DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date NOV 17 1998

From June Gibbs Brown
Inspector General

Subject Review of Outpatient Psychiatric Services Provided by the Franklin Medical Center for the Fiscal Year Ending September 30, 1996 (A-01-98-00503)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on Thursday, November 19, 1998, of our final report "Review of Outpatient Psychiatric Services Provided by the Franklin Medical Center for the Fiscal Year Ending September 30, 1996." 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 the Franklin Medical Center (Hospital), located in Greenfield, Massachusetts did not establish or follow existing procedures for the proper billing of outpatient psychiatric services.

This audit was conducted as a probe into the area of hospital outpatient psychiatric services. We will use these results, in conjunction with our review of Medicare's partial hospitalization programs (PHP) at community mental health centers, to structure our planned audit of the PHP services in the hospital outpatient setting. We look forward to coordinating these additional PHP reviews with your staff.

Our audit at the Hospital determined that at least $646,517 in charges for outpatient psychiatric services claimed by the Hospital did not meet the Medicare criteria for reimbursement. Specifically, we identified: (1) nursing home psychiatric services provided by clinical social workers (CSWs) who were not properly supervised by a physician; (2) charges for psychiatric care not properly supported by medical records or otherwise found medically unnecessary and (3) Hospital overhead charges submitted to Medicare for the associated costs of Hospital employees working off-site at area nursing homes. 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 requirements. We will also provide the results of our review to the fiscal intermediary so that it can apply the appropriate adjustment of $646,517 to the Hospital's Fiscal Year 1996 Medicare cost report.

The Hospital, in its response dated August 26, 1998 believed that 1) the sampling methodology used by the OIG was inadequate, 2) the applicable regulations were confusing

and contradictory, 3) the services provided by CSWs were either diagnostic in nature or properly supervised and therefore allowable, and 4) certain services were either supported by the medical record or reasonable and necessary and therefore allowable. We believe that our final audit determinations are correct and in accordance with Medicare rules and regulations. We have, however, adjusted our findings to reflect our agreement with the Hospital in some cases. These adjustments reduced the lower limit of the projected error in Medicare outpatient psychiatric charges from $664,194 to $646,517.

Attachment

For further information, contact:

William J. Hornby
Regional Inspector General
for Audit Services, Region I
(617) 565-2689

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY THE FRANKLIN MEDICAL CENTER FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1996

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1998
A-01-98-00503

NOTICES

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://www.hhs.gov/progorg/oig/

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

CIN: A-01-98-00503

Mr. Harlan Smith
President and Chief Executive Officer
Franklin Medical Center
164 High Street
Greenfield, Massachusetts 01301

Dear Mr. Smith:

This report provides you with the results of our "Review of Outpatient Psychiatric Services Provided by the Franklin Medical Center for the Fiscal Year Ending September 30, 1996." 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.

Medicare defines outpatient occasions of service as "Each examination, consultation or treatment received by an outpatient in any service department of a hospital." Medicare also requires that charges reflect reasonable costs and such services be supported by medical records. These records must contain sufficient documentation to justify the treatment provided.

In Fiscal Year (FY) 1996, the Franklin Medical Center (Hospital) submitted for reimbursement about $1.2 million in charges for outpatient psychiatric services. To determine whether controls were in place to ensure compliance with Medicare regulations, we reviewed the medical and billing records for 100 randomly selected claims totaling $20,871. Our analysis showed that $13,242[1] of these charges did not meet Medicare criteria for reimbursement. Specifically, we noted that:

- $6,903 represented the Hospital's charge for off-site clinical social worker (CSW) services either not provided with the proper physician supervision required by regulation or otherwise not medically necessary,

- $3,116 was charged for services not properly supported by medical records, and

- $3,223 represented non-allocable charges submitted by the Hospital for its overhead costs associated with Hospital employees working off-site at area nursing homes.

[1] This amount has been adjusted subsequent to the issuance of the draft report dated July 16, 1998.

We noted that the Hospital did not establish or follow existing procedures for the proper billing of outpatient psychiatric services. Based on a statistical sample, we estimate that the Hospital had overstated its FY 1996 Medicare outpatient psychiatric charges by at least $646,517.

We recommend 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 requirements. We will provide the results of our review to Mutual of Omaha, the Medicare Fiscal Intermediary (FI), so that it can apply the appropriate adjustment to the Hospital's FY 1996 Medicare cost report.

The Hospital, in its response dated August 26, 1998 believed that 1) the sampling methodology used by the OIG was inadequate, 2) the applicable regulations were confusing and contradictory, 3) the services provided by CSWs were either diagnostic in nature or properly supervised and therefore allowable, and 4) certain services were either supported by the medical record or reasonable and necessary and therefore allowable.

We believe that our final audit determinations are correct. We have, however, adjusted our findings to reflect our agreement with the Hospital in some cases. These adjustments reduced the lower limit of the projected error in Medicare outpatient psychiatric charges from $664,194 to $646,517.

INTRODUCTION

BACKGROUND

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. Hospital costs for such services are generally facility costs for providing the services of staff psychiatrists, psychologists, clinical nurse specialists, and CSWs. These costs are reimbursed through the hospital's Medicare cost report. Medicare rules and regulations define:

- reasonable costs as "...all necessary and proper expenses incurred in furnishing services..." [Title 42 CFR 413.9(c)(3)]

- outpatient therapeutic services as "...incident to the services of physicians in the treatment of patients...To be covered as incident to physicians' services, the services and supplies must be furnished on a physician's order by hospital personnel under hospital medical staff supervision..." If such services are provided outside the hospital, services must be furnished "...under the direct personal supervision of a physician who is treating the patient..." [HCFA Hospital Manual section 230.4]

- outpatient occasions of service as "...Each examination, consultation or treatment received by an outpatient in any service department of a hospital..." [HCFA Provider Reimbursement Manual section 2302.11]

Medicare regulations further state that for benefits to be paid:

- "...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." [Title 42 CFR §482.24(c)]

The Hospital, a 121 bed acute care facility in Greenfield, Massachusetts, provides outpatient psychiatric services including a partial hospitalization program. For FY 1996, the Hospital submitted for Medicare reimbursement 6,575 claims for outpatient psychiatric services valued at $1,262,503.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicare regulations. Our review included services provided during FY 1996.

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

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 Provider Statistical and Reimbursement Report provided by the FI for the Hospital's FY 1996 to identify 6,575 outpatient psychiatric claims from the Hospital valued at $1,262,503,
- employed a simple random sample approach to randomly 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 the FI's medical review staff to review selected cases,
- used a variable appraisal program to estimate the dollar impact of improper payments in the total population,

- reviewed Medicare Part B claims processed by the local Medicare Part B Carrier (Carrier) which correspond to our sampled claims processed by the FI.

Our field work was performed in February and March 1998 at the Hospital in Greenfield, Massachusetts.

The Hospital's response to the draft report is appended to this report (see Appendix II) and is addressed on pages 7 through 9. We deleted from the response certain sensitive information on individuals and others that the OIG would not release under the Freedom of Information Act (FOIA).

FINDINGS AND RECOMMENDATIONS

In FY 1996 the Hospital submitted for reimbursement about $1.2 million in charges for outpatient psychiatric services. We reviewed the medical and billing records for 100 randomly selected claims totaling $20,871. Our analysis disclosed that $13,242 of the sampled charges did not meet the Medicare criteria for reimbursement. Based on a statistical sample, we estimate that the Hospital had overstated its FY 1996 Medicare outpatient psychiatric charges by at least $646,517. Findings from our review of the sample of 100 claims are described in detail below.

Clinical Social Workers Performing Off-Site Services

The Hospital contracts with local nursing homes to provide psychiatric services to their residents. Many of these services are provided by CSWs at the nursing homes and are billed by the Hospital to the FI as outpatient psychiatric services. Our review of a statistical sample of claims disclosed that $6,903 in charges were ineligible for Medicare reimbursement because the CSW services were not provided under the direct supervision of a physician or were medically unnecessary.

The HCFA Hospital Manual section 230.4 defines outpatient therapeutic services as those services which are "...incident to the services of physicians in the treatment of patients...To be covered as incident to physicians' services, the services and supplies must be furnished on a physician's order by hospital personnel under hospital medical staff supervision..." If such services are provided outside the hospital, services must be furnished "...under the direct personal supervision of a physician who is treating the patient..." Section 230.4 continues with the following example; "...if a hospital respiratory therapist goes to a patient's home to give treatment and no physician accompanies him, the therapist's services are not covered."

We examined the billing and medical records for the sampled claims and found that medical record documentation for CSWs providing therapeutic services at nursing homes, totaling $4,604, did not contain evidence of direct physician supervision on the date of service. Further, we requested the assistance of the medical review staff from the FI for 10 additional CSW services provided at nursing homes which the Hospital maintained were allowable diagnostic services in their response to our draft report. The FI concurred that these were diagnostic services but concluded that 9 of these services, totaling $2,299, were medically unnecessary and

that one service was allowable. For example, in one case the Hospital billed for a psychiatric evaluation of a beneficiary which the FI determined was unnecessary based on the beneficiary's medical condition. Therefore, the hospital should not have billed for $6,903 of such services.

Services Not Supported By Medical Records

Our audit disclosed a weakness in the Hospital's system of internal controls regarding medical record documentation supporting the charge. Our review of a statistical sample of claims disclosed that $3,116 in charges were not properly supported in the medical records.

Title 42 CFR, §482.24 states that, "...A medical record must be maintained for every individual evaluated or treated in the hospital...The hospital must maintain a medical record for each inpatient and outpatient...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."

We examined the billing and medical records for the 100 claims in our sample. Subsequent to our examination, we requested the assistance of the medical review staff from the FI for selected services performed at the Hospital. Based on our review, we identified:

- $1,811 for charges not sufficiently documented in accordance with Medicare regulations. These charges were related to the Hospital's partial hospitalization program. In this respect, we noted that the only medical record documentation to support the group therapy sessions charged were "checkmarks" next to the session name in the patient's medical record. Based on the review of the medical records by the FI medical review staff, they concluded that there was insufficient evidence to show that these services were medically necessary.

- $727 in charges for which hospital staff could not locate for us the therapist's progress note for the charged therapy session. This amount reflects additional evidence provided to us by the Hospital in their response to our draft report and the FI's concurrence.

- $388 for charges showing no medical record documentation of physician orders or any involvement in the patient's treatment by the physician. The FI determined these claims were unallowable.

- $190 in charges for which patient progress notes indicated that the scheduled therapy session was canceled but billed nonetheless.

As a result, we concluded that $3,116 in outpatient psychiatric charges did not meet Medicare's criteria for reimbursement.

Hospital Charging for Off-Site Services

We found that the Hospital did not have procedures in place to exclude billing the FI for the overhead charges related to the services of Hospital staff performed off-site of the Hospital's facilities. From our review of the billing and medical records of our 100 claim sample, we found that $3,223 represented non-allocable overhead charges that should not have been billed to Medicare.

The HCFA Provider Reimbursement Manual section 2302.11 defines outpatient occasions of service as "...Each examination, consultation or treatment received by an outpatient in any service department of a hospital..." Further, Medicare reimburses for reasonable costs, defined in Title 42 CFR 413.9(c)(3) as "...all necessary and proper expenses incurred in furnishing services..."

Hospital-employed psychiatrists, clinical nurse specialists, and psychologists provide psychiatric services at area nursing homes. These psychiatric professionals bill the Carrier individually for their professional fee. In addition, we noted that the Hospital also bills the FI for outpatient charges representing its overhead costs for these services whether performed at the Hospital or off-site. For example, we found that a psychiatrist providing a psychiatric evaluation at a nursing home had billed his fee to the Carrier for $53, while the Hospital had also billed the FI for its outpatient charge of $118. We believe that the Hospital's charge for services performed by its employees off-site does not meet the definition of an outpatient occasion of service as such services were not provided at the Hospital facility. Further, we believe such services billed to the FI do not represent a reasonable cost to the Medicare program.

Based on our analysis, we concluded that $3,223 in outpatient psychiatric charges are not reimbursable from the Medicare program.

Conclusion

For FY 1996, the Hospital submitted for reimbursement $1,262,503 in charges for outpatient psychiatric services. Our audit of 100 randomly selected claims totaling $20,871 in charges disclosed that $13,242 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 $646,517 in error for FY 1996. (See APPENDIX I)

Recommendations

We recommend 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 requirements.

We will provide the results of our review to the FI, so that it can apply the appropriate adjustment of $646,517 to the Hospital's FY 1996 Medicare cost report.

AUDITEE RESPONSE AND OIG COMMENTS

The Hospital, in its response dated August 26, 1998 believed that 1) the sampling methodology used by the OIG was inadequate, 2) the applicable regulations are confusing and contradictory, 3) the services provided by CSWs were either diagnostic in nature or properly supervised and therefore allowable, and 4) certain services were either supported by the medical record or reasonable and necessary and therefore allowable.

We believe that our final audit determinations are correct. We have, however, adjusted our findings to reflect our agreement with the Hospital in some cases. These adjustments reduced the lower limit of the projected error in Medicare outpatient psychiatric charges from $664,194 to $646,517.

Auditee Response Regarding OIG Sampling Methodology

The Hospital believed that the 100 claims were inadequate to obtain a precise estimate and provide an adequate sample precision. Further, the Hospital believed the sampling was suspect because the auditors used a mean point estimate which was subjected to highly skewed cost data and outliers. In addition, the Hospital questioned the sample because the population contained a wide variability in charges among different types of patients and representativeness could not be assured in such a small sample. In this regard, the Hospital believed that the auditors should have (1) used a narrower confidence limit of 95 percent and a tighter precision at 10 percent, (2) eliminated outliers; i.e., lowest and highest costs questioned and use the median average, and (3) assured more representativeness of the types of patients in the population.

Finally, the Hospital believed that the report did not account for its discontinued use of the checkmark system in its partial hospitalization program as of August 1, 1996 and the sample's extrapolation was based on an assumption that any violations continued throughout all 12 months of the year.

OIG Comments

The OIG policy regarding the use of statistical estimators for monetary recovery requires the use of the difference estimator and the lower limit of the 90 percent two-sided confidence interval for determining the recommended recovery amount. The report repeatedly refers to the minimum amount of overpayments which was estimated at the lower limit of a two sided 90 percent confidence interval. Referring to the minimum overpayment in terms of the lower limit presents the most conservative position in reporting the potential amount that needs to be financially adjusted. Any attempts to make the sample more precise by increasing sample size or by further stratifying would make both lower and upper confidence limits closer to the point estimate and result in an increased lower limit and an increase in the minimum estimate of potential overpayments. Since the sample was randomly selected, every charge for all type patients had an equal chance of selection, providing representation of all type patients and their respective

amounts. The variability in charges in our sample was representative of the charges in the population because the average charge in our sample approximated the average charge in the population.

In regard to the comment that the report did not account for discontinued use of the checkmark system during FY 96, we believe the sample itself and the sample appraisal fairly presented only those situations which could be characterized as a violation. The random selection process provided an equal chance to select any charges throughout the entire year whether or not the charge was affected by the checkmark system and classified as a violation. All such charges were appraised in the sample. Accordingly, there was no assumption made that such violations continued throughout the entire year.

Auditee Response Regarding Applicable Guidelines

The Hospital believes that the applicable guidelines concerning billing for outpatient psychiatric services are confusing and contradictory and the OIG should instruct the FI to provide the Hospital with clear written guidance on how the Hospital should bill for these services.

OIG Comments

The applicable coverage regulations and guidelines used in our report to support our findings are correct. It should be noted that we do not reference in our report section 4162 of the Medicare Carrier Manual, section 3662 of the Medicare Intermediary Manual, Mutual of Omaha's Medicare newsletter number 96-39, Medicare Part B Answer Book or HCFA Form 1450. However, if the Hospital believes that these billing instructions are not clear, it is the Hospital's responsibility as a Medicare provider to obtain guidance from the applicable Medicare carrier, FI, and HCFA regional office prior to the submission of any claims.

Auditee Response Regarding Clinical Social Workers Performing Off-Site Services

The Hospital believed that diagnostic services rendered by CSWs were covered by Medicare whether furnished in a hospital or other location without the direct personal supervision of a physician. Further, the Hospital also believed that some of the therapeutic services rendered by the CSWs were covered by Medicare as a psychiatrist was present in the nursing home on the day the therapy was provided to the nursing home resident.

OIG Comments

We agree with the Hospital that the diagnostic services rendered by CSWs are not subject to the same supervision requirements as therapeutic services. However, we requested that the medical review staff from the FI review 10 diagnostic services which the Hospital maintained were allowable in their response to our draft report. The FI concluded that 9 of these cases were medically unnecessary and that one was allowable. Accordingly, we have adjusted our finding based on the Hospital's and the FI's additional comments concerning these services. The Hospital, however, has not provided any additional documentation to support their assertion that

CSWs rendering therapeutic services off-site were supervised in accordance with Medicare requirements. We therefore believe that our original audit determination was correct.

Auditee Response Regarding Services Supported By Medical Records

The Hospital disagreed with the OIG's treatment of five individual claims. In this regard, the Hospital believes that five claims were not errors because 1) the service questioned by the OIG was in fact rendered, although a billing error made it appear as though it did not, 2) the service questioned by the OIG was rendered based on a court order, 3) the medical records adequately support the services rendered, 4) its patient attendance records show the beneficiary was at the Hospital on the claimed date of service, and 5) the services were rendered by an appropriately qualified therapist.

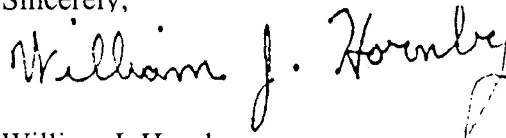
OIG Comments

We agree with the Hospital that the first error was caused by a clerical mistake, and with the FI's concurrence, have adjusted our finding accordingly. We believe, however, that our original audit determination was correct for the remaining four errors. In this regard, 1) two claims lacked medical necessity based on the FI's medical review, 2) one claim lacked support in the medical record, and 3) one claim lacked documented physician involvement in the case based on the FI's medical review.

Final determination as to actions taken on all matters reported will be made by the DHHS Action Official named below. We request that you respond to the DHHS 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.

Please refer to Common Identification Number A-01-98-00503 in all correspondence relating to this report.

Sincerely,



William J. Hornby
Regional Inspector General
for Audit Services

Direct reply to DHHS Action Official:
Joseph Tilghman, Regional Administrator, Region VII
Health Care Financing Administration

APPENDICES

REVIEW OF
OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY THE
FRANKLIN MEDICAL CENTER

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 6,575 Claims	Items: 100 Claims	Items: 63
Dollars: $1,262,503 Charges	Dollars: $20,871 Charges	Dollars: $13,242

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level
Using a Single Stage Appraisal Program[1]

Point Estimate: $870,661
Lower Limit: $646,517
Upper Limit: $1,094,806
Precision Percent: 26 percent

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1 The projection of the sample results have been adjusted subsequent to the issuance of the draft report dated July 16, 1998.

CHOATE, HALL & STEWART
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS
EXCHANGE PLACE
53 STATE STREET
BOSTON, MASSACHUSETTS 02109-2891
TELEPHONE (617) 248-5000
FACSIMILE (617) 248-4000
TELEX 49615880

MICHAEL G JONES
DIRECT DIAL (617) 248-5231
E-MAIL MGJ@CHOATE.COM

August 26, 1998

BY MESSENGER DELIVERY

Mr. William J. Hornby
Regional Inspector General
Office of Audit Services
U.S. Department of Health and Human Services
John F. Kennedy Federal Building
Boston, Massachusetts 02203

RE: CIN: A-01-98-00503
Franklin Medical Center

Dear Mr. Hornby:

We represent Franklin Medical Center ("FMC") in connection with a review by the Office of the Inspector General (the "OIG") of certain outpatient psychiatric services at FMC for the fiscal year ending September 30, 1996 ("FY 96"). You delivered preliminary findings from that review in a report dated July 16, 1998 (the "Report"). As requested at the end of the Report, FMC is submitting its written comments in response thereto. FMC's comments are presented in four separate sections: (I) General Comments; (II) Clinical Social Workers Performing Off-Site Services; (III) Services Supported by Medical Records; and (IV) Conclusions.

I. GENERAL COMMENTS

FMC takes issue with the Report for the following reasons. First, the extrapolation methodology utilized in calculating the alleged overpayment is based on an inadequate and overinclusive sampling of claims. Second, while the Report makes note of certain deficiencies in FMC's record-keeping procedures and related internal controls, it does not refute that medically necessary outpatient psychiatric services were provided to beneficiaries in area nursing homes and in FMC's partial hospitalization program throughout FY 96. These services were provided in a clinically appropriate manner and by qualified professionals. Third, in billing for these services, FMC did its best to follow what can, at best, be called confusing regulations. In fact, the regulations and other instructions which govern how FMC is to bill for these services

are extremely hard to understand, let alone follow, and are oftentimes self-contradicting.[1] Any errors FMC may have made in billing the outpatient psychiatric services are therefore understandable and certainly inadvertent. For all of these reasons, FMC respectfully requests that the OIG reduce the amount of the alleged overpayment in keeping with the arguments that follow.

(A) The Sample Is Inconclusive.

The Report's conclusions are not substantiated by the underlying data for three principal reasons.

First, a random sample of 100 claims is inadequate to obtain a precise estimate of FMC's actual billing practices. The auditors used a 90 percent confidence interval, which estimated the true population charges to within 25 percent. At least a 95 percent confidence interval should have been used to achieve adequate precision. Moreover, given the seriousness of the Report's conclusions, the auditors should have provided an estimate to within at least 10 percent.

Second, the sampling is suspect because the auditors used a mean point estimate. Because cost data tends to be highly skewed, the auditors' use of the mean as a point estimate for the current sample is questionable. A median would have been more appropriate with a sample of this size and variability. It also would have been more appropriate to exclude the lowest and highest costs (*i.e.*, the outliers) to eliminate some of the skewness and to reduce the sample standard deviation, before making any conclusions about the data. The OIG should eliminate the outliers from the sample before issuing a final report.

Third, the use of simple random sampling for this type of patient population is also questionable as there is likely to be wide variability in charges among different types of patients. Simple random sampling does not ensure that various types of patients will be adequately represented in the sample, especially one of this relatively small size. Some type of proportional stratified sampling would have been more appropriate. Again, elimination of the outlier cases will alleviate many of FMC's concerns in this regard.

(B) The Sample Generates An Overly Inclusive Extrapolation.

On June 10, 1998, the OIG delivered a report to FMC including certain materials labeled as *Objective Attributes Recap Sheets*. FMC received these sheets in anticipation of its scheduled exit conference with the OIG's auditors, to review the auditors' preliminary findings. With respect to the services allegedly billed by FMC but not supported by corresponding entries in FMC's medical records, the relevant recap sheet notes that the "majority of these error cases were found in the Hospital's partial hospitalization program... [where] the only evidence of a

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[1] The OIG's own auditors acknowledged these facts while conducting their site work at FMC in February/March of this year. One of the auditors even noted that he "hadn't been trained for something like this."

patient's attendance at a group therapy session was a checkmark next to the session name in the patient's medical record... ."

FMC's partial hospitalization program did utilize a checkmark system for some portion of FY 96. FMC utilized this system in its partial hospitalization program following a review by the Massachusetts Division of Medical Assistance and the Massachusetts Department of Public Health of the checkmark system utilized in other similar Massachusetts treatment programs. However, FMC abandoned this record-keeping system as of August 1, 1996, and adopted its present narrative format. The Report does not account for the fact that FMC discontinued its use of the checkmark system during FY 96. Rather, the extrapolation is based on an assumption that any violations continued to occur throughout all twelve months of the year. That assumption is incorrect.

(C) The Applicable Regulations Are Confusing And Contradictory.

FMC has tried as best it can to abide by the regulations and other instructions applicable to billing for the services its licensed clinical social workers ("CSWs") provide in area nursing homes. FMC's overarching concern, however, has always been to ensure that the nursing home residents receive the outpatient psychiatric services they need. FMC developed its Geropsychiatric Team approach in response to the high demand for outpatient psychiatric services in the greater-Greenfield and surrounding communities. Put simply, had it not been for FMC providing these services,[2] many nursing home residents would have gone without them.

Prior to expanding the use of its Geropsychiatric Team in area nursing homes, FMC was audited by Aetna (FMC's prior fiscal intermediary) to review the need for these services and FMC's proposed structure for providing them. The fiscal intermediary (the "FI") never objected to FMC's plans or voiced any concern about FMC's proposed billing procedures. In fact, the FI fully supported FMC's plans in this regard. Accordingly, because the Report apparently takes issue with FMC's billing practices, the OIG should inquire of Aetna representatives about their understanding and approval of FMC's nursing home services.

FMC also requests that as part of its final report, the OIG issue an instruction to Mutual of Omaha, FMC's new FI, to provide FMC with clear written guidance on how FMC should bill for all of the outpatient psychiatric services it provides (both at FMC and elsewhere). Existing "guidance" is confusing and often contradictory. For example, §4162 of the Medicare Carrier Manual and §3662 of the Medicare Intermediary Manual indicate that hospitals must submit claims to the carrier, with the exception of partial hospitalization services which must be billed to the intermediary. Despite these provisions, Mutual of Omaha, in its Medicare newsletter for hospitals (#96-39, December 1996), indicates that hospitals must submit claims to the intermediary. Moreover, the situation is rendered more confusing by an answer given in the

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[2]These services include consultation to the patient's primary care physician ("PCP") with respect to differential diagnoses and psychotropic medications, and the provision of a broad array of clinical and other therapeutic services to patients and their family members.

Part B Answer Book (at 21101) which states that a hospital must bill the carrier for CSW services provided in an outpatient department, as these services are bundled into the hospital payment. Yet, Form HCFA 1450, reprinted at CCH Medicare/Medicaid Guide, ¶10,220, provides that CSW partial hospitalization services are bundled and, therefore, should be billed to the intermediary.

Given the conflicting nature of the aforementioned provisions, it is no wonder that FMC may have inadvertently submitted a claim to the "wrong" fiscal agent and/or on the "wrong" form.[3]

II. CLINICAL SOCIAL WORKERS PERFORMING OFF-SITE SERVICES

Many of the outpatient psychiatric services provided by FMC in FY 96 were rendered in area nursing homes by FMC's Geropsychiatric Team. The Team functions as a multidisciplinary unit under the supervision/leadership of an FMC psychiatrist. All referrals to the Team are made by the patient's PCP. All referred patients are seen by FMC psychiatrists who make an assessment and a specific recommendation for medication, and then prescribe a plan of treatment. Frequently, a CSW, clinical nurse specialist or psychologist sees the patient prior to the psychiatric evaluation to perform a psycho-social assessment, which the psychiatrist can then use in formulating a treatment plan for the patient. FMC's team of CSWs, psychologists and clinical nurse specialists (Master's level) then follow-through on the psychiatrist's treatment plan and his/her other clinical recommendations. Each patient's ongoing treatment and progress is monitored in weekly staff conferences and in individualized direct supervision sessions with the psychiatrist.

(A) The Auditors Improperly Denied Charges Associated With Diagnostic Services.

Diagnostic services are covered whether furnished in the hospital or at other locations, and hospital personnel may provide diagnostic services outside the hospital premises without the direct personal supervision of a physician. Hospital-employed CSWs may provide diagnostic services outside the hospital premises without the direct personal supervision of a physician, and such diagnostic services are covered hospital services.[4]

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[3]Statements made by the OIG's audit personnel during the site visit in February/March 1998 indicated that even the OIG finds these regulatory provisions to be less than clear.

[4]Medicare Part A Manual, §§230.2 and 230.5. A service is "diagnostic if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are . . . psychological tests and other tests given to determine the nature and severity of an ailment or an injury." (Medicare Intermediary Manual, §3112.3).

All of the services listed in Table A below were diagnostic. Accordingly, it was entirely appropriate for FMC to bill for these services, despite the fact that a physician may not have directly supervised the CSW.

TABLE A

Case #	Date of Service	Type of Service
4	09/10/96	Initial Evaluation
12	06/26/96	Initial Evaluation
32	11/27/95	Initial Evaluation
36	07/10/98	Consultation
43	05/16/98	Consultation
66	04/03/96	Initial Evaluation
73	07/23/96	Initial Evaluation
73	07/23/98	Initial Evaluation
73	09/11/96	Initial Evaluation
73	09/13/96	Initial Evaluation
82	05/28/96	Initial Evaluation
86	08/28/96	Initial Evaluation
97	10/04/95	Initial Evaluation

(B) The Auditors Also Should Have Given FMC Credit For Certain Therapeutic Services Provided By The CSWs.

The auditors also should have given FMC credit for 16 cases in which a CSW provided therapeutic services to a nursing home resident while a psychiatrist was present in the nursing home. Since the OIG's site audit in February/March, FMC has reviewed all of the records at issue in the Report. This review disclosed that for those cases listed below in Table B, a psychiatrist was present in the nursing home on the day when FMC's CSW provided therapy to the nursing home resident. While the notes for these 16 cases do not reflect this fact, other nursing home and FMC records from each specific date of service confirm that a psychiatrist was present at the nursing home. FMC is also confident that in each case where the OIG auditors

have denied payment there were patient-specific clinical discussions each week (and oftentimes daily) between the supervising psychiatrist and the CSW and other qualified therapists.[5]

TABLE B

Case #	Date	Other Nursing Home Patient Billed That Day	Physician	Nursing Home
2	01/18/96	[illegible]	[illegible]	[illegible]
5	03/21/96	[illegible]	[illegible]	[illegible]
10	11/21/95	[illegible]	[illegible]	[illegible]
53	01/18/96	[illegible]	[illegible]	[illegible]
23	07/31/96	[illegible]	[illegible]	[illegible]
39	01/25/96	[illegible]	[illegible]	[illegible]
44	02/12/96	[illegible]	[illegible]	[illegible]
46	06/18/96	[illegible]	[illegible]	[illegible]
47	05/30/96	[illegible]	[illegible]	[illegible]
51	08/07/96	[illegible]	[illegible]	[illegible]
11	04/04/96	[illegible]	[illegible]	[illegible]
73	09/20/96	[illegible]	[illegible]	[illegible]
82	05/28/96	[illegible]	[illegible]	[illegible]
86	08/28/96	[illegible]	[illegible]	[illegible]
100	11/30/95	[illegible]	[illegible]	[illegible]
97	10/05/95	[illegible]	[illegible]	[illegible]

OIG NOTE: We deleted from this table sensitive information which the OIG would not release under the Freedom of Information Act.

[5] FMC reserves its right to submit such records for the OIG's review if and when they are located. However, FMC has not yet been able to locate records to substantiate this fact.

III. SERVICES SUPPORTED BY MEDICAL RECORDS

(A) Case Number 49.

According to the Report. there was no information in the medical record to support FMC's reimbursement claims for case number 49. On further review. FMC has learned that it used the wrong date of service in billing for this patient. FMC billed a one hour therapy session on October 23. and a half-hour therapy session on October 24. 1995. The notes from the actual therapy sessions. however. are dated October 25 (for the one hour session) and October 26 (for the half- hour session).[6] FMC has concluded that the therapist put the wrong date on the notes. as four therapy sessions would not have been provided to this patient in the same week.

The services at issue were actually rendered on October 25-26. 1995. Despite the fact that therapy was provided on October 25-26. FMC never billed for those dates of service. The patient came in twice. FMC billed twice. and FMC has two notes for the two sessions provided to the patient that week. Thus. it seems clear that FMC mistakenly billed for services actually provided on October 25-26. using dates of service of October 23-24, 1995. Given that medically necessary services were provided to the patient. and those services are properly reflected in contemporaneous (albeit wrongly dated) notes. FMC's reimbursement for this patient should be reinstated.

(B) Case Number 14.

With respect to case number 14. the services rendered to this patient were provided because of a court order. There is no dispute that the services were provided by appropriately trained personnel. only that a physician was not initially involved in the patient's care. The court's order did not require that the patient undergo a psychiatric evaluation -- a diagnostic service that FMC could be paid for whether a psychiatrist performed it or not -- or even see a psychiatrist. FMC provided the court-ordered therapy and should be paid for its services.

(C) Case Number 25.

This case reflects a woman who was in conflict with her treaters (both inpatient and outpatient) and who needed FMC's partial hospitalization program in order to further assess her safety. sobriety and motivation to stay in treatment. Additionally, treatment was needed to focus the patient on enabling her to return to functioning in the community. The patient's records reflect that an appropriate clinical assessment was done on the patient and that a treatment plan and corresponding goals were established for her. The patient continued to be monitored on a weekly basis and showed steady progress. being discharged at a higher functioning level than on her admission to the program. The notes clearly reflect the fact that medically necessary outpatient psychiatric services were provided to the patient and that she benefited from those

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[6] A copy of the therapist's notes for this patient is attached hereto as Exhibit A.
[See OIG Note on page 9 of 11.]

services. Moreover, the services she received, as well as the patient's steady progress, are clearly documented in the patient's medical record. Accordingly, FMC should be permitted to keep the payment it received for treating this patient.

(D) Case Number 78.

This patient was seen for therapy at FMC on December 11, 1995. She received 60 minutes of individual therapy as reflected in the document attached hereto as Exhibit B. The check marks which appear on this exhibit (next to the patient's name) reflect the fact that the patient appeared at FMC and received her therapy there. The check marks were placed on the exhibit by the secretary at the clinic who registered the patient for the individual therapy session by entering certain confirmatory information into FMC's computer system. That entry, in turn, resulted in a bill generating for the patient's individual therapy session.

This patient is to be contrasted with the one appearing directly above her on the exhibit, where "NS" is written beside the patient's name. The NS entry reflects the fact that the patient did not show up for his/her therapy session. The secretary in FMC's clinic would not have placed a checkmark next to patient #78's name if the patient had not appeared for and actually received her individual therapy.

(E) Case Number 58.

This patient was seen by a Certified Alcohol Counselor with a Master's Degree in Counseling Psychology. The auditors denied payment for this case because of the therapist's credentials. However, the auditors overlooked the fact that the therapist's credentials are recognized by the Commonwealth of Massachusetts as adequate vis-a-vis the therapy provided (*i.e.*, the therapist was appropriately licensed by the state to provide the therapy services to the patient in a substance abuse clinic). Payment should not be denied where the therapist was appropriately certified to provide the services actually rendered to the patient.

IV. CONCLUSIONS

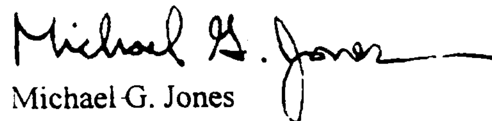
The Report should be revised to take account of the deficiencies noted above in Sections I-III. FMC's alleged overpayments should be reduced to reflect the identified deficiencies with the OIG's sample size and extrapolation methodology. Such a reduction is especially warranted in light of the confusing and contradictory nature of the regulations and other instructions applicable to FMC's billings.

With respect to the diagnostic services provided by the CSWs in the nursing homes, all of those charges (as listed in Table A) should be reinstated as they were entirely appropriate under Sections 230.2 and 230.5 of the Medicare Manual. The therapeutic services rendered by the CSWs for those cases referenced in Table B should also be reinstated as a physician was present at the nursing home on each date of service.

Finally. appropriate adjustments should be made to correct the patient-specific deficiencies noted above in Section III.

Most importantly. given the findings set forth in the Report. as well as the contradictory regulatory scheme under which FMC continues to operate its outpatient psychiatric treatment programs. FMC respectfully requests that the OIG instruct FMC's fiscal intermediary (Mutual of Omaha) to provide FMC with clear. written instructions as to how FMC should submit its bills for all of the outpatient psychiatric services it provides. FMC has sought such advice from the FI. but to date. no information has emerged other than a statement to the effect that the FI will get involved only after the OIG issues its final report. FMC respectfully requests the OIG's assistance in securing that information from the FI as soon as possible.

Very truly yours.



Michael G. Jones

MGJ/lp
cc: Mr. David R. Fager
Mr. Harlan Smith
Mark A. Borreliz. Esq.
DS1 429008.1

OIG Note: We deleted Exhibits A and B of the hospital's response as they contained sensitive information that OIG would not release under the Freedom of Information Act.