have the burden of proof, and the burden of establishing via auditable documentation that the audit adjustments at issue were erroneous. Providers must comply with MCL 400.1 *et seq*, state-published manuals and certain relevant federal principles, all of which state the conclusion that the provider bears the burden of proof. The statute provides: "Submission of a claim or claims for services rendered under the (Medicaid) program does not establish in the provider a right to receive payment from the program." MCL 400.111b (10). And, "[b]efore billing for any medical services," MCL 400.111b(6), (7), (8) require the provider to have records to support each claim for Medicaid reimbursement. Thus, MCL 400.111b(6) states in pertinent part: "A provider shall maintain records necessary to document fully the . . . cost of services, supplies, or equipment provided to a medically indigent individual."

Thus it is up to Petitioner to establish by a preponderance of the evidence that the audit adjustment at issue in this appeal was improper. See Director's Final Order in *Ciena Healthcare Management, et al v Dep't of Health and Human Services*, MAHS Docket No. 2010-37557-AAH, *et al*, dated March 6, 2013. See also *Prechel v Dep't of Social Services*, 186 Mich App 547; 465 NW2d 337 (1990) (holding that placing the burden of proof on audited Medicaid providers is consistent with the legislative scheme underlying the program).

Policy with respect to hospice admissions is contained in the Medicaid Provider Manual (MPM). That policy provides in the pertinent parts:

> Hospice is a health care program designed to meet the needs of terminally ill individuals when the individual decides that the physical and emotional toll of curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity, and quality of life. Hospice is intended to address the full range of needs of the individual with a terminal illness, while also considering family needs. Care must be consistent with the individual's values, regardless of the location where care is provided.
>
> The primary objective of the Medicaid Hospice Program is to ensure that essential medical/health services are available to those who would not otherwise have the financial resources to purchase them. Medicaid policies are designed to achieve this objective with fiscal responsibility. Hospice

providers must verify Medicaid eligibility of beneficiaries prior to provision of services.

* * *

Hospice providers are bound to all rules, regulations, and policies specified in this chapter for program participation/enrollment of Medicaid beneficiaries. Hospice providers must also comply with the Medicare Conditions of Participation (42 CFR 418) which generally apply to non-Medicare beneficiaries as well as to Medicare beneficiaries.

Additional information regarding federal Hospice requirements and guidelines is contained in the Centers for Medicare & Medicaid Services (CMS) State Operations Manual 2083.

* * *

3.5 DURATION OF COVERAGE

Based on hospice eligibility criteria, the duration of hospice services is generally six months or less.

There is no minimum period of hospice enrollment. A change in the beneficiary's prognosis could eliminate the need for hospice care. A beneficiary may cancel his enrollment in the hospice at any time and without cause. Beneficiaries who become ineligible for Medicaid while enrolled in a hospice also become ineligible for Medicaid reimbursement for hospice services.

* * *

Section 5.1 – Hospice Election Periods

The duration of hospice coverage is measured in election periods, also known as benefit periods. A beneficiary may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period;
- A subsequent 90-day period;
- An unlimited number of subsequent 60-day periods.

Section 5.2 – Certification of the Terminal Illness

A hospice must obtain written certification of the terminal illness for each election period before a claim for services is submitted. If the hospice is unable to obtain a written certification within three days of initiation of hospice care, a verbal certification must be obtained, documented, and signed by the person receiving the certification. Statements covering a beneficiary's initial certification must be obtained from the hospice medical director or the physician member of the Interdisciplinary Group (IDG), and the beneficiary's attending physician if the beneficiary has an attending physician. The hospice medical director or the physician member of the IDG certifies the terminal illness for all subsequent election periods.

Each written certification must include:

- A statement that the beneficiary's life expectancy is six months or less if the terminal illness runs its normal course;
- Specific clinical findings and other documentation as needed to support the life expectancy of six months or less;
- A brief narrative summary;
- An explanation why the clinical findings of the face-to-face encounter support a life expectancy of six months or less (beginning with the third benefit period and thereafter); and
- Physician signature(s), date signed, and specific election period dates covered by the certification or recertification.

Documentation of all written/verbal certifications must be prepared no more than 15 calendar days prior to the effective date of election and must be kept in the beneficiary's medical record.

Section 5.3 – Narrative Summary

Each hospice certification and recertification must be accompanied by a brief narrative describing the clinical

findings supporting the beneficiary's life expectancy of six months or less. Each narrative must reflect the clinical circumstances and should not contain checkboxes or non-specific, standard language.

5.4 Face-To-Face Encounter

A hospice physician, hospice-employed nurse practitioner (NP), or hospice-employed physician assistant (PA) must have a face-to-face encounter with every hospice beneficiary prior to the 180th day of recertification of the beneficiary's terminal illness for the purpose of determining continued eligibility. The 180th day recertification is defined as the recertification that occurs at the start of the third benefit (election) period or the benefit period following the second 90-day benefit period. Additionally, a face-to-face must be conducted at each subsequent recertification (every 60 days thereafter) for as long as the beneficiary is in hospice. Face-to-face encounters must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to each subsequent benefit period thereafter.

The hospice physician, NP, or PA must attest in writing to the face-to-face encounter with the beneficiary and include the date of the visit. A NP or PA is allowed to perform and attest to the face-to-face encounter; however, the hospice physician must certify and recertify the terminal illness.

Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the recertification of the terminal illness requirement. This results in the beneficiary no longer being eligible for the hospice benefit. If this should happen, the hospice must complete a Hospice Membership Notice (form DCH-1074), with the last date of the benefit period as the effective disenrollment date. A comment in the Remarks Section of the form is required to explain the reason for the disenrollment.

There may be an occasional case when a hospice admits a beneficiary who received services from another hospice provider, and the beneficiary chose to revoke or was discharged from that provider. When this occurs, the admitting hospice may begin their care with the beneficiary's first benefit period unless the beneficiary is a direct transfer from the other hospice. When this is the case, the

> beneficiary's benefit period remains the same, and the transferring hospice should provide the receiving hospice with all required documentation. A hospice resuming care for a beneficiary formerly served by their hospice must restart care in the next or subsequent benefit period.
>
> *MPM, July 1, 2014 version*
> *Hospice Chapter, pages 1-2, 6, 9-10*

As described in the above policy, hospice providers must also comply with the Medicare Conditions of Participation found in 42 CFR 418 and the federal hospice requirements and guidelines is contained in the Centers for Medicare & Medicaid Services (CMS) State Operations Manual 2083.

The CMS website also contains information about the Local Coverage Determination (LCD) used in determining the terminal status of hospice patients. The LCD includes information about the CMS National Coverage Policy; indications and limitations of coverage and medical necessity; clinical status guidelines; non-disease specific baseline guidelines; and disease specific guidelines.

In the pertinent part, the applicable LCD reads:

> **Coverage Indications Limitations and/or Medical Necessity**
>
> **Abstract**
>
> Medicare coverage of hospice depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. This LCD describes guidelines to be used by National Government Services (NGS) in reviewing hospice claims and by hospice providers to determine eligibility of beneficiaries for hospice benefits. Although guidelines applicable to certain disease categories are included, this LCD is applicable to all hospice patients. It is intended to be used to identify any Medicare beneficiary whose current clinical status and anticipated progression of disease is more likely than not to result in a life expectancy of six months or less.
>
> Clinical variables with general applicability without regard to diagnosis, as well as clinical variables applicable to a limited number of specific diagnoses, are provided. Patients who meet the guidelines established herein are expected to have a life expectancy of six months or less if the terminal illness

runs its normal course. Some patients may not meet these guidelines, yet still have a life expectancy of six months or less. Coverage for these patients may be approved if documentation otherwise supporting a less than six-month life expectancy is provided.

Section 322 of BIPA amended section 1814(a) of the Social Security Act by clarifying that the certification of an individual who elects hospice "shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." The amendment clarified that the certification is based on a clinical judgment regarding the usual course of a terminal illness, and recognizes the fact that making medical prognostications of life expectancy is not always exact.

However, the amendment regarding the physician's clinical judgment does not negate the fact that there must be a basis for a certification. A hospice needs to be certain that the physician's clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of 6 months or less if the illness runs its normal course.

If a patient improves and/or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit. Such patients can be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less. On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care.

With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180th-day recertification and every recertification thereafter, and to attest that the encounter occurred. CMS proposed and implemented policies related to this new requirement in the Home Health

Prospective Payment System Rate Update for CY 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule (75 FR 70372). This new face-to-face encounter requirement became effective on January 1, 2011.

Indications

A patient will be considered to have a life expectancy of six months or less if he/she meets the non-disease specific **"Decline in clinical status"** guidelines described in Part I. Alternatively, the baseline non-disease specific guidelines described in Part II plus the applicable disease specific guidelines listed in Part III will establish the necessary

Part I. Decline in clinical status guidelines

Patients will be considered to have a life expectancy of six months or less if there is documented evidence of decline in clinical status based on the guidelines listed below. Since determination of decline presumes assessment of the patient's status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Baseline data may be established on admission to hospice or by using existing information from records. Other clinical variables not on this list may support a six-month or less life expectancy. These should be documented in the clinical record.

These changes in clinical variables apply to patients whose decline is not considered to be reversible. They are examples of findings that generally connote a poor prognosis. However, some are clearly more predictive of a poor prognosis than others; significant ongoing weight loss is a strong predictor, while decreased functional status is less so.

A. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results.

Clinical Status:

a. Recurrent or intractable serious infections such as pneumonia, sepsis or pyelonephritis;

b. Progressive inanition as documented by:

    1. Weight loss of at least 10% body weight in the prior six months, not due to reversible causes such as depression or use of diuretics;

    2. Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics;

    3. Observation of ill-fitting clothes, decrease in skin turgor, increasing skin folds or other observation of weight loss in a patient without documented weight;

    4. Decreasing serum albumin or cholesterol.

    5. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

Symptoms:

a. Dyspnea with increasing respiratory rate;

b. Cough, intractable;

c. Nausea/vomiting poorly responsive to treatment;

d. Diarrhea, intractable;

e. Pain requiring increasing doses of major analgesics more than briefly.

Signs:

a. Decline in systolic blood pressure to below 90 or progressive postural hypotension;

b. Ascites;

c. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease;

d. Edema;

e. Pleural/pericardial effusion;

f. Weakness;

g. Change in level of consciousness.

Laboratory (When available. Lab testing is not required to establish hospice eligibility.):

a. Increasing pCO2 or decreasing pO2 or decreasing SaO2;

b. Increasing calcium, creatinine or liver function studies;

c. Increasing tumor markers (e.g. CEA, PSA);

d. Progressively decreasing or increasing serum sodium or increasing serum potassium.

B. Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) due to progression of disease.

C. Progressive decline in Functional Assessment Staging (FAST) for dementia (from 7A on the FAST).

D. Progression to dependence on assistance with additional activities of daily living (see Part II, Section 2).

E. Progressive stage 3-4 pressure ulcers in spite of optimal care.

F. History of increasing ER visits, hospitalizations, or physician visits related to the hospice primary diagnosis prior to election of the hospice benefit.

Part II. Non-disease specific baseline guidelines (both A and B should be met)

A. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) < 70%. Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.

B. Dependence on assistance for two or more activities of daily living (ADLs):

    1. Ambulation;
    2. Continence;
    3. Transfer;
    4. Dressing;
    5. Feeding;
    6. Bathing.

C. Co-morbidities – although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.

    1. Chronic obstructive pulmonary disease
    2. Congestive heart failure
    3. Ischemic heart disease
    4. Diabetes mellitus
    5. Neurologic disease (CVA, ALS, MS, Parkinson’s)
    6. Renal failure
    7. Liver Disease
    8. Neoplasia

9. Acquired immune deficiency syndrome

10. Dementia

11. Acquired Immune Deficiency Syndrome/HIV

12. Refractory severe autoimmune disease (e.g. Lupus or Rheumatoid Arthritis)

D. See Part III for disease specific guidelines to be used with these baseline guidelines. The baseline guidelines do not independently qualify a patient for hospice coverage.

Note: The word "should" in the disease specific guidelines means that on medical review the guideline so identified will be given great weight in making a coverage determination. It does not mean, however, that meeting the guideline is required. The only requirement is that the documentation supports the beneficiary's prognosis of six months or less, if the illness runs its normal course.

Part III. Disease Specific Guidelines

Note: These guidelines are to be used in conjunction with the "Non-disease specific baseline guidelines" described in Part II . . .

Here, as discussed above, the Department has decided to recover payments made to Petitioner for a Medicaid beneficiary's [redacted] through [redacted] hospice stay following an audit by HMS, the RAC for the Department.

In support of that decision, the Department's witness testified the submitted documentation in this case failed to reflect that, as required by policy, JL had a terminal illness with a life expectancy of six months or less if the terminal illness runs its normal course. Specifically, the Department's witness noted that there were no signs of new infection or worsening clinical status as of [redacted] and that JL's KFS and PPL scores instead remained unchanged from the time of admission two-and-a-half years earlier; his MAC remained unchanged from earlier certifications; and there were no noted changes in JL's vital signs. Moreover, the physician's addendum to the applicable recertification also showed the JL's COPD was stable and not advanced to the point of limiting prognosis; his HTN was stable; and his CAD was asymptomatic and not contributing to the terminal prognosis. The Department's witness further testified that, while JL did an have ongoing issue of his heart rate increasing when he elevated his head while smoking, he had no hospitalization for that or any other issues; he

received PT; and he was weaned off narcotics, with his pain kept tolerable with just Norco and Gabapentin.

In response, Petitioner's witness testified and argued that the record in this case supported that recertification of JL's terminal diagnosis as required for hospice services. In particular, Petitioner's witness noted that throughout his stay, JL's KFS and PPS remained at 30%; he was non-ambulatory and always remained completely dependent on others for his ADLs; and he had both progressive ulcers and non-healing wounds. She also testified that JL had recurring infections, as exhibited by his incurable osteomyelitis, which is an infection of the bone, and that, to the extent treatment for infections stopped at one point, it was only because the treatment was ineffective and JL was again receiving Doxycycline for his osteomyelitis as of [redacted]. Petitioner's witness further testified that there were no new laboratory studies because such a workup was neither indicated nor a standard practice of hospice providers; JL was malnourished, as exhibited by his weight, to the extent they were previously able to weight him; and that, while his MAC stayed the same, JL was only able to maintain that muscle mass on his arm because it was all he could use following his amputations. Additionally, while JL was weaned off morphine, Petitioner's witness testified that the weaning was not recommended; his pain continued; and it only worked to the extent that it did because JL's acceptable pain level was high; and he continued to use medication for nerve pain and short-acting medications. Similarly, with respect to PT, Petitioner's witness testified that the therapy was an attempt to improve JL's quality of life and his mental health, but that it was not successful and was not a sign of any improvement. Overall, according to Petitioner's witness, there were no changes that would eliminate the terminal prognosis and the length of time that JL had spent in hospice should not affect his later prognosis.

As indicated above, Petitioner must prove, by a preponderance of the evidence, that the Department's decision to recover payments for hospice services for JL was improper.

Based on the above findings of fact and conclusions of law, Petitioner has failed to meet this burden.

As provided in the above policy, coverage of hospice depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course and a hospice needs to be certain that the physician's clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of six months or less if the illness runs its normal course.

Here, while Petitioner's physician did recertify for the time period of [redacted] through [redacted] that JL had a life expectancy of six months or less if his terminal illness ran its normal course, the clinical information and documentation failed to sufficiently support that finding. JL had clearly not declined since his hospice admission two-and-a half years earlier as his health and vital signs were stable; he did not undergo any hospitalizations; and his KFS score; PPS score; and MAC had all remained the same

from earlier certifications. Moreover, while Petitioner argues that JL remain eligible regardless as his prognosis had not changed from when he was admitted and the length of time a patient is in hospice does not affect his prognosis going forward, there was evidence in the record regarding significant changes. For example, JL was able to be weaned off narcotics as he requested and he did participate in PT, albeit briefly. Similarly, while the initial certification identified comorbid conditions of CAD, COPD and HTN as contributed to the terminal prognosis, by the time of the recertification at issue in this case, the same doctor expressly found that JL's COPD was stable, did not require oxygen, and was not advanced to the point of limiting his prognosis; his CAD was quiescent, asymptomatic, and not contributing to his terminal prognosis; and his HTN was stable off of medications and was not contributing to his decline at present.

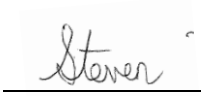
Policy provides that the decision on whether to keep a patient in hospice is up to the treating physician, but that decision also must be supported by the corresponding medical records. Here, for the reasons indicated above, Petitioner's decision was not supported by the medical records and the undersigned Administrative Law Judge therefore recommends that the Department's decision be upheld.

IT IS THEREFORE PROPOSED THAT:

The Administrative Law Judge, based on the above findings of fact and conclusions of law, RECOMMENDS that the Department's decision to recoup payment for hospice services be AFFIRMED.

EXCEPTIONS

Any party may, within ten (10) days from the date of mailing this decision, file exceptions with the Michigan Administrative Hearing System for the Department of Health and Human Services, P.O. Box 30763, 611 W. Ottawa, 2nd Floor, Lansing, Michigan 48909. Exceptions shall be served on all parties.



SK/tm

Steven Kibit
Administrative Law Judge

PROOF OF SERVICE

I hereby state, to the best of my knowledge, information and belief, that a copy of the foregoing document was served upon all parties and/or attorneys of record in this matter by Inter-Departmental mail to those parties employed by the State of Michigan and by UPS/Next Day Air, facsimile, and/or by mailing same to them via first class mail and/or certified mail, return receipt requested, at their respective addresses as disclosed below this 15th day of March, 2017.

Antonette H. Mehi

Antonette Mehi
Michigan Administrative Hearing System

[redacted]

[redacted]

[redacted]