Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Rief HealthCare L.L.C. d/b/a Med Plus Hospice,
(CCN: 26-1656),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-558

Decision No. CR5021

Date: February 6, 2018

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to terminate the Medicare participation of Petitioner, Rief HealthCare L.L.C. d/b/a Med Plus Hospice.

I. Background

Petitioner has participated in the Medicare program as a hospice. In this case it challenges CMS's determination to terminate its Medicare participation based on findings that Petitioner failed to comply with at least one Medicare condition of participation. I held an in-person hearing on November 28, 2017, in order to receive exhibits into the record and to allow the cross-examination of witnesses. At the hearing I received exhibits from CMS that are identified as CMS Ex. 1-CMS Ex. 8. I received exhibits from Petitioner that are identified as P. Ex. 1-P. Ex. 3 and P. Ex. 8-P. Ex. 21.

II. Issue, Findings of Fact and Conclusions of Law

A. Issue

The sole issue in this case is whether Petitioner failed to comply with at least one Medicare condition of participation as of a survey of its operations that was conducted on March 30, 2017.

B. Findings of Fact and Conclusions of Law

The Social Security Act (Act) and implementing regulations provide for the reimbursement for hospice services for individuals who are terminally ill and who are expected to die within six months. Act §§ 1812(d) and 1861(dd); 42 C.F.R. Part 418. Hospice care is care that is provided for by the Medicare program that is in addition to other covered care. It is not intended to duplicate care such as skilled nursing care or home health services. Rather, it is care uniquely conceived to help program beneficiaries who are dying from their illnesses and to provide these beneficiaries with care and benefits in addition to that which they might expect to receive from other covered items and services. Hospice care, therefore, does not cover skilled nursing services. It covers services such as medication for pain control and relief (not curative medication) and grief and loss counseling for the beneficiary and his or her family that are not covered under Medicare's long-term care benefit. Above all else, it covers those items and services that are uniquely intended to help individuals and their families through the end stages of terminal illnesses.

It would be pointless for Medicare to reimburse hospices simply for providing services that are covered under other parts of the program. Moreover, a hospice may not excuse its failure to provide required services on the ground that those services are provided by someone else. A participating hospice is absolutely required to provide that care for which Medicare reimburses.

Surveyors scrutinized the care that Petitioner provided on four occasions over a period of about four months. On each instance the surveyors found failures by Petitioner to comply with Medicare conditions of participation. Finally, CMS terminated Petitioner's participation effective April 16, 2017, after surveyors found at a March 30, 2017 survey that Petitioner continued to be noncompliant. CMS Ex. 3 at 16-18.

I note at the outset of my analysis that Petitioner raises an irrelevant defense to CMS's noncompliance allegations. Specifically, Petitioner alleges that the surveyors who conducted the various surveys of Petitioner's facility violated surveyor protocols and/or were biased against Petitioner. This defense is irrelevant because findings of noncompliance will stand or fall based on the objective evidence obtained by surveyors. How or why they obtain that evidence doesn't matter: if the evidence produced by surveyors shows that Petitioner failed to comply with participation requirements, then that evidence establishes grounds for remedial action, whether or not the surveyors complied with applicable protocol or were motivated by animus. Conversely, if surveyors scrupulously follow protocol or conduct their surveys with the purest of

intentions, that level of rigorousness is of no consequence if they fail to obtain evidence establishing noncompliance. *Del Rosa Villa*, DAB No. 2458 at 20 & n.10 (2012), *aff'd*, *Del Rosa Villa v. Sebelius*, 546 F. App'x 666 (9th Cir. 2013).[1]

In this decision I focus solely on the noncompliance that surveyors identified at the March 30, 2017 survey. Noncompliance identified at previous surveys is irrelevant to the issue of CMS's authority to terminate Petitioner's Medicare participation on or after March 30. What matters is whether Petitioner was noncompliant as of the date of termination and that noncompliance either is or is not established by the March 30, 2017 survey findings.

Regulations governing hospice participation in Medicare are explicit. CMS may terminate a hospice's participation in Medicare grounded on noncompliance with a single condition of participation. 42 C.F.R. § 489.53(a)(1), (3).

Findings made at the March 30 survey included findings that Petitioner's noncompliance was so egregious as to constitute immediate jeopardy for beneficiaries receiving Petitioner's services. I do not address the question of immediate jeopardy in this decision because CMS's authority to terminate participation in this case is not contingent on an immediate jeopardy level noncompliance finding. All that is necessary to justify termination is a finding of noncompliance with one participation condition, whether or not immediate jeopardy exists.

CMS focuses on two conditions of participation that it alleges Petitioner was not complying with as of March 30. I have considered the evidence and the parties' arguments concerning these conditions. CMS's findings are amply justified as to both conditions although termination is supported here by noncompliance with just one participation condition.[2]

The two conditions of participation that CMS alleges Petitioner contravened are at 42 C.F.R. §§ 418.52 and 418.112. CMS asserts that Petitioner violated multiple standards (a "standard" is a subpart of a condition) of these conditions and the violations, when viewed individually and in the aggregate, amount to condition-level noncompliance.

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[1] A very narrow exception to this rule, not at issue here, may occur when a facility is able to prove that surveyor bias or impropriety called into question the authenticity of the documentation that the surveyors obtained. *Del Rosa Villa*, DAB No. 2458 at 20 n.10.

[2] CMS alleged that Petitioner failed to comply with several additional conditions of participation as of March 30. However, it has not provided me with argument about those conditions or cited to specific evidence addressing them. I make no findings as to those additional conditions.

The first regulation, 42 C.F.R. § 418.52, in part governs the rights of patients who are provided hospice care. The regulation provides that a patient has the right to receive effective pain management and symptom control from the hospice for conditions related to his or her terminal illness. 42 C.F.R. § 418.52(c)(1). Additionally, the patient is entitled to receive information about the services covered by the hospice benefit. 42 C.F.R. § 418.52(c)(7). CMS alleges that Petitioner failed in two respects to comply with these requirements as of March 30. First, it contends that Petitioner failed to insure that its patients received adequate pain management because hospice staff was not effectively coordinating availability and administration of care with the staffs of the nursing homes at which beneficiaries receiving Petitioner's services resided.

CMS bases its allegations on the care that Petitioner provided to a patient who had been admitted to hospice on February 20, 2017. CMS Ex. 1 at 5. The patient was a resident of a skilled nursing facility. The hospice supervisory nurse wrote a standing medication order for the patient that provided for the administration of morphine every four hours, as needed, for pain and the administration of an anti-anxiety medication (Ativan) at four-hour intervals, as needed. *Id.* at 6. But, notwithstanding these orders, the records that Petitioner generated to document care fail to show any coordination with the skilled nursing facility's staff concerning administration of these medications. *Id.* at 6-7.

Petitioner's failure to document coordination is not a trivial omission or a mere record-keeping error. As I have stated, the whole point of hospice care is to provide beneficiaries with specific services that are not generally provided by others, including skilled nursing facilities, for problems such as pain management. Here, however, Petitioner failed to fulfill a basic obligation. It failed to document how a patient's needs for medication to alleviate pain and anxiety were being communicated to the staff of the skilled nursing facility in which the patient resided. Absent such communication and coordination, there could be no guarantee that the patient would receive the care that the hospice had decided was necessary. The failure to coordinate care didn't just affect this one patient. It evidences a general failure by Petitioner to understand that coordination with skilled nursing facility staff is a critical component of hospice care.

Petitioner not only failed to coordinate the care that the patient received but it also failed to assure that medication was available to carry out the standing order that the patient receive morphine and Ativan on an as-needed basis. There was no documentation in the patient's medication administration record (MAR) during the period from March 1 through March 30, 2017, showing that orders for administration of morphine and Ativan had been issued. CMS Ex. 2 at 353-54. Nor was there any record of the standing order for morphine and Ativan in the skilled nursing facility's records. CMS Ex. 1 at 6-9. As a consequence, the skilled nursing facility had no official communication from Petitioner that it had issued a standing order for the administration of morphine and Ativan to the patient.

In its defense, Petitioner argues first that the surveyors' findings are based on allegedly irrelevant evidence, contending that records generated prior to Petitioner's filing of a plan of correction have no meaning in terms of Petitioner's compliance as of March 30. Petitioner's post-hearing brief at 8-9. I disagree. The evidence offered by CMS shows a continuing pattern of noncompliance beginning in late February 2017 and continuing through March 30, weeks after Petitioner filed its plan of correction. The evidence shows that nothing changed in terms of coordination with the skilled nursing facility's staff after the filing date of the plan of correction. Rather, there was a seamless and ongoing failure by Petitioner's staff to assure coordination of the patient's medication administration with the staff of the skilled nursing facility. That is not only proof of noncompliance but it underscores the severity of that noncompliance. It is evidence that while Petitioner may have said all of the right things in its plan, it wasn't implementing it.

Petitioner argues that the patient was not experiencing pain and that there was no need for administration of pain medication. It asserts that had the patient actually experienced pain there would have been coordination with the skilled nursing facility's staff to assure that the patient received appropriate medication. Petitioner's post-hearing brief at 10-11. This is a kind of "no harm, no foul" argument in which Petitioner attempts to excuse its noncompliance by asserting that the patient really didn't need the services that Petitioner's staff had ordered but failed to provide. It may be providential that this patient didn't need pain medication but that doesn't excuse Petitioner's noncompliance. The failure to coordinate the care provided to this patient is evidence from which I infer that Petitioner did not implement a comprehensive scheme of coordination for all of its patients as it had promised to do.

Petitioner asserts, without evidence, that it followed its policies and procedures "precisely by updating skilled nursing facility medication record[s] (MAR) as directed . . . , with PRN [as needed] medication for patient[s] not exhibiting pain." Petitioner's post-hearing brief at 11. I find this assertion to be belied by the evidence offered by CMS and not refuted by Petitioner. Petitioner's undocumented claim notwithstanding, the credible evidence establishes that it was not updating its patient's MAR, nor did it record the standing order for administration of morphine and Ativan in the skilled nursing facility's records.

Petitioner also asserts that, even if it did not provide morphine and Ativan directly to the patient, this medication was present at the skilled nursing facility and at others serviced by Petitioner and the staffs of those facilities had access to the medication if Petitioner's patients needed it. Petitioner's post-hearing brief at 11. But, this doesn't excuse Petitioner's nonperformance. As I state at the inception of this decision, the Medicare program doesn't reimburse hospices for items or services that it does not provide but that others do. Petitioner may not hide behind the possibility that its patients may have been able to receive medication from other sources that Petitioner failed to assure was available.

CMS makes a second allegation concerning Petitioner's failure to provide services to the patient and that relates to Petitioner's failure to manage the patient's constipation. Hospice staff did not document that the patient had a bowel movement between March 9 and March 23, 2017. Despite that, there is nothing to show discussions with the skilled nursing facility staff concerning this issue. CMS Ex. 1 at 7. Petitioner did not offer arguments or evidence to rebut these findings.

As a second alleged condition-level noncompliance CMS contends that Petitioner failed to comply with the requirements of 42 C.F.R. § 418.112. This regulation governs the care that a hospice must provide to patients who are also residents of skilled nursing facilities. CMS contends that Petitioner violated standards set forth in subparts (b), (d), and (e) of this regulation. Subpart (b) requires a hospice to assume management of the care of hospice services provided to residents of skilled nursing facilities and to make any arrangements necessary for hospice-related inpatient care in facilities that participate in Medicare or Medicaid.

Subpart (d) requires a hospice to establish and maintain a plan of care in consultation with representatives of any skilled nursing facility within which one of its patients resides. All hospice care provided must be provided pursuant to that plan of care. The plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the functions that have been agreed upon and included in the hospice plan of care.

Subpart (e) requires a hospice to provide a skilled nursing facility within which one of its patients resides with documentation comprehensively described in that subpart.

CMS charges that as of the March 30 survey Petitioner was not providing services that complied with the regulation's requirements. Specifically, CMS asserts that:

- Petitioner had failed to re-educate its staff concerning the services that it provided, in accordance with its corrective action plan. As of the date of the survey a skilled nursing facility director of nursing hadn't attended the training that Petitioner had promised to complete by March 14. CMS Ex. 1 at 29-30. One of Petitioner's staff averred that he/she hadn't received the promised re-education and was unsure of what corrective actions had been implemented by Petitioner since the previous survey. *Id.* at 35.

- Contrary to Petitioner's own policy, Petitioner failed to maintain complete and accurate coordinated task plans for each patient. CMS Ex. 1 at 37-44. One patient's coordinated task plan failed to include treatments ordered for prevention of skin breakdown, and lacked information and plans concerning the patient's risk for aspiration (inhaling food). *Id.* at 40. As respects another patient, Petitioner's

coordinated task plan failed to state which provider would monitor that patient's blood sugar levels. *Id.* at 44.

- Petitioner failed to provide skilled nursing facilities housing Petitioner's patients with accurate and up-to-date information about the medications that the patients were receiving. One patient's MAR was dated about 11 months prior to the patient's current certification period. CMS Ex. 1 at 47-48. Another patient's MAR did not show an order for morphine and Ativan that the hospice placed on March 14, 2017, two weeks prior to the March 30 survey (this is the same patient whose care I discuss with respect to Petitioner's noncompliance with 42 C.F.R. § 418.52). *Id.* at 48-51.

- In the case of another patient, the patient's hospice binder failed to include a copy of the patient's advanced directive. CMS Ex. 1 at 45-46, 53. *See* 42 C.F.R. § 418.112(e)(3)(ii).

When viewed collectively, these failures by Petitioner are not simply isolated failures to comply with standards of participation. Rather, they paint a picture of a facility that, after months of intensive review, was still failing to engage in the basic communications with skilled nursing facilities that are required by regulation. The lapses uncovered at the March 30 survey were fundamental. For example, not telling a skilled nursing facility about the hospice's plans for dealing with a patient's skin breakdown and the risk of aspiration amounted to abdication by Petitioner of its basic responsibilities. To put it another way, Petitioner was failing to provide basic services that it was claiming reimbursement for and leaving it to others to provide those services, if they were provided at all.

The risk to patients from these derelictions is plain. It is not simply a case here of Petitioner failing to fulfill its obligations to its patients. Without coordination and communication, patients were put at risk of being in a state of limbo, with the skilled nursing facility staff being unaware of what it was that the hospice had determined to provide and not knowing whether they were to provide a service or not. If, for example, a patient's blood sugar level required monitoring and the hospice did not coordinate the monitoring with the skilled nursing facility at which that patient resided, the patient ran the risk of not having his/her blood sugar monitored at all.

Although Petitioner contends that evidence supports its contention that it complied with these regulatory requirements, it has failed to provide evidence that rebuts the specific allegations that I have addressed. Petitioner offers no evidence to address CMS's specific contention that individuals did not receive the re-education and training that Petitioner averred it would provide in its plan of correction. Rather, Petitioner asserts generally that it re-educated its staff. This general claim is inadequate rebuttal of the specific evidence of noncompliance offered by CMS.

Petitioner argues that it was not required to provide copies of its patients' documents, including care plans and MARs, to skilled nursing facilities, averring that it maintained these records electronically and that the facilities knew where to obtain them if their staffs wanted to review them. Petitioner's post-hearing brief at 15. But, that assertion evades answering CMS's specific allegation that Petitioner failed to provide skilled nursing facilities with updated treatment information. CMS isn't alleging that Petitioner failed to provide a copy of its MARs to facilities. Rather, CMS offered evidence to prove that Petitioner failed to *update* MARs. The MARs were incomplete whether or not Petitioner maintained them electronically.

Petitioner does not address CMS's evidence that Petitioner failed to maintain accurate and up-to-date coordinated task plans for its patients. It offers no response to CMS's evidence showing that a coordinated task plan failed to include treatments ordered for prevention of skin breakdown and lacked information and plans concerning a patient's risk for aspiration. Instead, Petitioner recites a list of documents that it contends that surveyors found in patient binders. Petitioner's post-hearing brief at 15. That assertion evades addressing CMS's evidence and does not rebut it.

Petitioner offers nothing to respond to CMS's assertion that one patient binder failed to contain a copy of the patient's advanced directive.

The evidence thus proves that Petitioner failed to comply with two conditions of participation that govern hospices. As I have stated even one failure to comply with a condition as of March 30, 2017, justified CMS's determination to terminate Petitioner's participation in Medicare.

_____/s/_____
Steven T. Kessel
Administrative Law Judge