DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services
REGION IV
61 Forsyth Street, Room 3T41
Atlanta, GA 30303-8909

Memorandum

Date: DEC 17 1999

From: Regional Inspector General
for Audit Services, Region IV

Subject: Review of St. Francis Behavioral Health Center's Partial Hospitalization Program (CIN: A-04-97-02141)

To: Rose Crum-Johnson
Regional Administrator
Health Care Financing Administration

This final report provides you with the results of our review of St. Francis Behavioral Health Center's Partial Hospitalization Program. Medicare covers partial hospitalization services to eligible beneficiaries for services that are reasonable and necessary for the diagnosis and treatment of an individual's mental condition and reasonably expected to improve or maintain the individual's functional level to prevent relapse or hospitalization.

EXECUTIVE SUMMARY

The objective of our review was to determine whether the partial hospitalization services claimed by the provider for 20 beneficiaries in the 12-month period ended December 31, 1996 met the Medicare eligibility and reimbursement requirements.

Summary of Finding

Our review showed that for the 12-month period ended December 31, 1996, St. Francis Behavioral Health Center (St. Francis) was paid $573,506 for services to 20 beneficiaries that did not meet the Medicare eligibility and reimbursement criteria.

We reviewed a judgmental sample of 20 beneficiaries who received partial hospitalization (PHP) services during the 12-month period ended December 31, 1996 at St. Francis. The review showed that all of the services claimed for the 20 beneficiaries did not meet the Medicare eligibility and reimbursement criteria.

The 20 beneficiaries did not meet the eligibility criteria for admission to the PHP, received services from unlicensed staff, and received services that were not reasonable and necessary for the patients' condition.

We believe that the unallowable claims were submitted because the provider did not adhere to Medicare guidelines. Also, the Fiscal Intermediary's (FI) policies to identify improperly billed services may be inadequate. Based on the results of our review, we recommend that the Health

Care Financing Administration (HCFA) instruct the FI to:

- initiate recovery action against the provider for the $573,506 overpayment, and
- monitor the PHP providers to ensure that proper reimbursement procedures are followed.

The HCFA generally concurred with these recommendations. The HCFA's response, in it's entirety, is included in Appendix A of this report.

BACKGROUND

St. Francis is a for-profit corporation with its principal place of business in Hialeah, Florida. Its effective date of participation in the Medicare program was June 15, 1995. The Medicare provider number was issued based on a self-attestation statement certifying the Community Mental Health Center's (CMHC) compliance with the Federal requirements in Sec. 1861 (ff)(3)(B) of the Social Security Act.

Section 4162 of the Omnibus Budget Reconciliation Act of 1990 amended Section 1861 of the Social Security Act to include CMHCs as entities that are authorized to provide PHP services under Medicare. The Public Health Service (PHS) has primary responsibility for regulating CMHCs, and Section 1916(c)(4)[1] of the PHS Act lists the services that must be provided by a CMHC. The legislation states that any entity that provides these services would be considered a CMHC for the purpose of the Act.

The HCFA contracts with FIs, usually large insurance companies, to assist them in administering the PHP benefit program. They are responsible for processing, reviewing, and paying claims submitted by CMHCs for PHP services. The FI responsible for processing St. Francis's claims was Blue Cross/Blue Shield of Florida (now incorporated as First Coast Service Options, Inc.).

During the year, a CMHC receives interim payments based on a percentage of its billed charges. These payments are intended to approximate the CMHC's reasonable costs. Upon receipt of the annual Medicare cost report, the FI determines whether the provider has received an overpayment or is due a settlement payment based on the reasonable costs incurred for the year.

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[1]In 1992, the PHS Act was amended to require only four core services. The amendment eliminated the requirements to provide consultation and education services. The four core services are currently listed at section 1913(c)(1) of the Act, which superceded section 1916(c)(4).

From June 1995 through May 1997, St. Francis received interim payments of $3,717,045 from Medicare.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether the partial hospitalization services claimed by the provider for 20 beneficiaries in the 12-month period ended December 31, 1996 met the Medicare eligibility and reimbursement requirements.

Scope and Methodology

We obtained the provider's 1996 Provider Statistical and Reimbursement Report and sorted the data by beneficiary based on total reimbursement. We selected the 20 beneficiaries with the highest reimbursement amounts as our sample. The services reviewed were not based upon a statistical sample and therefore, the results will not be extrapolated to determine unallowable services in the entire universe of the provider's claims.

We obtained the medical records documentation for each of the 20 beneficiaries selected from the provider and requested the FI to perform a medical review for each medical record to determine whether the beneficiary met the Medicare eligibility criteria to receive PHP services and whether the services met the Medicare reimbursement requirements.

For each of the 20 beneficiaries, we interviewed the beneficiary, a family member, or a close acquaintance.

Our work was conducted at the Miami field office, the provider's office, and the beneficiaries' places of residence. Our site visit began September 15, 1997, and concluded on October 3, 1997.

We did not test the provider's internal control structure. Based on the objective of our review, we judged that a review of internal controls was not necessary.

During our field work, we identified conditions that led us to believe that St. Francis may be a part of a network of companies created to defraud the Medicare program. We referred this case to the Office of Investigations for further review.

Our audit was performed in accordance with generally accepted government auditing standards. The review was performed under the auspices of Operation Restore Trust and was initiated by

the Office of Inspector General Office of Audit Services in Miami.

DETAILED RESULTS OF MEDICAL REVIEW

Our review showed that St. Francis was reimbursed $573,506 for services that did not meet the Medicare eligibility and reimbursement requirements. The FI medical reviewers concluded that none of the services rendered to the 20 beneficiaries in our sample met the Medicare reimbursement requirements because the services were provided to beneficiaries who did not meet the eligibility criteria, were rendered by unlicenced staff, and were not reasonable and necessary for the patient's condition.

Ineligible Beneficiaries

In the opinion of FI medical reviewers, the 20 beneficiaries were not eligible for the PHP program because there was no indication of a precipitating factor, crisis or acute exacerbation of a psychiatric illness. In several cases, it was documented that the patients refused or lacked the ability to participate in the group process due to their level of functioning.

Section 1835 (a)(2)(F)(i) of the Social Security Act states that an eligible beneficiary is one who *"in the case of partial hospitalization services, . . . would require inpatient psychiatric care in the absence of such services."* The HCFA Program Memorandum (PM), A-96-2 further explains that *"Partial hospitalization programs are designed to treat patients who exhibit severe or disabling conditions related to an acute psychiatric/psychological conditions or an exacerbation of a severe and persistent mental disorder."* In addition, a beneficiary must be able to benefit from the program of services.

Services Provided by Unlicenced Personnel

The review of medical records for the 20 beneficiaries showed that unlicenced personnel rendered the psychotherapy. In many cases, the physician's progress notes were written by a physician's assistant, not licensed to render psychotherapy, and cosigned by the physician.

The Community Mental Health Centers Act, Title II, Part A, Sec.201(c)(2) defines a provider of health care as an *"individual who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, or physician assistant) in that the individual's primary current activity is the provision of health care to individuals . . . and is licensed or certified for such provision or administration."* In addition, Interim Final Rule 59 FR 6570 states that services provided by CMHCs must be, among other things, *"individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State Law."*

Services Not Reasonable and Necessary

In the opinion of FI medical reviewers, the 20 beneficiaries received services that were not reasonable and necessary for the patient's condition. The services were not reasonable and necessary because the length of stay was excessive and the treatment planning was inadequate. The review showed that the average length of stay for the beneficiaries was approximately 4 months, however the documentation did not support medical necessity for continued stay in the program. No progress was made toward treatment goals.

Section 42 of the Code of Federal Regulations, Part 410.43 requires that the services be *". . . reasonable and necessary for the diagnosis or active treatment of the individual's condition and functional level and to prevent relapse or hospitalization."*

Other

The FI medical reviewers also found that the medical records documentation was not legible, not specific, and in some cases not complete.

CONCLUSIONS AND RECOMMENDATIONS

We believe that the unallowable claims were submitted because the provider did not adhere to Medicare guidelines. Also, the FI's policies to identify improperly billed services may be inadequate. Based on the results of our review, we recommend that HCFA instruct the FI to:

- initiate recovery action against the provider for the $573,506 overpayment, and
- monitor the PHP providers to ensure that proper reimbursement procedures are followed.

The HCFA generally concurred with these recommendations. The HCFA's response, in it's entirety, is included in Appendix A of this report.

Charles J. Curtis

APPENDIX A

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OPERATION RESTORE TRUST

November 29, 1999

June Gibbs Brown
Inspector General
Department of Health & Human Services
Wilbur Cohen Building-Suite 5250
330 Independence Avenue, S.W.
Washington, D.C. 20201

Re: St. Jude A-04-97-02142
and St. Frances A-04-97-02141

Dear Ms. Gibbs Brown:

HCFA and the Florida State agency did not participate on this review, therefore no report was issued.

(Redacted) The provider agreement to participate in the Medicare program was terminated in January 1998, due to a cessation of business.

Sincerely,

Sheila M. Kanaly
for

William Dewey Price
Program Integrity Branch
HCFA Region IV