

**Memorandum**

JUN 19 2000

Date

*Michael Mangano*From *JB*June Gibbs Brown
Inspector General

Subject

Review of Outpatient Psychiatric Services Provided by Saint Luke's-Roosevelt Hospital for
Calendar Year Ended December 31, 1997 (A-02-99-01016)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on Wednesday, June 21, 2000, of our final report "Review of Outpatient Psychiatric Services Provided by Saint Luke's-Roosevelt Hospital for Calendar Year Ended December 31, 1997." A copy of the report is attached. The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements. We found that Saint Luke's-Roosevelt Hospital (Hospital), located in New York, NY, did not establish or follow existing procedures for the proper billing of outpatient psychiatric services.

Our audit at the Hospital determined that many of the outpatient psychiatric services claimed by the Hospital did not meet the Medicare criteria for reimbursement. Specifically, we identified charges for outpatient psychiatric services which lacked sufficient patient treatment plans, sufficient medical record documentation, and/or were not reasonable and necessary. Based on a statistical sample, we estimate that at least \$1,129,740 in outpatient psychiatric charges were submitted by the Hospital, yet did not meet Medicare criteria for reimbursement. We also identified \$46,019 in costs ineligible for Medicare reimbursement claimed for outpatient psychiatric services by the Hospital on its Calendar Year (CY) 1997 Medicare cost report. We recommended that the Hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are reasonable and necessary and are properly documented in accordance with Medicare regulations and guidelines. We also recommended that the Hospital develop procedures to report noncovered services as nonreimbursable cost centers on its Medicare cost reports. We will also provide the results of our review to the fiscal intermediary so that it can apply the appropriate adjustments of \$1,129,740 and \$46,019 to the Hospital's CY 1997 Medicare cost report.

The Hospital, in its response to our report, believed that certain services questioned by the Office of Inspector General (OIG) were sufficiently documented and were medically reasonable and necessary. Based on additional documentation provided by the Hospital and reviewed by the fiscal intermediary and Island Peer Review Organization, we allowed

Page 2 - Nancy-Ann Min DeParle

\$1,110 of our previously denied determinations. The Hospital concurred with the OIG that food and patient transportation costs claimed on the CY 1997 Medicare cost report are unallowable. We believe that our final audit determinations are correct and no further adjustments to our draft report are necessary.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, at (212) 264-4620.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT
PSYCHIATRIC SERVICES PROVIDED BY
SAINT LUKE'S-ROOSEVELT HOSPITAL
FOR CALENDAR YEAR ENDED
DECEMBER 31, 1997**



**JUNE GIBBS BROWN
Inspector General**

**JUNE 2000
A-02-99-01016**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

CIN A-02-99-01016

Ms. Elizabeth E. Moore
Senior Administrator, Department of Psychiatry
St. Luke's-Roosevelt Hospital
1090 Amsterdam Avenue, 16th Floor
New York, New York 10025

Dear Ms. Moore:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Outpatient Psychiatric Services Provided by Saint Luke's-Roosevelt Hospital for Calendar Year Ended December 31, 1997." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

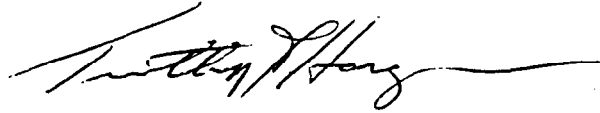
Final determinations as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein, is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR Part 5).

Page 2 - Ms. Elizabeth E. Moore

To facilitate identification, please refer to Common Identification Number A-02-99-01016 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Timothy J. Horgan", with a long horizontal flourish extending to the right.

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Mr. Peter Reisman
Associate Regional Administrator
Division of Financial Management
Health Care Financing Administration, Region II
U.S. Department of Health and Human Services
26 Federal Plaza, Room 38-130
New York, New York 10278

EXECUTIVE SUMMARY

Background

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. Medicare requirements define outpatient services as "Each examination, consultation or treatment received by an outpatient in any service department of a hospital...." Medicare further requires that charges reflect reasonable costs and services provided be supported by medical records. These records must contain sufficient documentation to justify the treatment provided. Hospital costs for such services are generally facility costs for providing the services of staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis, based on submitted charges. At year end, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final reimbursement.

Objective

The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements. We also tested the reasonableness of selected expenses reported on the related cost report.

Summary of Findings

In Calendar Year (CY) 1997, Saint Luke's-Roosevelt Hospital (Hospital) submitted for reimbursement about \$2.9 million in charges for outpatient psychiatric services. To determine whether controls were in place to ensure compliance with Medicare regulations and guidelines, we reviewed the medical and billing records for 100 statistically selected claims totaling \$71,965. These charges were made on behalf of patients who received services in the Hospital's outpatient psychiatric department. Our analysis showed that \$37,000 of these charges did not meet Medicare criteria for reimbursement. Charges found unallowable were for services which lacked sufficient treatment plans, sufficient medical record documentation, and/or were not reasonable and necessary.

We extrapolated these results to the population of claims at the Hospital during CY 1997 and estimated that the Hospital overstated its billings to Medicare by \$1,129,740. We found that the Hospital staff did not establish and/or follow existing Medicare procedures for the proper billing of outpatient psychiatric services.

Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We judgmentally selected cost centers relating to outpatient psychiatric services, totaling \$295,139, from the Hospital's CY 1997 Medicare cost report and found that \$46,019 in meals and transportation costs were ineligible for reimbursement under the Medicare program for outpatient psychiatric services.

Recommendations

We recommended that the Hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are reasonable and necessary and are properly documented in accordance with Medicare regulations and guidelines. In addition, we will provide the results of our review to Empire Medicare Services (Empire), the Medicare FI, so that it can apply the appropriate adjustment of approximately \$1.1 million during the settlement of the Hospital's CY 1997 Medicare cost report.

We also recommended that the Hospital develop procedures to report noncovered services as nonreimbursable costs on its Medicare cost reports. We will also provide the FI with details of the identified \$46,019 in unallowable costs so that it can apply the appropriate adjustment to the Hospital's CY 1997 Medicare cost report.

In response to our draft report (see APPENDIX B), Hospital officials believed that certain services questioned by the OIG were sufficiently documented and were medically reasonable and necessary. Based on additional documentation provided by the Hospital and reviewed by the FI and the Island Peer Review Organization (IPRO), we allowed \$1,110 of our previously denied determinations.

We believe that our final audit determinations are correct and no further adjustments to our report are necessary. The basis for our position is discussed starting on page 8 of this report.

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INTRODUCTION

BACKGROUND

The Medicare program established by Title XVIII of the Social Security Act (Act) provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Health Care Financing Administration (HCFA). Under section 1862 (a)(1)(A), the Act excludes coverage for services, including outpatient psychiatric services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury. Outpatient psychiatric services are generally provided by hospital employees such as staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis predicated on submitted charges. At year end, the hospital submits a cost report to the Medicare FI for final reimbursement. Medicare requires that for benefits to be paid:

- ◇ “A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.” [42 CFR 482.24]
- ◇ Psychiatric “...services must be...reasonable and necessary for the diagnosis or treatment of the patient’s condition...Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.” [Medicare Intermediary Manual section 3112.7]
- ◇ “Documentation must show reevaluation of the course of treatment (at least every six months) identifying the patient’s response to treatment and specifically noting changes in clinical status and/or treatment plan.” [Empire’s Medicare Part A Medical Review Policy for Outpatient Psychiatric Services - dated October 1993]

For costs claimed on a hospital’s Medicare cost report, Medicare requirements stipulate:

- ◇ reasonable costs as “...all necessary and proper expenses incurred in furnishing services...However, if the provider’s operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable....” [42 CFR 413.9(c)(3)]
- ◇ that “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.” [Provider Reimbursement Manual section 2102.1]
- ◇ costs related to patient care as those which “...include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider’s activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others....” [Provider Reimbursement Manual section 2102.2]
- ◇ noncovered outpatient psychiatric services to include patient meals and patient transportation. It also limits drug coverage only to those which cannot be self-administered. [Medicare Intermediary Manual section 3112.7]

Saint Luke’s-Roosevelt Hospital is a not-for-profit organization which provides, among other services, outpatient psychiatric services at two facilities in New York, NY. The Hospital does not provide outpatient psychiatric partial hospitalization program (PHP) services. For CY 1997, the Hospital submitted for Medicare reimbursement 4,831 outpatient psychiatric claims valued at \$2,933,980.

Objective, Scope, and Methodology

The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare regulations and guidelines. We also tested the reasonableness of selected expenses reported on the related cost report. Our review included services provided during CY 1997.

To accomplish our objective, we:

- ◇ reviewed criteria related to outpatient psychiatric services.
- ◇ interviewed appropriate Hospital staff concerning internal controls over Medicare claims submission.
- ◇ used the Hospital's CY 1997 Provider Statistical and Reimbursement Report, which was provided by the FI, to identify 4,831 outpatient psychiatric claims valued at \$2,933,980.
- ◇ employed a simple random sample approach to select a statistical sample of 100 outpatient psychiatric claims.
- ◇ performed detailed audit testing on the billing and medical records for the claims selected in the sample.
- ◇ utilized medical review staff from the FI and a psychiatrist and registered nurses from IPRO, the New York peer review organization (PRO), to review the selected claims.
- ◇ used a variables appraisal program to estimate the dollar impact of improper charges in the total population.
- ◇ reviewed Medicare Part B claims processed by Empire, the Medicare Part B carrier, which corresponded to our sampled claims.

In addition, the Hospital claimed \$6,597,273 (\$3,788,263 allocated to Medicare) in outpatient psychiatric costs after reclassifications and adjustments on its CY 1997 Medicare cost report. We tested the appropriateness of a judgmental sample of \$295,139 of these costs through review of supporting documentation.

We limited consideration of the internal control structure to those controls relating to the submission of claims to Medicare because the objective of our review did not require an understanding or assessment of the entire internal control structure at the Hospital.

Our review was made in accordance with generally accepted government auditing standards. Our field work was performed at the Hospital facilities located in New York, NY.

The Hospital's response to the draft report is appended to this report (see APPENDIX B) and is addressed on pages 8 through 10. We deleted from the response sensitive information on Medicare beneficiaries and others that the OIG could not release under the Freedom of Information Act.

FINDINGS AND RECOMMENDATIONS

In CY 1997, the Hospital submitted for Medicare reimbursement approximately \$2.9 million in charges for outpatient psychiatric services. We reviewed the medical and billing records for 100 statistically selected claims comprising 389 services totaling \$71,965 in charges. Our analysis showed that \$37,000 of the sampled charges did not meet the Medicare criteria for reimbursement. Based on an extrapolation of the statistical sample, we estimate that the Hospital overstated its CY 1997 Medicare outpatient psychiatric charges by approximately \$1.1 million. Charges found unallowable were for services which lacked sufficient treatment plans, sufficient medical record documentation, and/or were not reasonable and necessary.

The Hospital claimed about \$3.8 million in costs for providing these outpatient psychiatric services, after reclassifications and adjustments, on its CY 1997 Medicare cost report. Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We reviewed a judgmental sample of \$295,139 in selected outpatient psychiatric costs on the Hospital's CY 1997 Medicare cost report, and found that \$46,019 of these costs were unallowable under Medicare guidelines. These unallowable costs included patient meals and patient transportation.

Findings from our review of the outpatient psychiatric charges and costs are described in detail below.

OUTPATIENT PSYCHIATRIC SERVICES

The Hospital provides outpatient psychiatric services including periodic psychotherapy, medication monitoring, and other psychiatric care. From our sample of 100 outpatient psychiatric claims, we found that \$37,000 for 200 services on 36 claims did not meet Medicare criteria for reimbursement as detailed below. Further, services on 2 of the 36 claims were denied for more than one reason.

Insufficient Patient Treatment Plans

The Medicare Intermediary Manual, section 3112.7(B), states that for outpatient hospital psychiatric services to be covered, "Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...."

Section 3112.7 continues by stating, "Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this

involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.”

In addition, according to Empire’s Medicare Part A Medical Review Policy for Outpatient Psychiatric Services, dated October 1993, “Documentation must show reevaluation of the course of treatment (at least every six months) identifying the patient’s response to treatment and specifically noting changes in clinical status and/or treatment plan.”

We found that the Hospital did not have adequate procedures in place for preparing individualized treatment plans for each patient receiving ongoing psychiatric care. From our review of the billing and medical records for the 100 outpatient psychiatric claims in our sample, we identified 24 claims with \$28,675 in charges for 155 services to patients who had treatment plans which did not comply with Medicare guidelines or were otherwise missing. With the assistance of medical review personnel from the FI and IPRO, we identified:

- ◇ \$23,310 in charges for 126 services to patients whose treatment plan did not indicate the service modality, frequency, or duration.
- ◇ \$2,775 in charges for 15 services to patients whose treatment plan did not contain a date or was otherwise outdated.
- ◇ \$2,590 in charges for 14 services to patients whose existing treatment plan could not be located by hospital staff.

Examples of errors found to be insufficiently documented due to improper treatment plans (also known as “tx” plans) follow:

On one claim disallowed for 14 group therapy sessions totaling \$2,590, the medical reviewer noted:

“...tx plan problems/goals/intervention does not contain modalities on all interventions (ie Living Skills - ? group or individual) & there is no frequency listed for any of the interventions listed. These should be on the treatment plan, not only on program schedules - it was noted that the schedule is given to the patient but not contained in the patient’s chart. We base our review on a comparison of frequency of treatments ordered versus those documented/billed. Therefore, frequency must be ordered by the physician on the treatment plan.”

On one claim disallowed for two group therapy sessions totaling \$370, the medical reviewer noted:

“...When tx plan was developed on 12/27/96, the “Date Objective Will Be Met” is an anticipated date - no way for hospital to anticipate discharge when treatment plan established - therefore, frequency needs to be ordered on the treatment plan. No group schedule provided in the record.”

Without an up-to-date and proper treatment plan prescribed by a physician to identify the type, amount, frequency, and duration of services to be furnished to the patient, we could not determine with any certainty that the services were indeed reasonable and necessary.

Services Not Supported by Medical Records

The 42 CFR 482.24 states that, “A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.”

Our audit disclosed a weakness in the Hospital’s system of internal controls regarding medical record documentation supporting services. Our review of the 100 outpatient psychiatric claims showed that 11 claims with \$8,140 in charges representing 44 services were not properly supported in the medical records. With the assistance of medical review personnel from the FI and IPRO, we noted that progress notes were either missing or insufficient (e.g., no group names, modalities, or signatures) for those 11 claims. An example of an error that was found to be insufficiently documented follows:

On one claim for three individual sessions totaling \$555, one session totaling \$185 was disallowed. The medical reviewer noted:

“...No progress note sent for a 3rd Individual vst for dates of service billed. Deny 1 vst - no note.”

As a result, we concluded that \$8,140 in outpatient psychiatric charges did not have adequate documentation required for Medicare billing and, therefore, did not meet Medicare’s criteria for reimbursement. Without complete medical record documentation, including a description of what took place in a therapy session, the patient’s interaction with group members, his/her progress compared to the treatment plan goals, and future plans of treatment, the appropriateness

of the patient's level of care is unclear. Further, inadequate documentation of patient therapies and treatment provides little guidance to physicians and therapists to guide future treatment. In this regard, the lack of required documentation, as described above, precluded us from determining whether those services were needed.

Services Not Reasonable and Necessary

The Medicare Intermediary Manual, section 3112.7 identifies a wide range of services a hospital may provide to outpatients who need psychiatric care. For such services to be covered, they must be "...reasonable and necessary for the diagnosis or treatment of the patient's condition...."

The Hospital did not have adequate procedures in place for ensuring that services billed to the Medicare program are reasonable and necessary for the treatment of a patient's condition. With the assistance of medical reviewers from the FI and IPRO, we found \$185 in erroneous charges for one service determined not to be reasonable and necessary. These charges were from one claim for one therapy service for which the medical record documentation did not demonstrate that the level of treatment was reasonable and necessary. A description of the error found to be not medically reasonable and necessary follows:

On one claim for one individual session totaling \$185, the medical reviewer noted:

"No progress note sent for date of service billed. Physician review indicates that patient does not have specific complaints. Reason for clinic visits unclear. Question is raised regarding continued need for treatment."

OUTPATIENT PSYCHIATRIC COSTS

The Hospital claimed about \$3.8 million in costs for providing these outpatient psychiatric services, after reclassifications and adjustments, on its CY 1997 Medicare cost report. Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We reviewed a judgmental sample of \$295,139 in selected outpatient psychiatric costs on the Hospital's CY 1997 Medicare cost report and found that \$46,019 of these costs were unallowable under Medicare regulations and guidelines.

Medicare Intermediary Manual section 3112.7 states that noncovered outpatient psychiatric services include meals and transportation. We found that the Hospital did not have adequate procedures in place to report noncovered services as nonreimbursable costs on its CY 1997 Medicare cost report.

As part of the Hospital's outpatient psychiatric programs, the Hospital provided patients with subway tokens for transportation to their facility. In addition, the Hospital provided food to

certain outpatient psychiatric patients who were enrolled in the day treatment program. These costs are not covered under the Medicare program. Our analysis showed that \$4,822 was related to patient transportation costs and \$41,197 was related to meal expenses. During the course of our audit, Hospital staff stated that they were unaware that meal and patient transportation costs were not covered as Medicare expenses on the cost report.

Conclusion

For CY 1997, the Hospital submitted for reimbursement \$2,933,980 in charges for outpatient psychiatric services. Our audit of 100 statistically selected claims totaling \$71,965 in charges showed that \$37,000 should not have been billed to the Medicare program. Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that the Hospital billed at least \$1,129,740 in error for CY 1997. We attained our estimate by using a single stage appraisal program. The details of our sample appraisal can be found in APPENDIX A.

The Hospital also claimed about \$3.8 million in costs for providing these outpatient psychiatric services, after reclassifications and adjustments, on its CY 1997 Medicare cost report. We reviewed a judgmental sample of \$295,139 in selected outpatient psychiatric costs on the Hospital's 1997 Medicare cost report, and found that \$46,019 of these costs were unallowable.

Recommendations

We recommended that the Hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are for covered services and are properly documented in accordance with Medicare regulations and guidelines. In addition, we will provide the results of our review to the FI, so that it can apply the appropriate adjustment of \$1,129,740 to the Hospital's CY 1997 Medicare cost report.

We also recommended that the Hospital develop procedures to report noncovered services as nonreimbursable costs on its Medicare cost reports. We will also provide the FI with details of the identified \$46,019 in unallowable costs so that it can apply the appropriate adjustment to the Hospital's CY 1997 Medicare cost report.

AUDITEE RESPONSE AND OIG COMMENTS

The Hospital, in its response (see APPENDIX B), believed that certain services questioned by the OIG were sufficiently documented and were medically reasonable and necessary. Of the \$38,110 in charges questioned by the OIG, the Hospital officials believed that \$11,470 did in fact meet

the Medicare criteria for reimbursement.¹ The Hospital concurred with the auditors' determination that food and patient transportation costs were unallowable.

The Hospital also stated that improvements have been made to both their billing and documentation procedures subsequent to our audit period, and that repayment of the identified overpayment was not reasonable and would impede the hospital's ability to provide care to its clients.

We have summarized the auditee's relevant responses and provide our comments below.

Auditee Response Regarding Insufficient Patient Treatment Plans

The Hospital officials believed that of the \$28,305 in charges with improper treatment plans, \$7,955 had in fact proper treatment plans. The Hospital stated that although the treatment plan sometimes listed the program instead of the specific modality, complete on-site records were maintained for each patient detailing which groups the patient attended each month. Other on-site documentation maintained by the hospital, but not incorporated into each individual medical chart, included schedules listing the length and frequency of each program modality. In addition, the Hospital maintained program manuals describing each modality, its purpose, frequency, and intended duration. Further, the Hospital believed that the duration of treatment can be inferred by the date the goals of the treatment will be met or reevaluated. The Hospital also believed that the frequency of treatment can be determined from the progress notes, where the date of return to the clinic is stated.

OIG Comments on Insufficient Patient Treatment Plans

We reviewed the Hospital's response and its three concerns regarding insufficient patient treatment plans. First, the Hospital believed that the specific modality was not necessary on the treatment plan because the program name was listed on the treatment plan and program descriptions were contained in other documentation maintained at the Hospital. We disagree. The FI and IPRO medical reviewers indicated that the modality (e.g., Living Skills for Recovery Group) must be listed on the treatment plan, and that program names (e.g., Activities of Daily Living) are only components of the modality and are considered topics for discussion.

Second, on one reviewed claim, the Hospital believed that the duration of treatment could be inferred from the "date the goals of the treatment will be met or reevaluated." In this regard, the medical reviewers did accept "Date Objective Will Be Met" listed on the treatment plan as the duration, but this claim was still disallowed because the dates of service were subsequent to the

¹The Hospital in its written response stated that \$12,395 met the Medicare criteria for reimbursement. However, in subsequent communication, the Hospital only provided us with detailed documentation for charges totaling \$11,470, and indicated the discrepancy was due to clerical error in preparing the written response.

date the objective would be met. The claim was also disallowed because the frequency was not listed on the treatment plan. We agree with the medical reviewer determination on this claim.

Third, the Hospital stated that “frequency of the services” can be determined from the progress notes. We disagree. The Medicare Intermediary Manual section 3112.7(B) specifically requires that the treatment plan state the frequency of the services to be furnished. According to the medical reviewers, progress notes do not document the frequency of services ordered on the treatment plan, but only document that a patient has received services on that date.

Based on the additional documentation provided by the Hospital and reviewed by the medical reviewers, we adjusted our determinations for two claims. Specifically, we reversed the disallowance on one claim for two services totaling \$370. Also, we re-categorized four services totaling \$740 on one claim from Services Not Supported by Medical Records to Insufficient Patient Treatment Plans. We maintain no further adjustments to our report are necessary for the remaining 24 claims totaling \$28,675.

Auditee Response Regarding Services Not Supported by Medical Records

The Hospital officials believed that of the \$9,065 in charges not supported by medical records, \$2,960 were in fact sufficiently supported by the medical records. The Hospital stated that, although the notes referred to dates of service rather than modalities, complete on-site records were maintained for each patient, detailing which groups they attended each month. The Hospital also stated that sometimes the name of a component within a modality was cited on the progress note instead of the modality that was listed on the treatment plan. The group protocol maintained on-site describes each of these modalities and their components.

OIG Comments on Services Not Supported by Medical Records

We reviewed the Hospital’s two concerns regarding services not supported by medical records. First, the Hospital believed that the modality was not necessary on the progress notes because the day the service was rendered could be referenced back to the program schedule maintained in separate on-site documentation. We disagree. According to the medical reviewers, the modality must be contained in the progress note because the program schedule does not specify that patients are to attend all scheduled sessions.

Second, the Hospital believed that it was sufficient to cite a component within the modality on the progress note instead of the modality listed on the treatment plan. We disagree. According to the medical reviewers, a comparison of modalities specifically ordered on the treatment plan is made to the modalities contained in the progress notes provided. When a component is listed on the progress note without the modality, that component appears to be a separate modality not ordered on the treatment plan.

Based on the additional documentation provided by the Hospital and reviewed by the medical reviewers, we adjusted our determination for one claim. Specifically, we reversed the disallowance for one service on this claim totaling \$185 and re-categorized four services totaling \$740 from Services Not Supported by Medical Records to Insufficient Patient Treatment Plans. We maintain no further adjustments to our report are necessary for the remaining 11 claims totaling \$8,140.

Auditee Response Regarding Services Found Not Reasonable and Necessary

The Hospital officials believed that of the \$740 in charges determined to be not reasonable and necessary, \$555 was in fact reasonable and necessary. The Hospital felt that the patient needed the treatment to prevent a recurrence of major depression, diminish phobic symptoms, eliminate panic attacks, and avoid subsequent hospitalizations.

OIG Comments on Services Found Not Reasonable and Necessary

Based on additional documentation provided by the Hospital and reviewed by medical reviewers, we reversed the \$555 disallowance for the claim disputed by the auditee. We believe no further adjustments to our report are necessary for the remaining disallowed claim totaling \$185.

Auditee Response Regarding Cost Report Findings

The Hospital officials agreed that the food and patient transportation expenses of \$46,019 are unallowable costs and should not have been included on the CY 1997 Medicare cost report. They will establish controls to insure that the inclusion of unallowable expenses does not occur on future cost reports.

APPENDIX A

**REVIEW OF
OUTPATIENT PSYCHIATRIC SERVICES
PROVIDED BY SAINT LUKE'S-ROOSEVELT HOSPITAL
FOR CALENDAR YEAR ENDED DECEMBER 31, 1997**

STATISTICAL SAMPLE INFORMATION

POPULATION

Items: 4,831 Claims
Charges: \$2,933,980

SAMPLE

Items: 100 Claims
Charges: \$71,965

ERRORS

Items: 36 Claims
Charges: \$37,000

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: \$1,787,470
Lower Limit: \$1,129,740
Upper Limit: \$2,445,200

Elizabeth E. Moore

Senior Administrator, Department of Psychiatry

January 19, 2000

Timothy J. Horgan, Regional Inspector General for Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

HHS/OIG
OFFICE OF AUDIT
NEW YORK REGIONAL OFFICE

JAN 21 2000

RECEIVED

Reference: Common Identification number A-02-99-
01016

Dear Mr. Horgan:

We are in receipt of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' draft report entitled "Review of Outpatient Psychiatric Services Provided by St. Luke's-Roosevelt Hospital for Calendar Year Ending December 31, 1997". We would like to respond formally to the report. Our response will have two components. First we will address the validity of the facts and findings presented and second, we will address the reasonableness of the recommendations.

VALIDITY OF FACTS AND FINDINGS:Claim Review Findings

The Office of Audit services found that \$38,110 of the sampled charges did not meet the Medicare criteria for reimbursement. In reviewing the reasons for denial, we found that for 67 units of service in 16 claims totaling \$12,395 we did not agree with the denial. This amounts to 32.5% of denied charges. We are in the process of submitting appeals for these claims. Attachment A details these cases, the medical review comments, and the basis of our appeal. Reasons for denial include: judgement of medical necessity; questions of group identification; visits documenting the first and last days of treatment; and, chart copying errors (chart copying was done by both St. Luke's-Roosevelt Hospital Center and audit staff).

Cost Report Findings

The Office of Audit findings included the disallowance of \$46,019 of expenses related to patient transportation and food. We will put controls into place to insure that the inclusion on non-allowable expenses does not occur on future cost reports. As stated in the audit findings the Intermediary should be advised to reduce 1997 allowable outpatient psychiatric expense by \$46,019.

REASONABLENESS OF RECOMMENDATIONS:

In August of 1996, the Department of Psychiatry of St. Luke's-Roosevelt Hospital Center (SLRHC) learned of the issues related to our Medicare billing and documentation procedures when we attended a special training at Empire Medicare in Syracuse. Since that time we have made a major and sustained effort to improve both billing and documentation procedures. This effort has proceeded in the context of ongoing formal and informal liaison with Empire Medicare. It has involved the hiring of dedicated personnel and consultants, major redesign of documentation formats and of charting and billing systems, and extensive in-service education of both clinical and billing staff. It has taken us three years to reach our current level of compliance. This is due in part to the complexities and frequent changes in the Medicare regulations, and in part to the burden of responding to a massive and ongoing pre-payment Focused Medical Review

During the last three years, we have continued to improve our denial rate. Further refinements to our billing system should enable us to lower our denial rates dramatically in the next 6 months. Below is a summary of corrective actions SLRHC has taken in many different areas to improve Medicare compliance:

PROGRESS 9/96-12/99**Staff Education:**

- 8/96 Key staff trained by Empire Medicare in Syracuse as part of corrective action plan.
- 11/96-2/97 In-service education provided to all Outpatient Psychiatry staff in Medicare regulations and documentation. In-service consisted of two-hour sessions supplemented with an extensive training manual.
- 10/97-3/98 All Outpatient Psychiatry staff trained in new, Medicare compliant documentation. Continuing Day Treatment clerical and clinical staff also trained in component billing documentation and procedures. All new trainees given small group (2-3 individuals) training.
- 1/98 Key staff from Psychiatry and Billing attended full day Medicare sponsored workshop on Outpatient Part A Psychiatric Services.

- 10/98-11/98 Individual training provided for staff in the use of a computerized treatment plan.
- 11/99-12/99 All billing and registration staff trained in new procedures to allow processing of demand bills.
- Ongoing: All new staff is trained in Medicare compliant documentation and billing procedures.

Consultation

- 10/96 A four day consultation with Ernst and Young helped us to begin reviewing and revising our documentation.
- 3/97 A two day consultation with Karen Fitzhugh Ph.D. helped us to identify particular documentation strategies, and facilitated collaboration with billing and finance to develop component billing procedures.

Documentation:

- 2/97 In-service followed up with memos to instruct staff regarding initial evaluations and admission notes. Internal audit showed these elements of documentation were not improving at the expected pace.
- 9/97 completely revised Medicare compliant documentation packet accepted by Chart Review Committee.
- 3/98 New documentation completely implemented.
- 3/98 Electronic PII form used to respond to ADRs at St. Luke's and Roosevelt Sites.
- 8/98 Research assistants report that in the vast majority of cases they are finding necessary documentation in the charts.

Billing Issues:

- 1/97 Billing table corrected for collateral visits, medical visits, and miscellaneous errors.

- 1/98 Component billing began in Start Programs.
- 10/98 Component billing began in TDTP Program
- 12/98 Psychiatry and Patient Accounts completed the technical plan for billing Code 21.
- 12/99 First month that Code 21 bills were sent to Medicare.

Communications with Empire Medicare

- 1997 Written and telephone communication took place regularly with Terri Dix RN, Manager of Psychiatric Medical Review, and Rosemary Stafford, Psychiatric Educator. All steps of in-service training and all proposed documentation changes were checked by them and tentatively approved.
- 1998 Communications became more difficult over the year due to staff transfers and reassignments at Empire
- 1999 All communication with Empire Medicare took place via the Empire Medicare website and the Part A provider hotline.

Collaboration:

- We have met repeatedly with representatives of the Greater New York Hospital Association, HANYS, and Medicare in joint efforts to resolve Medicare Outpatient Psychiatry problems.
- We have collaborated directly with the following institutions on various aspects of the Medicare billing process: Mt. Sinai, Beth Israel, New York Hospital, LIJ Hillside, and St. Vincent's Harrison and New York divisions.

As can be seen from the above information, SLRHC Department of Psychiatry has spent three years working to correct the Medicare billing and documentation problems. However, we were unable to implement the major corrective actions (revised documentation and component billing) until early 1998. The final piece of corrective action, the ability to differentially bill the services for our patients when we disagree with Medicare about the level of care required, required major modifications of our mainframe billing system. This was only accomplished in December, 1999.

In 1997, we were billing and documenting Continuing Day Treatment according to the standards set by the New York Office of Mental Health. This involved the submission of one visit per day attended, per patient. This actually amounted to billing fewer

services than allowed according to the Medicare law. Currently, we bill Medicare for 1-5 allowable services per day. Additionally, while the treatment plan sometimes listed the program, rather than each specific modality, and while notes referred to dates of service rather than modalities, complete onsite records were maintained itemizing which groups each patient attended each month. Other onsite documentation includes schedules listing the length and frequency of each program modality, and program manuals describing each modality, its purpose, frequency, and intended duration. This material was not submitted as part of the audit, as it is not maintained in the patient's chart, however we would be happy to submit it as back-up documentation.

In 1997, our clinic treatment plans did not explicitly have a space for the frequency and duration of treatment. Most of the time this information was included on the treatment plan forms. In those cases where the duration is not explicitly stated, the date that the goals of the treatment will be met or reevaluated is always stated. This is substantively the duration of treatment. The frequency of treatment can be ascertained very easily from the last line of each progress note where the date of return to the clinic is stated.

While we realize that many of the services documented as described in the two paragraphs above can not be appealed as they technically do not meet every Medicare documentation standard, we argue that the deviations are minor and do not impede that ability to determine medical necessity. According to the OIG report, \$22,940 in charges for 124 services were denied for the reasons above. As a matter of fact, in the 6 months following the billing and documentation improvements implemented 1/1/98, Empire, based on ADR review, completely approved at least one claim for each of 8 patients, who have been denied in the audit for 59 visits totaling \$10,915. In other words, 48% of the units of service denied for treatment plan deficiencies during the audit, were later judged to be receiving care that was medically necessary (See attachment B). Considering that a large percentage of patients reviewed in the 1997 audit were no longer receiving treatment in 1998, this becomes a powerful argument for the appropriateness of the treatment being provided.

All cases were reviewed for medical necessity. In only 1% of the reviewed sample (\$740 of charges) did the auditors find that the services delivered were not medically necessary. We are appealing these charges.

In conclusion, since August of 1996 SLRHC has been working actively in conjunction with Empire Medicare to perfect our Medicare billing and documentation procedures. Medicare regulations are extensive, change frequently and are sometimes unclear (as in the case of determining medical necessity). Despite the extensive auditing and Focused Medical Review that SLRHC's Department of Psychiatry has undergone, it has never

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been questioned that we are making a good faith effort to provide the appropriate care, billed and documented in the appropriate manner to our patients. We have demonstrated vigilance in overseeing our procedures and a pattern of improvement. Currently, our rate of technical denials is almost nil, and we expect our rate of denials for medical necessity to decrease rapidly over the next few months. Large, centralized multi site, not for profit institutions such as ours, have great difficulty moving rapidly to implement change. We feel confident that we are currently in full compliance with all Medicare billing and documentation regulations.

While we agree that some sort of repayment might be indicated for our failure to comply with several technical procedures in the past, we feel that our documented changes and improvements make the size of the payback Medicare is requesting excessive. SLRHC serves a poor, seriously and persistently mentally ill population, with many confounding social and medical problems. The large majority of our patients receive Medicare because they are chronically disabled. This is exactly the population for which increased attention and care is being urged by the Surgeon General, legislators and the public. Taking back \$1,179,461 from billings of \$2,900,000, or approximately 40%, for technical errors, will impede our ability to provide care for this vulnerable population and does not seem reasonable.

We wish to schedule a meeting with you and your staff, in the near future, to discuss further the issues presented in this letter. Our goal is to reach an amicable settlement in the best interests of both parties and of our patients.

Sincerely,



Elizabeth Moore