2026 ANNUAL CONFERENCE & EXPO
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Hospice – Suspensions, Revocations, & Rebuttals: What Providers Need to Know

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June 25, 2026

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Current State of Our Industry

- New day, new age for the Hospice Industry
  - Increased Federal oversight with little warning (suspension of payment)
  - Payment Suspensions/loss of billing privileges related to:
    - Quality Indicators – live discharges
    - ADR requests for 5 patients
    - Surveys Results: # of and severity of Conditions of Participation.
- Small agencies are making decisions whether to stay in the industry or surrender their license.
- New State Regulations pending.
- Moratorium – federal, new license and CHOW license.

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PPEO – Provisional Period of Enhanced Oversight

The following states are involved with PPEO:

- Arizona, California, Georgia, Ohio, Nevada, Texas
- This can be triggered by an acquisition or 100% ownership change (CHOW)
- Pre-Payment Reviews with no consistency in the number of charts requested. Generally, round 1, then round 2 but this is not like TPE and agencies are not advancing to round 2 without explanation.
- Reactivate Medicare Billing Privileges after an agency billing privilege has been deactivated. Also pay attention to the time frame to bill. Must have submitted a claim within 6 months or billing privileges can be deactivated.

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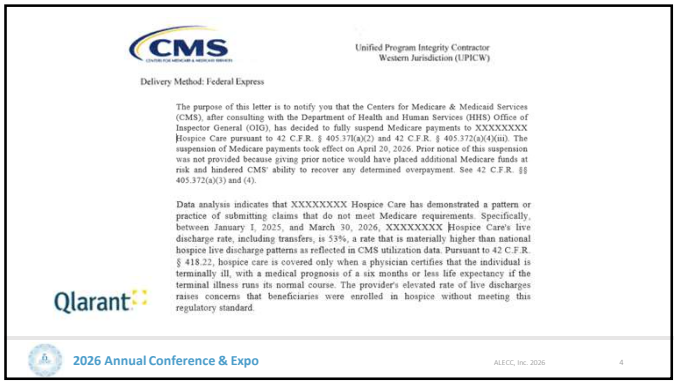

CMS

Unified Program Integrity Contractor
Western Jurisdiction (UPICW)

Delivery Method: Federal Express

The purpose of this letter is to notify you that the Centers for Medicare & Medicaid Services (CMS), after consulting with the Department of Health and Human Services (HHS) Office of Inspector General (OIG), has decided to fully suspend Medicare payments to XXXXXXXX Hospice Care pursuant to 42 C.F.R. § 405.371(a)(2) and 42 C.F.R. § 405.372(a)(4)(iii). The suspension of Medicare payments took effect on April 20, 2026. Prior notice of this suspension was not provided because giving prior notice would have placed additional Medicare funds at risk and hindered CMS' ability to recover any determined overpayment. See 42 C.F.R. §§ 405.372(a)(3) and (4).

Data analysis indicates that XXXXXXXX Hospice Care has demonstrated a pattern or practice of submitting claims that do not meet Medicare requirements. Specifically, between January 1, 2025, and March 30, 2026, XXXXXXXX Hospice Care's live discharge rate, including transfers, is 53%, a rate that is materially higher than national hospice live discharge patterns as reflected in CMS utilization data. Pursuant to 42 C.F.R. § 418.22, hospice care is covered only when a physician certifies that the individual is terminally ill, with a medical prognosis of a six months or less life expectancy if the terminal illness runs its normal course. The provider's elevated rate of live discharges raises concerns that beneficiaries were enrolled in hospice without meeting this regulatory standard.

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Clinical Documentation to Support Rebuttal

Specifically, with respect to the claim examples provided in this notice, documentation should support that all applicable Medicare coverage and payment requirements were met. This typically should include:

- **Signed Election Statement** by the beneficiary or authorized representative
- **Election Statement Addendum -** if requested by the beneficiary or other applicable party
- **Where applicable, documentation of the required face-to-face encounter** with a qualified medical professional
  - Required beginning with the third benefit period and all subsequent benefit periods
- **Initial 90-day Certification of Terminal Illness** including physician narrative
- **Recertification of Terminal Illness** including physician narrative
  - Required for all subsequent benefit periods
- **Plan of Care**
- **Interdisciplinary Team (IDT) meeting documentation**

Merely providing general assertions or denials typically will be insufficient to overcome the allegation(s). Your rebuttal statement should be received within 15 business days of receipt of this notice. Requests for additional time to submit a rebuttal statement will be considered on a case-by-case basis.

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Suspension of Payment – Survey Related

SUBJECT: Enforcement Actions for Non-IJ Condition Level Deficiencies
Imposition of Suspension of Payment for All New (Medicare/Medicaid) Admissions (SPNA) Effective April 22, 2026, Remedy

SUMMARY OF ENFORCEMENT REMEDIES
In addition to termination of your Medicare provider agreement and in accordance with 42 C.F.R. § 488.1220, your hospice program could be subject to the imposition of enforcement remedies. Based on the findings of noncompliance cited in the Statement of Deficiencies (Form CMS-2567), CMS is imposing the following remedy:

- **Suspension of Payment for New Admissions (SPNA) for all new Medicare Admissions effective April 22, 2026.**

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Payment Suspension and Rebuttals – Next Steps

- Project Management/Legal outreach/Extensions
- Chart Audits
- Clinical Summary letters
- Organizing key data and info with clients to assemble for legal assistance:
  - Previous PPEO submissions and results (some agencies may have had previous pre-payment audits with excellent results, pull that info together).
  - Pull data related to live discharges/overall census.
  - Medical Director CV.
  - Special populations served.
  - Standing in the community.

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Certification of Terminal Illness (CTI) Documentation Audit

Initial Physician Certification for Hospice Benefit (CTI)		
CTI – summary (must have)	☐	
Is there a statement of terminality?	☐	
Does the written certification include a medical prognosis statement of six months or less should the disease run its normal course?	☐	
Are there specific clinical findings to support terminality? • Brief physician narrative explains the clinical findings supporting the terminal diagnosis and terminality. Assessments, labs, etc.	☐	
Are the dates of the benefit period documented and accurate?	☐	
Is the Initial Physician Certification present and signed by the hospice medical director or hospice physician team member **(and attending physician if applicable)** within 2 days of care initiated. By the end of the 3rd day, however, no earlier than 15 days before hospice was elected.	☐	
If no written certification within two days of admission, is a verbal certification documented and dated?	☐	
Is the written certification dated?	☐	
Is certification on file for all dates billed?	☐	
If the written certification was not obtained within two days, is it on file prior to filing a claim?	☐	
Does a statement appear directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative?	☐	
ALECC recommends… ***Make sure to use the LCD guidelines when possible. If an attending physician is identified on the ELECTION OF BENEFIT, you must obtain a certification from the attending only for the initial benefit period. Make sure dates are correct, the CTI is signed, dated and if you do not have a written CTI within the required timeframes, make certain you have obtained a verbal CTI, this is critical!! Digitally verified signatures by staff on a CTI is not a signed CTI, you must have an electronically signed CTI, not just verified signatures.***		

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Physician Narrative Documentation Audit

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Physician Narrative		
Documented under Physician Narrative?	☐	
Documentation in narrative reflects clinical findings that support the terminal diagnosis/prognosis identified in the CTI. • Clinical justification – were LCD guidelines used?	☐	
Re-certification, was a comparative done from previous benefit period with clinical findings to support terminality?	☐	
Attestation statement included?	☐	
Signed and dated?	☐	
ALECC recommends… The Physician Narrative is just that, a clinical narrative that supports the terminal diagnosis. This is not a generalization, a cut, copy, paste section but rather clinical specifics including hospitalizations, ER visits, physical, functional, and cognitive changes. Make sure to use the LCD guidelines and all supporting documentation to build that narrative. This technical requirement is frequently denied in audits if not completed correctly.		

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F2F Documentation Audit Checklist Examples

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Completed by Hospice MD or NP? (Not PA)	☐	
Attestation in writing that he/she performed the F2F encounter with the patient, including the date of the encounter?	☐	
MD/NP signing F2F attest that the clinical findings of that visit were provided to the certifying physician?	☐	
Evidence of documented pertinent diagnostic data?	☐	
Review status for diagnosis-specific LCD criteria?	☐	
Signed and dated by person performing F2F encounter?	☐	

ALECC recommends...

Use the LCD guidelines when completing a F2F to support the terminal diagnosis. Subsequent F2F should show documented changes from the previous F2F. Document clinical findings and note any physical, functional, and cognitive changes that continue to support terminality and the hospice benefit. Make sure if using any scoring tools such as FAST/KPS/PPS the team understands how to use the tools and that they are documenting appropriately. Documentation discrepancies with the tools can trigger denials upon an audit. NP/MD can complete the F2F, not PA.

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Plan of Care – Audit (This Is a Critical Area to Audit)

Plan of Care		
The plan of care is individualized.	☐	
Initial Plan of Care (POC) must be established before care is rendered?	☐	
Plan of care present to cover all dates billed.	☐	
Interventions identified to manage pain and symptoms.	☐	
Detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs? • Were services provided per the POC?	☐	
Measurable outcomes anticipated from implementing and coordinating the POC?	☐	
Medical supplies and appliances necessary to meet the needs of the patient are identified?	☐	
IDG documentation of the patient's or representatives' level of understanding, involvement, and agreement with the POC is documented in the clinical record (per the agency policies)?	☐	

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Chart Audit Section Review

- Election of Benefit/Non-Covered Items – Patient Addendum
- CTI/Subsequent CTI's
- Physician Narrative
- F2F if applicable
- POC/IDG
- Nursing Assessment
- H&P

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Clinical Summary for Rebuttal

Hospice Patient: Madame Curie
Claim Number: 225246014447O7CAR
MBI: 4TG3-V38-FT98
DOB: 7/4/54
DOS: 8/14/25 - 8/28/25

Madame Curie was admitted to hospice services provided by Radioactivity Hospice Care on 8/14/25 with a primary diagnosis of malignant neoplasm of her pancreas and comorbidities including insulin-dependent diabetes, hypertension, hypothyroidism, COVID, and recurrent UTIs. The patient revoked hospice services with Radioactivity Hospice Care effective 8/28/25.

Evidenced below you will find an outline and documentation to support the patient's course of care and eligibility for the claim period in review based on the following COP:

Subpart B §418.20 – A Beneficiary Must:

- *Be entitled to Medicare Part A and receive hospice from a Medicare-certified hospice agency.*
- *Be certified as being terminally ill. §418.22*
- *A medical prognosis is that if the disease process runs its normal course, life expectancy is six months or less.*
- *Establishment of a benefit period*
- *Face-to-face (F2F) visits for the third benefit or greater.*
- *Plan of care (POC)*
- *Interdisciplinary team or group (IDT/IDG) – manages and oversees the POC*

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Clinical Summary for Rebuttal

Claim Number: XXXXXXXXXXXCAR
DOS: 8/14/25 - 8/28/25

8/15/25: Nursing admission assessment demonstrates that the patient was diagnosed with pancreatic cancer in the summer of 2025. After her initial hospitalization and biliary drain placement, there were no further options and hospice care was elected. The patient's appetite was fair and reported significant weight loss with a recent documented 15# loss and potentially more per the daughter. She is bedbound with nursing staff ordering a wheelchair and hoyer lift. The patient required assistance with 5/6 ADLs, incontinent of bowel and bladder, PPS score 30 and KPS score of 40. Pain was rated at 8/10 and used Norco to manage. She was using oxygen at 3L per NC continually.

8/18/25 Nursing note indicates the patient's appetite remained poor taking in only a couple bites. She continued to have a pressure area to her coccyx. She also presented with severe generalized weakness and remains bedbound. Later that same day, the patient's caregiver required assistance with management of biliary drain with flushing due to obstruction.

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Clinical Summary for Rebuttal

Based on the evidence provided, we feel that the patient does meet the hospice eligibility requirements, and the level of care provided during this claim period. Based on *LCD Hospice Eligibility Determination* (L34538) and documentation provided:

Part II. Non-disease specific baseline guidelines *(both of these should be met)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.*
- *Dependence on assistance for two or more activities of daily living (ADLs)*

Section I: Cancer Diagnoses

A. Disease with distant metastases at presentation OR

B. Progression from an earlier stage of disease to metastatic disease with either:

1. *a continued decline in spite of therapy*
2. *patient declines further disease directed therapy*

The patient required assistance with 5/6 ADLs, incontinent of bowel and bladder, PPS score 30 and KPS score of 40. Pancreatic cancer was diagnosed with continued decline as documented as well as no further treatment.

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Clinical Summary for Rebuttal

8/28/25 The agency received a call from the answering service that the caregiver called 911 and the patient was being transferred to the hospital due to the patient having trouble breathing and swallowing. She was admitted to Loma Linda hospital for treatment. This patient then exercised the right to revoke services with Radioactivity Hospice Care and signed a hospice revocation on August 28, 2025, as per COPs.

This patient had the right to revoke hospice services at any time during the election period based on the following COP:

§ 418.28 Revoking the election of hospice care.

(a) An individual or representative may revoke the individual's election of hospice care at any time during an election period.

(b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:

(1) A signed statement that the individual or representative revokes the individual's election for Medicare coverage of hospice care for the remainder of that election period.

(2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is

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Documentation Request Guide	Example: John Doe
HR Documents	
Names and licenses for the hospice medical directors, physicians, and advanced practice providers active during the review period	N/A
Documentation Request	
ADR Letter - Additional Documentation Request Letter	Yes
Cover Letter	Pending
Hospice Election Statement (NOE)	No
Patient Addendum Hospice Non-Covered Items	Yes
Hospice Certification of Terminal Illness (Initial and Subsequent) Signed/Dated CTI for each claim period	Yes
Completed Recovation Forms (if applicable)	
Face2Face documentation (if applicable) 3rd benefit period and beyond	Yes
Physician's Orders (including medication, level of care changes and any DME)	No
Hospice Plan of Care	Yes
Clinical Documentation	
Initial Assessment & Visit Notes	Yes
IDG Notes	
Treatment, Medications, Wound Care	Yes
Hospice Team Documentation - to support the medical necessity of the services billed:	
Hospital discharge summaries, recent History & Physical Exams, Consultations, Skilled Nursing, Home Health, Facility Notes	Yes
Pathology reports and diagnostic imaging or tests	N/A
Records from the referring physician	Yes
Medication administration record (MAR), weights, measurements, and treatment administration record (TAR) for the period under review, if available.	Yes
Advance Beneficiary Notice of Non-Coverage (ABN)/ Notice of Medicare Non-Coverage (NOMNC)	N/A
Signature Log/attestation	Yes
Electronic Signature Policy	Yes

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Looking Forward
Where Do You Go From Here

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Have a Proactive Agency – Not "if", "when".

Audit, Audit, Audit –

- Compliance program and OIG –
  - Follows the 7 elements of the OIGs Compliance Plan (more detail at the July lunch and learn).
- Internal and External Audits both for Survey and Financial Readiness
  - Pre-billing audits – make it part of your compliance plan/program.
  - Survey readiness – Mock Surveys (6-9 months prior to survey).
  - Review your compliance program – does it cover everything you need, time for an update?
  - Identify risks, pull reports – look at the reports CMS reviews, pull internal reports from your EHR.
  - Education/QA – trends, do you need some outside help to do auditing and identify risks?

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CMS Gathers Hospice Live Discharge Data

- Medicare Claims (UB-04) – Primary source for tracking the reason for live discharges (e.g. revocations, no longer terminally ill, transfers).
- Hospice Item Set (HIS) – submit records within 30 days of discharge (now the HOPE Tool).
- Care Compare – Data compiled from CAHPS/HIS later HOPE.
- PECOS – make certain all enrollment info is correct.
- PEPPER Reports.

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PEPPER (Program for Evaluating Payment Patterns Electronic Report)

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Target Pepper Areas and Live Discharges

1. Live Discharges

- **Live Discharges No Longer Terminally Ill:** Tracks the rate of beneficiaries discharged alive because they were no longer terminally ill.
- **Live Discharges – Revocations:** Measures the rate at which patients revoke their hospice benefit.
- **Live Discharges LOS 61 – 179 Days:** Monitors live discharges of patients with a length of stay between 61 and 179 days. (High rates here can sometimes trigger audits, as payment rates are higher for the first 60 days of Routine Home Care). PEPPER Resources +4

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References and Resources

- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418
- https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-may-28-2026
- https://pepper.cbrpepper.org/index.html
- https://oig.hhs.gov/documents/compliance-guidance/1135/HHS-OIG-GCPG-2023.pdf

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Thank You!

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