

**Memorandum**

Date · JUL - 9 2002
From Dennis J. Duquette *Dennis J. Duquette*
Deputy Inspector General
for Audit Services
Subject
To Partnership Review of Psychotherapy Claims Submitted by Two Payees Under the Illinois Medicaid Program (A-05-01-00068)

Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

As part of the Office of Inspector General's partnership efforts with State auditors, we are alerting you to the issuance within 5 business days of our final report entitled, "Partnership Review of Psychotherapy Claims Submitted by Two Payees Under the Illinois Medicaid Program." A copy of the report is attached. We suggest you share this report with components of the Centers for Medicare & Medicaid Services involved with program integrity, provider issues, and State Medicaid agency oversight, particularly the Center for Medicaid and State Operations. This report is one of a series of partnership reports focusing on the time dependent billing routine developed by our partner, the Inspector General, Illinois Department of Public Aid (IDPA).

The objective of our review was to develop and validate a time dependent billing routine that would identify practitioners who submitted claims for more time than is feasible in a day. The routine identified practitioners who billed for one or more 12-hour days for dates of service from July 1, 1998 to June 30, 2000. Two organizations were identified as alternate payees for several physicians in the time dependent billing project. The alternate payees claimed physician psychotherapy services and received payments on behalf of the physicians.

We concluded that the physicians did not provide the psychotherapy services claimed by the alternate payees. Counselors employed by the alternate payees allegedly provided family counseling services, which were claimed, using the physicians' Medicaid provider number, as individual psychotherapy services provided by physicians. None of the services billed by the two alternate payees, during the audit period, were performed by physicians; therefore, we recommended that IDPA recover the unallowable payments made to the two alternate payees totaling \$7,581,693 (Federal share \$3,790,846). In responding to our report, the State agency concurred with our findings and recommendation.

Any questions or comments on any aspect of this memorandum are welcome. Please call me or have your staff contact George M. Reeb, Assistant Inspector General for Centers for Medicare and Medicaid Audits, at 410-786-7104 or Paul Swanson, Regional Inspector General for Audit Services, Region V at 312-353-2618.

Page 2 – Neil Donovan

To facilitate identification, please refer to Common Identification Number A-05-01-00068 in all correspondence relating to this report.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

Common Identification Number: A-05-01-00068

Ms. Jackie Garner
Director
Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, Illinois 62763

JUL 12 2002

Dear Ms. Garner:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, "Partnership Review of Psychotherapy Claims Submitted by Two Payees Under the Illinois Medicaid Program." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS 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, 5 U.S.C. 552, as amended by Public Law 104-231, OIG OAS reports issued to the Department's grantees and contractors are made available 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.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at <http://oig.hhs.gov>.

To facilitate identification, please refer to Common Identification Number A-05-01-00068 in all correspondence relating to this report.

Sincerely,

Paul Swanson
Regional Inspector General
for Audit Services

Robb Miller
Inspector General
Illinois Department of Public Aid

Enclosures – as stated

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Direct Reply to HHS Action Official:

Cheryl Harris, Associate Regional Administrator
Centers for Medicare & Medicaid Services – Division of Medicaid, Region V
233 North Michigan Avenue
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PARTNERSHIP REVIEW OF
PSYCHOTHERAPY CLAIMS
SUBMITTED BY TWO PAYEES UNDER
THE ILLINOIS MEDICAID PROGRAM**

**ILLINOIS DEPARTMENT OF
PUBLIC AID
SPRINGFIELD, ILLINOIS**



JANET REHNQUIST
Inspector General

JULY 2002
A-05-01-00068



JUL 12 2002

Common Identification Number: A-05-01-00068

Ms. Jackie Garner
Director
Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, Illinois 62763

Dear Ms. Garner:

This final report provides you with the results of the partnership review of psychotherapy claims submitted by two payees under the Illinois Medicaid Program. Under its Partnership Plan, the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services (OAS), entered into this joint project with the Illinois Department of Public Aid's (IDPA) OIG. The IDPA administers the Illinois Medicaid Program and submits the quarterly claims to the Centers for Medicare & Medicaid Services (CMS), previously referred to as the Health Care Financing Administration.

The objective of our joint review was to develop and validate a time dependent billing routine that would identify practitioners who submitted claims for more time than is feasible in a day. To identify these practitioners, IDPA OIG performed an analysis of claims for specific procedure codes billed to the Medicaid program based on minimum established time guidelines. The time dependent billing routine identified practitioners who billed for one or more 12-hour days for dates of service from July 1, 1998 to June 30, 2000, inclusive. Under the Partnership Plan, two organizations were identified as alternate payees for several physicians in the time dependent billing project. These physicians had charged for more time than is feasible in a day.

These alternate payees submitted claims for physician psychotherapy services and received payments on behalf of the physicians. Based on our fieldwork, we have concluded that the physicians did not provide any of the psychotherapy services claimed under the Medicaid program. Counselors employed by the alternate payees allegedly provided family counseling services, which were claimed as individual psychotherapy services provided by a physician. As a result, we are recommending that IDPA take the necessary steps to recover the unallowable payments to the two payees totaling \$7,581,693 (Federal share \$3,790,846) for dates of service during the period April 1, 1997 through May 31, 2001, inclusive. While the time dependent billing routine analyzed dates of service from July 1, 1998 to June 30, 2000 to identify practitioners who submitted claims for more time than is feasible in a day, the scope of our claims validation for the two payees also included claims outside the above 24-month period.

The IDPA concurred with the findings and recommendation presented in the report. They will pursue legal and administrative remedies to collect the identified overpayment. We agree that IDPA should make every attempt to recover the unallowable payments from the culpable physicians and alternate payees.

INTRODUCTION

BACKGROUND

In order to provide broader audit coverage of State Medicaid programs in Region V States, HHS OIG proposed to jointly review Medicaid payments with IDPA OIG and the Division of Medical Programs. As our model, we referred to previously successful approaches presented in the existing publication, *Partnerships Work and Deliver Results, A Summary of Federal/State Joint Audit Initiatives*. That document suggests that State and Federal oversight groups working together are the most effective and efficient use of scarce Federal and State resources. In implementing the partnership approach, the following offices with their compatible missions participated in this joint project.

HHS, OIG OAS: The mission of the HHS OIG is to improve programs and operations of HHS and to protect against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, the HHS OIG provides timely, useful, and reliable information and advice to HHS officials, the Administration, the Congress, and the public.

The OAS, one component of the HHS OIG, provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs, in general, and of its grantees and contractors, in regard to carrying out their respective responsibilities. These audits are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency in HHS programs.

IDPA OIG: The IDPA OIG employs 280 staff to fulfill the Illinois General Assembly's mandate to prevent, detect, and eliminate fraud, waste, abuse, mismanagement and misconduct in programs administered by the Department of Public Aid. The IDPA OIG has a multi-disciplinary staff of professionals who initiate enforcement actions and develop prevention strategies to safeguard the Illinois Medical Assistance, Food Stamp, and Temporary Assistance for Needy Families programs.

The IDPA OIG conducts numerous research projects and studies issues affecting the fiscal integrity of the programs it monitors. The IDPA OIG conducted the nation's first statistically valid study of the accuracy of Medicaid payments in Illinois. The project's findings have provided significant guidance to continuing fraud prevention work, and its methodology has served as a blueprint for other States and other payers who are undertaking medical payment accuracy studies. The IDPA OIG also produced numerous reports on key program integrity issues.

The IDPA OIG Fraud Science Team (FST) also has an active effort to develop innovative fraud and overpayment detection routines of which this project is a component. The FST staff developed and implemented the detection routine used in this review and identified the physicians for field validation. They also contributed to the field validation by providing consultation and detailed claim and payment information for the physicians included in the review.

The IDPA OIG has a Fraud and Abuse Executive who coordinates actions with State and Federal law enforcement agencies. The Fraud and Abuse Executive also leads and coordinates other State-Federal initiatives for the IDPA OIG, including the HHS OIG Partnership Plan.

OBJECTIVES, SCOPE, AND METHODOLOGY

The OAS conducted this audit in accordance with generally accepted government auditing standards. The primary objectives of this review were:

- ▶ to identify physicians who are billing for more time than is feasible in a day, and
- ▶ to determine whether the physicians properly billed the Medicaid program for services provided.

The OAS conducted its fieldwork at offices of Payee A and Payee B in Chicago. Fieldwork was completed in October 2001.

Methodology Used by IDPA OIG to Identify Medical Physicians. The time dependent billing routine was designed to identify practitioners who billed for more time than is feasible in a day. Using practitioner claims data available on IDPA's data warehouse, the routine provides an estimate of the number of hours a practitioner spends on patient care for each day. From that information, IDPA generates a series of reports that can be used to identify providers and payees who warrant follow-up action.

To develop this routine, IDPA identified those Current Procedural Terminology (CPT) and local codes that reference time in their description or in American Medical Association's CPT manual. Where a time range is provided, IDPA assigned the lower time value. Since some visit procedure codes did not have a specific time expressed in the CPT, the IDPA assigned three minutes to those non-time dependent codes, with the exception of group codes which were assigned a value of zero minutes in the billing routine. The IDPA continues work to refine and enhance this routine currently.

The Partnership examined the results of the IDPA analysis for dates of services between July 1, 1998 and June 30, 2000, inclusive. The routine identified 146 practitioners with at least 1 day greater than 12 hours. There were 16 practitioners identified in the routine with over

10 days greater than 24 hours, the most being 371 days. Of the 146 practitioners, 32 are currently the subject of an ongoing investigation or review. Six of the 114 remaining had over 10 days greater than 24 hours. Of these, one practitioner had 328 days exceeding 24 hours.

Selection of Physicians for Validation of Claims. Under the Partnership Plan, it was the general consensus that we would determine the propriety of Physician A's claims submitted under the Medicaid program. For dates of service between July 1, 1998 and June 30, 2000, inclusive, the billing routine identified Physician A as billing 328 days greater than 24 hours and being paid \$1,524,372. According to IDPA records, his specialty was listed as family practice. Over 79 percent of the amount paid pertained to procedure code 90806: Individual psychotherapy, insight oriented, behavior modifying, and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.

Selection of Dates of Service for Validation. To determine the propriety of the billings, the IDPA OIG selected 3 consecutive days during January 2001 (22nd, 23rd, 24th). The claim detail showed that 508 claims for 170 different recipients during the 3-day period were submitted to IDPA for payment under Physician A's provider number. Claims were submitted for 168 of the recipients on all 3 days and for 2 of the recipients for 2 days. The procedure code billed for January 22nd and January 24th was 90806 relating to individual psychotherapy 45 to 50 minutes face-to-face with the patient. The procedure code billed for services on January 23rd was 90804, which also related to individual psychotherapy, but for 20 to 30 minutes.

Alternate Payee Arrangements. Under certain conditions, IDPA permits individual physicians to designate an alternate payee for payment of claims for services provided by the physician. We found that the majority of the Medicaid payments made on behalf of Physician A were paid to two alternate payees, referred to as Payee A and Payee B in this report. Payee A was a not-for-profit corporation that was organized to provide community based social services to at-risk children and their families. These services were to include counseling, educational enrichment, youth leadership, youth employment training, GED program, computer literacy, and youth recreational programs. Payee B was a related for-profit entity that contracted with counselors to provide counseling services to Payee A's clients. Both corporations share the same Chief Executive Officer (CEO).

During the course of the Partnership, it was determined that neither Payee A nor Payee B met the conditions of the 89 Illinois Administrative Code to qualify as an alternate payee for physicians. As a result, their alternate payee agreements were canceled by IDPA on August 30, 2001.

Other Related Physicians. The time dependent billing routine identified several other physicians, utilizing Payee A as an alternate payee, who also submitted claims for more time than was feasible in a day. The results of the routine and the total payments to all payees of these physicians (including Physician A) for dates of service between July 1, 1998 and June 30, 2000, inclusive, were as follows:

<u>Physician</u>	<u>Days Greater Than 24 Hours</u>	<u>Total Payments</u>
A	328	\$1,524,372
B	306	2,790,191
C	235	2,669,462
D	137	1,267,455
E	45	324,394

The scope of our review was expanded beyond Physician A to include all of the physicians utilizing Payee A and the related for profit company, Payee B, as alternate payees.

FINDINGS AND RECOMMENDATION

PSYCHOTHERAPY SERVICES NOT PROVIDED

Our review of the client files showed that Physician A did not provide the psychotherapy services claimed by Payees A and B and paid by IDPA under the Medicaid program. Counselors employed by the alternate payees performed individual counseling for its clientele, however, such services were not allowable for Medicaid reimbursement. Only psychiatric services provided by a physician are reimbursable. The role of Physician A, and the other Physicians, B through E, was to provide supervision and consultation to the alternate payee's employees, as needed. However, the alternate payees submitted claims to IDPA for counseling services provided by its employees. These claims were coded to reflect individual face-to-face psychotherapy services performed by a physician.

According to section A-210.4, Psychiatric Services, of the IDPA Handbook For Physicians,

“...psychiatric therapies must be provided by the physician who submits charges. Services provided by a psychologist, social worker, etc., are not reimbursable.”

Since Physicians A through E did not provide the psychotherapy services, the charges were ineligible for reimbursement under the Medicaid program. As a result, we recommended that IDPA take the necessary steps to recover the unallowable payments to Payees A and B totaling \$7,581,693 (Federal share \$3,790,846) for dates of service during the period April 1, 1997 through May 31, 2001, inclusive.

Review of Client Files. We requested the client files for 170 individuals, for which Payees A and B submitted claims on behalf of Physician A to IDPA for psychotherapy services. We specifically requested documentation to substantiate the claims for services provided to the clients without indicating the exact dates of service within January 2001 that we wanted to review. Alternate Payee A provided records for 138 of the 170 clients; however, many of the

folders were incomplete. Although we asked for the clients' complete files, the client files generally contained only Service Documentation Forms (SDF) for the month of January 2001.

Although the SDFs indicated face-to-face individual counseling was provided on a specific date, a physician did not provide the counseling services. Payees A and B employed counselors identified as rehabilitative services associates, mental health professionals, and qualified mental health professionals. None of these positions qualified as a physician and, therefore, were not reimbursable under the Medicaid program.

The client file review showed that many of the SDFs in the folders did not support services on the date claimed. Further, the SDFs were altered by white-out correction and duplicated to include other client names and dates of service. The January documentation provided for review did not always agree with the documentation included in the client's complete folder when received on a later date. The CEO of Payees A and B stated that the missing 32 records were most likely in the possession of the counselors that provided the services. These counselors were terminated when Medicaid reimbursement was discontinued by IDPA.

Our review of the clients' files found no indication that face-to-face psychotherapy services were provided by a physician. The CEO of Payees A and B confirmed that Physicians A through E never provided psychotherapy services. The physicians were supposedly acting in a supervisory/consultant role to advise the counselors and review files, as needed. Physicians A, B, and C corroborated the CEO's statement that they never provided face-to-face psychotherapy services to the clients. Furthermore, Physician A stated that he visited the Payee A and B facility only once every 3 or 4 months.

Arrangements Between Parties. Another corporation, Corporation C, referred the physicians to Payee A and Payee B to provide supervision and consultation to the counselors. Alternate payee agreements were executed between Payees A and B with the physicians, thereby authorizing Payees A and B to claim and receive the Medicaid payments for services provided by the physicians. According to the CEO, Payees A and B paid Corporation C 10 percent of the total amount received from IDPA for referring the physician. In addition, Payee A and B paid their billing company \$3.50 for each claim submitted to IDPA. The same people who made the physician referral and operated Corporation C owned this billing company.

Total Payments to Alternate Payees. The IDPA OIG identified all payments for physicians having alternate payee agreements with Payee A or Payee B. For services provided during the period April 1, 1997 through May 31, 2001, Payee A and Payee B were paid \$7,581,693 for individual face-to-face psychotherapy services that should have been provided by these physicians. The payments by physicians and period were as follows:

	<u>Physician</u>	<u>Dates of Service</u>	<u>Payments</u>
Payee A:			
	A	May 98 – May 01	\$ 983,018
	B	June 98 – Dec 99	2,235,484
	C	Jan 98 – Mar 99	423,921
	D	July 99 – Dec 00	1,743,155
	E	Apr 97 – Mar 99	<u>554,153</u>
	Total		\$5,939,731
Payee B:			
	A	Apr 98 – May 01	<u>\$1,641,962</u>
Total			<u>\$7,581,693</u>

Based on our review of the client files and discussions with Physician A and the CEO of Payees A and B, it was evident that the counseling services provided to the clients were not provided by the physicians. This was also confirmed through interviews conducted by the Medicaid Fraud Control Unit with Physicians B and C. We found no evidence of psychotherapy services being provided by the physicians at any time. While there appears to have been some family transition and youth counseling provided by counselors employed by Payee A and Payee B, these counseling services would not be eligible for reimbursement under the Medicaid program as physician services.

Based on discussions with the parties, they contend that they were confused about the alternate payee arrangement and the type of services allowable to be billed under the Medicaid program using the physician’s provider number. The CEO of Payees A and B stated that she thought counseling services could be claimed under the Medicaid program. In addition, Physician A stated that he was unaware of the volume of psychotherapy claims being submitted to IDPA by the alternate payees with his provider number.

Recommendation

We jointly recommend that IDPA take the necessary steps to recover the unallowable payments to Payee A and Payee B, totaling \$7,581,693 (Federal share \$3,790,846), for dates of service during the period April 1, 1997 through May 31, 2001, inclusive.

IDPA’s Comments

In a letter dated March 18, 2002, the IDPA concurred with the findings and recommendation presented in the report. To the extent possible, the IDPA will pursue every legal and administrative remedy to collect the identified overpayment. In addition, the IDPA’s Division of Medical Programs will work with the IDPA OIG to develop informational notices to providers reminding them of the Department’s policies. The full text of IDPA’s comments is included as an APPENDIX to this report.

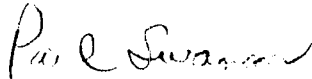
OAS's Response

We agree that IDPA should make every attempt to recover the unallowable payments from the five physicians and two alternate payees who share culpability for the inappropriate psychotherapy claims totaling \$7,581,693 (Federal share \$3,790,846).

OTHER MATTERS

Based on our review of the client files, it appears that most of the SDFs, if not all, were fabricated and altered in an attempt to support the claims submitted to IDPA and that the relationships and financial arrangements between the parties may represent a scheme to defraud the Medicaid program. The related physicians, who authorized Payee A to be an alternate payee, were part of ongoing reviews by other agencies. Based on the above issues, a copy of this report is being forwarded to the HHS/OIG/Office of Investigations for possible criminal and/or civil investigation.

Sincerely,



Paul Swanson
Regional Inspector General
for Audit Services



Robb Miller
Inspector General
Illinois Department of
Public Aid

APPENDIX



George H. Ryan, Governor
Jackie Garner, Director

Illinois Department of Public Aid

201 South Grand Avenue East
Springfield, Illinois 62763-0001

Telephone: (217) 782-1200
TTY: (800) 526-5812

March 18, 2002

Paul Swanson
Regional Inspector General for Audit Services
HHS-OIG Office of Audit Services
Illinois Business Center
400 West Monroe, Suite 204B
Springfield, Illinois 62704

CIN: A-05-01-00068

Dear Mr. Swanson:

I am writing in response to your letter dated January 28, 2002 regarding the draft report titled "Partnership Review of Psychotherapy Claims Submitted by Two Payees under the Illinois Medicaid Program." The Illinois Department of Public Aid (IDPA), Division of Medical Programs actively participated and performed several crucial roles in this joint project.

We have reviewed the draft report and concur with the findings and recommendations. To the extent possible, the Department will pursue every legal and administrative remedy to collect the identified final overpayment. The final overpayment is determined after the provider has his/her due process through the Administrative Hearing process and possibly even civil proceedings. In addition, the Division of Medical Programs and the Office of Inspector General are working through the Medicaid Fraud Prevention Executive Workgroup to see if developing computer edits might eliminate these activities from occurring in the future. In addition, we will work with the OIG to develop informational notices to providers reminding them of the Department's policies.

In order to provide future audit coverage of the State Medicaid Programs, we will continue to work with the Federal work groups in implementing the partnership approach. Any further questions regarding our comments, please contact Steve Bradley at (217) 785-2867.

Sincerely,

Matt Powers, Administrator
Division of Medical Programs