Responding to Hospice Audits

Documentation, Appeals, and Lessons Learned

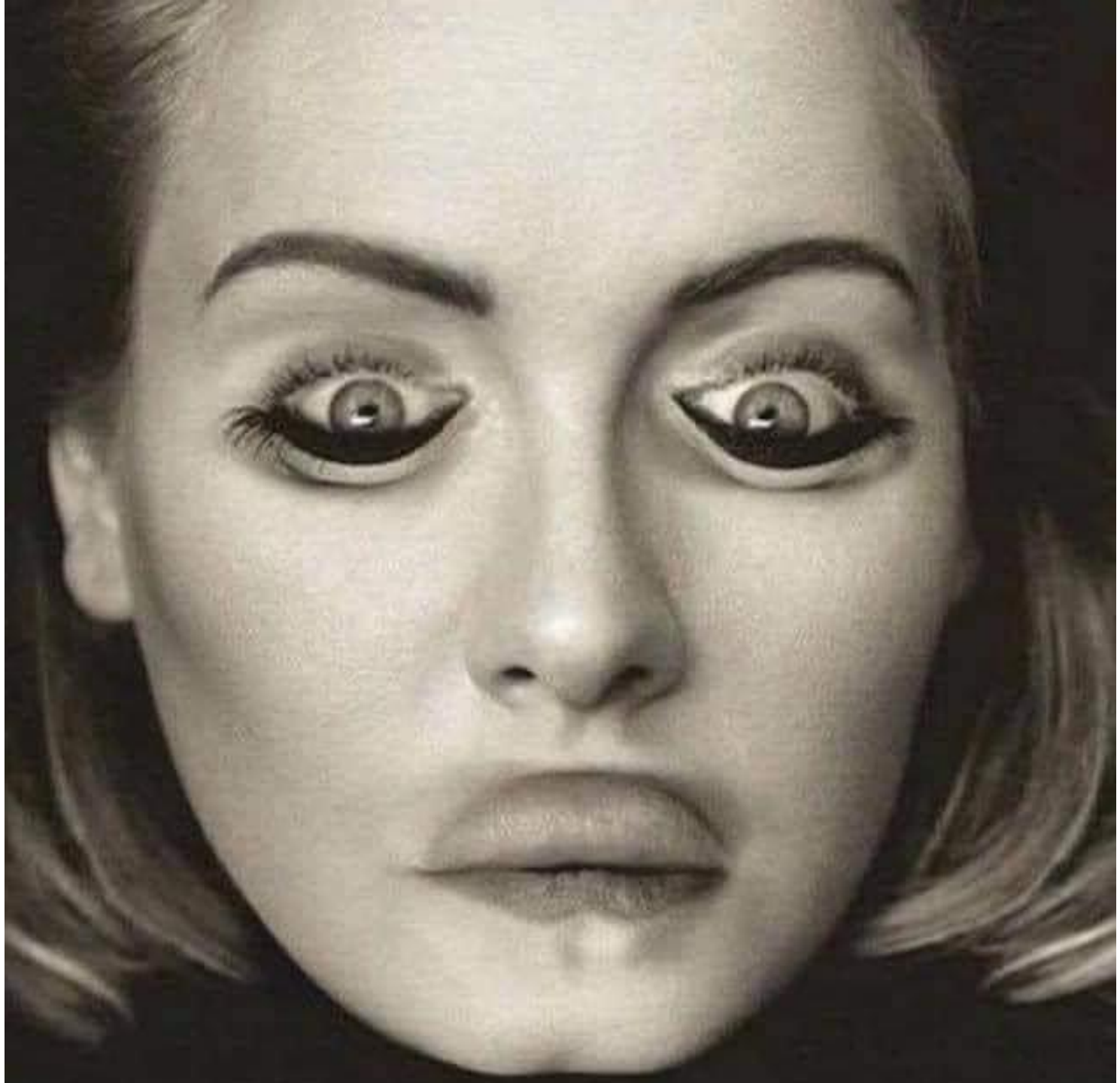
Disclaimer

This course provides education on tools and ideas to help with the ADR process and does not replace legal or regulatory advice. Although every reasonable effort has been made to assure the accuracy of the information within this course, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of the services.

Healthcare professionals should consult their organization’s policies and seek legal counsel when necessary.

Learning Objectives

1. *Understanding the Current Audit Landscape*
2. *Common Documentation Gaps and Denial Drivers*
3. *Strengthening Audit Response Processes*
4. *Building an Effective Appeals Strategy*



Conditions of Participation

Regulatory requirements for participating in Medicare enforced by **Surveyors** through citations.

Conditions of Payment

A subset of requirements to obtain Medicare Payments enforced by **Auditors** through claim denials.

- Conditions relate to medical necessity, the hospice election, creation / maintenance of the plan of care, and the certification of terminal illness.
- **Clinical Denials**: Lack of clinical eligibility for hospice services or for level of care.
- **Technical Denials**: Insufficient, invalid, or missing medical record documentation.

Differences

Surveys

VS.

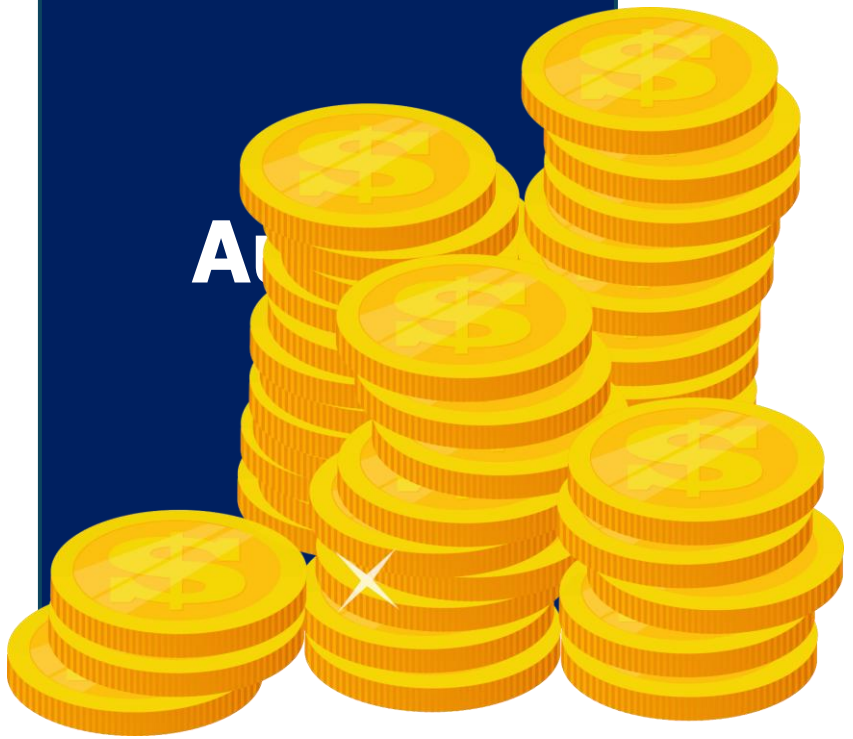
Audits

Differences

Surveys

VS.

A



Is Hospice Being Unfairly Audited?

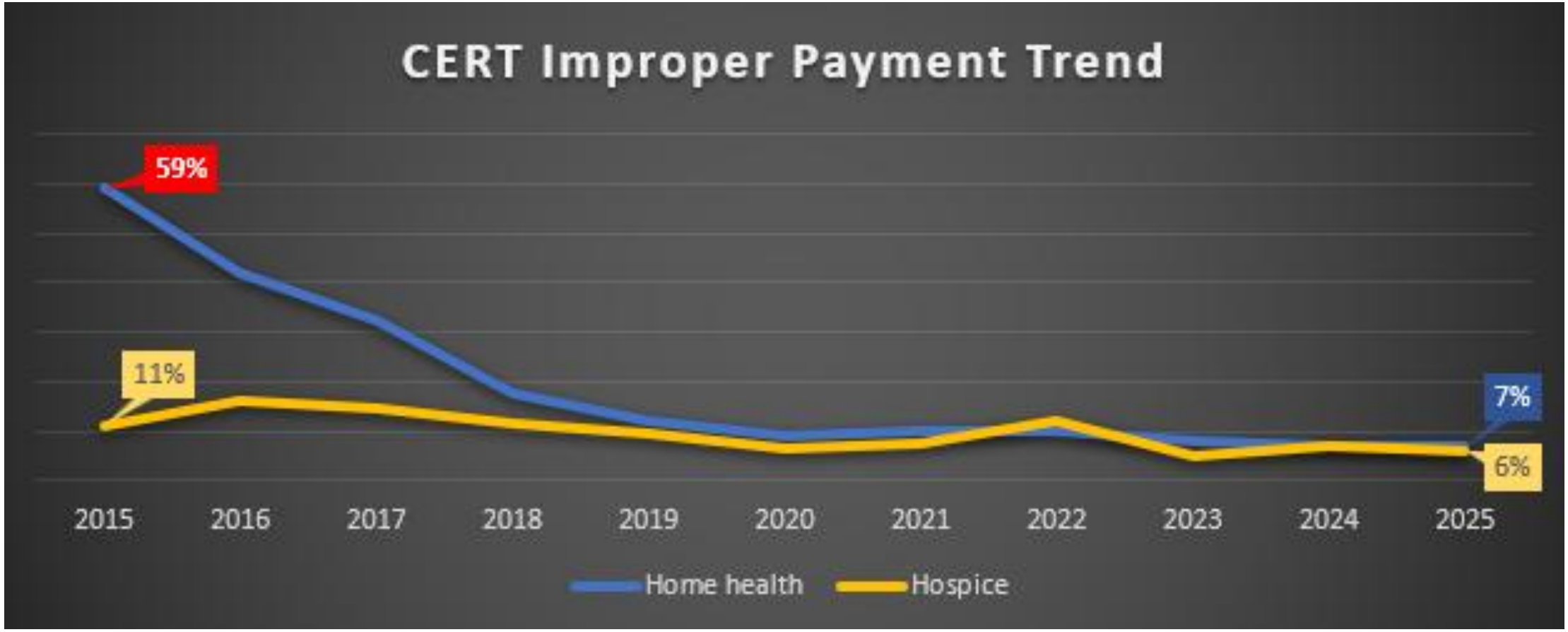
In 2024, more than **1.8 million Medicare Beneficiaries** received hospice services from approximately **6,700 Providers**, and Medicare hospice expenditures totaled **$28.3 billion**.

Source: MedPAC Annual Report to Congress, Chapter 10, Hospice Services, March 2026

Audit Reasons

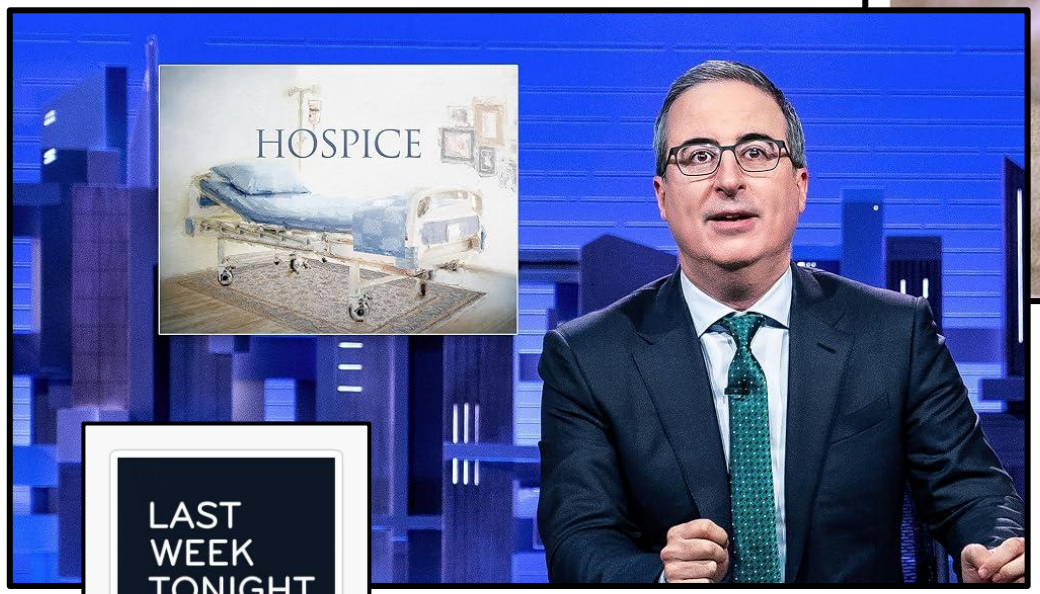
- Regulatory Compliance
- Fraud Prevention
- Quality Assurance
- Data Integrity
- Financial Accountability

Fraud, Waste, and Abuse



Source: CERT Medicare Fee-for-Service Supplemental Improper Payment Data

Fraud, Waste, and Abuse



FIRST OPINION

The hospice industry needs major reforms. It should start with apologies

By Ira Byock Aug. 22, 2023 Reprints

THE NEW YORKER

A REPORTER AT LARGE

HOW HOSPICE BECAME A FOR-PROFIT HUSTLE

It began as a visionary notion—that patients could die with dignity at home. Now it's a twenty-two-billion-dollar industry plagued by exploitation.

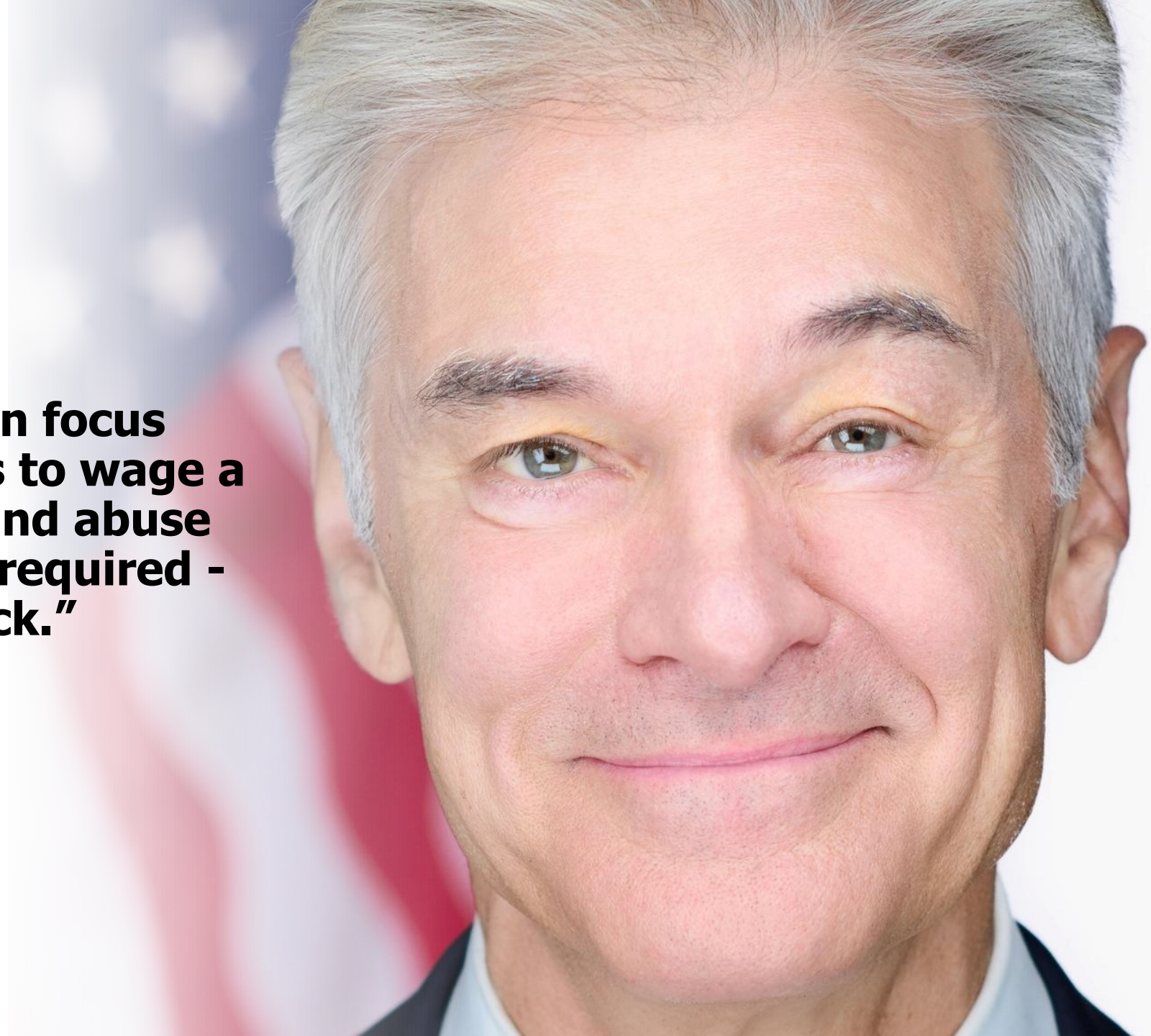
By Ava Kofman
November 28, 2022

“Right now, my main focus without any question is to wage a war on fraud, waste and abuse because that’s what’s required - all hands-on deck.”

CMS Administrator

Dr. Oz

4.25.25



“It is imperative that we continue to protect timely access to high-quality hospice care for all Americans who need it.

The current hospice benefit has largely proven successful in delivering that compassionate care, and I am working to continue to improve the patient experience.”

Congresswoman Beth Van Dyne
(R-TX)

Source: Hospice News 6.24.25

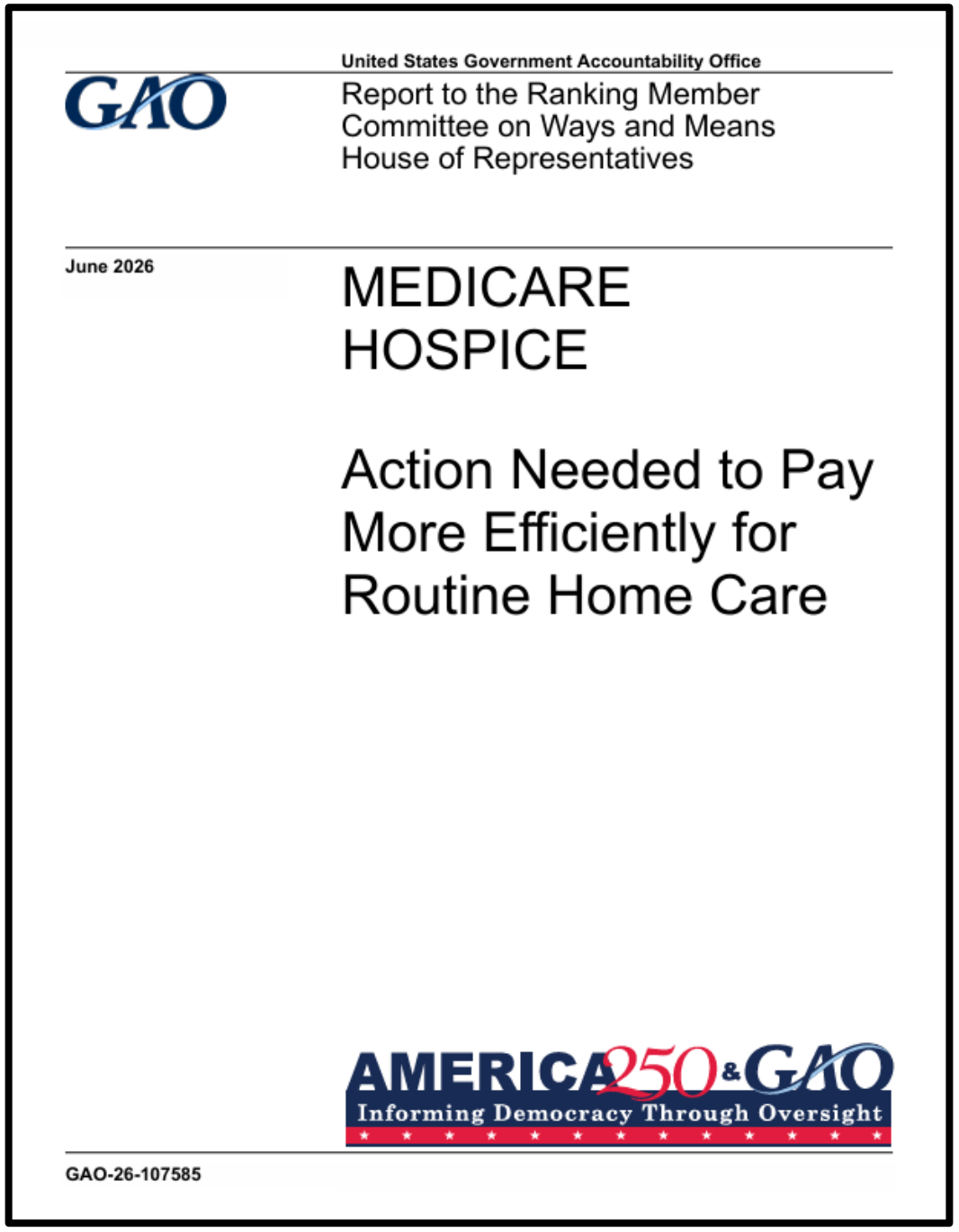
MEDPAC Medicare Payment Advisory Commission

RECOMMENDATION

10 For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Source: MedPAC Annual Report to Congress, Chapter 10, Hospice Services, March 2026



GAO recommends that Congress consider directing the Secretary of the Department of Health and Human Services (HHS) to revise the hospice payment system for routine home care services to better promote payment efficiency and realize savings for the Medicare program.

Source: www.gao.gov/assets/gao-26-107585.pdf

Hospice Visits Are A Signal

Visit frequency is the new lens:

Low-visit hospices — the bottom 20% at about 2.5 visits per week — are now explicitly flagged. Expect reviewers to look at how often you actually show up.

Document every visit:

Under a daily rate, sparse visit patterns invite both quality and payment questions. Make the record show the care you deliver.

Payment-reform pressure is building:

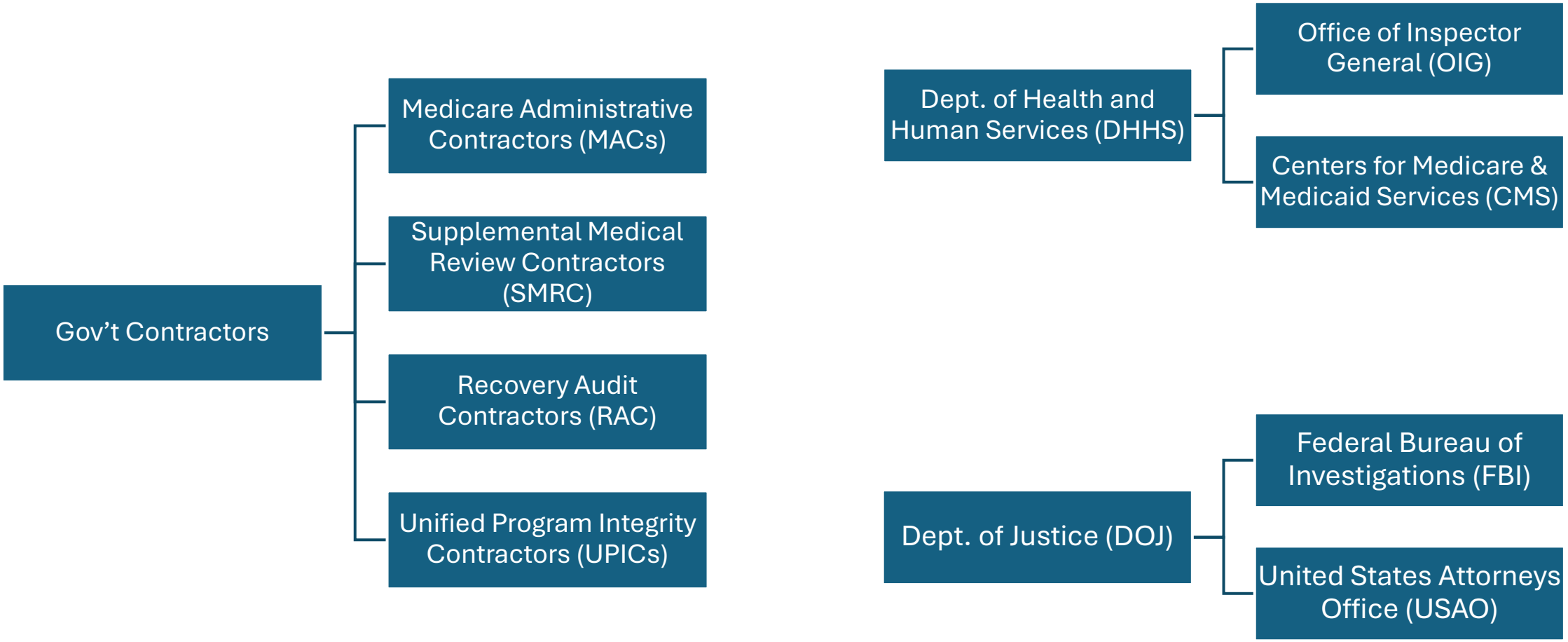
GAO now joins MedPAC in pushing to refine the per-diem — a per-visit or tiered model could follow.

Change takes action by Congress:

CMS says the daily rate is statutory, so change needs legislation — but the target is now squarely on routine home care.

Audit Landscape

Who Is Auditing?



Audit Types

AUDIT TYPE	REVIEW	RECORD REQUEST / INITIAL REVIEWER
Targeted Probe & Educate (TPE)	Pre- and Post-Payment	MAC
Provisional Period of Enhanced Oversight (PPEO)	Pre-Payment	MAC
Expanded Pre-Payment Review (EPR)	Pre-Payment	MAC
Supplemental Medical Review Contractor (SMRC)	Post-Payment	SMRC
Center For Program Integrity (CPI)	Post-Payment	SMRC
Recovery Audit Contractor (RAC)	Post-Payment	RAC
Unified Program Integrity Contractor (UPIC)	Pre- and Post-Payment	UPIC
Office of Inspector General (OIG)	Post-Payment	OIG

Compliance Environment - TPE

Code Type	Specific Code	Edit Topic	Edit Description
Bene sharing	All	Hospice services bene sharing	Review of claims submitted for hospice services for eligibility and medical necessity bene sharing
Rev code	GIP	GIP	Review of inpatient claims for inpatient hospice care greater than or equal to 7 days for revenue code 656 and place of service codes Q5004–Q5009
Rev code	New hospice providers	New hospice providers	Review of new hospice provider claims
Rev code	0651, 0652, 0655, 0656	Hospice LOS greater than 365 days	Review of claims submitted for hospice LOS greater than 365 days
Rev code	RHC – 0651	RHC – Rev code 0651	Review of hospice RHC — rev code 0651
Rev code	0652	Hospice services CHC	Review of claims submitted for hospice services CHC

Source: Palmetto GBA

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Compliance Environment - TPE

Edit Topic	Q2 2026 TPE Results
Hospice services bene sharing (*Q1 results*)	120 hospices selected (0 Texas) 97 hospices compliant (0 Texas) 23 hospices non-compliant (0 Texas)
GIP	17 hospices selected (2 Texas) 13 hospices compliant (2 Texas) 4 hospices non-compliant (0 Texas)
New hospice providers	38 hospices selected (10 Texas) 24 hospices compliant (6 Texas) 14 hospices non-compliant (4 Texas)
Hospice LOS greater than 365 days	2 hospices selected (1 Texas) 2 hospices compliant (1 Texas) 0 hospices non-compliant (0 Texas)

Edit Topic	Q2 2026 TPE Results
RHC – Rev code 0651	13 hospices selected (0 Texas) 9 hospices compliant (0 Texas) 4 hospices non-compliant (0 Texas)
Hospice services CHC	7 hospices selected (1 Texas) 4 hospices compliant (0 Texas) 3 hospices non-compliant (1 Texas)
NCLOS (*Q1 results*)	1 hospices selected (0 Texas) 0 hospices compliant (0 Texas) 1 hospices non-compliant (0 Texas)
Hospice place of service	21 hospices selected (0 Texas) 19 hospices compliant (0 Texas) 2 hospices non-compliant (0 Texas)
Hospice respite (*Q1 results*)	36 hospices selected (3 Texas) 27 hospices compliant (3 Texas) 9 hospices non-compliant (0 Texas)

Source: Palmetto GBA

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Compliance Environment – Focus States

July 13, 2023:
PPEO launched in California, Arizona, Nevada, and Texas.

September 17, 2024:
Expanded Prepayment Review of existing hospices began in focus states.

As of June 2025, 668 hospices under PPEO resulted in 122 hospices been revoked.

December 30, 2025:
Georgia and Ohio were added.

Fig. 1 - High Risk States

PPEO

mln FACT SHEET

KNOWLEDGE • RESOURCES • TRAINING

Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, Texas, Georgia & Ohio

What's Changed?

We added the Georgia and Ohio start date for the provisional period of enhanced oversight (page 3).

Substantive content changes are in dark red.

CMS is placing newly enrolling hospices located in Arizona, California, Nevada, Texas, Georgia, and Ohio in a provisional period of enhanced oversight. We received numerous reports of hospice fraud, waste, and abuse. The number of hospices enrolled has increased significantly in these states, raising serious concerns about market oversaturation.

What's the Goal?

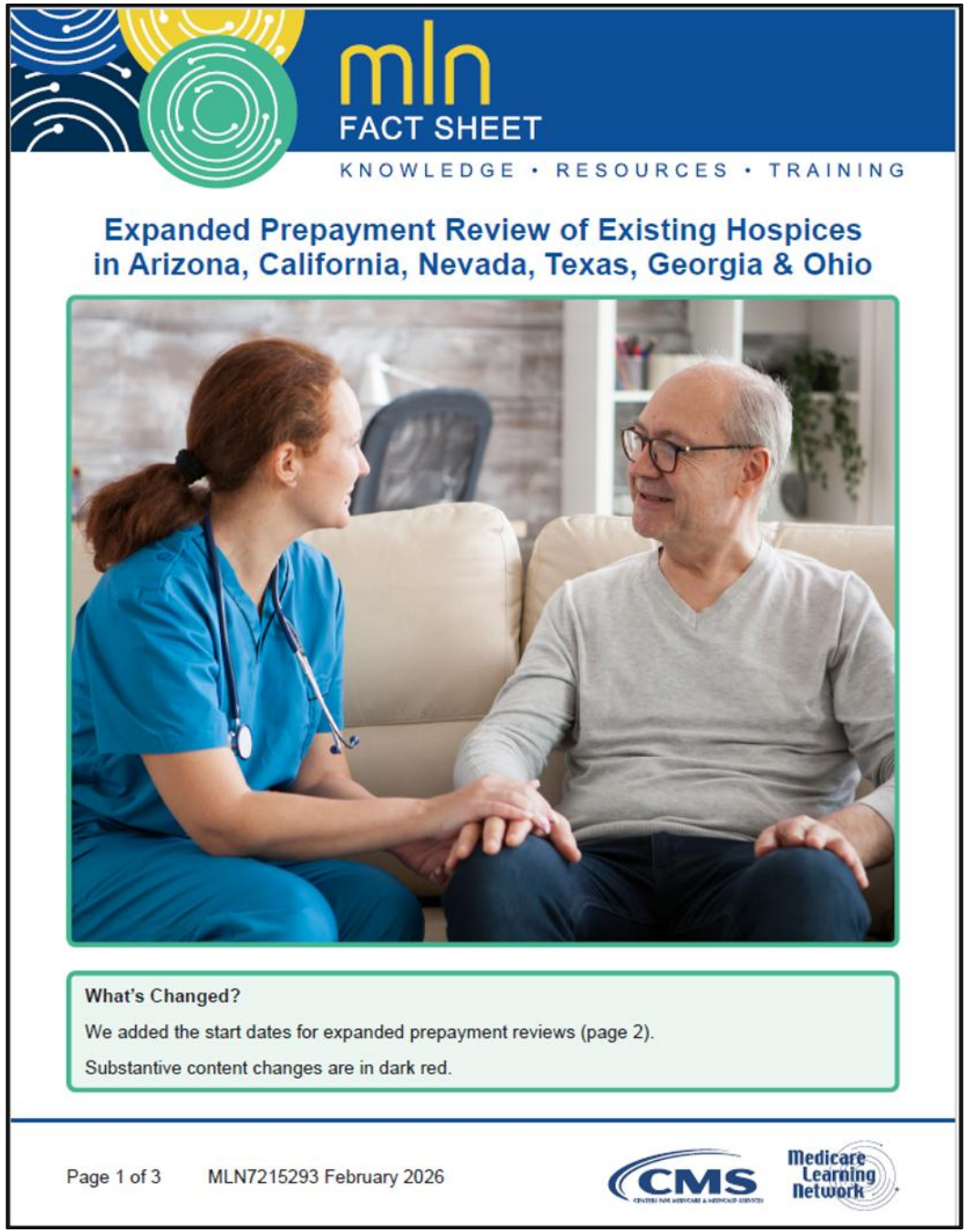
The goal of enhanced oversight is to reduce hospice fraud, waste, and abuse.

Am I Considered a New Hospice?

For the period of enhanced oversight, new hospices include those:

- Newly enrolled in the Medicare Program
- Submitting a change of ownership that meets all the regulatory requirements under 42 CFR 489.18
- Undergoing a 100% ownership change that doesn't fall under 42 CFR 489.18
- Reactivating after being in a deactivated status

EPR



mln FACT SHEET

KNOWLEDGE • RESOURCES • TRAINING

Expanded Prepayment Review of Existing Hospices in Arizona, California, Nevada, Texas, Georgia & Ohio

What's Changed?

We added the start dates for expanded prepayment reviews (page 2).

Substantive content changes are in dark red.

Page 1 of 3 MLN7215293 February 2026

CMS conducts expanded prepayment reviews and related activities for existing hospices in Arizona, California, Nevada, Texas, Georgia, and Ohio.

What's the Goal?

The goal is to reduce hospice fraud, waste, and abuse.

Does This Affect Me?

This may affect you if you're an existing hospice provider in the states of Arizona, California, Nevada, Texas, Georgia, or Ohio.

What Type of Expanded Prepayment Review Will You Perform?

To help reduce the burden on compliant providers, we're keeping the initial review volumes low and adjusting them based on the results. If you're noncompliant, we may continue to review or take additional administrative actions.

Compliance Environment – SMRC

Supplemental Medical Review Contractor

Noridian Healthcare Solutions will notify CMS of any identified improper payments and noncompliance with documentation requests.

Top denial reasons with SMRC audits

- Lack of medical necessity.
- No response to the documentation request.
- Certification deficiencies.

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

March 26, 2025

CMS Project ID: 02-349

Request Type & Purpose: CMS Notification of Post-Payment Claim Review
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

This letter is a formal request for medical record documentation associated with the reopening of Medicare claims previously submitted for payment. Additional information is necessary to properly evaluate these claims. Please review the directions and information set forth within this letter.

The federal regulation governing good cause for reopening is found at 42 CFR § 405.986 and in relevant part, states the following:

a) Establishing good cause. Good cause may be established when-
   1) There is new and material evidence that--
      i) Was not available or known at the time of the determination or decision; and
      ii) May result in a different conclusion ….

Noridian is reopening the claims associated with the beneficiaries referenced on the enclosed list for good cause. The reopening is based on credible evidence regarding data analysis identifying potential aberrancies in your Medicare billing. Additional information may be needed to properly evaluate the Medicare claims submitted for payment. Social Security Act (SSA) Title XVIII, § 1815 outlines details of payment to providers including periodic assessment of the amounts and frequency in which providers are reimbursed for care provided.

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

November 6, 2025

Project ID: 02-349

RE: SMRC Post-payment Claim Review Results

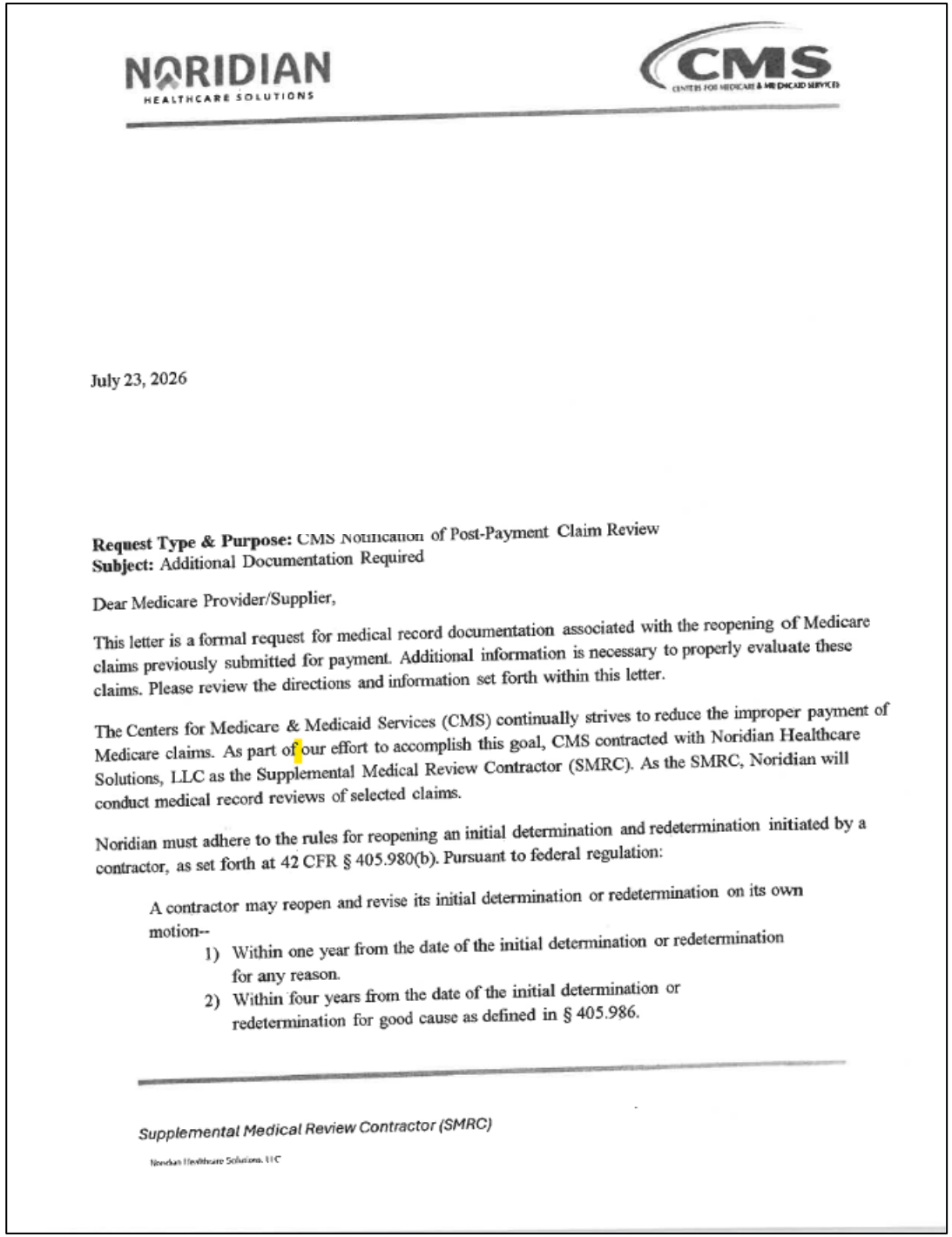
Claim Review Summary

Medical review was performed to determine if the claims and submitted documentation met Medicare requirements as set forth by federal statute. These include Title XVIII of the Social Security Act, the Code of Federal Regulations, the Medicare Program Integrity Manual, and any applicable National or Local Coverage Determinations. In accordance with the reopening rules found at 42 CFR § 405.980(b), the information below outlines the total number of claims reviewed, error rate summary and the estimated overpayment amount.

Total Number of Claims Reviewed: 159

Error Rate: 85%

Overpayment Amount: $719,858



NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

July 23, 2026

Request Type & Purpose: CMS Notification of Post-Payment Claim Review
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

This letter is a formal request for medical record documentation associated with the reopening of Medicare claims previously submitted for payment. Additional information is necessary to properly evaluate these claims. Please review the directions and information set forth within this letter.

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce the improper payment of Medicare claims. As part of our effort to accomplish this goal, CMS contracted with Noridian Healthcare Solutions, LLC as the Supplemental Medical Review Contractor (SMRC). As the SMRC, Noridian will conduct medical record reviews of selected claims.

Noridian must adhere to the rules for reopening an initial determination and redetermination initiated by a contractor, as set forth at 42 CFR § 405.980(b). Pursuant to federal regulation:

> A contractor may reopen and revise its initial determination or redetermination on its own motion--
>
> 1) Within one year from the date of the initial determination or redetermination for any reason.
> 2) Within four years from the date of the initial determination or redetermination for good cause as defined in § 405.986.

Supplemental Medical Review Contractor (SMRC)

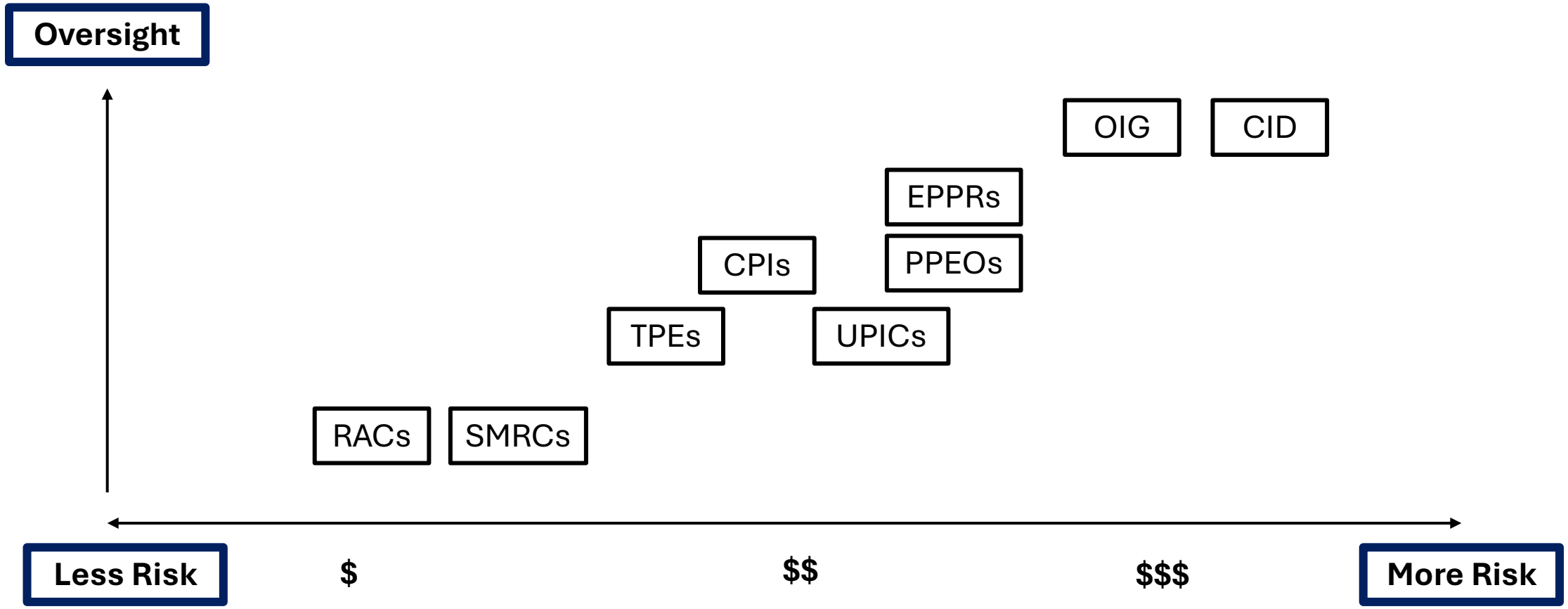
Noridian Healthcare Solutions, LLC

*"Please note that, due to the **involvement of several providers and the urgency surrounding this project**, this extension will be the last and only one approved."*

*"Because **multiple providers** are associated with this project number and there is a completion timeline, we are limiting the extensions we provide. This approach is necessary **to ensure that all participating providers** can complete the process within the required timeframes and that we maintain consistency and fairness throughout the project.*

*Additionally, please note that **audit results will not be provided until the medical review is complete for all providers**, followed by CMS's review and approval of the final report."*

Audit Risk Continuum



Other Auditors

Medicare Part D

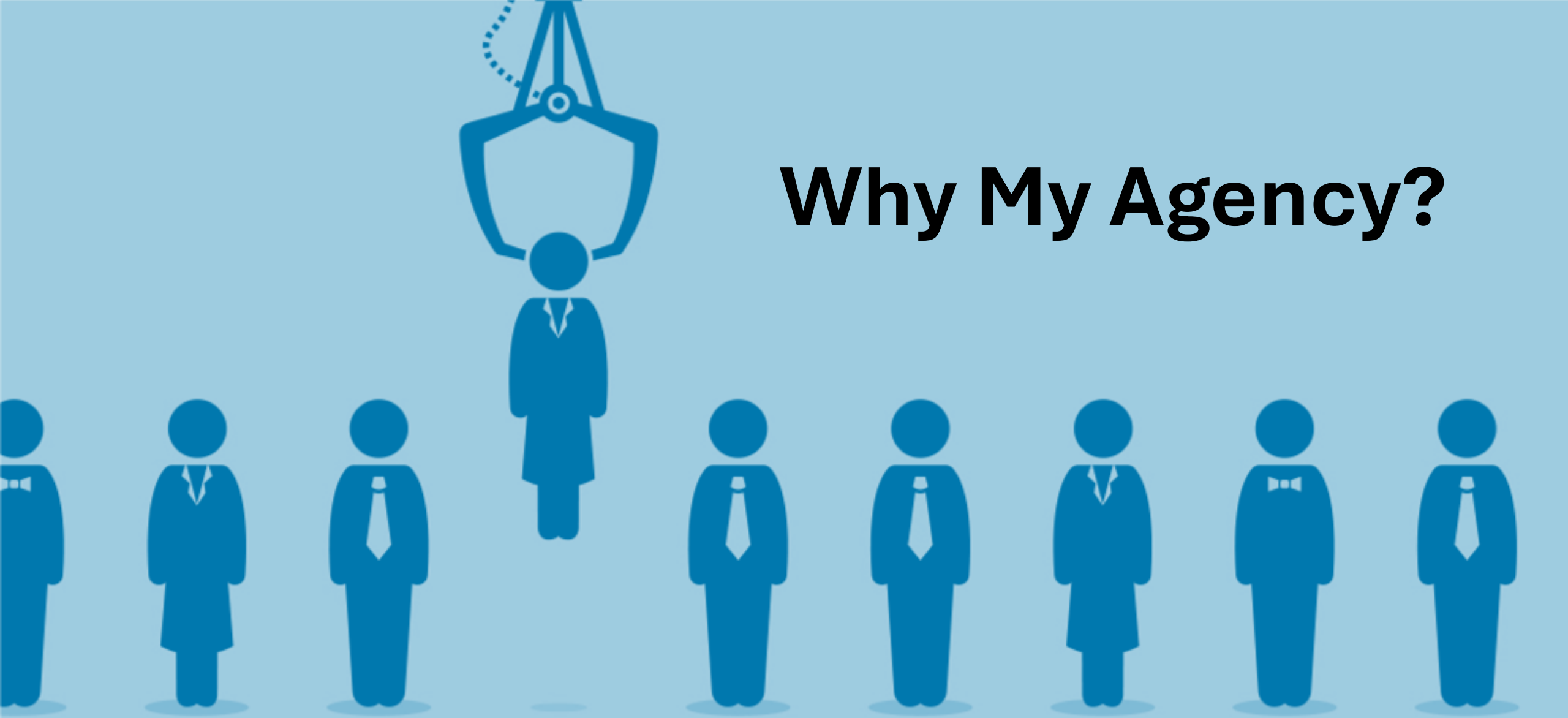
Medicare Advantage

Commercial/Private Insurance

Medicaid Fraud Control Unit (MFCU)

State Insurance Fraud Prosecutor (or similar entity)

Why My Agency?



Why My Agency?

Auditors utilize **Data Analytics** and **Artificial Intelligence** (AI) to scrutinize hospice claim activities.

They analyze your data to identify:

- A surge in the number of claims billed.
- Patterns of unusual or atypical claims that stand out as irregular.
- Providers located in areas known for fraudulent activities, as flagged by CMS.
- A rise in claims for products that yield higher reimbursements.
- An uptick in the quantity of claims filed for each beneficiary.

Why My Agency?

External Sources:

- Complaints lodged with CMS by a patient or their caregiver/family
- Insider reports exposing questionable practices of a Provider
- Allegations from competing businesses about unfair or illegal operations
- Evidence or testimonies gathered during the probe of another Provider
- Disgruntled employee

Audit Response

“If a record request for an audit arrived tomorrow, how quickly could you respond?”

Initial Timeframe to Respond

Pre-Payment Review by MACs - TPE

- As outlined in 42 CFR § 405.903 Prepayment review, a provider or supplier will be provided **45 calendar days** to submit additional documentation in response to a contractor's request.

Pre-Payment Review by UPICs

- As outlined in 42 CFR § 405.903 Prepayment review, a provider or supplier will be provided **30 calendar days** to submit additional documentation in response to a UPIC's request for additional documentation.

Post-Payment Review by MACs, SMRC, and RACs

- As outlined in 42 CFR § 405.929 Post-payment review, a provider or supplier will be provided **45 calendar days** to submit additional documentation in response to a contractor's request.

Post-payment Review by UPICs

- As outlined in 42 CFR § 405.929 Post-payment review, A provider or supplier will be provided **30 calendar days** to submit additional documentation in response to a UPIC's request for additional documentation.

Submission Extensions

MACs, SMRC, and RACs Reviews:

The contractor may accept documentation received after the 45-calendar days for good cause.

UPIC Reviews:

The contractor may accept documentation received after the 30-calendar days for good cause.

Work with your designated MAC if additional time is needed.

Hospice Top Denial Reasons

Clinical

- Terminal Prognosis Not Supported
- Level of Care Not Supported

Technical

- Notice of Election Missing / Invalid
- F2F Encounter Invalid
- Physician Narrative Missing / Invalid
- IDG Meeting Attendance and Participation

What If I Don’t Respond?

42 CFR §405.930:

→ **Failure To Respond**

→ 

The goal is submitting responsive and organized documents for the Reviewer.

Pre-Submission Best Practices

Understand The Request

Type of audit; Documents requested; Deadline for submission.

Organized Documents

Complete, timely, and consistent; Cover letter; Page numbers

Quality Control

Double check; Verify submission method; Maintain copy

Post-Submission Best Practices

Audit response team debrief

Analyze internal and external findings for compliance gaps

Prepare for next steps

Additional rounds of review, appeals, education

Update internal audit tools and checklists

Leverage technology and data

Provide on-going staff training

Documentation requirements; Audit triggers

Common Traps To Avoid

Obsessing over “Why is this happening?”

Performing lengthy self-audit of records

Responding too fast

Appeal Process

The Results

Fully Favorable

Partially Favorable

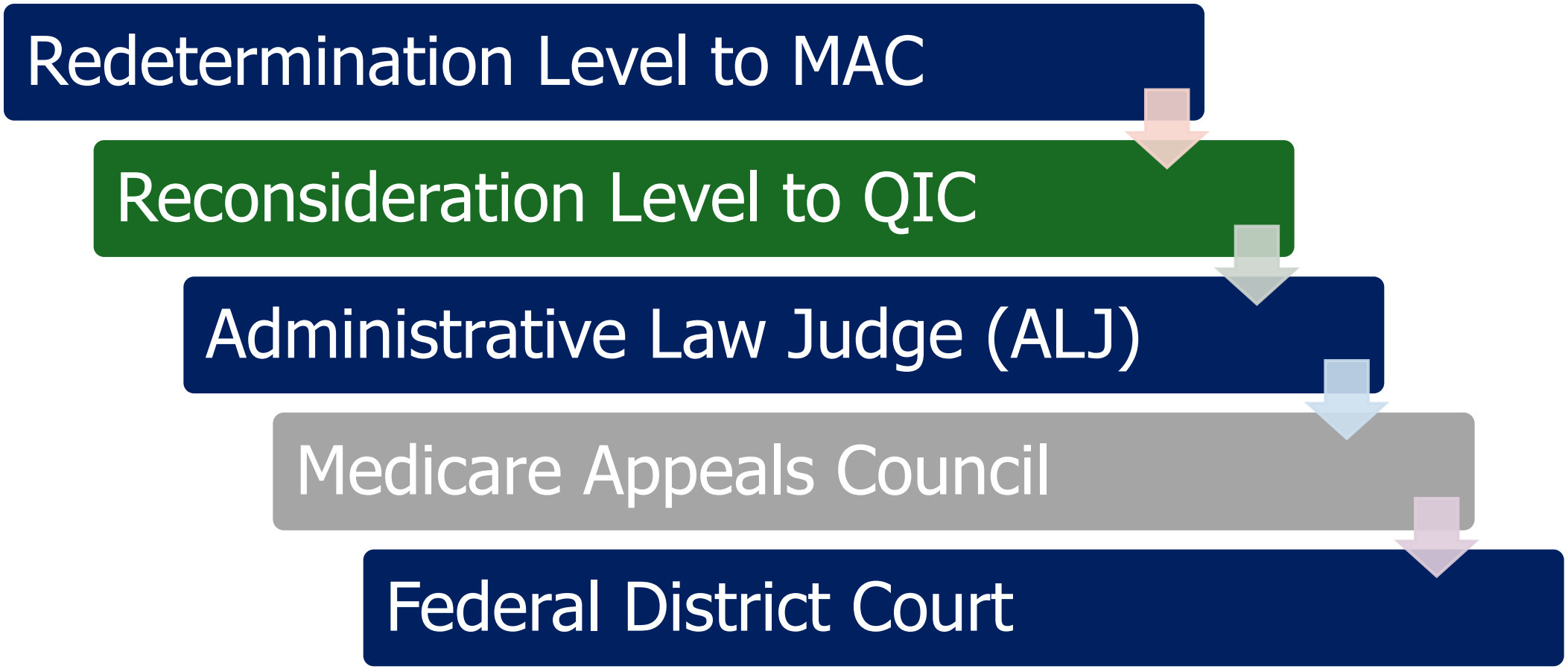
Unfavorable

When To Appeal

If you disagree:

- With the amount paid
- Denied as “Non-Covered”
- Denied as “Not Reasonable and Necessary”
- Denied for failure to meet eligibility criteria
- Denied as contractual obligation
- Denied by an auditing entity

Levels of Appeal



Appeal Process

Redetermination	Reconsideration	ALJ
File request with MAC within 120 days of the initial determination.	File request for QIC review within 180 days of redetermination decision notice.	File request with OMHA within 60 days of the reconsideration decision notice.
Include additional evidence to support your case.	Last opportunity to provide additional evidence to support your case.	Able to explain case and to call witnesses before an ALJ.
No set amount limit to contest.	No set amount limit to contest.	$200 minimum limit contested.
MAC has 60 days to issue a decision.	QIC has 60 days to issue a decision.	ALJ has 90 days to issue a decision.

Appeal Process

Medicare Appeals Council

File request within 60 days of the ALJ decision.

Record limited to prior submissions.

Appeals Council will review case if: abuse of discretion by the ALJ; an error of law; conclusions of ALJ not supported by substantial evidence; a broad policy or procedural issue occured.

Federal District Court

File request within 60 days of the Appeals Council decision or an ALJ decision (if the Appeals Council does not review the ALJ decision).

Record limited to prior submissions.

$1,960 minimum limit contested.

No timeframe for decision.

Appeal Process: Recoupment

Redetermination

Appeal must be received by MAC within 30 days to stay recoupment.
Once received, recoupment will stop. Interest will accrue.

Reconsideration

Appeal must be received by QIC within 60 days to stay recoupment.
Once received, recoupment will stop. Interest will accrue.

ALJ, Medicare Appeals Council, and Federal District Court

Cannot stop recoupment at these stages of appeal.

*Prompt repayment avoids interest accrual (approx. 12%); Payment plan options

Appeal Process: Considerations

The dollar amount and number of claims at issue

Extrapolation

The issues being appealed:

- **Technical**
- **Clinical**
- **Legal**
- **Statistical**
- **Other**

Assistance from Consultants and/or an Attorney:

- **Internal vs external analysis of risk and review of records**
- **Assistance with medical review summaries and submissions**
- **Presentation to the ALJ and above**

Appeal Process: Response Brief

Know Your Audience:

Clinician or Adjudicator

Identify and Analyze Key Data Points:

Objective, Measurable, and Comparative Data

Use Layman's Terminology:

Explain technical terms and significance of data.

Use Descriptive Language:

Clearly explain details.

Appeal Process: Submissions

Accuracy and Completeness:

Ensure all information is accurate, complete, and well-organized.

Professionalism:

Maintain a professional tone throughout all interactions and documentation.

Attention To Detail:

Carefully review all submissions for any errors or omissions.

Timeliness:

Be mindful of submission deadlines.

Best Defense To Prevent Denials

Strong Medical Records

Build the clinical story from the beginning.

Zero Tolerance For Technical Issues

Process, Process, Process – Elections, dates, signatures, etc.

Get Everyone Aligned

Consistent clinical documentation from Nurses, NP, Physicians

Social Workers and Chaplains telling the same story

Conclusion

High audit volume and increased scrutiny require a team approach.

Responding To Hospice Audits

1. **Do Not Ignore A Notice From A Payor**
2. **Implement Compliance Measures Immediately**
3. **Take Ownership & Stay Informed**
4. **Act Quickly**
5. **Address The Issue Directly**
6. **Seek Assistance Promptly**

Responding To Hospice Audits

Responding To Hospice Audits

Acronyms

ADR Additional Development / Document Request

AI Artificial Intelligence

ALJ Administrative Law Judge

BFCC-QIO Beneficiary & Family Centered Care-Quality Improvement Organization

CERT Comprehensive Error Rate Testing Contractor

CLD Condition Level Deficiency

CMP Civil Money Penalties

CMS Centers for Medicare and Medicaid Services

CoP Condition of Participation

CPI Center for Program Integrity

DOJ Department of Justice

EPR Extend Pre-payment Review

F2F Face-to-Face

IDR Informal Dispute Resolution

IJ Immediate Jeopardy

LCDs Local Coverage Determinations

MAC Medicare Administrative Contractor

OIG Office of Inspector General

OMHA Office of Medicare Hearings and Appeals

PPEO Provisional Period of Enhanced Oversight

PTAN Provider Transaction Access Number

QIC Qualified Independent Contractor

RAC Recovery Audit Contractor

SA State Survey Agency

SMRC Supplemental Medical Review Contractor

TPE Targeted Probe & Educate

UPIC Unified Program Integrity Contractor

References

Code of Federal Regulations 42 CFR Part 424-Conditions for Medicare Payment: https://www.ecfr.gov

Medicare Program Integrity Manual Chapter 3: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

CMS Targeted Probe and Educate Web Page: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html

Targeted Probe and Educate Top Provider Questions: https://cgsmedicare.com/parta/mr/tpe_faqs.html

National Coverage Determinations (NCDs):
Medicare Coverage Database: https://www.cms.gov/medicare-coverage-database/search.aspx?redirect=Y&from=Overview
Medicare National Coverage Determination Manual: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/ncd103c1_Part4_02032012.pdf

Local Coverage Determinations (LCDs):
Medicare Coverage Database: https://www.cms.gov/medicare-coverage-database/search.aspx?redirect=Y&from=Overview

ADRs and Appeals Resources

Level of Appeal	Where To File	Deadline For Filing The Appeal	Decision Makers Timeframe For Sending Appeal Decision	Monetary Threshold (2026)	Deadline to Halt Recoupment
1. Redetermination	Medicare Administrative Contractor (MAC)	120 days from date of initial claim determination / demand letter	60 days	None	30 days
2. Reconsideration	Qualified Independent Contractor (QIC)	180 days	60 days*	None	60 days
3. Administrative Law Judge (ALJ) Hearing	Office of Medicare Hearings and Appeals (OMHA)	60 days	90 days	$200	Can no longer halt recoupment.
4. Departmental Appeals Board Review (DAB) / Medicare Appeals Council	Medicare Appeals Council	60 days	60 days	None	N/A
5. Federal Court	Federal District Court	60 days	n/a	$1960	N/A

** Providers have the option to escalate the case to the ALJ if the QIC does not issue a decision within the required timeframe.*