CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

SafeGuard Services LLC

CONFIDENTIAL

September 23, 2016

JJE, Inc. dba Hospicio Toque de Amor
P.O. Box 1102
Manati, Puerto Rico 00674 -1102

Re: Notice of Suspension of Medicare Payments for JJE, Inc. dba Hospicio Toque de Amor
NPI:
WMM #

Dear JJE, Inc. dba Hospicio Toque de Amor:

The purpose of this letter is to notify you of the Centers for Medicare and Medicaid Services' (CMS) determination to suspend JJE, Inc. dba Hospicio Toque de Amor's (hereinafter "JJE") Medicare payments. The suspension of your Medicare payments became effective on September 22, 2016. Prior notice of the suspension was not provided because CMS determined that the Medicare Trust Funds would be harmed by giving prior notice. See 42 C.F.R. §405.372(a)(3). CMS determination to suspend JJE's Medicare payments is based on reliable information that an overpayment exists or that payments to be made may not be correct. See 42 C.F.R. §405.371(a)(1)

CMS, through its Central Office, is responsible for the decision to suspend your Medicare payments. The suspension of JJE's Medicare payments may last up to 180 days from the effective date of the suspension and may be extended under certain circumstances. See 42 C.F.R. §405.372(d).

As noted above, the suspension of JJE's Medicare payments is based, in part, on "reliable information that an overpayment exists or that the payments to be made may not be correct, although additional information may be needed for a determination." See 42 C.F.R. §405.371(a)(1). Here, CMS received reliable information through SafeGuard Services LLC

(SGS) that JJE was submitting claims to Medicare for payment for hospice services provided to beneficiaries who did not qualify for hospice care.

On July 20, 2016, an investigative team consisting of SGS investigators and a Registered Nurse Medical Reviewer conducted in-person interviews with Medicare beneficiaries for whom JJE submitted claims for hospice services to Medicare for payment. The investigative team determined the five (5) beneficiaries interviewed did not meet the eligibility criteria for terminal illness as outlined in the Medicare Benefit Policy Manual. See Id. at Chapter 9, Section 10. See also Local Coverage Determination (LCD) L33393 and 42 C.F.R. § 418.

Based on observations and physical assessments made by the SGS investigative team and statements made by the beneficiaries and their caregivers during the interviews, the investigative team determined the five (5) Medicare beneficiaries did not meet Medicare criteria to qualify for hospice services. According to Local Coverage Determination (LCD) L33393, to qualify as terminally ill, a physician must certify that a patient's prognosis is a life expectancy of six (6) months or less if the terminal illness were to run its course. SGS investigators determined the five (5) beneficiaries interviewed did not have a life expectancy of six (6) months or less during the dates in which they received hospice services from JJE. All five (5) beneficiaries had stable medical conditions and were not experiencing a decline in their functional status.

Additionally, three (3) of the five (5) beneficiaries interviewed had a primary diagnosis of Alzheimer's disease upon admission to JJE. As noted in LCD L33393, there are certain criteria that must be met for a beneficiary suffering from Alzheimer's disease to qualify as terminally ill. Based on observations and physical assessments made by the SGS investigative team and statements made by the beneficiaries and their caregivers, the investigative team determined that one (1) of the beneficiaries did not meet the criteria listed in LCD 33393 required for patients suffering from Alzheimer's disease to qualify as terminally ill. The beneficiary did not meet the criteria for Stage 7 Alzheimer's disease and exhibited stable medical conditions with no continuing decline in clinical status. However, two (2) of the beneficiaries interviewed did meet the criteria for Stage 7 Alzheimer's disease, but based on an assessment by the registered nurse, the beneficiaries' medical conditions have remained stable and the beneficiaries do not have a life expectancy of six (6) months or less as required by Medicare regulations to qualify for hospice services.

The examples below are claims submitted by JJE to Medicare for payment for hospice services purportedly rendered to beneficiaries who did not meet Medicare criteria for terminal illness or Stage 7 Alzheimer's disease during the dates of service for which JJE submitted claims for hospice services to Medicare on their behalf:

Claim Number	Claim From Date	Claim Thru Date	Basis for Selected Claim
	02/01/2016	02/29/2016	Beneficiary's diagnosis for hospice is Alzheimer's and under Medicare regulations, a beneficiary must meet

			the Stage 7 criteria to receive hospice services with a prognosis of a life expectancy of six (6) months or less. Beneficiary is a Stage 7 Alzheimer's patient whose medical condition has stabilized and beneficiary has not presented any medical complications or clinical decline in the past six (6) months. Beneficiary does not meet the Medicare criteria to receive hospice services as the beneficiary does not have a life expectancy of six (6) months or less.
	05/01/2016	05/31/2016	Beneficiary is not terminally ill and does not have a life expectancy of six (6) months or less. Beneficiary does not meet the Medicare criteria to receive hospice services.
	04/01/2016	04/30/2016	Beneficiary's diagnosis for hospice is Alzheimer's and under Medicare regulations, a beneficiary must meet the Stage 7 criteria to receive hospice services with a prognosis of a life expectancy of six (6) months or less. Beneficiary does not meet the Stage 7 Medicare requirements and does not qualify to receive hospice services.
	04/01/2016	04/30/2016	Beneficiary's diagnosis for hospice is Alzheimer's and under Medicare regulations, a beneficiary must meet the Stage 7 criteria to receive hospice services with a prognosis of a life expectancy of six (6) months or less. Beneficiary is an early Stage 7 Alzheimer's patient whose medical condition has stabilized and beneficiary has not presented any medical complications or clinical decline in the past six (6) months. Beneficiary does not meet the Medicare criteria to receive hospice services as the beneficiary does not have a life expectancy of six (6) months or less.
	04/01/2016	04/30/2016	Beneficiary is not terminally ill and

			does not have a life expectancy of six (6) months or less. Beneficiary does not meet the Medicare criteria to receive hospice services.

CMS' investigation into this matter is continuing. The information is provided by way of example, in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. §405.372(b)(2), JJE has the right to submit a Rebuttal Statement addressing why the payment suspension should be terminated. JJE may include with the Rebuttal Statement any evidence you believe is pertinent addressing why the suspension should be removed. The Rebuttal Statement should be sent to the following individual:

William Turner
Program Integrity Manager
SGS Zone 7 - Zone Program Integrity Contractor
3450 Lakeside Drive, Suite 201, Miramar, FL 33027
(954) 624-3999 (Telephone)
(954) 252-1109 (Fax)

Upon receipt, SGS will send the Rebuttal Statement to CMS for consideration and determination. See 42 C.F.R. §405.375(a). CMS, in coordination with SGS, must, within 15 days from the date the Rebuttal Statement is received, consider the Rebuttal Statement (including any pertinent evidence submitted), together with any other material bearing upon the investigation, and determine whether the facts justify termination of the suspension. Id.

After CMS has made its determination, SGS will issue that determination (also known as the Response) to JJE. This determination is not appealable. See 42 C.F.R. §405.375(c). The suspension of your payments will continue while the Rebuttal Statement is being reviewed. See 42 C.F.R. §405.375(a).

If the suspension is continued, SGS will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists, and if so, the amount of the overpayment. See 42 C.F.R. §405.372(e)(1). SGS may need to contact JJE with specific requests for further information. You will be informed of the developments, and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and JJE will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. Payment suspension applies to both claims in process and future claims.

In the event an overpayment is determined, and it is determined that a recoupment of payments under 42 C.F.R. §405.371(a)(3) should be put into effect, JJE will receive a separate written notice of the intention to recoup and the reasons therefore, and will be given an opportunity for rebuttal in accordance with 42 C.F.R. §405.373. Subject to these provisions, once the payment suspension has been removed, suspended payments will first be applied to reduce or eliminate

any overpayments, and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services, in accordance with 42 C.F.R. §405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to JJE. Id.

If you have any questions, please contact SGS Investigator Scarlet Sevilla at our customer service number (954) 624-3999.

Sincerely,

Gary Portman, September 23, 2016

Gary Portman
Administrative Action Coordinator
SafeGuard Services, LLC – A CMS Zone Program Integrity Contractor
Medicare Integrity Program