Memorandum

Date JUN 19 2000

From /for June Gibbs Brown
Inspector General

Subject Review of Partial Hospitalization Services and Fiscal Year 1997 Cost Report--New Center Community Mental Health Services, Detroit, Michigan (A-05-00-00004)

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 Partial Hospitalization Services and Fiscal Year 1997 Cost Report--New Center Community Mental Health Services, Detroit, Michigan (A-05-00-00004). A copy of the report is attached.

The objectives of our review were to determine whether Medicare payments to New Center for partial hospitalization program (PHP) services were billed for and reimbursed in accordance with Medicare requirements, and whether selected costs reported through the provider's cost report were reimbursable pursuant to applicable Medicare criteria.

Based on a medical necessity review of services reimbursed by Medicare, performed on our behalf by the fiscal intermediary (FI), we recommend that New Center work with its FI to: (1) refund $1,109,523 for unallowable Medicare PHP services; and (2) establish policies to ensure that PHP services provided to Medicare beneficiaries meet Medicare requirements.

We identified $71,478 of costs reported through the Fiscal Year (FY)1997 cost report that were not allocable or reimbursable according to Medicare regulation. The New Center was unable to furnish acceptable documentation to support questioned general and administrative expenditures and overcharged service costs due to a cost reporting error. We recommend that New Center adjust its FY 1997 cost report to reflect the adjustment or removal of $71,478 in inappropriate costs; and establish nonreimburseable cost centers or otherwise exclude costs related to noncovered items from its cost report.

Generally, New Center did not concur with our findings. In New Center's response, a consultant employed by the provider made several comments objecting to the review procedures used by the FI and requested that information prepared by the provider's medical director, in response to findings regarding medical necessity, be shared with the FI. We have forwarded this information to assist the FI in the audit resolution process. The consultant

also expressed concern regarding the clinical credentials of the FI's medical reviewers. The full text of the provider's response is attached to the report.

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 Paul P. Swanson, Regional Inspector General for Audit Services, Region V, (312) 353-2621.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PARTIAL HOSPITALIZATION SERVICES AND FISCAL YEAR 1997 COST REPORT--NEW CENTER COMMUNITY MENTAL HEALTH SERVICES, DETROIT, MICHIGAN

JUNE GIBBS BROWN
Inspector General

JUNE 2000
A-05-00-00004

EXECUTIVE SUMMARY

Nationally, Medicare payments to community mental health centers (CMHC) increased from about $60 million in Calendar Year (CY) 1993 to about $350 million in CY 1997. The Health Care Financing Administration (HCFA) and the Department of Health and Human Services, Office of Inspector General (OIG) have worked together to review the Medicare partial hospitalization program (PHP) benefit provided through CMHCs.

New Center Community Mental Health Services (New Center) received over $2.8 million in Medicare payments during CY 1997, with a corresponding average payment per patient of about $20,000. This provider also experienced a significant increase in Medicare billings for PHP services over a 1-year period.

Objective

The objectives of our review were to determine whether Medicare payments to New Center for PHP services were billed for and reimbursed in accordance with Medicare requirements, and whether selected costs reported through the provider's cost report were reimbursable pursuant to applicable Medicare criteria.

Summary of Results

We identified unallowable Medicare PHP payments and inappropriate cost report items as follows:

- $1,109,523 of payments for services that were not reasonable and necessary, and
- $71,478 of inappropriate costs allocated through New Center's Fiscal Year (FY) 1997 cost report.

Recommendations

We recommend that New Center work with the fiscal intermediary (FI) to:

- refund $1,109,523 for unallowable Medicare PHP services;
- establish policies to ensure that PHP services provided to Medicare beneficiaries meet Medicare requirements;
- adjust its FY 1997 cost report to reflect the adjustment or removal of $71,478 in reported inappropriate costs; and
- establish nonreimbursable cost centers or otherwise exclude costs related to noncovered items from its cost reports.

PROVIDER'S COMMENTS AND OIG RESPONSE

The New Center's written comments were prepared by a consultant. The consultant made several technical comments asserting, for various reasons, that the FI had no authority to make a liability for overpayment finding and that guidance used by FI medical reviewers was flawed. The consultant also contended that our findings on medical necessity were not objectively developed because information prepared by New Center, in response to our draft report findings, was not shared with the FI. More recent statements by New Center's medical director were also submitted with the comments. The consultant requested that we furnish these statements to the FI for consideration. Additional documentation was submitted for certain cost report items, which were questioned in our draft report.

We have made minor changes in the report based on the comments but reject the assertions made regarding lack of authority and/or flawed guidance. All information on medical necessity, submitted to us by New Center, has been forwarded to the FI for consideration during the audit resolution process. The New Center's comments and OIG's response appear after each finding and the full text of the comments is included as Appendix B.

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INTRODUCTION

BACKGROUND

Nationally, Medicare payments to CMHCs increased from about $60 million in 1993 to about $350 million in 1997. Correspondingly, the average Medicare payment per CMHC beneficiary also increased from about $1,642 to about $10,352 during the same time period.

> Medicare payments to CMHCs increased from about $60 million in 1993 to $350 million in 1997.

The HCFA and the Department of Health and Human Services, OIG worked together to review the Medicare PHP benefit provided through CMHCs. The HCFA site visits and other reviews showed that CMHCs often bill Medicare for services that are: (i) not covered under the PHP benefit, (ii) not provided to the beneficiary, or (iii) not medically necessary for the well being of the patient.

The New Center received over $2.8 million in Medicare payments during 1997, with a corresponding average payment per patient of about $20,000. The New Center also experienced a significant increase in Medicare billings for PHP services during a 1 year period.

The Partial Hospitalization Program Benefit

The PHP benefit is a distinct, organized, and intensive psychiatric outpatient treatment program of less than 24 hours of daily care for beneficiaries afflicted by profound or disabling mental conditions. The benefit differs from inpatient hospitalization and outpatient management in both the program intensity and frequency of patient participation. The PHP is a structured program designed to provide comprehensive services specifically tailored to each patient through an individualized plan of treatment. The benefit is furnished through CMHCs or hospital outpatient settings as an alternative to inpatient treatment for those beneficiaries suffering from acute mental conditions.

> The PHP benefit is furnished through CMHCs or hospital outpatient settings as an alternative to inpatient treatment for patients suffering from acute mental conditions.

Beneficiaries eligible to receive PHP services include:

- those who have been discharged from an inpatient hospital treatment program and will receive the benefit in lieu of continued inpatient hospitalization, and

- those who would require inpatient hospitalization if the benefit was not available.

Treatment of patients through PHPs includes the provision of services that are reasonable and necessary for the diagnoses and treatment of the individual's condition and, which are reasonably expected to improve or maintain the individual's functional level and prevent a relapse or hospitalization.

Community Mental Health Centers

The Community Mental Health Center Act, enacted in 1963, created a Federal grant program to help States in the construction of CMHCs and designated the Public Health Service (PHS) as the regulatory agency responsible for the grant program. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) authorized Medicare coverage and payment for PHP services provided by CMHCs effective October 1, 1991. In 1998 there were about 1,150 Medicare certified CMHCs.

OBRA 1990 authorized Medicare coverage and payment for PHP services provided by CMHCs effective October 1, 1991.

The OBRA 1990 defined a CMHC as an entity that provides the services described in the PHS Act and also meets State licensing requirements, if applicable. The Social Security Act (Act) incorporates these requirements in section 1861(ff)(3)(B).

The HCFA requires that all CMHCs which apply to become a Medicare provider attest to the fact that they provide the four core services of a CMHC as required by section 1913(c)(1) of the PHS Act.

The HCFA contracts with FIs to assist them in administering the Medicare program. The FIs are responsible for conducting audits of cost reports submitted by CMHCs, for processing and reviewing claims for PHP services, payment safeguard activities, performing liaison activities, and disseminating information and educational materials. The CMHCs receive interim payments for the provision of PHP services which are based on the prior year's cost report.

New Center Community Mental Health Center

New Center is a non-chain affiliated, nonprofit corporation, organized and operated to provide mental health services to the residents of Wayne County, Michigan. The New Center is governed by a board of directors and receives its patient referrals from several local hospitals, adult foster care centers, and other community based referral sources. The New Center is generally funded through State grants and receives additional payment for services

provided through both the Medicaid and Medicare programs. It received HCFA approval to provide PHP services effective December 12, 1995, and has a current program capacity of about 40 patients. Care is delivered through a contract staffing agency.

Between CY 1996 and CY 1997, New Center's Medicare billing for PHP services increased fourfold, from about $445,000 to over $1.9 million. The New Center is currently serviced by its Medicare FI, United Government Services (UGS). During CY 1997, the previous FI, Health Care Service Corporation, performed a review of the medical records for 10 Medicare beneficiaries receiving services from New Center. About $200,000 was disallowed relating to 5 of the 10 medical records reviewed. These disallowances were based on a determination that the services were not medically necessary or were otherwise in conflict with applicable criteria.

> During 1997, the fiscal intermediary disallowed about $200,000 for services that were not medically necessary.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objectives of our review were to determine whether Medicare payments to New Center for PHP services were billed for and reimbursed in accordance with Medicare requirements, and to determine whether selected costs submitted through New Center's cost report were reimbursable pursuant to applicable Medicare guidelines.

> Our audit consisted of two parts: a medical necessity review and a cost report review.

Scope

Our audit was performed in accordance with generally accepted government auditing standards and consisted of two parts:

- ***Medical Necessity Review*** - A statistical sample was selected to evaluate the medical necessity of services furnished by New Center and paid by the FI during the period October 1, 1995 through July 31, 1998. For this period, claims consisted of about $5.3 million paid for 904 beneficiary service months. From a population of 904 service months, we sampled 100 service months, representing about $594,000 in claims paid on behalf of 72 beneficiaries.

- ***Cost Report Review*** - We selected and reviewed about $1.4 million from approximately $3.7 million of costs reported through New Center's FY 1997

cost report. These included costs for rent, legal expenses, supplies, meals, repair and maintenance, and utilities.

Our audit objectives were accomplished through substantive testing and did not require or include an evaluation of New Center's internal control structure. Audit field work was conducted at New Center in Detroit, Michigan from September 1998 through March 1999.

Methodology

Medical Necessity Review - The medical necessity of the services furnished by New Center and paid by the FI during the period October 1, 1995 through July 31, 1998 was evaluated based on a review of a statistical sample. An unrestricted random sample of 100 beneficiary service months was selected from a population of 904 beneficiary service months. Each sampled item consisted of services furnished to an individual Medicare beneficiary during a specified 1-month period. The 100 sampled service months represented 584 claims that included a total of 9,178 units of service. A projection of the results of our review was made to estimate the value of payments to New Center for unallowable services during the sampled period. The unallowable amount was calculated using the lower limit of the projection at the 90 percent confidence level.

UGS, New Center's FI, assisted us in completing this portion of the review. Medical review personnel of UGS evaluated the medical records for the sampled services to determine whether the furnished services were allowable based on applicable Medicare criteria.

Cost Report Review - We judgementally selected about $1.4 million of reported costs that were allocated, in part, to the Medicare program. Our review included a reconciliation of these amounts to New Center's accounting records and an evaluation of available supporting documentation including invoices, canceled checks, payroll records, and contractual agreements to determine whether the costs were allowable based on applicable Medicare criteria.

RESULTS OF REVIEW

We identified unallowable PHP payments and cost report items as follows:

- Approximately $1.1 million of unallowable payments during the period October 1, 1995 through July 31, 1998 for services identified through the medical record review portion of our audit; and

- $71,478 of inappropriate costs that were allocated to Medicare through the FY 1997 cost report.

Medical Necessity Review

Based on a projection of the results of our statistical sample review, we estimate that at least $1,109,523 of Medicare payments were made to New Center for services that were not reasonable, necessary, or appropriate for the patients' conditions. Our medical review of 100 sampled service months, incorporated within 72 beneficiary case files, identified 27 periods of unallowable Medicare PHP services with corresponding provider payments of $172,750. These payments, when projected to the universe of 904 service months, results in a lower limit of $1,109,523 at the 90 percent confidence level (see Appendix A).

> Medicare payments of about $1.1 million were made for services that were not reasonable, necessary, or appropriate for the patients' conditions.

Medicare regulations presented in 42 CFR 410.43(a) state:

> "Partial hospitalization services are services that...(1) are reasonable and necessary for the diagnosis or active treatment of the individual's condition;...."

Based on this criteria, UGS medical review personnel determined that services furnished by New Center for 27 of the 100 reviewed service months were not reasonable, necessary, and appropriate for the conditions of the patients. The 27 unallowable service months included 2,710 units of service from a total of 9,178 units of service.

Additional criteria presented in the HCFA Program Memorandum, Transmittal number A-95-08, requires:

> "In order for a Medicare patient to be eligible for a partial hospitalization program, a physician must certify...(1) That the individual would require inpatient psychiatric care in the absence of such services...."

Included within the 27 identified unallowable service months, UGS medical review personnel identified the following generally inappropriate conditions of treatment relative to the criteria cited above:

- 14 months of service provided to beneficiaries afflicted by chronic, or non-acute, medical conditions who could not reasonably benefit from active treatment; and/or

- 22 months of service provided to beneficiaries who were not appropriate for inpatient treatment and would have received greater benefit from other less intense outpatient or daycare programs.

Recommendations

We recommend that New Center work with the FI to:

- refund $1,109,523 for unallowable Medicare PHP services; and
- establish policies to ensure that PHP services provided to Medicare beneficiaries meet Medicare requirements.

Auditee's Comments

In a draft of this report, we made reference to the FI's local medical review policy (LMRP). In written comments to the draft report, New Center contended that any medical review findings based on the LMRP should not be binding.

OIG Response

Reference to the LMRP has been deleted from the final report since the FI's medical review personnel did not rely on this policy during their review of the medical records. Instead, each of the 27 service months were found to be unallowable for the specific reason that the services were not reasonable, necessary, and appropriate for the patient's condition. The applicable criteria is at 42 CFR 410.43(a).

Auditee's Comments

The New Center also contended that because OIG did not forward to the FI additional evidence prepared by New Center's medical director in response to our draft report, OIG impeded the ability of the FI to make final determinations.

In addition, New Center commented that providers are entitled to reimbursement, under the law, if New Center did not know, and could not reasonably be expected to know, that payment would not be made. Further, New Center contends that there is no evidence in the report that an analysis of the foregoing principle, identified in the comments as the "waiver of liability" principle, was performed by the auditors.

OIG Response

The OIG makes recommendations to New Center and the FI. The FIs are HCFA's representatives, responsible for reviewing and adjudicating the reasonableness and medical necessity of claims presented by providers. The FI bases its determinations on Medicare regulations, guidelines, and sound medical review procedures. The FI has the authority to collect overpayments determined by the audit through the issuance of an overpayment collection notice. The New Center then has the right to challenge the collection of these overpayments through a multi-level appeals process and the courts.

The additional evidence referred to in the comments contained only a restatement of New Center's viewpoint based on the opinions of its medical director. It did not include new or additional medical evidence. This data, however, was forwarded to the FI for its use in the final audit settlement process.

Regarding whether New Center did not know, or could not reasonably be expected to know that payment would not be made, the OIG does not have the authority to withhold or disallow payments. Rather, we are recommending that certain past payments be refunded, and HCFA, with the assistance of the FI, will make the final determinations.

Auditee's Comments

The New Center also commented on the report's statement that the audit was performed in accordance with generally accepted government auditing standards. The New Center referred to the field work standards for performance audits which state that the staff assigned to the job must have the appropriate skills and knowledge for the job. The New Center was concerned as to whether the UGS medical reviewers had the appropriate clinical credentials.

OIG Response

The Statement on Auditing Standards No. 73 permits the auditor to engage a specialist and use that specialist's work as evidential matter in performing substantive tests. We are testing paid claims for compliance with the applicable Medicare requirements. As auditors, however, we are not expected to have the expertise of a person trained for or qualified to engage in the practice of another profession or occupation. For instance, the implementation of audit procedures for determining whether payment was for services which were medically necessary, correctly coded, and sufficiently documented require the expertise of licensed medical review personnel. Therefore, we utilized the FI's medical review staff to assist us in the detailed review of the beneficiaries' medical records. These medical reviewers were licensed medical personnel with experience in reviewing medical records supporting claims submitted to Medicare for payment.

Cost Report Review

We identified $71,478 of costs reported through the FY 1997 cost report that were not allocable or reimbursable according to Medicare regulations, including:

- $47,557 of unsupported general and administrative costs;
- $11,261 of costs that were the result of a cost reporting error; and
- $12,660 of unallowable meal costs.

We identified $71,478 of costs that were not allocable or reimbursable according to Medicare regulations.

42 CFR, section 413.24, entitled, "Adequate Cost Data and Cost Finding" states:

> "Providers receiving payment on the basis of reimbursable costs must provide adequate cost data...The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended...."

The New Center was unable to furnish acceptable documentation to support the $47,557 in questioned general and administrative expenditures. Regarding the $11,261 in overcharged service costs, our analysis of New Center's accounting and billing records showed that this amount was the result of a cost reporting error.

We also identified $12,660 of unallowable meal costs provided to program recipients. These costs are unallowable based on section 1861 (ff) of the Act, which states:

> "...(1) The term "partial hospitalization services" means the items and services described in paragraph (2)...(2)(I) such other items and services as the secretary may provide (but in no event to include meals and transportation)...."

Recommendations

We recommend that New Center work with the FI to:

- adjust its FY 1997 cost report to reflect the adjustment or removal of $71,478 in reported inappropriate costs; and

- establish nonreimbursable cost centers or otherwise exclude costs related to noncovered items from its cost reports.

Auditee's Comments

In a draft of this report, we initially identified $128,000 in unsupported items and overcharges which were recommended for adjustment. Together with written comments to the draft report, New Center submitted additional documents to support many of the questioned items.

OIG Response

We reviewed the documentation and concluded that questioned items totaling $56,522 were now supported. The remainder of $71,478 ($128,000 - $56,522) is still questioned. We adjusted our finding and recommendation accordingly.

Appendix A

New Center Community Mental Health Services

Statistics from Projection of Random Sample
for the Period October 1, 1995 through July 31, 1998

Results of Sample Review:

Number of beneficiary months of service:	
Size of universe	904
Size of random sample	100
Number of sampled items found to be unallowable	27
Dollar value of sampled items found to be unallowable	$ 172,750
Mean of unallowable dollar value	$ 1,728
Standard error	$ 301

Projection of Sample Results to the Universe:

Point estimate of projection (midpoint of projection)	$ 1,561,656
At the 90 percent confidence level:	
Lower limit of projection	$ 1,109,523
Upper limit of projection	$ 2,013,790

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January 28, 2000

Via Federal Express

Mr. Robert Weideman
Senior Auditor
DHHS/OIG
OAS Region V
Illinois Business Center
400 W. Monroe, Room 204B
Springfield, Illinois 62704

RE: New Center Community Mental Health Services
RESPONSE TO DRAFT OIG REPORT
Common Identification Number A-05-00-00004

Dear Mr. Weideman:

Thank you for the opportunity to respond to the draft report by the Department of Health and Human Services Office of the Inspector General ("OIG") entitled "Review of Partial Hospitalization Services and Fiscal Year 1997 Cost Report, New Center Community Mental Health Services, Detroit, Michigan" (the "Report"). We have carefully reviewed the report. Our comments are set forth below.

I. Results of the Medical Necessity Review are Legally Invalid

The Report alleges that the Provider was paid for services that did not meet Medicare reimbursement criteria. Because the OIG relied on inappropriate reimbursement standards and failed to address certain mandatory criteria, the result set forth in the Report is contrary to law.

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A. The Provider Can Not Legally Be Held to the Medical Review Standards Used in the Report

The Report states that the medical necessity review was not performed by OIG staff, but rather was performed by "medical review personnel" of United Government Services ("UGS"), the Provider's fiscal intermediary since October 1998. (Report, p. 4). Though the Report does not list all of the laws, regulations, Medicare Manual provisions, or other documents relied upon by UGS, the Report does state that UGS relied upon its Local Medical Review Policy ("LMRP") that is dated May 1998 ("UGS LMRP"). (Report, p. 5). As explained below, it was inappropriate for the OIG to allow UGS to rely on these criteria for purposes of the Report.

As explained in the Medicare Intermediary Manual ("MIM"), LMRPs are policies that are developed by a fiscal intermediary to clarify and provide specific detail as to the applicability of national coverage guidelines for a specific geographic area. (MIM § 3911). LMRPs are adjuncts to national coverage policy and are to be used to make *local* medical coverage decisions. (MIM § 3911). LMRPs from different intermediaries, therefore, may reflect different coverage standards.

HCFA warns intermediaries not to use LMRPs as final coverage guidelines. HCFA has specifically instructed its fiscal intermediaries that it should not always follow an LMRP when evaluating a claim. Instead, the intermediaries must individually review each case to determine whether an exception to the LMRP should be made. Exceptions can be based on extenuating circumstances or particular facts. (MIM § 3911).

As applied to the Report, there are several problems with the use of the UGS LMRP. First, per the Report, the LMRP is dated May 1998. The claims involved in the Report represent services rendered from October 1, 1995 through July 31, 1998. Thus, *the UGS LMRP existed for only one of the months that the services were rendered. The Provider can not legally be held to standards that were not applicable at the time services were rendered.* This requirement is specifically set forth in MIM § 3939, wherein intermediaries are specifically instructed not to implement new LMRPs retroactively.

As you should be aware, there are significant differences between the LMRP and the HCFA Program Memorandum, Transmittal no. A-95-08, July 1996 (the "Transmittal"), which the Provider had at the time the services were rendered and which was also used in this review. Of particular relevance to the Report are the following differences:

1. **Use of GAF Score to Determine Eligibility.** The Report states the LMRP requires that patients admitted to a PHP "will usually have a level of functioning below 40, as measured using the Global Assessment of Functioning Scale." (LMRP, p. 3). By contrast, the Transmittal does not mention this criteria and states only that a Medicare

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patient is eligible for PHP "if the individual would require inpatient psychiatric care in the absence of such services" including "where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted." (Transmittal, p. 3.)

2. **Eligibility Based on the Need for Inpatient Care.** The LMRP states that patients eligible for PHP are those that either have been discharged from an inpatient hospital treatment program or "those patients who, in the absence of partial hospitalization, would require inpatient hospitalization." (LMRP, p. 2). The Transmittal, however, states a much different and broader standard. Under the Transmittal, services are covered if the services are "reasonably expected to ... **maintain** the individual's condition and functional level to prevent relapse or hospitalization." (Transmittal, p. 1).

3. **Eligibility Based on the Treatment of Acute Conditions.** The LMRP states that only patients suffering from dysfunction "of an acute nature and not a chronic circumstance" are eligible for PHP. (LMRP, p. 2). Again, the Transmittal states a different and broader standard, that eligible patients include those with an "acute psychiatric/psychological conditions *or an exacerbation of a severe and persistent mental disorder*." (Transmittal, p.2).

4. **Basis for Discharge.** The LMRP states a broad standard for when a patient may be discharged from PHP. Specifically, the LMRP states that patients may be discharged when they "no longer require the multidisciplinary and multimodal program." (LMRP, p. 3). By contrast, the Transmittal is more specific, stating that a patient is no longer eligible for PHP when the patient has achieved three standards: "sufficient stabilization of the presenting symptoms, sufficient intervention in skills or coping ability, and mobilization of family and/or community supports..." (Transmittal, p. 4).

Thus, any denials that were based on the UGS LMRP should be reversed. These would include those denials that were based on: (1) the use of the Global Assessment of Functioning Scale; (2) the fact that a patient was admitted in order to maintain the patient's condition and prevent relapse; (3) the fact that a patient was suffering from an exacerbation of a persistent mental disorder; and (4) the fact that a patient was not discharged because the patient did not meet certain criteria.

Second, intermediaries are not permitted to automatically apply the LMRP in every situation. They must determine whether an exception to the LMRP should be made in the case of each individual claim. There is no mention in the Report that this analysis was made. In fact, the Report inaccurately makes it sound as if the failure to meet one of the criteria in the LMRP represents "inappropriate treatment." Specifically, the Report alleges that UGS review personnel identified the following inappropriate treatment: "16 periods of service furnished to

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beneficiaries having Global Assessment Function scores of 40 or above." As stated above, even if this statement were true, the failure to meet one of the criteria in an LMRP does not automatically mean that the care was inappropriate and it should not be characterized as such.

Moreover, the OIG impeded UGS's ability to determine whether the LMRP should be strictly applied because it specifically refused to forward to the UGS medical reviewers documents prepared by the Provider's medical director that explain, in great detail, the specific standards that each Medicare beneficiary met to qualify for PHP services. (See letter from the OIG at Exhibit I).

For these reasons, we request that the OIG obtain new medical reviews of the claims at issue and that this new review rely solely on the published reimbursement guidance that was available at the time the services were rendered.

B. The OIG Did Not Perform the Waiver of Liability Analysis that is Required by Law

Pursuant to Section 1879 of the Social Security Act, providers are entitled to be reimbursed for services rendered when the provider did not know, and could not reasonably have been expected to know, that payment would not be made (referred to herein as the "waiver of liability analysis"). As explained by HCFA in MIM § 3708, intermediaries are *required* to determine whether the provider is liable for any overpayment. In other words, if an intermediary discovered that a provider was incorrectly paid, the intermediary is not to automatically assume that the provider is not entitled to the reimbursement. Rather, the intermediary must determine whether a provider was without fault. Under §3708.1 of the MIM:

> A provider is without fault if it exercised reasonable care in billing for, and accepting, the payment; i.e. ...On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct ...

There is absolutely no discussion of this requirement in the Report. We assume, therefore, that this required analysis was not performed. *It is inaccurate for the OIG to state that a provider should repay the Medicare program if the OIG has not performed a waiver of liability analysis. A provider can not be made to repay Medicare until a waiver of liability analysis has been performed.*

In this case, it is unclear whether the payments made to the Provider met Medicare's reimbursement guidelines because, as explained above, the medical reviewers did not use the appropriate reimbursement guidelines to make those determinations. If on review under the appropriate reimbursement guidelines, the claims were still denied, the Provider would be very

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likely to qualify for payment under the waiver of liability provisions. There is no question that the published Medicare reimbursement rules available in 1995 through 1998 were vague. That is the only reason why an intermediary would need to develop an LMRP, as was done in this case.

In addition, the Provider relied on statements by the prior intermediary, Health Care Service Corporation ("HCSC"), that it fully complied with Medicare's reimbursement criteria. In 1997, HCSC reviewed ten of the Provider's claims. Pursuant to that review, the Provider made certain changes to its policies and furnished inservices to its staff, which HCSC approved. Other than the discussions regarding those policies, HCSC furnished the provider with no education or other guidance regarding Medicare's reimbursement criteria for partial hospitalization services. Thus, the Provider was forced to rely on the program memorandum that it had at the time, Transmittal No. A-96-2, dated July 1996. This Transmittal sets forth general guidelines and is not nearly as specific as the UGS LMRP. The Provider is confident that it complied with the standards set forth in the Transmittal. To the extent that more detailed criteria were used in 1995 through 1998 than those set forth in the Transmittal, the Provider would qualify under the waiver of liability provisions to receive Medicare reimbursement for the services rendered because "based on the information available," the Provider had a reasonable basis for assuming that payment was correct.

The failure to even mention the waiver of liability provisions, not to mention the failure to perform the required analysis, calls into question the entire Report. The objective of the Report is to determine "whether the Medicare program incurred financial loss due to the provider's receipt of payments for services that did not meet Medicare reimbursement requirements." (Report, p. 3). This statement *assumes* that if Medicare pays a provider for services rendered, that payment constitutes a loss for the Medicare program and the provider should repay that payment to Medicare. However, as explained above, Medicare is *required* in some instances to reimburse providers for services that may not meet reimbursement guidelines. Thus, the Report can not meet its objective unless it includes an analysis of what reimbursement guidance was available to the Provider at the time the services were rendered and whether the Provider's claims met that criteria.

II. Results of Cost Report Review

We have reviewed the $128,000 of costs which were deemed non-reimbursable based on the audit findings. Based on that review we wish to submit further documentation for $81,518.24 of the $104,079.20 of Administrative and General expense that was deemed undocumented during the audit.

This documentation is included under Exhibit II which is attached. The documentation is referenced back by sample number to the original audit workpaper. The lead sheet includes a description and explanation of the expense, as well as an indication of whether we were able to

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locate the invoice. Either the supporting invoice is enclosed or we have been able to identify the nature of the expense and the vendor.

Please incorporate this documentation in your findings and let us know if you have questions or need any further clarification in regard to these expenses.

III. Inaccurate Statements in the Report

The Report includes the following inaccurate statements, which we request be removed or modified before the report is finalized.

1. The Report alleges that the Provider inappropriately received at least $1.1 million in Medicare payments and should refund that amount to Medicare. (Report, pgs 5 and 7). The Report also states that the Provider was paid $5.3 million in Medicare payments for the period October 1, 1995 through July 31, 1998.

In fact, the Provider received only $5.2 million in Medicare payments for that period. We have attached at Exhibit III documentation supporting this fact.

This error leads us to be concerned that the OIG may not have taken into account the cost reporting process when it made its calculation of the alleged $1.1 million overpayment. Under Medicare, a provider is paid a percentage of its claims based on an estimate of what the providers' costs will be for a given year. If the provider's allowable costs exceed the amount that the provider was paid for its claims at the end of the year, Medicare owes the provider the difference between what it was paid and the allowable costs incurred. If the provider's allowable costs were less than the amount that the provider was paid, the provider pays the difference to Medicare. This means that a provider may be paid a certain amount for claims billed, but as a result of the year-end reconciliation, the Provider may pay back some of those payments to Medicare. Thus, a determination of the amount that Medicare paid a provider based on claims submitted is not always an accurate estimate of the amount that a provider actually received from Medicare.

With respect to the Report, it is unclear whether the OIG has taken the year-end reconciliation process into account when calculating the alleged $1.1 million overpayment. Thus, the Provider may not have actually been paid and/or retained the $1.1 million stated in the report. We request that the OIG confirm this statement.

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2. The Report states that UGS used "applicable Medicare criteria" to make its determination of whether services rendered by the Provider were allowable. (Report, p.4).

As explained above, UGS did *not* use "applicable Medicare criteria." UGS used its LMRP that is dated from 1998. The LMRP was not in existence at the time that the Provider rendered the services reviewed by UGS. Therefore, UGS used *in*applicable Medicare criteria in its review of the claims.

Moreover, there is no evidence that UGS or OIG evaluated whether the Provider is actually liable for the payments made under the criteria discussed above. The waiver of liability provisions constitute "applicable Medicare criteria" and must be part of this review.

IV. Misleading Statements in the Report

The Report contains the following misleading statements, which we request be removed or modified before the Report is finalized.

1. The Report states that additional coverage limitations are addressed through the intermediary's LMRP. (Report, p. 5).

This statement is misleading because it implies that the LMRP standards were available when the services were rendered and should be applied to the claims at issue in the Report. As explained above, the LMRP was not available at the time the services were rendered and should not be applied to the claims at issue in the Report. Accordingly, all references to the LMRP should be removed because the LMRP is irrelevant for purposes of meeting the Report's objectives.

2. The Report quotes only part of a coverage criterion, implying that a patient must require inpatient care in the absence of PHP, but this is incorrect. (Report, p. 6). The Report compounds this misstatement by alleging that the Provider furnished inappropriate treatment by furnishing services to individuals that did not require inpatient treatment. (Report, p. 6).

The Report quotes from the Transmittal, stating that "In order for a Medicare patient to be eligible for a partial hospitalization program, a physician must certify ... 1) That the individual would require inpatient psychiatric care in the absence of such service..." Unfortunately, this quote omits the following sentence that states that: "This certification may be made where the physician believes that the course of the patient's current episode of illness

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would result in psychiatric hospitalization if the partial hospitalization services are not substituted." (Transmittal, p. 3). The entire criterion should be included in the report.

The problem with this misstatement is that it is used in the Report to allege that the Provider furnished inappropriate treatment by furnishing services to "beneficiaries who were not appropriate for inpatient treatment..." In fact, under the Transmittal's standards, the mere fact that a patient does not immediately require inpatient services does not mean that the patient is ineligible for PHP services under Medicare. Therefore, this statement should be removed from the report and the medical review should be reviewed to determine whether this inappropriate standard was used to deny claims.

3. The Report asserts that the Provider rendered inappropriate treatment by furnishing services to beneficiaries having Global Assessment Function scores of 40 or above. (Report, p. 6).

This statement has two inappropriate implications. First, it implies that the GAF standard applies to the services at issue in the Report. As explained above, this standard appears only in the UGS LMRP and that LMRP can not be applied to these services. Second, it implies that Medicare prohibits furnishing PHP services to beneficiaries with GAF scores of 40 or above. In fact, the LMRP states that patients will *usually* have a score below 40. In the Provider's case, only 16 of the 100 service periods reviewed allegedly had scores of 40 or above. This represents just 16% of all periods reviewed. A 16% result can hardly be considered outside the "usual" standard articulated in the LMRP. This statement should be removed entirely from the report because the LMRP is irrelevant for purposes of meeting the Report's objectives.

V. Government Auditing Standards Not followed

The Report states that the audit was performed in accordance with generally accepted government auditing standards. (Report, p. 3). We are concerned, however, that several of the standards were not followed in this case.

A. The Provider's Comments Were Not Objectively Evaluated

When the Provider was first notified of the OIG's assertions that certain claims should have been denied, it reviewed each and every claim at issue and prepared very specific discussions of why each patient met Medicare's coverage criteria. The Provider requested that this information be forwarded to the UGS medical reviewers. However, the OIG refused to forward this information, stating that the information "did not include new medical evidence, but rather reflected opinions of the provider based on the same clinical records." We believe that this response conflicts with §§ 7.41 and 7.42 of the Government Auditing Standards, Reporting Standards for Performance Audits.

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The sections referenced above require that advance comments be objectively evaluated and recognized in the report. Because the OIG did not perform the medical necessity reviews, the only way for the OIG to comply with this standard would be to send the reviews to the UGS medical reviewers for response. Medical charts are typically voluminous and it is not unusual for a medical reviewer to miss certain notes in the chart that support coverage and to discuss the chart with the provider before making a final coverage determination. For this reason, an objective review of the Provider's documents is necessary to ensure that UGS's determinations are accurate. Moreover, per government audit standard § 7.42, if the UGS medical staff disagreed with the Provider's reviews, the UGS medical staff should have been required to state its reasons for rejecting them.

However, to address the OIG's statement that the medical evidence reflected "opinions," we have revised the statements we originally submitted. First, because the OIG forwarded to us on January 11, 2000 the reasons that the 27 claims were denied, we tailored our analysis to those specific reasons for each claim. Second, instead of stating why we believe that that the services met Medicare's coverage guidelines, we identified each entry in the medical record that supports that contention and attached the medical record with those entries tabbed for easy review. Again, the types of medical charts are voluminous and it is not uncommon for a medical reviewer to overlook certain notes or other documentation. Thus, per the government audit standards, we request that this information be forwarded to the UGS medical reviewers and that, if the reviewers continue to contend that the services should be denied, the reviewers should be required to state their reasons for that contention. [This information is attached at Exhibit IV_.]

B. The Educational Background of the Medical Necessity Reviewers Was Not Evaluated

Section 6.17 of the Government Auditing Standards' Field Work Standards for Performance Audits states that staff assigned to perform an audit must have the appropriate skills and knowledge for the job. By letter dated January 6, 2000, the Provider requested the clinical credentials of the medical reviewers that reviewed the Provider's claims in the Report. Unfortunately, the OIG refused to release that information, stating that the medical review was conducted by "the same staff responsible for routine medical review of this and other providers under the Medicare program." (See Exhibit V). However, just because the medical reviewers are responsible for routine reviews does not mean that they have the background necessary to make these determinations. In fact, according to a recent OIG report, medical reviews performed by fiscal intermediaries are often overturned on appeal.[1] As examples of this, the OIG report states that 81 percent of home health appeals were reversed in 1996 and 78 percent of durable medical equipment appeals were reversed in 1997. It is entirely reasonable, therefore, to

[1] Office of Inspector General Report No. OEI-04-97-00160, September 1, 1999.

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question the clinical credentials of the UGS medical reviewers and troubling that the OIG would not release that information.

C. The Appropriate Laws and Regulations Were Not Identified

Sections 6.26 - 6.29 of the Government Auditing Standards' Field Work Standards for Performance Audits requires that the OIG identify the laws and regulations and other compliance requirements that are significant for the audit objectives. The Provider specifically requested from the OIG by letter dated January 6, 2000 the legal and clinical authority used by the UGS medical reviewers and the effective date of that authority. The OIG responded to that letter on January 11, 2000, but did not furnish the Provider with that information, nor did it give the Provider its reasons for refusing that request. As was made clear above, the UGS medical reviewers used inapplicable criteria (i.e. the UGS LMRP) when evaluating the Provider's claims. That LMRP was inapplicable because it became effective after the services had been rendered. Accordingly, we again request that the OIG furnish to us the laws, regulations, and other compliance requirements that the OIG deemed significant to the Report's objectives, with the effective date of those requirements, as required under §§6.26 – 6.29 of the Government Auditing Standards' Field Work Standards for Performance Audits. If the OIG does not intend to release the requested information, we request that the OIG furnish the Provider with its reasons for refusing this request.

VI. Statistical Sampling Technique Utilized in the Medical Necessity Review

We have not had an adequate period of time to fully study the statistical sampling methodology utilized by the auditor. Therefore we will submit comments on this issue in a follow-up correspondence.

Thank you for the opportunity to review the Report. We hope that you will consider our comments and look forward to working with you resolve the issues raised in this letter.

If you have any questions or need any further information, please feel free to call us at (949) 261-6482.

Very truly yours,
CERTUS CORPORATION

Donald E. Hagen,
Senior Manager

Cc: Ms. Roberta Sanders, CEO New Center Community Mental Health Services