DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JAN 5 1998

From June Gibbs Brown
Inspector General

Subject Review of Partial Hospitalization Services and Audit of Medicare Cost Report for Community Behavioral Services, a Florida Community Mental Health Center (A-04-96-02118 and A-04-96-02124)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on Wednesday, January 7, 1998, of two final reports (copies attached) relating to Community Behavioral Services (CBS), a Florida community mental health center.

The objectives of our reviews were to determine whether the partial hospitalization services claimed by CBS in Fiscal Year (FY) ended December 31, 1995 and costs claimed in its cost report for FY ended December 31, 1994 met the Medicare reimbursement requirements. Medicare covers partial hospitalization services that are reasonable and necessary for the diagnosis and treatment of the individual's mental condition.

These audits were performed as part of our ongoing Project Operation Restore Trust reviews. As a result of our findings, the Health Care Financing Administration (HCFA) suspended Medicare payments to CBS.

Review of FY 1995 Services at CBS (A-04-96-02118)

For FY 1995, CBS claimed gross charges totaling $4,483,780 representing 31,951 services to 305 Medicare beneficiaries. Our review included a medical evaluation of services to 43 Medicare beneficiaries representing 11,082 partial hospitalization program (PHP) services and gross charges totaling $1,633,670.

Our review showed that 8,154 or 74 percent of the services reviewed did not meet the Medicare reimbursement requirements.

- 7,868 (71 percent) of the services were provided to 31 beneficiaries who, in the opinion of medical experts, did not meet the Medicare eligibility criteria for receiving PHP services.

- 286 (3 percent) of the services provided to 6 beneficiaries, were considered unallowable by medical review personnel because they were either not

documented, the services were not reasonable and necessary, the services were not ordered, or the supporting documentation was not dated, not signed, or duplicated.

The medical determinations were made by the fiscal intermediary's (FI) medical review personnel to determine whether the medical records supported the need for the claimed services and otherwise met the Medicare eligibility and reimbursement requirements. We believe that the identified problems occurred because CBS did not properly screen beneficiaries for enrollment and required nonclinical staff to identify referrals for the partial hospitalization program.

We recommend that the FI recover the amount overpaid to CBS and place the four providers owned by CBS under focused medical review with special emphasis on beneficiary eligibility.

Audit of the Medicare Cost Report for FY 1994 for CBS (A-04-96-02124)

For FY 1994, CBS claimed costs totaling $2.3 million. Our review showed that the claimed costs included costs that were not allocable or reimbursable according to Medicare reimbursement requirements. The cost report included $1.4 million in costs that were not related to patient care, not reasonable and necessary and costs that were not supported with sufficient documentation to determine whether the costs were incurred, reasonable and necessary, and related to patient care.

We believe that nonreimbursable costs were claimed by CBS because they did not apply Medicare cost reporting principles to ensure that the costs claimed were related to patient care, reasonable and necessary, and properly documented. CBS did not allocate shared costs between Medicare and non-Medicare companies. For example, employees who conducted work for non-Medicare companies were charged 100 percent to Medicare. Shared costs at the corporate office such as telephones were not allocated to the non-Medicare companies.

The FI has notified CBS of the unallowed costs and is taking recovery action. The HCFA has taken action to suspend payments to this provider until the overpayments are recovered. We recommend that the FI continue recovery action and review subsequent cost reports for similar unallowed costs.

The FI responded to our draft reports for both audits. The FI generally agreed with our recommendations and notified CBS of the overpayment.

The CBS also commented on our audit findings. They generally disagreed with the reported results, but they did not indicate that they would exercise their appeal rights.

For further information, contact:

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV
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Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PARTIAL HOSPITALIZATION SERVICES FOR COMMUNITY BEHAVIORAL SERVICES A FLORIDA COMMUNITY MENTAL HEALTH CENTER

JUNE GIBBS BROWN
Inspector General

JANUARY 1998
A-04-96-02118

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
P.O. BOX 2047
ATLANTA, GEORGIA 30301

CIN: A-04-96-02118

Mr. Curtis Lord
Vice President of Government Programs
P.O. Box 2078F, 12 Tower
Jacksonville, Florida 32231

Dear Mr. Lord:

This report provides you with the results of our review of the Community Behavioral Services (CBS) Partial Hospitalization Program (PHP). Medicare covers partial hospital services that are reasonable and necessary for the diagnosis and treatment of the individual's mental condition.

EXECUTIVE SUMMARY

The objective of our audit was to determine whether the partial hospitalization services claimed by CBS in Fiscal Year (FY) ended December 31, 1995 met the Medicare reimbursement requirements.

SUMMARY OF FINDINGS

We reviewed the services provided to 43 Medicare beneficiaries for whom CBS submitted claims in FY 1995 representing 11,082 PHP services and gross charges totaling $1,633,670. The medical review conducted by intermediary officials showed that 8,154 or 74 percent of the services did not meet the Medicare reimbursement requirements.

- 7,868 (71 percent) of the services were provided to 31 beneficiaries who, in the opinion of medical experts, did not meet the Medicare eligibility criteria for receiving PHP services.

- 286 (3 percent) of the services provided to 6 beneficiaries, were considered unallowable by medical review personnel because they were either not documented, the services were not reasonable and necessary, the services were not ordered, or the supporting documentation was not dated, not signed, or duplicated.

The provider claimed gross charges totaling $4,483,780 for 31,951 services to 305 Medicare beneficiaries in FY 1995. We determined that $1,204,565 for 8,154 services to 37 beneficiaries did not meet the Medicare reimbursement guidelines and therefore, constitute unallowable charges.

We believe that the unallowable claims were submitted by the provider because they did not have effective monitoring to ensure that the beneficiaries identified for enrollment met Medicare eligibility criteria and that services billed met the Medicare reimbursement guidelines. Further, the provider employees were required as a condition of employment to identify and admit beneficiaries into the partial hospitalization program.

We recommend that the fiscal intermediary (FI) recover the amount overpaid to CBS and place the four providers owned by CBS under focused medical review (FMR) with special emphasis on beneficiary eligibility.

We notified the Health Care Financing Administration (HCFA) in Region IV of our tentative audit results through an "Early Alert" memorandum dated January 15, 1997. The Early Alert recommended that HCFA authorize the intermediary to suspend payments to the provider under each of its four provider numbers. The HCFA notified the intermediary to suspend payments; the intermediary notified the provider that no payments would be made after March 18, 1997. The provider objected to the suspension and HCFA ultimately suspended the provider on June 13, 1997.

Aetna Life Insurance Company (Aetna), the FI formally responded to a draft of this report. Generally, Aetna agreed with our audit results and has initiated administrative procedures to deny the unallowable services claimed in FY 1995. The FI concluded that CBS was overpaid $917,789 for the unallowable services and has begun collection through a repayment agreement. The unallowable amount was calculated by the FI based on reimbursable charges instead of gross charges. Aetna agreed to put the four CBS providers on FMR. The complete written text of the FI's comments is included as Appendix B.

The provider also responded to a draft of this audit report and generally disagreed with our findings. However, they did not indicate that they would exercise their right to appeal the medical review decisions. Instead, they entered into a repayment agreement with the intermediary. Their comments are incorporated into the body of this report, where appropriate, and included as Appendix C to this report.

BACKGROUND

The CBS is the operating name of Neurorestoration Programs, Inc. which was incorporated on October 24, 1991. The effective date of participation in the Medicare program is April 15, 1994. The provider is a for profit corporation with a home office in Fort Lauderdale, Florida. It began operating a PHP program at three sites in June of 1994, and received net reimbursements of $1,457,737 for the year ended December 1994. Since then, the provider has added another site and has obtained additional provider numbers for each of the centers. As of August 31, 1996, the provider had received net reimbursements totaling $10,498,579.

The provider obtained the Medicare provider numbers through a self attestation process. The process requires the applicant to attest that they comply with the requirements of a Community Mental Health Center (CMHC) as defined by the Public Health Service (PHS) Act, that they provided the services required by the Act. A Medicare certified CMHC, such as CBS, can either provide PHP services directly or under arrangement with other providers to render the services required to be considered a CMHC as defined in the Act. Clinical services claimed by CBS in FY 1995 were provided under arrangement.

The provider received interim payments totaling $3,348,925 during FY 1995. Interim payments are adjusted to actual costs based on annual cost reports. The provider submitted a cost report for FY 1995 and claimed costs totaling $4,593,930.

The provider directly and indirectly employed psychiatrists, nurses, psychologists, social workers, mental health counselors, therapists and administrative personnel in Dade and Broward counties.

Fiscal Intermediary Responsibilities

The HCFA contracts with FIs, usually large insurance companies, to assist them in administering the PHP benefits program. The FI for CBS during the period of our audit was Aetna Life Insurance Company in Clearwater, Florida. The FI is now Blue Cross Blue Shield of Florida. The FIs are responsible for:

- processing claims for partial hospitalization services.
- reviewing claims submitted by CMHCs.
- performing liaison activities between HCFA and CMHCs.
- dissemination of information and educational material.
- making interim payments to CMHCs.
- conducting audits of cost reports submitted by CMHCs.

Laws

Title XVIII of the Social Security Act authorizes the Medicare program to provide medical benefits to individuals 65 years of age and older, and certain individuals under age 65 who are disabled or suffer from chronic kidney disease. Section 1832 of the Act established coverage of partial hospitalization services by CMHCs for Medicare beneficiaries. Section 1861(ff)(2) of the Act generally defines partial hospitalization services as those (mental health) services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization. Section 1835 of the Act requires physicians to certify that patients would otherwise require inpatient psychiatric care.

Section 4162 of P.L. 101-508 (OBRA 1990) amended Section 1861(ff) of the Act to extend Medicare coverage of partial hospitalization services to CMHCs. The PHS has primary responsibility for regulating CMHCs. Section 1916(c)(4) of the PHS Act lists the services that must be provided by a CMHC. Section 1861(ff) defines a community mental health center for Medicare as an entity that furnishes the services in Section 1916(c)(4) of the PHS Act and meets applicable State licensure requirements. The legislation states that any entity that provides these services would be considered a CMHC for purpose of the Act.

Section 1833 (a)(2)(b) of the Act provides that CMHCs will be paid for partial hospitalization services on the basis of reasonable cost. During the year, a CMHC receives interim payments based on a percentage of its billed charges. These payments are intended to approximate the CMHC's reasonable cost. Upon receipt of the Medicare cost report for the year, the intermediary makes a settlement payment based on the reasonable costs incurred.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether the PHP services claimed by CBS in FY 1995 met the Medicare eligibility and reimbursement guidelines.

Scope and Methodology

Our review was performed in accordance with generally accepted governmental auditing standards. We reviewed services claimed by CBS for 43 beneficiaries in FY 1995. The services we reviewed were not a statistical sample, therefore, the results cannot be extrapolated to determine unallowable services in the entire universe of CBS claims.

The claims reviewed were submitted during the period January 1, 1995 through December 31, 1995. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed met the Medicare eligibility and reimbursement guidelines.

Generally, for each of the 43 beneficiaries, we interviewed:

- the beneficiary or a close relative.
- the physician who signed the plan of care.
- the beneficiary's personal physician, if one was identified.

We obtained and reviewed supporting medical records maintained by the provider for each of the 43 beneficiaries. The medical records were also reviewed by the FI's medical review personnel to determine whether the claimed services met the Medicare eligibility and reimbursement requirements.

Our field work was performed at the CMHCs in Dade and Broward counties, the Miami Field Office, and the FI's office in Clearwater. The interviews were conducted in the beneficiaries' places of residence, the physicians' offices, and the CMHCs. Our field work was started in March 1996 and completed in December 1996.

The review was performed under the auspices of Operation Restore Trust and was initiated by the Office of Inspector General (OIG) in cooperation with the FI. The names of the individuals who participated in this review are shown on Appendix A.

DETAILED RESULTS OF REVIEW

Our review showed that all of the services claimed by CBS for 31 of the 43 beneficiaries should be disallowed because the beneficiaries did not meet the eligibility criteria. For 6 of the remaining 12 beneficiaries, our review showed that some services should be disallowed because either the supporting documentation was missing or inadequate to meet the reimbursement guidelines. For these 37 beneficiaries, CBS claimed 8,154 noncovered PHP services and submitted gross charges totaling $1,204,565.

Beneficiaries Did Not Meet the Medicare Eligibility Criteria

In the opinion of the FI's medical review personnel, 31 of the 43 beneficiaries did not meet the eligibility criteria for coverage of PHP services.

Title 42 CFR 410.43 states that Medicare covers PHP services that are reasonable and necessary for the active treatment of an individual's (mental) condition, are expected to improve or maintain the individual's condition, and to prevent relapse or hospitalization. The beneficiaries in our audit did not have a history of mental illness diagnoses nor would they have required hospitalization had the PHP services not been provided. These beneficiaries account for 7,868 PHP services with gross charges totaling $1,161,580.

Although our interviews were not utilized in the medical review process, they confirm the medical review results. The majority of the beneficiaries we interviewed recalled only receiving services that, appeared recreational in nature. The medical review showed that the services for 24 beneficiaries appeared to be diversionary or recreational in nature. Beneficiaries also told us that they were not aware that the services were for psychiatric treatment.

Following are examples of information obtained through our interviews of ineligible beneficiaries.

- A husband and wife were enrolled for PHP services so that they could spend time away from home and socialize with other senior adults. They referred to the PHP as the little school because they attended classes in drawing, arts and crafts, or watched television, played bingo, listened to music and conversed with other seniors. The prescribing physician was employed by CBS as co-medical director. The physician said that the wife had Alzheimer's disease and acknowledged that he had never seen the husband. The personal physician for the couple could not locate the medical records for the husband and, therefore, had no opinion as to the need for the services. However, he stated that the wife suffers from dementia and, in his opinion, her medical condition did not warrant PHP services.

- Two sisters who lived together called a physician employed by CBS to enroll in the program. Both were admitted to the program by the physician. As in the previous case, the two sisters told us they spent the days attending classes in arts and crafts, music, story and joke telling sessions, playing dominoes and bingo, or celebrating birthdays and special occasions. The signing physician stated that one of the sisters needed the services because of anxiety and depression caused by her relationship with the other sister. However, he admitted them both to the same program and the same group. He stated that one of the sisters suffered from anxiety, but acknowledged that the other had no need for the program. The personal physician for both sisters stated that, in his opinion, neither one had a medical condition to justify attending PHP services.

- Two beneficiaries suffered from advanced Alzheimer's disease. Although criteria allows for maintenance of a condition, it must still prevent relapse or hospitalization. Medical review found that the PHP services could not improve their level of functioning and would not prevent relapse or hospitalization.

- Two other beneficiaries appeared to be enrolled in the program simply for the purpose of socializing. Both were approached by CBS in adult congregate living facilities.

The provider objected to the medical review determinations because the partial hospitalization benefit was relatively new to the Medicare program, eligibility regulations were not issued timely, and coverage criteria was vague.

We do not agree that partial hospitalization programs are new. They were first offered as a Medicare covered service of psychiatric hospitals in 1987 and extended to CMHCs in 1991. The partial hospitalization program has accepted norms of medical practice and eligibility criteria including reasonable expectations of patient improvements.

The provider also objected to the examples from beneficiary interviews on the basis that a physician had certified the beneficiaries suffered a psychiatric condition, and therefore, the accuracy of the interview responses were subject to question. This position by the provider implies that the beneficiary had such severe psychiatric disorders that they were unable to provide reliable information. This is not the case. Most of the beneficiaries had no history of psychiatric illnesses and denied they were being treated for a psychiatric illness. The partial hospitalization program embodies a plan of care designed and discussed with each patient. The treatment includes discussions about therapy and expected outcomes. The beneficiaries that we interviewed did not recall these attributes concerning their attendance at the provider's program.

Other Technical Issues

We found that the supporting documentation for some of the services claimed for 6 of the 43 beneficiaries was either missing or inadequate to meet the reimbursement guidelines.

Conditions cited by the FI's medical personnel include: services not ordered, medically unnecessary, not documented, or documentation missing, not dated, not signed or duplicated. These conditions accounted for 286 PHP services totaling $42,985.

Criteria

Title 42 CFR 424.24 provides that Medicare Part B pays for partial hospitalization services only if a physician certifies that the patient would otherwise require inpatient psychiatric care and the content of a plan of care. The plan must include the physician diagnosis, the type, amount and duration of services, and the treatment goals. The frequency and duration are based on accepted norms of medical practice.

Cause

The provider did not properly screen beneficiaries for enrollment. Furthermore, CBS did not conduct procedures that would detect beneficiaries or services that were contrary to the Medicare eligibility and reimbursement guidelines. It appeared that clinical personnel generally admitted anyone referred by the Community Service Representatives (CSR).

We found that the employment agreement for CSRs required a minimum number of client contacts and included provisions for a base salary and performance bonuses. Further, we found correspondence between a CSR and a corporate officer that mentioned "admits" required of the CSR. In our opinion, this equates to a quota system. We believe use of a quota system increases the likelihood of inappropriate referrals and admissions.

The provider stated that all CBS employees were evaluated and compensated on the basis of standardized, company-wide factors and that no evaluation/compensation factor is tied to the volume or value of patient referrals. The provider further maintained that "given the short response time since the exit conference, the provider was unable to locate a copy of its employee evaluation form in effect during the relevant dates of service."

We believe that any employee evaluation forms used during the period under review should have either been included in the employees' personnel files or at least obtainable in the month long period between the exit conference and the provider's formal response.

Our review showed that the majority of the beneficiaries interviewed resided in adult congregate living facilities or nursing homes. They were usually approached and enrolled in the PHP program by either a CSR or a physician employed by CBS. Although beneficiaries living in adult facilities are not specifically disallowed from receiving PHP services, we do think it is inappropriate for CBS to target individuals living in these facilities and pursue referrals through the employment of CSRs who are not medically trained. We were told in interviews with four past CBS employees that the corporate office pressured clinical staff to admit inappropriate patients and that discharges had to be cleared through the corporate office.

Most of the beneficiaries stated that they did not have psychiatric problems and thought of the PHP as a social program that afforded an opportunity to get away from the facilities and socialize with other people 5 days a week. The absence of psychiatric problems was confirmed by the intermediary's medical review.

The beneficiaries we interviewed told us that CBS did not inform them of their financial responsibility for the 20 percent copayment not covered by Medicare; instead, the beneficiaries were told either not to worry about it, to ignore the bill even if they received it, or that CBS had a private insurance policy that would cover it.

The provider stated that our findings regarding copayment were not relevant to the recommendations and should be deleted. The comments included a copy of the bill that they assert was sent to the beneficiary.

We believe the comments are relevant to the audit results. The copayment acts as a control to ensure that the beneficiary received and needed the services provided. The "bill" that the provider exhibited did not indicate that a copayment was due from the beneficiary; it was only a listing by date of the services billed and the cumulative balance. There was no indication on the "bill" that the beneficiary would be required to pay any part of the balance.

Effect

Our review showed that for 37 of the 43 cases reviewed, services claimed by CBS for FY 1995 representing $1,204,565 of gross charges should be disallowed because: the beneficiaries did not meet the Medicare eligibility criteria and the supporting documentation for some of the PHP services did not meet the reimbursement guidelines.

The FI agreed with our audit results and has initiated administrative procedures for denial of the unallowable services claimed in FY 1995. The FI concluded that CBS was overpaid $917,789 for the unallowable services. The denied amount was calculated based on reimbursable charges instead of gross charges.

RECOMMENDATIONS

We recommend that the FI:

- continue administrative procedures to recover the amount overpaid to CBS in FY 1995.

- place the four providers owned by CBS under FMR to look specifically for ineligible beneficiaries and to identify and refer as necessary to the OIG, Office of Investigations, any trends or practices that are potentially fraudulent.

AUDITEE RESPONSE

On May 13, 1997, the intermediary responded to a draft of this audit report. Aetna generally agreed with our findings and recommendations. With regard to the specific recommendations Aetna made the following comments. It has already authorized a repayment schedule for the overpayments. It has placed the four CBS providers on FMR. Aetna has always worked closely with OIG and HCFA to identify and investigate potential instances of fraud and abuse.

The full text of Aetna's response is found in Appendix B.

PROVIDER COMMENTS

On June 4, 1997, the provider responded to a draft of this audit report. We incorporated discussions of some of the issues raised in the body of the report. The full text of CBS' response is found in Appendix C.

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Final determinations as to the actions to be taken on all matters reported will be made by the Department of Health and Human Services official identified below. An action official representative will contact you in the near future. This report includes your response to the findings, however, you may want to update or provide any additional information that you believe may have a bearing on the final determination.

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

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

HHS Action Official
Associate Regional Administrator
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APPENDIX A

MAJOR CONTRIBUTORS TO THIS REPORT

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May 13, 1997

Gerald Dunham, Audit Manager
PO Box 2047
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Dear Mr. Dunham:

Re: Common Identification #A-04-96-02118

Thank you for the opportunity to comment on the draft report entitled Review of the Partial Hospitalization Program at Community Behavioral Services, Fort Lauderdale, Florida.

In general, we believe there is a need for strong administrative policies and controls within provider organizations to ensure appropriate billing to the Medicare Program. Providers need to develop and regularly employ procedures to detect ineligible services and ensure that the Medicare Program is billed only for services which meet Program eligibility and reimbursement guidelines.

With regard to the specific recommendations made in your report, we offer the following comments:

> *. . . continue administrative procedures to recover the amount overpaid to CBS in FY 1995.*
>
> A repayment schedule has been authorized and approved by HCFA to recover the overpayment of $917,789 relating to beneficiaries or services found to be unallowable by Aetna medical review staff. Of this amount $322,591 has been collected to date. Aetna continues to monitor aggressively repayment activity to recover the outstanding balance.
>
> *. . . investigate all cases of possible fraud and abuse and refer them as necessary to the OIG, office of Investigations.*
>
> Aetna has worked extremely closely with HCFA and with the Office of Inspector General to actively pursue fraud and abuse within the Medicare Program. Aetna has referred numerous cases to the OIG office of Investigations, both as part of our ongoing program safeguard activities and as part of special efforts undertaken as part of Operation Restore Trust.

. . . place the four providers owned by CBS under focused medical review to ensure that they discontinue aberrant billing practices.

As recommended, the four providers were placed on focused medical review in October 1996. Since that time, Aetna has seen improvement in billing practices, and continues to carefully review submissions to ensure that aberrancies are identified and pursued.

In summary, Aetna remains committed to working closely with HCFA and the OIG to strengthen Medicare Program safeguards.

Sincerely,

Janet M. Kalas
Medicare Administration
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June 4, 1997

Via Telecopier and Federal Express

Mr. Gerald Dunham
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Re: Community Behavioral Services' ("CBS") Response to Draft Report entitled, "Review of the Partial Hospitalization Program at Community Behavioral Services, Ft. Lauderdale, Florida."
Common Identification Number: A-04-96-02118

Dear Mr. Dunham:

Thank you for the opportunity to submit written comments regarding the OIG's Draft Report entitled, "Review of the Partial Hospitalization Program at Community Behavioral Services, Ft. Lauderdale, Florida" ("Draft Report"). In addition, we appreciate the time you spent reviewing and commenting on our rebuttal statement. Also, thank you for presenting the OIG's audit findings during an exit conference held on April 24, 1997. During the exit conference, attended by Mario Palaez, Senior OIG Auditor; Kimberly Henderson, OIG Office of Audit Services; Doug Miller, CBS; you, and me, and in subsequent conversations with Maureen Testoni of our office, you explained in greater detail the OIG's methodology, findings, and recommendations in connection with the OIG's audit of certain 1995 claims for partial hospitalization services.

This letter serves as the provider's response to the Draft Report and the information furnished verbally during the exit conference. In summary, the provider describes below its: (1) concerns and objections with respect to certain procedural issues; (2) responses to certain OIG assertions and allegations; and (3) proposed revisions to the Draft Report.

1. Procedural Matters.

A. *Intermediary Redeterminations*

First, CBS strongly objects to the medical redeterminations made by the intermediary, and, because these redeterminations served as a basis for many of the OIG's conclusions, CBS also strongly objects to the medical review conclusions set forth in the Draft Report.

The partial hospitalization benefit is relatively new to the Medicare program. Regulations governing the provision of these services by Community Mental Health Centers ("CMHCs") were not promulgated until the middle of 1994.[1] These regulations did not directly address eligibility criteria. Accordingly, HCFA issued further guidance on eligibility criteria in June 1995.[2] The services at issue in the Draft Report were rendered in 1995. Thus, for half the period in which the services were rendered, HCFA had not yet issued specific eligibility criteria.

Moreover, the coverage criteria that was available *at the time that the services at issue were rendered* was extremely vague. We were informed by the intermediary that its redeterminations were based on the criteria set forth in § 205.8, HCFA Publication Nine, and the Local Medical Review Policy. Section 205.8 provides:

> In general, to be covered, the services must be reasonable and necessary for the diagnosis or active treatment of a patient's condition. **The services must be for the purpose of diagnostic study or they must be reasonably expected to improve or maintain the patient's condition and to prevent relapse or hospitalization.**
>
> **It is not necessary that a course of therapy have, as its goal, restoration of the patient to the level of functioning exhibited prior to the onset of the illness,** although this may be appropriate for some patients. For many other psychiatric

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[1] Partial Hospitalization Services in Community Mental Health Centers, Interim Final Rule, 59 Fed. Reg. 6570, Feb. 11, 1994, as corrected at 59 Fed. Reg. 13458, March 22, 1994.

[2] Partial Hospitalization Coverage, Program Memorandum (Intermediaries) No. A-95-8, June 1, 1995. (Stating that this PM provides "clarification of the requirements applicable to the Medicare partial hospitalization benefit" and that it is "intended to help providers understand the conditions and limits of Medicare coverage...")

> patients, particularly those with long term, chronic conditions, control of systems and **maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement.** "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. **Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.**
>
> Some patients may undergo a course of treatment which increases their level of functioning but then reach a point where further significant increase is not expected. Continued coverage may be possible even though the condition has stabilized or treatment is primarily for the purpose of maintaining the present level of functioning. Coverage is denied only where evidence shows that the criteria discussed above are not met; e.g., that stability can be maintained without further treatment or with less intensive treatment. (§ 205, emphasis added)

The patients treated by CBS in 1995 were "reasonably expected to improve or maintain each patient's condition and to prevent relapse or hospitalization", and, therefore, did meet the Medicare eligibility criteria that was available at the time the services were rendered.

B. *OIG Interviews*

Second, the provider has certain concerns respecting the OIG's beneficiary interviews. During the exit conference, you explained that the OIG conducted in person interviews of the sampled beneficiaries (and in some cases, beneficiary family members and care givers) based on a standardized questionnaire. These interview results are relied upon as alleged "examples" of the OIG's findings.

However, despite the materiality of the interview results, the provider has not been furnished with the individual interview responses; and therefore is unable to respond with particularity to significant portions of the Draft Report. In addition to this general objection, the provider raises the following objections and concerns regarding the interviews:

- The beneficiaries interviewed were evaluated by a physician who certified that, in his professional judgment, the beneficiaries suffered from psychiatric conditions. CBS believes that the accuracy of the interview responses is, therefore, subject to question and professional/clinical interpretation.

- The OIG interviewers were not licensed clinicians; and it is unclear whether beneficiary interview responses were confirmed or placed in context with the patients' overall psychiatric treatment, as documented in the medical records.

- The beneficiaries responses are based on their recollection of services that were rendered approximately six months to one year prior to the interview.

- During the exit conference, the OIG agreed to furnish a copy of the interview questions asked during the patient interviews. However, the provider has not yet received a copy of this audit tool; and, therefore, is unable to comment or respond at this time with respect to the patient interview content. The provider reserves its right to supplement this response, as necessary, once it is provided with a copy of the audit questionnaire.

2. Responses to OIG Assertions.

In addition to the general procedural concerns and objections raised above, the provider responds as follows to certain OIG assertions appearing in the Draft Report.

- **At no time has CBS evaluated or compensated any employee based on any form of a "quota system."** The Draft Report erroneously claims that certain CBS staff operated under some type of "quota system." (Draft Report at pp. 2, 6). This assertion is factually inaccurate. We wish to be clear: all CBS employees during the relevant period, were evaluated and compensated on the basis of standardized, company-wide factors. No evaluation/compensation factor is tied to the volume or value of patient referrals. To the extent OIG records reflect otherwise, the provider requests an opportunity to review and address (if necessary) such documents.

The provider was unable to locate a copy of its employee evaluation form in effect during the relevant dates of service. However, a copy of the provider's current evaluation form is attached as Exhibit A. This form is substantially similar to the criteria in effect in 1995.

- We are concerned that the statement that CBS arranged for the provision of certain clinical services through one subcontractor (p. 3) could be misconstrued as indicating that the OIG found fault with the use of subcontractors. HCFA has specifically informed CMHCs that all of the services provided by CMHCs do not have to take place on site at the CMHC and that CMHCs may arrange for services to be provided under an agreement with other agencies, organizations, or individuals[3].

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[3] Division of Health Standards and Quality All States Letter Number: 76-95.

- At no time did CBS furnish, or bill for, any bingo, joke-telling, story-telling, or cake-eating therapy sessions. As stated during the exit conference, CBS sometimes recognized and celebrated significant beneficiary achievements during the lunch hour; and such celebrations may have, at times, included a cake. However, these celebrations were not billed to Medicare. In addition, in the course of some therapy sessions, beneficiaries would observe and discuss portions of professionally produced and clinically recognized therapy videos. A list of videos used in CBS therapies is attached at Exhibit B. Last, music formed a portion of some therapy sessions and, at times, was used to relax or soothe patients.

- It is within a physician's professional judgment whether patients suffering from Alzheimer's disease may benefit from partial hospitalization services. Moreover, it is not necessary that Alzheimer patients must "improve their level of functioning," as stated in the Draft Report (p. 6). Aetna's local medical review policy sets a different standard, and allows coverage where the partial treatment "can be reasonably expected to improve **or maintain** the patient's conditions and function level." (Aetna Bulletin 95-14, p. 6, August 15, 1995).

- Patients residing at Adult Congregate Living Facilities ("ACLFs") are not precluded from receiving partial hospitalization services in the CMHC setting. In fact, during the time period in question, many ACLFs preferred to refer patients to CMHCs based on numerous reported Baker Act abuses in the inpatient setting. For this reason, CMHC treatment became a more desirable alternative for ACLF patients. CBS has forwarded to the OIG several published news articles discussing this trend.

3. Proposed Revisions.

To address the above and other CBS concerns, the provider requests the following revisions to the Draft Report:

- First, because you explained that the claims selected for review in this audit were not selected pursuant to a valid statistical sampling procedure, the Draft Report should be revised to state that the conclusions can not be extrapolated to the universe of CBS claims.[4] Because the

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[4] Chaves County Home Health Services, Inc., et al. v. Sullivan, 931 F. 2d 914 (D.C. Cir. 1991)(Holding that the Department of Health and Human Services may use statistical sampling "so long as the extrapolation is made from a representative sample and is statistically significant." (emphasis added); Riverside Hospital (Toledo, Ohio) v. Blue Cross and Blue Shield Association/Community Mutual Blue Cross and Blue Shield, PRRB Hearing Dec. No. 93-D13, Feb. 2, 1993, Case No. 90-1014. (Stating that because the Intermediary's sample was not randomly selected, "the Intermediary's method of sampling ... was unscientific." The PRRB concluded that, "the Intermediary's adjustment using a non-scientifically valid sample is inappropriate and invalid. ... The majority of the Board directs the Intermediary to appropriately audit these costs for their compliance with Medicare regulations and

Draft Report states that the review was conducted "in accordance with generally accepted government auditing standards" (p. 4), we are concerned that the audit results improperly appear to be statistically valid and reflective of all CBS claims.

- Second, all references to a "quota system" are factually erroneous and unrelated to the conclusions and recommendations identified in the Draft Report, and therefore should be deleted.

- Third, the statement regarding the provision of under-arrangement clinical services is misleading and should be revised to reflect the fact that all services were supervised by the provider at all times. (p. 3).

- Fourth, Examples 1 and 2, appearing on pages 5 and 6 must be substantially revised to reflect reality, or deleted altogether. As stated during the exit conference, the provider strongly objects to the negative and clearly erroneous characterization of CBS services stated in these examples. In our view, the references to joke-telling, bingo, dominoes, television watching, etc., are prejudicial, irrelevant to the findings, and will be extremely damaging to the provider's reputation if the report is published in its current form. To the extent the examples are included to illustrate, as you claimed, that the beneficiaries themselves were ineligible for partial hospitalization services, the references are irrelevant, unnecessary, and appear intended to damage CBS.

- Fifth, Example 3 should be revised to reflect the Aetna Local Medical Review Policy, or deleted altogether.

- Sixth, references to ACLFs should be deleted or the relevance of the ACLF references should be clearly stated.

- Seventh, the OIG has no support for its statement on page 6 that "CBS did not have procedures that would detect beneficiaries or services that were contrary to the Medicare eligibility and reimbursement guidelines." In fact, that statement is inaccurate and should be deleted. Prior to being admitted, each patient was screened by a physician along with a multi-disciplinary team (the "Team"), including nurses and other licensed health care professionals. Patients were admitted only upon the order of a physician. If the Team determined that a patient was ineligible, the Team's evaluation was reviewed for consistency and completeness by the Corporate Clinical Director, who was a nurse. As soon as the Corporate Clinical Director confirmed the Team's recommendation, the patient was informed that he or she was ineligible to

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program instructions. If the Intermediary chooses to use a sampling technique as part of its review of these costs, it must use a statistically valid sample.")

participate in the program. In addition, the provider's administrator was notified each time a patient was deemed ineligible. The purpose of this notification was to enable the administrator to inform the referring physician as to why the patient was not admitted.

- Eighth, the OIG findings respecting copayment obligations (p. 7) are not relevant to the recommendations and should be deleted. Moreover, as addressed in greater detail in previous correspondence with the OIG, dated April 10, 1997, the statements are inaccurate. A copy of the bills actually sent to beneficiaries is attached at Exhibit C.

- Ninth, the reference to "aberrant" billing practices (p. 7) is not relevant or supported and should be revised to address the ineligibility issue only, or deleted altogether.

- Tenth, the Final Report should discuss in greater detail the absence of formal written guidance on partial hospitalization coverage and eligibility issues and present a chronology of the effective dates of publicly available authorities on this benefit (*e.g.*, All-States Letter, Program Memorandum, Interim Final Regulations, etc.). This chronology will demonstrate that many CBS services were rendered prior to the issuance of any published guidance.

- Eleventh, we also object to the recommendation in the Draft Report that all four providers owned by CBS be placed under focused medical review ("FMR"). As the OIG is aware, all four providers were placed on 80 percent FMR in February 1996. Based on CBS's high compliance rate, three providers were removed completely from FMR in December 1996, while the fourth was reduced from 80 percent FMR to 20 percent FMR. In fact, the facility that is still on 20 percent FMR had a denial rate so far this year of less than .01 percent. Therefore, the recommendation that CBS be placed on FMR is misleading; because it implies that CBS' current claims do not meet Medicare eligibility requirements. The record, however, shows that CBS does meet those requirements.

- Twelfth, we also object to the recommendation that the fiscal intermediary refer cases of "fraud and abuse" to the OIG. This statement implies that the OIG actually found evidence of fraud. It is our understanding, however, that the OIG did not make such a finding. If that recommendation must be retained, then we urge that the Draft Report explain that no evidence of fraud was found during its audit.

- Finally, no discussion of this provider would be complete without a discussion of the provider's substantial efforts to restructure its operations and its good faith efforts to maintain compliance with all applicable Medicare laws, regulations, and policies. CBS recently restructured its operations and retained new clinical and management staff who have implemented various corrective steps, including educating staff and physicians, revising policies

and procedures, and developing new patient forms, new job descriptions, and evaluations. CBS outlined and supported these steps with documentation contained in its comprehensive "corrective action plan" submitted to its intermediary in December 1996. (A copy will be forwarded to you via federal express.) Moreover, as stated above, CBS' intermediary has recognized CBS' high overall compliance rate by removing three CBS facilities from 80 percent FMR and reducing the fourth facility from 80 percent FMR to 20 percent FMR.

Sincerely yours,

Christopher L. White

Encls;

cc: Doug Miller
Maureen Testoni

EXHIBIT A

COMMUNITY MENTAL HEALTH CENTER
COMPETENCY / SKILLS CHECKLIST

The following checklist will reflect competency of the skills as listed. The employee must be able to verbalize and/or perform the skill correctly without coaching / prompting. Competency may be assessed by observation or verbalization of specific principles. It is the responsibility of the direct supervisor to accurately assess the employee's performance.

COMPETENCY: INTAKE COORDINATOR	YES	NO	INITIALS OF OBSERVER	DATE
Organizational Skills				
Time Management Skills				
Follows Policies and Procedures				
Professional & Community Educational Seminars				
Inservices				
Referral Development Program				
Referral Development Staff Education				
Referral Development Meetings				
Productivity				
Inquiry Follow-up				
Intake / Screening Form				
Face-to-Face Contacts				
Admissions Process				
Physician & Allied Staff Relationships				
Confidentiality				

INTAKE COORD / COMPETENCY

COMPETENCY: INTAKE COORDINATOR	YES	NO	INITIALS OF OBSERVER	DATE
Committee Participation				
Contact Log				
Admissions Log				
90 - Day Planner				
Performance Profile(s)				
Special Community Services Plan				
Annual Plan				
Other Reports				
"Tracking" of Reports				
Statistical Data Collection				
Verbal & Written Skills				
Addresses Patient/Community Satisfaction				
Collaborates with Executive Director				
Collaborates with Corporate Director of Community Services				

Based upon my review of this competency checklist, along with my observations and interaction with this employee and input from other staff members, this employee is:
(Please circle appropriate number below)

1) Employee is competent to function within the current position description.

2) Employee is able to function within current position description with improvement outlined in the Performance Improvement Action Plan.

Employee's Signature:_____ Date:_____

Supervisor's Signature:_____ Date:_____

COMMUNITY MENTAL HEALTH CENTER
PHYSICAL DEMANDS - Position: INTAKE COORDINATOR

Physical Demands				
Physical Tasks	0 - 25%	25 - 50%	51 - 75%	76 - 100%
Standing			X	
Walking				X
Bending	X			
Crouching	X			
Carrying	X			
Pushing	X			
Pulling	X			
Sitting		X		
Reaching	X			

LIFTING/LOWERING				
Light(1-20 lbs)	X			
Med (21-50 lbs)	X			
Heavy (51+lbs)	X			

Psychological	High	Medium	Low
Mental Stress	X		
Work with Others	X		

UNIVERSAL PRECAUTIONS

Category I:

_____ Routine tasks involve exposure to blood, body fluids or tissues. All procedures or other job-related tasks that involve an inherent potential for mucous membrane or skin contact with blood, body fluids or tissues or a potential for spills or splashes of them are Category I tasks. Use of appropriate protective measures are required.

Category II:

_____ Routine tasks involve no exposure to blood, body fluids, or tissues, but employment may require performing unplanned Category I tasks.

Category III:

_____ Routine tasks involve no exposure to blood, body fluids, or tissues (although situations may arise which the employee might encounter potential exposure to any of the above).

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

STAGE	AGE	COMPETENCY Demonstrates knowledge/skills necessary to:	COMPETENT	IMPROVEMENT NEEDED	DATE
Neonate/Infant	0 to 1 year	• Assists parents to identify & meet needs • Involves family as much as possible • Controls environment so that physical & psychological needs are met			
Toddlerhood	1 to 3 years	• Explains procedures at child's level of understanding • Includes parents as needed • Provides opportunities for play/social activity • Explains equipment & unfamiliar objects • Provides privacy during procedure(s)			
Preschool	3 to 6 years	• Explains procedures at child's level of understanding • Includes parents as needed • Provides opportunities for play/social activity • Explains equipment & unfamiliar objects • Provides privacy during procedure(s)			
School Age	6 to 12 years	• Explains procedures at child's level of understanding • Includes parents as indicated • Provides opportunities for play/social activity • Explains equipment & unfamiliar objects • Provides privacy during procedure(s)			
Adolescent	12 to 18 years	• Explains procedures in terminology they can understand • Encourage their input in planning goals • Alleviates fears by addressing all questions • Provides privacy & space of their own while establishing ground rules			
Adult	18 to 65 years	• Involves them in care planning by meeting needs identified during assessment • Identifies normal patterns of living & assists them in trying to achieve them • Provides privacy during procedure(s)			
Older Adult	65 years & older	• Strives to obtain understanding by speaking distinctly & moving slowly • Involves family as much as possible • Explains all procedures, provides adequate rest periods • Listens to concerns and fears • Assesses sight & hearing • Provides privacy during procedure(s)			

Employee Signature Date

Supervisor Signature Date

RATINGS KEY

Instructions: Complete the position responsibilities section of the Position Description and assign one of the following ratings (1 - 5) as described below to each responsibility or objective. Upon completion, assign an overall rating to the performance of the employee based on the ratings below.

Rating = 1: Performance is below acceptable level. Substantial improvement in accomplishment of responsibilities and objectives is needed. The results of one as an overall rating is the placement into a probationary period for a period not to exceed ninety (90) days. Unsatisfactory progress at any time during the probationary period will result in termination of employment.

Rating = 2: Performance is generally acceptable in most aspects of the position, although improvement is needed in one or more areas to meet the requirements expected of a qualified / experienced employee.

Rating = 3: Performance consistently meets primary responsibilities and objectives of the position. Performance is at the expected level of a qualified / experienced employee.

Rating = 4: Performance consistently meets and often exceeds the desired position responsibilities and objectives. Overall performance is clearly above the level of performance expected of a qualified / experienced employee.

Rating = 5: Outstanding performance that exceeds expectations in all responsibilities and objectives of the position. Uniformly superior work resulting in exceptional accomplishments.

COMMUNITY MENTAL HEALTH CENTER
POSITION DESCRIPTION

The following criteria based appraisal reflects performance on the duties as listed. It is the responsibility of the supervisor to accurately assess the employee's performance.

INTAKE COORDINATOR POSITION RESPONSIBILITIES	RATING 1	2	3	4	5	OVERALL RATING
I. Referral Development:						
Conducts an established target for community educational purposes (at least 20 face to face contacts weekly).						
Develop and implement 90-Day Planner.						
Follow-up with all inquiries.						
Develops and manages the referral development program.						
Schedules referral development meetings in coordination with the Executive Director.						
Provides on-going staff training on referral development.						
Develops and provides professional/community education and awareness programs to support referral development activities.						
Reviews patient and referral source satisfaction and works with the Executive Director to address issues and enhance satisfaction.						
Implements specific relationship building strategies to broaden community bases (i.e. judicial system, schools, clinicians)						
Attends training seminars as required.						
II. Intake / Admissions:						
Follows-up on referral activity daily.						
Assists Admissions Coordinator in coordinating and facilitating assessments and admissions.						
Completes Intake Forms and maintains log.						
Utilizes intake and/or clinical skills to complete Screening Form						
III. Community & Professional Awareness / Education:						
Assists in developing and coordinating all professional and educational events.						
Follow-up with all professional seminar attendees.						
Assists in developing and coordinating community education seminars.						
Follow-up with all community seminar attendees.						
Conducts educational inservices for new and ongoing referral sources.						

INTAKE COORDINATOR POSITION RESPONSIBILITIES	RATING 1	 2	 3	 4	 5	OVERALL RATING
Integrates Executive Director and staff in Community Service efforts.						
Develops and maintains relationships with community-based clinicians.						
IV. Business & Industry Relations:						
Educates community and staff on our Managed-Care Contracts.						
Works closely with the Corporate Director of Community Services and the Executive Director to develop new contracts.						
Meets with affiliates of all contracted entities (as applicable).						
V. Reports & Tracking:						
Completes all reports thoroughly and on a timely basis, inclusive of, but not limited to: contact log, admission log, 90-day planner, performance profiles, and overall annual plan.						
Tracks reports to identify patterns, trends, weaknesses, and strengths.						
Discusses findings of tracking with Executive Director, and coordinates action plan with Corporate Director of Community Services.						
VI. Planning:						
Collaborates with Executive Director, in coordination with Corporate Director of Community Services to develop all plans.						
Executes all plans under the guidance of the Executive Director.						
VII. Abides by all safety/risk, infection control and other guidelines as required:						
Follows infection control policies and procedures at all times.						
Utilizes hand-washing techniques as necessary.						
Reports personal symptoms of suspected illness or contagious diseases to Program Nurse.						
Assists in maintaining the safety of the center at all times, following safety/risk policies and procedures.						
VIII. Performs all other tasks as assigned.						
IX. Overall Performance Rating						

I have reviewed and understand this job description and its position responsibilities; I agree to perform the duties described herein.

Employee Signature **Date**

EXHIBIT B

ENGLISH VIDEOS-PSYCHIATRY/PSYCHOLOGY

Stress and Anxiety	Time Life Medical Series Dr. E. Koop MD
Depression	Time Life Medical Series Dr. E. Koop MD
Insomnia	Time Life Medical Series Dr. E. Koop MD
What everyone should know about wellness	Channing L. Bete Co.
About Good Nutrition	Channing L. Bete Co.
When bad things happen to good people	Harold Kushner, MD
Stress and Emotions	Brain Series
Learning and Memory	Brain Series
The two Brains	Brain Series
Madness	Brain Series
State of Mind	Brain Series
Four Lives/Manic Depression	Irene Pollin, PHD

ENGLISH VIDEOS-ADDICTION AND RECOVERY

AA and the Alcoholic	Motivational Media, Inc.
The Aftercare Film	Motivational Media, Inc.
The Spirituality Tape	Motivational Media, Inc.-James Crossen, PHD
The Sponsor Tape	Motivational Media, Inc.-James Crossen, PHD
Working the Steps 1-7	Motivational Media, Inc.-James Crossen, PHD
Turning it Over	Motivational Media, Inc.-Father Terry Richey
Powerlessness	Motivational Media, Inc.-Father Terry Richey
Disease Concept I	Motivational Media, Inc.-Father Terry Richey
Alcholism	Time Life Medical, Dr. E. Koop, MD
Alcoholism:Live under the influence	Nova Media

ENGLISH VIDEOS-MEDITATION AND RELAXATION

Serenity: A Visual Imaging Video	Motivational Media, Inc.-Emmett Miller, MD
Canyon Dreams	Miramar Productions

SPANISH VIDEOS

Young People in NA	**World Services Inc. (AAWS)**
The Cat Who Drank and Used Too Much	**FMS Productions**
A time for decision	**AIMS Media Production**
Psychoactive	**Madera Cinevideo Inc.**
Uppers, Downers: All Arounders- Part: The Effects	**Madera Cinevideo Educational Division**
Uppers, Downers: All Arounders- Part II- The drugs	**Madera Cinevideo Educational Division**
The Cocaine Film	**Madera Cinevideo Educational Division**

EXHIBIT C

COMMUNITY BEHAVIORAL SERVICE
Dept L-1419
Columbus, OH 43260-1419
954 755-1277

D2114

STATEMENT DATE 06/04/97
ADMIT DATE 03/30/95
DISCHARGE DATE 05/19/95

[redacted]

SVC DATE	DESCRIPTION OF SERVICE	D/U	PRC	AMOUNT	BALANCE
03/31/95	Previous Balance				1,120.00
04/03/95	COPING SKILLS GRP 90853	1	915	160.00	1,280.00
04/03/95	DECISION MAKING GRP 90853	1	915	160.00	1,440.00
04/03/95	INSIGHT THERAPY 90853	1	915	160.00	1,600.00
04/04/95	GOALS GROUP 90853	1	915	160.00	1,760.00
04/04/95	LIFE SKILLS GRP 90853	1	915	160.00	1,920.00
04/04/95	PSYCH-ED PROCESS GRP 90853	1	915	160.00	2,080.00
04/04/95	SELF ESTEEM GRP 90853	1	915	160.00	2,240.00
04/05/95	ART THERAPY 90853	1	915	160.00	2,400.00
04/05/95	ASSERTIVENESS THERAPY 90853	1	915	160.00	2,560.00
04/05/95	BEHAVIOR THERAPY 90853	1	915	160.00	2,720.00
04/05/95	PSYCHTHRPY INDIV 20-30 90843	1	914	175.00	2,895.00
04/05/95	STRESS MANAGEMENT GRP 90853	1	915	160.00	3,055.00
04/06/95	DEPRESSION GRP 90853	1	915	160.00	3,215.00
04/06/95	PSYCH-ED PROCESS GRP 90853	1	915	160.00	3,375.00
04/06/95	REALITY ORIENTATION GRP 90853	1	915	160.00	3,535.00
04/06/95	TREATMENT GOALS GRP 90853	1	915	160.00	3,695.00
04/07/95	ACTIVITY TIME 90853	1	915	160.00	3,855.00
04/07/95	COMMUNICATION THERAPY 90853	1	915	160.00	4,015.00
04/07/95	PSYCHOTHERAPY COMPLEX 90853	1	915	200.00	4,215.00
04/07/95	RAP GRP 90853	1	915	160.00	4,375.00
04/10/95	COMMUNITY MEETING 90853	1	915	160.00	4,535.00
04/10/95	GRIEF THERAPY 90853	1	915	160.00	4,695.00
04/10/95	PSYCHTHRPY INDIV 45-50 90844	1	914	200.00	4,895.00
04/11/95	GOALS GROUP 90853	1	915	160.00	5,055.00
04/11/95	LIFE SKILLS GRP 90853	1	915	160.00	5,215.00
04/13/95	MED EDUCATION GRP 90853	1	915	160.00	5,375.00
04/13/95	PSYCH-ED PROCESS GRP 90853	1	915	160.00	5,535.00
04/13/95	REALITY ORIENTATION GRP 90853	1	915	160.00	5,695.00
04/14/95	ACTIVITY TIME 90853	1	915	160.00	5,855.00
04/14/95	COMMUNICATION THERAPY 90853	1	915	160.00	6,015.00
04/14/95	PSYCHOTHERAPY COMPLEX 90853	1	915	200.00	6,215.00
04/14/95	RAP GRP 90853	1	915	160.00	6,375.00
04/17/95	COMMUNITY MEETING 90853	1	915	160.00	6,535.00
04/17/95	COPING SKILLS GRP 90853	1	915	160.00	6,695.00
04/17/95	DECISION MAKING GRP 90853	1	915	160.00	6,855.00
04/17/95	INTERPERSONAL SKILLS GRP 90853	1	915	160.00	7,015.00
04/18/95	GOALS GROUP 90853	1	915	160.00	7,175.00
04/18/95	LIFE SKILLS GRP 90853	1	915	160.00	7,335.00
04/18/95	PSYCHTHRPY INDIV 20-30 90843	1	914	175.00	7,510.00
04/18/95	PSYCHTHRPY PROCESS GRP 90853	1	915	160.00	7,670.00
04/18/95	SELF ESTEEM GRP 90853	1	915	160.00	7,830.00

04/19/95	STRESS MANAGEMENT GRP 90853	1	915	160.00	8,470.00
04/20/95	ACTIVITY TIME 90853	1	915	160.00	8,630.00
04/20/95	COPING SKILLS GRP 90853	1	915	160.00	8,790.00
04/20/95	DEPRESSION GRP 90853	1	915	160.00	8,950.00
04/20/95	PSYCH-ED PROCESS GRP 90853	1	915	160.00	9,110.00
04/21/95	ACTIVITY TIME 90853	1	915	160.00	9,270.00
04/21/95	ANGER MANAGEMENT GRP 90853	1	915	160.00	9,430.00
04/21/95	ART THERAPY 90853	1	915	160.00	9,590.00
04/21/95	PSYCHOTHERAPY COMPLEX 90853	1	915	200.00	9,790.00
04/24/95	ACTIVITY TIME 90853	1	915	160.00	9,950.00
04/24/95	COMMUNITY MEETING 90853	1	915	160.00	10,110.00
04/24/95	GRIEF THERAPY 90853	1	915	160.00	10,270.00
04/24/95	DECISION MAKING GRP 90853	1	915	160.00	10,430.00
04/25/95	ACTIVITY TIME 90853	1	915	160.00	10,590.00
04/25/95	GOALS GROUP 90853	1	915	160.00	10,750.00
04/25/95	PSYCH-ED PROCESS GRP 90853	1	915	160.00	10,910.00
04/25/95	RAP GRP 90853	1	915	160.00	11,070.00
04/26/95	ACTIVITY TIME 90853	1	915	160.00	11,230.00
04/26/95	ASSERTIVENESS THERAPY 90853	1	915	160.00	11,390.00
04/26/95	BEHAVIOR THERAPY 90853	1	915	160.00	11,550.00
04/26/95	STRESS MANAGEMENT GRP 90853	1	915	160.00	11,710.00
04/27/95	ACTIVITY TIME 90853	1	915	160.00	11,870.00
04/27/95	DEPRESSION GRP 90853	1	915	160.00	12,030.00
04/27/95	PSYCH-ED PROCESS GRP 90853	1	915	160.00	12,190.00
04/27/95	REALITY ORIENTATION GRP 90853	1	915	160.00	12,350.00
04/28/95	ACTIVITY TIME 90853	1	915	160.00	12,510.00
04/28/95	COMMUNITY MEETING 90853	1	915	160.00	12,670.00
					12,670.00

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICARE COST REPORT FOR COMMUNITY BEHAVIORAL SERVICES A FLORIDA COMMUNITY MENTAL HEALTH CENTER

JUNE GIBBS BROWN
Inspector General

JANUARY 1998
A-04-96-02124

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
P.O. BOX 2047
ATLANTA, GEORGIA 30301

CIN: A-04-96-02124

Mr. Curtis Lord
Vice President of Government Programs
P.O. Box 2078F, 12 Tower
Jacksonville, Florida 32231

Dear Mr. Lord:

This report provides you with the results of our audit of the Medicare cost report for the Fiscal Year (FY) ended December 31, 1994 for Community Behavioral Services (CBS) (Provider), a community mental health center (CMHC). This audit was an initiative under Operation Restore Trust. Operation Restore Trust seeks to combat health care fraud, waste, and abuse in the five States with the highest Medicare expenditures.

EXECUTIVE SUMMARY

OBJECTIVE

The objective of our audit was to determine whether costs claimed by CBS on the FY 1994 Medicare cost report were in accordance with Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Our review showed that $1.4 million of $2.3 million included by CBS in the Medicare cost report were not allocable or reimbursable according to Medicare guidelines. The cost report contained costs that were not related to patient care and costs that were not reasonable and necessary. It also included costs that were not supported with sufficient documentation to determine whether the costs were incurred, reasonable and necessary or related to patient care. Medicare reimbursement requirements state that costs must be reasonable, related to the care of the Medicare beneficiary and adequately documented.

We believe non-reimbursable costs were claimed by the Provider because Medicare principles were poorly applied. The Provider did not allocate shared costs between Medicare and non-Medicare companies. Employees that conducted work for non-Medicare companies owned by the CBS principals were charged 100 percent to Medicare. Shared costs at the corporate office such as telephones were not allocated to the non-Medicare companies. Several invoices for non-Medicare companies for supplies, repairs, and maintenance were charged to CBS.

We have discussed these results with intermediary officials at Aetna Life Insurance (Aetna) and they concurred with our conclusions. We have also notified the Health Care Financing Administration (HCFA) Region IV officials that we believe our findings warrant immediate action to protect the Medicare program from further financial loss.

The Fiscal Intermediary (FI) has notified the Provider of the unallowable costs and is taking recovery action. The HCFA has taken action to suspend payments to this Provider until the overpayments are recovered. We recommend that the FI continue recovery action and review subsequent cost reports for similar unallowable costs.

Although the results of our audits were discussed with Aetna, Aetna terminated its Medicare contract before our report was finalized. The Blue Cross Blue Shield of Florida is the new FI for the Provider; we discussed our audit findings with the new FI and obtained their response. The FI also agreed with our audit findings. The complete written text of the FI's comments is included as Appendix B.

The Provider also responded to our audit findings presented at an exit conference, they generally disagreed with our findings. The concerns raised by the Provider are addressed individually throughout the body of the report where appropriate. However, the comments are too voluminous to be included as an attachment.

BACKGROUND

Community Behavioral Services

Community Behavioral Services is the operating name of NeuroRestoration Programs, Inc. NeuroRestoration Programs, Inc. was incorporated on October 24, 1991. The effective date of CBS' Medicare participation was April 15, 1994. It is a for profit corporation. In 1994, its corporate office was located in Coral Springs, Florida. It had three operating sites located in Coral Gables, Oakland Park, and Fort Lauderdale. Care was delivered through a contract staffing agency.

Regulations

Title XVIII of the Social Security Act authorizes the Medicare program to provide medical benefits to individuals 65 years of age and older, and certain individuals under age 65 who are disabled or suffer from chronic kidney disease. The Medicare program is administered by HCFA with assistance from FIs contracted by the Secretary. The intermediaries perform bill processing and benefit payment functions for Part A of the program.

Aetna was the FI for the Provider. However, Aetna terminated its Medicare contract before our report was finalized. The new FI for the Provider is the Blue Cross Blue Shield of Florida. The results of our audit findings were discussed with the new FI and their comments were requested and included as Appendix B.

Section 1832 of the Act established coverage of partial hospitalization services for Medicare beneficiaries. Section 1861 (ff)(2) of the Act generally defines partial hospitalization services as those services that are reasonable and necessary for the diagnosis or active treatment of the individual's mental condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization.

Section 4162 of Public Law 101-508 (Omnibus Budget Reconciliation Act 1990) amended section 1861 of the Act to extend Medicare coverage of partial hospitalization services to CMHCs. The Public Health Service (PHS) has primary responsibility for regulating CMHCs. Section 1916(C)(4) of the PHS Act lists the services that must be provided by a CMHC. The legislation stated that any entity that provided these services would be considered a CMHC for purposes of the Act.

Section 1833 (a)(2)(b) of the Act provides that CMHCs will be paid for partial hospitalization services on the basis of reasonable cost. During the year, a CMHC receives interim payments based on a percentage of its billed charges. These payments are intended to approximate the CMHC's reasonable cost. Upon receipt of the Medicare cost report for the year, the intermediary makes a settlement payment based on the reasonable costs incurred.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to determine whether the costs claimed by CBS on the FY 1994 Medicare cost report were in accordance with Medicare guidelines.

Scope

Our audit was performed in accordance with generally accepted government auditing standards. We reviewed the unaudited FY 1994 Medicare cost report and supporting documentation. We interviewed former and current CBS employees. We reviewed documentation supporting expenses at a CBS subcontractor. We obtained corporate officer information on the CBS principals from the Florida Division of Corporations. We utilized the results of the Aetna's desk audit of CBS and conferred with them on an on-going basis during the audit.

The cost report included total costs of $2,284,837. The cost items selected for review totaled $2,138,805. We did not test the internal controls because the objective of our audit was accomplished through substantive testing.

We conducted our field work between February and December 1996. We informally discussed the audit results with CBS officials and its legal counsel on March 20, 1997. As a result of this discussion, CBS submitted substantial written narrative in disagreement with our findings. They

also submitted additional documentation in support of the questioned costs. We have considered the comments and reviewed the additional documentation.

Methodology

We traced judgmentally selected costs on the cost report to the accounting records. We reviewed invoices, payroll records, and other financial documents to ensure the costs claimed were in compliance with Medicare guidelines. The determinations of allowability were based on the cost principles provided in the Provider Reimbursement Manual.

We reviewed expenses billed by the largest subcontractor, B&B Medical Management, and conducted an on-site verification. We interviewed CBS employees regarding their job duties and CBS' operations. We obtained support for the billings for clinical services and verified payments to the employees by reviewing W-2s and the payroll register.

DETAILED RESULTS OF AUDIT

Our review showed that $1.4 million of $2.3 million included by CBS in the Medicare cost report were not allocable or reimbursable according to Medicare guidelines. The cost report contained costs that were not related to patient care, were not reasonable or necessary and were specifically unallowable. It also included costs that were not supported with sufficient documentation to determine whether the costs were incurred, reasonable and necessary, or related to patient care.

Medicare Provider Reimbursement Requirements

Medicare cost principles limit reimbursement to the costs that would be incurred by a reasonable, prudent, and cost-conscious management. Section 2100 of the Provider Reimbursement Manual provides that all payments to providers must be based on the "reasonable cost" of services covered under title XVIII of the Act and related to the care of Medicare beneficiaries. Section 2102.3 of the Provider Reimbursement Manual states in part that:

> Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

Title 42 CFR 413.24 states that costs must be based on data that can be verified by a qualified auditor. The Provider records must contain adequate cost information to support payments made for services to beneficiaries. The regulation states that: "The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purpose for which it is intended." Further, all data necessary to support the accuracy of the entries on the annual cost

reports, including original invoices and canceled checks, used in preparing the annual cost report must be retained for a period of 5 years.

Our review showed that CBS claimed costs that were not related to patient care, not reasonable and necessary, and improperly documented.

NOT RELATED TO PATIENT CARE

Medicare guidelines require that all costs claimed on the Medicare cost report relate to facilitating patient care. We questioned $300,252 which did not meet this requirement.

Consultant and Contractor Costs

The Provider claimed $111,252 for consultants and contractors for services unrelated to the partial hospitalization program (PHP) patient care.

- $77,525 represented salaries for drivers who were billed as mental health technicians. Legal counsel for CBS argued that mental health technicians were used to transport patients to ensure that a trained individual was present in the event of an incident involving the patients.

- Medicare guidelines do not allow costs associated with transporting patients, therefore, the costs associated with mental health technicians accompanying patients while being transported to and from the centers are unallowable costs.

- $16,000 represented payments to business associates for consultation on development of PHPs. Some of the invoices submitted showed services that were not related to CBS' PHP and were not patient care related but, in fact, developmental in nature.

- $10,395 represented payments for nutritional assessments and lectures. These services are not Medicare reimbursable services when provided in a group setting. Therefore, the claimed costs are unallowable.

- $2,549 represented payments for occupational therapy assessments, group sessions, and paperwork. These services are not Medicare reimbursable services when provided in a group setting. Therefore, the claimed costs are unallowable.

- $4,478 represented costs of temporary employment services used by other companies owned by CBS principals.

- $305 charged in outside consultants was for computer software that was not described.

In addition to the problems we noted above, we found the documentation supporting the above costs was generally insufficient to determine whether or not the services were provided, to whom the services were provided and what, when and where the services were provided.

Non-CBS Employee Effort

We questioned $56,811 for employees that worked for non-CBS companies. This includes salary costs of $48,403 and related Federal Insurance Contribution Act (FICA) and unemployment taxes of $4,266 and amortization of start up salary costs of $4,142. We interviewed most of these employees. They acknowledged during the interviews that part of their time was spent working for companies other than CBS. For the most part, we based our determinations on estimates by these employees. For example, the controller did not know he was considered a CBS employee or that his salary would be included in CBS' Medicare cost report. He stated that the engagement letter was from another company and that initially, he only spent approximately 5 hours a month on CBS related activities. The remainder of his time was spent on non-CBS companies. We found one employee charged to CBS that was identified as an employee of a non-CBS company through other employee interviews. A personnel file was not provided for this employee.

We also questioned amortization of expenses of $4,142 of start up costs which included two employees' salaries that did very little work for CBS.

Non-CBS Office Costs

We questioned $19,659 of office telephone expense. According to the building leases, there were four suites at the corporate office. Only one was leased to CBS. Telephone expenses for all four suites were booked as CBS expenses. We allocated three-fourths of the office telephone expenses to non-CBS companies. In addition, we questioned $27,351 in lease payments on non-CBS space charged to CBS. We also questioned $2,495 for utility expenses for suites in the corporate office other than the one leased for CBS.

After our audit, we were informed by CBS' legal counsel that CBS took over the space that was leased by other companies. The Provider has since moved their corporate office to another location and we were not able to conduct an on-site verification of space usage. However, we have interviews that indicate employees located in this space conducted non-CBS work. In addition, other companies had the same corporate address as CBS in State records. We were not provided any evidence that CBS actually took over this space.

We questioned supplies of $5,985 that were for non-CBS companies owned by the same principals including Recovery Management, Recovery Health, and Vanguard. Similarly, we found equipment and furniture leases of $5,094 for Vanguard and Interphase and repairs and maintenance of $4,984 for Vanguard, Recovery Management, Recovery Health, and Interphase.

Marketing Employees

We questioned $60,942 for employees with marketing positions. The questioned costs included $48,427 for salaries, $4,827 for related FICA and unemployment taxes, and $7,688 primarily for mileage allowances for marketers and meals for marketing meetings. Marketing activities are not reimbursable under the guidelines of Section 2136.2 of the Provider Reimbursement Manual which states that costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable.

We believe these employees were actually marketers versus educators for the following reasons. Employment agreements for some of these employees stipulate that they must (a) market on an exclusive basis the company's mental health services, (b) make at least 80 client contacts per month, and (c) assist in the development and implementation of strategic plans to enhance the employer's marketing status. We also have internal correspondence from 1995 and 1996 between one of the principals and one of the community awareness representatives that was employed in 1994 that includes references to "marketing" meetings and that the community awareness representative focused on "admissions" for which she got credit.

Supplies and Other Costs

We questioned $4,632 for recreational supplies, incontinence supplies, bowling, food and party favors, wheelchair rental, aids for nutritional classes, Christmas cards and presents, holiday decorations, and flowers that are not related to patient care.

We questioned $1,047 for beeper and facsimile expenses. The beepers were primarily used by the owners and marketing staff. Further, some invoices for the beepers and all invoices for the facsimile machines had a non-CBS company name on them.

COST NOT REASONABLE AND NECESSARY

Medicare principles limit reimbursement to reasonable costs. We found $331,279 that we believe are not reasonable or necessary costs.

Owners Compensation

We questioned $282,110 for owners' compensation. This included salaries of $228,767 and related FICA and unemployment taxes of $10,467 because the compensation was unreasonable. We calculated a reasonable salary for a director/administrator using a contemporaneous survey of CMHCs by the American Association of Partial Hospitalization (AAPH). Our questioned costs also included $42,876 in bonuses, automobile and cellular car phone expenses that we consolidated with salaries and considered either excessive or unrelated to patient care.

Annualized salaries charged to Medicare on behalf of the owners were $275,000 for the president, $175,000 for the executive vice-president, and $75,000 for the vice-president (one-half of a $150,000 salary was self allocated to non-Medicare companies).

For the first two payroll periods, Medicare was charged only a portion of the owners' salaries. The remainder of their salary was allocated to two or more companies. After the first 2 payrolls, CBS began absorbing 100 percent of 2 of the principals' salaries while the third was increased to 50 percent, even though there was no apparent change in the other companies or their roles in those companies. We limited owners' compensation to $97,500 annualized, a reasonable salary for an administrator based on research of comparable Providers by the AAPH.

The three principals of CBS were involved in numerous corporate relationships. The resume' of the president showed that he was also the president of four other companies. Fourth-quarter wage reports showed that he received wages from two other sources.

The executive vice-president was listed as the cofounder and presently involved with six other organizations. A power of attorney document showed that he was granted (by his wife) the authority for "daily routine business affairs" of 22 other companies. Except for 3 years as CEO of an organization, he showed no experience that warrants the high salary claimed by CBS. Fourth quarter wage reports showed that he received wages from four other sources during 1994.

The vice-president was also associated with numerous non-CBS corporations. He was allocated as a 50 percent CBS employee. The resume' of the vice president that we obtained during the audit had been altered to delete all references to marketing and sales. The same resume submitted later by CBS' legal counsel had numerous references to marketing and sales.

Initially, we computed an allowable salary for each of the three owners based on a 1989 Aetna survey of outpatient rehabilitation facilities, adjusted for inflation to 1994. We then allocated the reasonable salary between companies that appeared to require at least some of the principals' time and effort of which, CBS was one. We came to a questioned cost of $221,767.

The Provider objected to our initial methodology for computing allowable owners' compensation. In a letter dated April 10, 1997, CBS' legal counsel argued that (1) we based our questioned cost on providers and/or positions that were not comparable; (2) the salary survey was not conducted during the same period of our review; (3) consideration was not given for geographic location, complexity of service provided or size of the organization; and (4) we raised no concerns regarding the duties of the owner administrators or the necessity of their services.

We continue to believe that our initial computation fairly reflects a reasonable salary. However, because opposition to the use of an inflation update factor had been successfully upheld in another case under a Provider Reimbursement Review Board appeal, we recomputed an allowable salary for the duties of a director/administrator using two alternative methods.

First, we obtained a HCFA approved audit program from Blue Cross Blue Shield of Florida to compute allowable compensation to an owner/administrator. By using this program, compensation to an owner/administrator would be limited to between $57,443 and $75,582.

Second, we obtained a survey, *1994 Salary, Benefits and Staffing Patterns in Partial Hospitalization Programs* from the AAPH. This survey considered geographic region, facility type, setting, ownership type, population served, average length of stay, and hours of operation. Data was gathered on the number, type and qualifications of staff and their job functions, salary ranges and benefits. The survey also allowed the AAPH to document the management structures of partial hospitalization programs by obtaining information on academic credentials and scope of responsibilities of program directors, managers, and coordinators. Using this survey, allowable annual compensation for a director/administrator ranges from $42,400 to $97,500. The highest being for a medical doctor. This will result in an even larger questioned cost of $228,767.

The survey gathered data on four types of management positions (1) director/ administrator, (2) coordinator/manager, (3) medical director, and (4) supervisor. The highest level of management found in CMHCs was the director/administrator. The responsibility for this position included overseeing all aspects of the program, including fiscal areas and policy decisions and may include oversight of more than one program. It is our opinion that the responsibilities of the president, executive-vice president and vice president of CBS overlap and CBS is using three people to carry out the job description held by one person by comparable providers. In fact, we found during our analysis of time sheets that the three principals frequently conducted the same service.

During our audit, CBS prepared and provided to us time sheets to document the efforts of the three CBS principals. Legal counsel for CBS provided these to us again after our audit and stated that they were prepared by the owners from their written schedules and planners.

The timesheets frequently showed that the three individuals participated in (usually word for word) the same activities on the same days and met with the same individuals. Although the number of hours sometimes varied, each timesheet appeared to have originated from the same source. There were several instances where the timesheets sometimes referred to activities as if the individual had met and discussed business matters with himself. For instance, the executive vice-president would have a meeting on the same day as the president with the same notation, however, the executive vice-president's own initials would be entered as the person with whom he met.

The timesheet of the executive vice-president had instructions on it to "Fill in missing hours from your calendar." On this particular timesheet, there were several handwritten additions. This indicates that the executive vice-president did not completely prepare his own timesheet from his own records as stated by CBS' legal counsel. Further, where these handwritten entries were made, approximately 75 hours were added after these hours were already included in the accumulated total for that day. Lastly, these timesheets did not include sufficient information to

determine the purpose of their activities. Frequently, timesheets contained only the names of individuals and hours. Some of the activities may not have been CBS related because the people listed could have been related to any one of the many other non-CBS business entities.

We concluded that the timesheets and resumes could not be relied upon to verify that the owners spent time on CBS patient care activities or that they had experience that would warrant the large salary. The documentation submitted to justify the owners compensation levels and level of effort was not adequate to indicate that they were more than passively involved in PHP activities. It did indicate that the owners claimed time as CBS related that was related to non-CBS activities.

For all the above reasons, we believe we have addressed CBS' concerns of our computations. We selected a conservative approach considering HCFA approved Blue Cross Blue Shield of Florida methodology would have resulted in a larger questioned cost and we allowed the highest average salary for a director/administrator that would go to a medical doctor. It should be noted that although the president of CBS is a medical doctor, the executive vice-president, and vice-president are not. In fact, their education and certifications would place them in the lower salary range.

In addition to salary, the three owners accrued bonuses totaling $27,028. We determined this was not reasonable and necessary based on the fact that they were excessive when included with other compensation and they were awarded to the 3 owners after being in operation only 4 months.

We questioned $8,300 that was primarily for automobile expenses for the owners because, combined with other compensation, these expenses are over and above a reasonable compensation to the owners. These costs include the capitalized portion of a down payment as well as monthly payments, insurance and repairs on a Lexus automobile for one of the owners, repairs on another owner's car, and gasoline purchases where no purpose was provided.

We questioned $7,548 for cellular car phones. We believe cellular car phones are personal items and unnecessary and unrelated to patient care. The majority of the cellular phone use was by the three owners and three unidentified users. There was no documentation explaining their purpose.

Interest

We questioned the entire $33,080 claimed for interest associated with the sale of accounts receivables.

The Director of Division of Cost Principles and Reporting, Office of Hospital Policy, Bureau of Policy Development, states in an opinion that,

> Whether or not the costs associated with accounts receivable financing are allowable costs under Medicare depends in part on whether the transaction is a sale or a loan. This determination is made by the

> provider's fiscal intermediary. Where there is a true sale of accounts receivable, the costs associated with the sale, including the origination fee and the discount on the accounts receivable, are not allowable costs. The provider has simply opted to receive payment prior to collection on the accounts.

We concluded that the financing of the Medicare receivables is, in fact, a sale of the receivables. There are numerous references in the contract which stipulate title is transferred to the finance company.

We also concluded that CBS is incurring unnecessary interest cost because it received the funds approximately 3 days faster than if they waited for payment from the intermediary.

Medical Directors

We questioned $16,089 for medical directors that we believe were unnecessary and unreasonable costs. We were told by a clinical director that only one physician at each center would be sufficient to run a PHP program. The Provider placed more than one medical director or codirector at each facility. We were told that CBS community awareness representatives identified physicians for recruitment with extensive patient bases so that they could admit patients into the program. These physicians were contracted as medical directors or codirectors and paid a monthly salary. Most of the patients in the program were referred by the facility medical directors. Additionally, contracts for three comedical directors, provided for salaries that equated to between $133 and $200 an hour. The survey by the AAPH cited average hourly salaries for physicians in the same region of $90.

COSTS IMPROPERLY DOCUMENTED

Medicare Providers are required to maintain documentation supporting all costs claimed on the Medicare cost report so that any authorized party could verify the expense was actually incurred, the expense was reasonable, related to patient care and is reimbursable by Medicare. We questioned $522,453 that we do not believe meet this requirement.

There were primarily two reasons for a determination that a cost was unsupported. First, there was no documentary evidence that the cost was actually incurred. Second, there were invoices, receipts or other evidence that the cost was incurred, but they did not adequately describe the cost or service provided.

Consultants and Contractors

A large part of the unsupported costs included $442,843 claimed for consultants and contractors providing legal and audit, nursing, therapy and support, medical and outside services that were not supported with contracts or sufficiently detailed invoices for services.

Unsupported costs of $245,059 were claimed for consulting services from a contract staffing company. Our review of the contractor's records showed that the documentation was not adequate to support the claim for services. The contract included a provision for community mental health consultant services. We were provided support for the charges that identified this service as licensed clinical social worker (LCSW) consulting. We were told by an employee of the contractor that $183,600 of this cost went to the two owners and $61,459 went to a LCSW. We were not provided any documentation supporting the time charged by either of these people. Nor were we provided any evidence that the owners were LCSWs or that their services were covered under the contract.

The Provider accrued costs of $62,000 that were billed by one consultant who provided advice on billing, funding, and policies and procedures. This consultant received five $21,000 checks in 1995. The consultant and CBS' legal counsel told us that three of these were for the 1994 accruals. However, according to a document that CBS' legal counsel provided to us, these checks were written during the same period that extremely large amounts were being billed by the same consultant. We were provided no other documentation supporting the purpose of those payments, therefore, we do not have conclusive evidence that those payments were, in fact, to liquidate the 1994 payables. Additionally, we are not satisfied that the costs were reasonable. We believe that the services listed in the invoices could have been obtained internally, especially in light of the combined experience of the three principals that was given as justification for their high salaries. Also, after repeated requests during our audit, CBS could not locate a copy of the contract for these services. We were told by CBS' legal counsel after our field work that he could obtain one from the contractor herself. However, we believe that Medicare guidelines require the Provider themselves to maintain support for all costs claimed to Medicare. For all of the above reasons, we are questioning these costs.

Unsupported costs of $33,922 were claimed for two consultants. We were provided a contract for one of the consultants which called for detailed invoices but no invoices were provided to us nor were we provided canceled checks. There was no contract for the other consultant and the invoices did not agree with the canceled checks.

Costs of $77,332 claimed for legal and audit consultants were not supported with invoices or contract during our audit. After our field work, CBS provided invoices supporting $61,800 in charges from one contractor for legal services. All of the invoices have the exact paragraph describing services performed. There is no identification of the specific service conducted during the hours billed. In addition, these contracted services were billed by an attorney that was already a paid employee of CBS.

Costs of $24,530 claimed for "Outside contract services" and "Medical Services" were not supported with contracts.

Building and Equipment Leases

There was inadequate support for $42,506 for building and equipment leases. We determined almost a third of the costs for building leases, $29,119, was unsupported. These costs were accrued each month, but not paid. We reviewed canceled checks through December 1995 and could not tie any checks to 1994 lease expenses. Also, $13,387 of unsupported costs for equipment leases were primarily from untraceable journal entries.

Office, Utilities, Supplies and Other

There was inadequate support for $11,114 in office and patient supplies. These were mostly from petty cash, journal entries that were untraceable, reimbursements to employees for expenses that were not documented, supported by only an American Express bill or supported by only a check request.

There was inadequate support for $4,155 in auto/gas, mileage, and entertainment. These expenses primarily consisted of untraceable journal entries, meals charged by the owners where no purpose was provided or reimbursement to employees with no documentation supporting the expense.

There was inadequate support for $5,158 for telephones, beepers, and facsimile machines. Some of these costs were from untraceable journal entries.

There was inadequate support for $16,677 for repairs and maintenance, utilities, depreciation, and recruitment. Costs of $1,105 for repairs and maintenance and $3,500 for recruitment were only supported by check requests. There were no receipts or invoices. There were two entries for utilities totaling $1,642 that were not supported by bills. We found $10,430 claimed for depreciation on assets for which we found no documentation of purchase.

OTHER UNALLOWABLE COSTS

We questioned an additional $240,167 for reasons other than being unrelated to patient care, not reasonable or necessary, or inadequately supported.

Bad Debts

We found the entire $235,153 claimed for bad debts unallowable.

The Provider Reimbursement Manual, Part I, Section 308 stipulates that a debt must meet the following criteria to be an allowable bad debt:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts.

2. The Provider must be able to establish that reasonable collection efforts were made.

3. The debt was actually uncollectible when claimed as worthless.

4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

Medicare guidelines further stipulate that bad debts for non-indigent patients cannot be written off until 120 days after the first billing date. We found that 77 percent of the bad debts for these patients were written off earlier than 120 days.

In addition, CBS recovered 29 percent of the debts claimed for Medicaid patients (26 percent of total bad debts) which indicates they were not truly uncollectible.

Statements sent to patients did not resemble bills for payment. Further, documentation of collection effort consisted of a log that stated the patient was called three times, however, there were no notes as to when the call was made, who the collector talked to and what was discussed. Some beneficiaries who received services in FY 1995 stated that they had been told by CBS not to worry about the copayment. In fact, we found 20 patient financial folders that had "Do not send statement to patient" written on them. Although these patients were enrolled in Medicaid, CBS was not a certified Medicaid provider until the end of 1994. Until CBS became a certified Medicaid Provider, it should have pursued bad debts for these patients as if they were self pay patients. Therefore, we do not believe their folders should have had this statement on them. For all the above reasons, we do not believe CBS has proven that it made a reasonable effort to collect bad debts.

Costs Not Incurred

We questioned $5,014 for costs that according to accounting records, were not incurred. We found a voided salary check and related payroll taxes that remained on the books for $1,069, duplicate entries totaling $671, and $3,274 for January 1995 rent that was accrued improperly in 1994.

Cause of Incorrect Charges on the Cost Report

We believe non-reimbursable costs were claimed by the Provider for the following reasons:

- Medicare principles were poorly applied. For example, except for the vice-president's salary, there was no allocation of shared costs between Medicare and non-Medicare companies. Employees that conducted work for non-Medicare companies owned by the CBS principals were charged 100 percent to Medicare. Shared costs at the corporate office such as telephones were not allocated to the

non-Medicare companies. Several invoices for non-Medicare companies for supplies, repairs, and maintenance were charged to CBS.

- Unclear and inconsistent supervision resulted in some employees not knowing under which company they were technically employed.

- Policies and procedures were inadequate to provide guidance to employees.

Intermediary Activity

The Provider Audit staff at Aetna had conducted a desk audit of CBS' FY 1994 cost report prior to the start of our audit. When we notified them of our planned audit, Provider Audit agreed not to proceed with an on-site review. Instead, they assisted us by providing the results of the desk audit and standard audit programs as well as guidance regarding cost report issues. During preparation of this report, Blue Cross Blue Shield became the intermediary.

CONCLUSIONS AND RECOMMENDATIONS

We recommend the intermediary:

- Transfer $1,394,156 on the FY 1994 cost report to non-reimbursable cost centers.

- Work with HCFA to suspend payments to CBS under the authority contained in Title 42 CFR Part 405, Subpart C.

- Coordinate with HCFA in providing training on Medicare cost principles to CMHCs.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

APPENDIX A

MAJOR CONTRIBUTORS TO THIS REPORT

HHS OIG OAS Region IV:	Gerald Dunham, HCFA Audit Manager (404) 331-2446, extension 107 Mario Pelaez, Senior Auditor Lisa Blake, Auditor Kimberly Henderson, Auditor Cavell Alexander, Auditor
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MEDICARE PART A POST OFFICE BOX 2711 • JACKSONVILLE, FLORIDA • 32231-0021

August 14, 1997

Gerald Dunham, Audit Manager
P. O. Box 2047
Atlanta, GA 30301-2047

Re: CIN: A-04-96-02124

Dear Mr. Dunham:

This is to reduce to writing your telephone conversation with Mike Davis, on Friday, August 8.

Based upon our review of the HHS-OIG's report A-04-96-02124, the issues and proposed adjustments appear reasonable. Blue Cross Blue Shield of Florida will perform a review of Community Behavioral Services FY 1994 cost reports using the information contained in this report. We will begin this review in October 1997, with a target completion date of March 31, 1998.

If you have any questions regarding this matter, please contact Frank Britt at 305-593-9534 or me at 904-791-8429.

Yours truly,

Suman K. Makker, Director
Provider Audit & Reimbursement Dept.

cc: Curtis Lord, VP Program Safeguards
Frank Britt, Manager, Miami PARD
Mike Davis, Manager, Jax/Orlando PARD