DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date DEC -5

From Thomas D. Roslewicz
Deputy Inspector General
for Audit Services

Subject Review of Outpatient Psychiatric Services Provided by Johns Hopkins Bayview Medical Center During Fiscal Year 1997 (A-03-99-00012)

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

This memorandum is to alert you to the issuance on December 7, 2001, of our final audit report entitled, "Review of Outpatient Psychiatric Services Provided by Johns Hopkins Bayview Medical Center During Fiscal Year 1997." A copy of the report is attached. The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed to Johns Hopkins Bayview Medical Center (JHBMC) in accordance with Medicare requirements.

During Fiscal Year (FY) 1997, JHBMC was reimbursed $1,139,893 for 2,935 Medicare claims submitted to the Medicare fiscal intermediary (FI) totaling $1,558,231 in charges. Our audit determined that many of the outpatient psychiatric services claimed by JHBMC did not meet Medicare criteria for reimbursement. Specifically, a team of medical experts determined that 59 of the 100 sampled paid claims included unallowable services. The 100 sampled claims contained 570 units of service of which 443 units were denied by medical reviewers.

Based on the results of the medical review, for the 100 claims in our sample, we calculated that $44,799 of $57,179 in charges were unallowable. We used a variable appraisal program to estimate the dollar impact of unallowable charges to the total population. Based on our statistical sample, we estimate that JHBMC overstated its FY 1997 Medicare outpatient psychiatric charges by at least $957,458.

We recommended that JHBMC strengthen procedures to ensure that charges for outpatient psychiatric services are for covered services and are properly documented in accordance with Medicare requirements. We will provide the results of our audit to CareFirst, the FI, so that they can recover the estimated overpayment and also ensure that the FY 1997 Medicare cost report is updated to accurately reflect allowable Medicare charges for outpatient psychiatric services rendered.

The JHBMC performed its own review of the claims that were audited in our sample. They opted not to comment on the specifics of the internal review, but rather chose to express disagreement with the Office of Inspector General audit procedures which led to the results. Most notably, JHBMC was critical of the statistical sampling methodology used and the criteria to which the services were compared. In its formal response to our draft report, the full text of which is included as APPENDIX B, JHBMC concluded the following:

"...this audit may not be extrapolated into the total universe of claims submitted by JHBMC to Medicare for FY 97 for the five programs that were the subject of this audit. In addition individual claims that were disallowed must be re-reviewed in accordance with applicable coverage criteria, local medical review policy as evidenced by the actual practice of the Fiscal Intermediary during FY 97, and applicable Medicare standards for documentation. In addition, determinations by OAS' expert reviewer that claims should be allowed must not be arbitrarily overruled by OAS auditors...."

After giving full consideration to the positions taken by JHBMC in its formal response to our draft report (see APPENDIX B), we made no substantive changes to the draft report. The statistical sampling method used in the audit is valid, and the results can be and were extrapolated appropriately, yielding a **conservative** estimate of the overpayment equaling at least $957,458. Additionally, all claims considered errors were based on the conclusions of medical reviewers. The JHBMC was provided with the conclusions reached by the medical reviewers on a claim-by-claim basis. The summaries of the conclusions reached, 100 in all, clearly reported the decisions reached by the medical reviewers.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to David M. Long, Regional Inspector General for Audit Services, Region III, at (215) 861-4501.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY JOHNS HOPKINS BAYVIEW MEDICAL CENTER DURING FISCAL YEAR 1997

JANET REHNQUIST
Inspector General

DECEMBER 2001
A-03-99-00012

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

Common Identification Number: A-03-99-00012

Mr. Carl Francioli
Senior Director, Finance
Johns Hopkins Bayview Medical Center
5300 Alpha Commons Drive, Room 339
Baltimore, Maryland 21224

Dear Mr. Francioli:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' report entitled, "Review of Outpatient Psychiatric Services Provided by Johns Hopkins Bayview Medical Center During Fiscal Year 1997." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to the action taken on all matters will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services' reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.)

To facilitate identification, please refer to Common Identification Number A-03-99-00012 in all correspondence relating to this report.

Sincerely yours,

David M. Long

David M. Long
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:
Mr. Steven McAdoo
Acting Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
150 S. Independence Mall West, Room 216
Philadelphia, Pennsylvania 19106-3499

EXECUTIVE SUMMARY

Background

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. Medicare requirements define outpatient services as "Each examination, consultation or treatment received by an outpatient in any service department of a hospital...." Medicare further requires that charges reflect reasonable costs and services provided be supported by medical records. These records must contain sufficient documentation to justify the treatment provided. Hospital costs for such services are generally facility costs for providing the services of staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis, predicated on submitted charges. At yearend, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final settlement.

However, in the State of Maryland, acute care hospitals operate under a "waiver" from Medicare's hospital reimbursement methodology. The Maryland rate-setting system, which is administered by the Maryland Health Services Cost Review Commission, produces a set of unit rates for each hospital department and a total approved revenue based upon the prospectively determined rates and projected volumes. Hospitals are required to charge those rates and all payers (including Medicare, Medicaid, and health maintenance organizations) reimburse providers on the basis of those rates.

Objective

The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed to Johns Hopkins Bayview Medical Center (JHBMC) in accordance with Medicare requirements.

Summary of Findings

During Fiscal Year (FY) 1997, JHBMC was reimbursed $1,139,893 for 2,935 Medicare claims submitted to the Medicare FI totaling $1,558,231 in charges. To determine whether controls were in place to ensure compliance with Medicare regulations and guidelines, we selected a statistical sample of 100 FY 1997 paid claims totaling $57,179 in charges. These claims were reviewed by a team of medical experts who determined that 59 of the 100 sampled paid claims included unallowable services based on Medicare requirements. The 100 sampled claims contained 570 units of service of which 443 units were denied by medical reviewers.

Based on the results of the medical review, for the 100 claims in our sample, we calculated that $44,799 of $57,179 in charges were unallowable. We used a variable appraisal program to estimate the dollar impact of unallowable charges to the total population. Based on our statistical sample, we estimate that JHBMC overstated its FY 1997 Medicare outpatient psychiatric charges by at least $957,458.

We recommended that JHBMC strengthen procedures to ensure that charges for outpatient psychiatric services are for covered services and are properly documented in accordance with Medicare requirements. We will provide the results of our audit to CareFirst, the FI, so that they can recover the estimated overpayment and also ensure that the FY 1997 Medicare cost report is updated to accurately reflect allowable Medicare charges for outpatient psychiatric services rendered.

JHBMC Comment

The JHBMC performed its own review of the claims that were audited in our sample. It opted not to comment on the specifics of the internal review, but rather JHBMC chose to express disagreement with the Office of Inspector General audit procedures which led to the results. Most notably, JHBMC was critical of the statistical sampling methodology used, the criteria to which the services were compared, and the work of the auditors in general. In its formal response to our draft report JHBMC concluded the following:

"...this audit may not be extrapolated into the total universe of claims submitted by JHBMC to Medicare for FY 97 for the five programs that were the subject of this audit. In addition individual claims that were disallowed must be re-reviewed in accordance with applicable coverage criteria, local medical review policy as evidenced by the actual practice of the Fiscal Intermediary during FY 97, and applicable Medicare standards for documentation. In addition, determinations by OAS' expert reviewer that claims should be allowed must not be arbitrarily overruled by OAS auditors...."

OIG Response

After giving full consideration to the positions taken by JHBMC in its formal response to our draft report (see APPENDIX B), we made no substantive changes to the draft report. The statistical sampling methodology used in the audit is valid, and the results can be and were extrapolated appropriately, yielding a **conservative** estimate of the overpayment equaling at least $957,458. Additionally, all claims considered errors were based on the conclusions of medical reviewers. The JHBMC was provided with the conclusions reached by the medical reviewers on a claim-by-claim basis. The summaries of the conclusions reached, 100 in all, clearly reported the decisions reached by the medical reviewers.

The JHMBC's comments on and our responses to the claims in error are included in the body of the findings. Their comments on and our response to the statistical sampling methodology are also presented at the end of the report.

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INTRODUCTION

Background

The Medicare program, established by Title XVIII of the Social Security Act (Act), provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Centers for Medicare & Medicaid Services (CMS). Under Section 1862 (a)(1)(A), the Act excludes coverage for services, including outpatient psychiatric services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury. Outpatient psychiatric services are generally provided by hospital employees such as staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis predicated on submitted charges. At yearend, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final settlement.

However, in the State of Maryland, acute care hospitals operate under a "waiver" from Medicare's hospital reimbursement methodology. The Maryland rate-setting system, which is administered by the Maryland Health Services Cost Review Commission, produces a set of unit rates for each hospital department and a total approved revenue based upon the prospectively determined rates and projected volumes. Hospitals are required to charge those rates and all payers (including Medicare, Medicaid, and health maintenance organizations) reimburse providers on the basis of those rates.

Medicare requires that for benefits to be paid:

- "A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services." [42 CFR 482.24]

- Psychiatric "...services must be...reasonable and necessary for the diagnosis or treatment of the patient's condition...Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed." [Medicare Intermediary Manual section 3112.7]

The Johns Hopkins Bayview Medical Center (JHBMC) is a wholly owned subsidiary of the not-for-profit Johns Hopkins Health System (JHHS). The JHBMC, formerly known as the Francis Scott Key Medical Center, was taken over by Johns Hopkins Medicine in 1984 when the city of Baltimore transferred ownership. The JHBMC is a 678 bed, full service medical center that includes a 331 bed community teaching hospital and 347 non-acute beds staffed by physicians who are primarily full-time faculty of the Johns Hopkins University School of Medicine. In Fiscal Year (FY) 1997, JHBMC received revenues of $218,797,000, of which $190,123,000 was for patient services.

Outpatient psychiatric services billed to Medicare by JHBMC during FY 1997 were provided within one of the following five program tracks:

1. The Adult Outpatient Program (AOP) - The AOP was established to provide comprehensive outpatient services to adults 18 years of age and older.

2. The Intensive Psychiatric Service Program (IPS) - The IPS was established to provide crisis intervention/urgent care psychiatric treatment, to prevent hospitalization, to provide a wide range of treatment modalities and services for the acute and chronically mentally ill, and to provide transitional services for patients leaving inpatient psychiatric units. This program replaced JHBMC's partial hospitalization program (PHP) during FY 1997.

3. The Variety Psychiatric Rehabilitation Program (Variety Program) - The Variety Program was designed to provide psychiatric rehabilitation services to adults ages 55 and older with mental illness or at risk. Services rendered included social activities such as bingo, party planning, arts and crafts, and movie viewing.

4. Mental Illness Substance Abuse Treatment Program (MISA) - The MISA was established to provide psychiatric and substance abuse treatment to adults with primary diagnoses of both major mental illness and active substance abuse problems.

5. The Addiction Treatment Services Program (ATS) - The ATS was designed to treat patients with severe substance abuse disorders. The primary objective of the program was to rapidly eliminate drug and alcohol use.

Objective, Scope, and Methodology

The objective of our audit was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed to JHBMC in accordance with Medicare requirements.

We conducted our audit in accordance with generally accepted government auditing standards. We performed all audit steps necessary to conclude whether JHBMC's FY 1997 outpatient psychiatric service claims were allowable in accordance with Medicare requirements. Specifically, we:

- reviewed Medicare criteria related to outpatient psychiatric services;
- obtained an understanding of JHBMC's internal controls over Medicare claims submission;
- used CMS's National Claims History File paid claims database to identify 2,935 outpatient psychiatric claims paid to JHBMC during FY 1997. The claims represented outpatient psychiatric services totaling $1,558,231 in charges;
- employed a simple random sample approach to select a statistical sample of 100 outpatient psychiatric claims;
- performed detailed audit testing on the billing and medical records for 100 sampled claims;
- utilized medical staff from the Delmarva Foundation, the Maryland peer review organization, to review each of the 100 claims; and
- used a variable appraisal program to estimate the dollar impact of improper charges in the total population.

FINDINGS AND RECOMMENDATIONS

During FY 1997, JHBMC was reimbursed $1,139,893 for 2,935 Medicare claims submitted to the FI totaling $1,558,231 in charges. To determine whether controls were in place to ensure compliance with Medicare regulations and guidelines, we selected a statistical sample of 100 FY 1997 paid claims totaling $57,179 in charges. These claims were reviewed by a team of medical experts who determined that 59 of the 100 sampled paid claims included unallowable services based on Medicare requirements. The 100 sampled claims contained 570 units of service of which 443 units were denied by medical reviewers.

SUMMARY OF SAMPLED CLAIMS						
JHBMC Outpatient Track	**Claims**		**Charges**		**Units[1]**	
	Total Sampled	**Total Denied**	**Total Sampled**	**Total Denied**	**Total Sampled**	**Total Denied**
AOP	57	20	$15,621	$5,162	165	64
IPS	4	2	2,936	2,099	38	26
Variety Program	22	22	16,388	16,388	216	216
MISA	3	1	2,740	1,656	32	18
ATS	14	14	19,494	19,494	119	119
TOTALS	**100**	**59**	**$57,179**	**$44,799**	**570**	**443**

Based on the results of the statistical sample, we estimate that JHBMC overstated Medicare outpatient psychiatric charges by at least $957,458 as shown in APPENDIX A. Services found unallowable lacked sufficient medical record documentation or were found to be not reasonable and necessary. Findings from our review of medical records are described in detail below for each of the outpatient psychiatric programs provided by JHBMC.

OUTPATIENT PSYCHIATRIC SERVICES

Adult Outpatient Program

The AOP was established to provide comprehensive outpatient services to adults 18 years of age and older. We found that 57 of the 100 sampled claims totaling $15,621 in charges were for psychiatric services provided in JHBMC's AOP tract. The 57 claims included a total of 165 service units of which 146 were billed as individual or group therapy. The remaining 19 units' charges were for services such as pharmacy, occupational therapy, activity therapy, and family therapy. The majority of sampled AOP claims, 47 of 57, were for only 1 to 3 service units. The average age of the beneficiary in the AOP was 56 years old. Based on the medical review, we determined that 20 of 57 claims totaling $5,162 in charges were not properly supported in the medical records.

The 42 CFR 482.24 states that, "A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support diagnosis, and describe the patient's progress and response to medications and services."

[1]Units represent the number of services billed within a claim.

Generally, for the 20 AOP claims, the medical reviewers found that although the medical records included documentation to support the diagnosis and an up-to-date individual treatment plan authorized by a physician, they found that the documentation was inadequate to support the services billed. Specifically the medical reviewers identified:

Claims for which there was no documentation that the billed services were provided. For example:

- Four claims totaling $501 which included four units of individual therapy. The Current Procedural Terminology (CPT) code 90841 was used indicating that the individual therapy billed was provided by a physician. The medical reviewers found no evidence to indicate an individual encounter occurred. In one case, a note in the beneficiary's chart indicated that the physician was not available for the date that the therapy was billed.

Claims for which the billed services were not adequately documented. For example:

- Nine claims for 37 services totaling $3,182 which lacked adequate documentation to support the billings, even though there was evidence that the patient attended a group or individual therapy session. The documentation provided did not describe what took place in each group or individual therapy session, the patient's progress compared to the treatment goals, or future plans for treatment.

Claims for which some of the billed services were not adequately documented. For example:

- Seven claims totaling $2,421 for which $1,479 of the services billed were not adequately supported. A total of 33 services were billed on these claims, and the medical reviewers determined that 23 were unsupported because the documentation pertaining to the services was nonexistent or insufficient.

In the absence of complete medical record documentation, including a description of what took place in a therapy session, the appropriateness of the patient's level of care is not established. Further, inadequate documentation of patient therapies and treatments provides little guidance to physicians and therapists for future treatment. In this regard, the lack of required documentation, as described above, precluded us from determining whether those services were indeed rendered and/or reasonable and necessary.

JHBMC Comments

The JHBMC contended that:

1. *Twelve of the 20 AOP claims denied were not reviewed by an expert*.

OIG Response

The medical review was performed by nurses and psychiatrists employed by the Delmarva Foundation. The review protocol was that all claims were first reviewed by the nurses. Claims that were not forwarded to the psychiatrist for review were determined by the nurses to lack sufficient supporting documentation to justify their coverage in accordance with Medicare requirements. The 12 claims that JHBMC refers to as having not been reviewed by an expert were not forwarded to a psychiatrist, but were reviewed by a nurse and determined to lack adequate documentation.

2. *Several of the AOP denials were for inadequate documentation which is not supported by regulatory requirements.*

OIG Response

The medical reviewers concluded that documentation included in the patient's chart was not adequate to allow them to determine if the services billed were in accordance with Medicare requirements or in some cases rendered at all.

3. *Three of the 20 claims denied were determined to be medically necessary by the Delmarva psychiatrist yet OAS recommended denial of the claims.*

OIG Response

Even though the psychiatrist concluded that the condition of the patients warranted care, the nurse reviewers concluded that the services JHBMC actually billed were not supported by sufficient documentation that the services were rendered in accordance with Medicare requirements or rendered at all. The Delmarva Foundation concluded that these claims were paid in error.

Intensive Psychiatric Services Program

The JHBMC's IPS program track replaced the PHP during FY 1997. Similar to a PHP, the IPS Program provided "psychiatric treatment for individuals experiencing an *acute* exacerbation of their mental illness in order to prevent further decompensation and increased symptomatology." We found that 4 of the 100 sampled claims totaling $2,936 were for psychiatric services provided in JHBMC's IPS track. The 4 claims included a total of 38 service units. The average age of the beneficiary in the IPS was 59 years old. The medical reviewers determined that 26 services on 2 claims totaling $2,099 were not properly supported in the medical records. Specifically, we found:

- One claim for a patient who did not require the level of intensity provided in JHBMC's IPS track. Although the medical reviewers determined that this patient should have been treated at a lower level of care in JHBMC's AOP track, they could not specifically quantify the amount of appropriate care. Five services totaling $589 were unallowable.

- One claim for which the documentation provided was not adequate to support that the services were rendered. The medical reviewers found 23 services totaling $1,550 were billed for this claim. They found 21 services totaling $1,510 were unallowable. Two units totaling $40 were allowable.

JHBMC Comments

The JHBMC questioned the conclusion reached for one of the two denied IPS claims stating that the claim was determined to be medically necessary by the Delmarva Foundation psychiatrist yet was denied by the Delmarva Foundation nurse reviewers due to lack of documentation.

OIG Response

Even though the psychiatrist concluded that the condition of the patient warranted care, the nurse reviewers concluded that the services JHBMC actually billed were not supported by sufficient documentation that the services were rendered in accordance with Medicare requirements. The Delmarva Foundation concluded that the claim was paid in error.

Variety Program

The Variety Program provided psychiatric rehabilitation services to adults, age 55 years and older with mental illness, or at risk. The average age of the beneficiaries in the Variety Program was 70 years old. The medical reviewers found that 22 of the 100 sampled claims totaling $16,388 were for services provided in JHBMC's Variety Program. The 22 claims represented 216 services of which all were billed as group therapy. We determined that all 216 services on the 22 claims totaling $16,388 were unallowable.

A typical day at the Variety Program track included attendance at several recreational type sessions during which patients participated in activities such as bingo, party planning, arts and crafts, and movie viewing. Medicare guidelines[2] state that activity therapies, group activities, or other services which are primarily recreational or diversional in nature are not Medicare covered

[2]CMS's Fiscal Intermediary Manual section 3112.7.

services. Billing documents indicated that one unit of group therapy was rendered per day for each patient. Attendance sheets located within each patient's medical file show several social type activities attended each day but did not identify a group therapy session for the day.

According to JHBMC officials, no specific session attended during a day in the Variety Program could be identified as the group therapy unit that was billed. Rather, JHBMC billed one service unit per day for each patient enrolled in the Variety Program. If the sessions attended by the patient in 1 day equaled a cumulative total of 180 minutes or more, the patient was considered to have attended a "full day", and one unit of group therapy was billed at $78. If the cumulative total was less than 180 minutes the patient was considered to have attended a "half day", and one unit of group therapy was billed at $55.

JHBMC Comments

The JHBMC contended that:

1. *Twelve of the 22 Variety program claims denied were not reviewed by an expert*.

OIG Response

The medical review was performed by nurses and psychiatrists employed by the Delmarva Foundation. The review protocol was that all claims were first reviewed by the nurses. Claims that were not forwarded to the psychiatrist for review were determined by the nurses to lack sufficient supporting documentation to justify their coverage in accordance with Medicare requirements. The 12 claims that JHBMC refers to as having not been reviewed by an expert, were not forwarded to a psychiatrist but were reviewed by a nurse and determined to lack adequate documentation.

2. *Three of the 20 claims denied were determined to be medically necessary by the Delmarva psychiatrist yet OAS recommended denial of the claims.*

OIG Response

Even though the psychiatrist concluded that the condition of the patients warranted care, the nurse reviewers concluded that the services JHBMC actually billed were not supported by sufficient documentation that the services were rendered in accordance with Medicare requirements or rendered at all. The Delmarva Foundation concluded that these claims were paid in error.

3. *The Variety Program claims were properly documented in light of the chronic illness suffered by the patients and the long term nature of the treatment provided.*

OIG Response

The conclusions reached by the medical reviewers were based on a review of the entire medical chart and billing documents. In the opinion of the medical reviewers, the services billed were not adequately documented.

Mentally Ill Substance Abuse Treatment Program

The JHBMC's MISA program track provided psychiatric and substance abuse treatment to adults who have a primary diagnosis of major mental illness, an active substance abuse problem, and a history of failing to successfully engage in traditional substance abuse treatment. We found that 3 of the 100 sampled claims totaling $2,740 were for psychiatric services provided in JHBMC's MISA tract. The 3 claims included a total of 32 service units. The average age of the beneficiary in the MISA was 40 years old. Based on the medical review, we determined that one of the three claims totaling $1,656 was not adequately supported in the medical records.

Specifically, the medical reviewers concluded that 1 claim for 18 services, including 6 group therapies and 12 individual therapies, was unallowable because the documentation supporting the therapies was inadequate. Although the diagnosis was appropriate, and the treatment plan was up-to-date and signed by a physician, the notes in the medical record documented attendance only and did not provide the detail necessary to support billable services. In addition, the 12 individual therapy sessions were billed using CPT code 90844 indicating that the duration of the sessions was 45-50 minutes. We found that the sessions lasted from 15-30 minutes, and thus should have been billed using CPT code 90843. The JHBMC's billing records list a lower rate of $69 for an individual session lasting 15-30 minutes. A rate of $92 per session was charged.

JHBMC Comments

The JHBMC questioned the conclusion reached for the denied MISA claim stating that the claim was determined to be medically necessary by the Delmarva Foundation psychiatrist, yet was denied by the Delmarva Foundation nurse reviewers due to lack of documentation.

OIG Response

Even though the psychiatrist concluded that the condition of the patient warranted care, the nurse reviewers concluded that the services JHBMC actually billed were not supported by sufficient documentation. The Delmarva Foundation concluded that the claim was paid in error.

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Addictive Treatment Services[3]

Claims from this program were part of our sample because JHBMC inappropriately billed the ATS claims to a revenue code for psychiatric services. The documentation supporting the services provided to the patients admitted to JHBMC's ATS program track indicated severe substance abuse disorders. The primary objective of the program was to rapidly eliminate drug and alcohol use. We found that 14 of the 100 sampled claims totaling $19,494 were for services provided in JHBMC's ATS track. The 14 claims included a total of 119 service units. Based on the medical review, all 119 services on the 14 claims under this program were unallowable. We determined that there were four different program levels within the ATS Program track. The programs were titled:

1. *Arc House* - A residential treatment program billed at $232 per day. Patients stayed overnight while enrolled in this program. Schedules included in the medical charts showed that the daily routine was from 8:00 AM to 9:00 PM and included breakfast, lunch, and dinner, and several group sessions. Four of the 14 ATS claims reviewed related to services rendered in this program.

2. *Intensive Outpatient Program (IOP)* - This program was also billed at $232 per day. The IOP followed a schedule similar to the ARC House except the patient did not stay overnight. Three of the 14 ATS claims reviewed related to services rendered in this program.

3. *Fresh Start* - This program was billed at $162.40 per day and was a 20 day program provided over 4 weeks. This program included patients who were stepped down from the ARC House Program or IOP. Three of the 14 ATS claims reviewed related to services rendered in this program.

4. *Outpatient* - This program was billed at either $60 per group counseling session or $70 per individual counseling session. This was an abstinence maintenance program. Patients in this program met with a therapist less frequently and in some cases were stepped down from the ARC House, IOP, or Fresh Start. Four of the 14 ATS claims reviewed related to services rendered in this program.

[3] Also referred to as Alcoholism Treatment Services.

SUMMARY OF 14 ATS CLAIMS REVIEWED		
	# of Claims	Total Charges
ATS/ Arc House	4	$5,000
ATS/ IOP	3	3,995
ATS/ Fresh Start	3	9,419
ATS/ Outpatient	4	1,080
TOTAL ATS Reviewed	14	$19,494

A common pattern with the patient charts that were reviewed was that patients were detoxified at JHBMC and then admitted to the Arc House or IOP program. Patients were then stepped down to the Fresh Start program and then to the Outpatient program. Based on the medical review, we determined that the services billed on all 14 of the ATS claims, totaling $19,494 in Medicare charges, were not adequately supported in the medical records.

The Arc House, IOP, and outpatient programs maintained attendance charts to document the patients attendance in group therapy sessions. However, even though the evidence showed the patients attended these programs, the documentation did not support the necessity of the services billed to Medicare. The group therapy sessions and the patient interactions were not described in sufficient detail.

The Fresh Start program did not maintain attendance charts. This program was a step down program for patients discharged from the Arc House and IOP programs. In each patient's chart, we found an agreement which was signed by the patient and represented that the patient agreed to attend the program for 20 days. However, we did not find evidence supporting the patient's attendance. The medical records provided did not contain evidence that services were rendered.

Billing of ATS Program

As discussed, the medical review results determined that all of the services on ATS claims were unallowable. However, we also noted problems related to the billing of this particular program track. First, JHBMC used an inappropriate revenue code to bill ATS services. The JHBMC used the same revenue code for all ATS claims. The definition of the revenue code used is

"Psychiatric/Psychological Treatments-General Classification." We could not determine why JHBMC used the inappropriate code.

Also, for the ATS Fresh Start program claims in our sample, Medicare was billed for 20 days of service at $162.40 per day. We found agreements signed by the patients upon admission to the Fresh Start program indicating that the Fresh Start program was a 20 day program. However, we did not find any evidence that the patients, whose claims were included in our sample, attended the program for 20 days. Our concern is that JHBMC automatically billed Medicare for 20 days every time a patient was admitted to the Fresh Start program.

JHBMC Comments

The JHBMC contended that:

1. *The OIG "medical review of the ATS claims was virtually non-existent."*

OIG Response

The ATS claims were subject to the same medical review as every other claim selected as part of our sample. A formal written conclusion for each of the 100 sampled claims, including the 14 ATS claims, was prepared by the medical reviewers and shared by OIG with JHBMC.

2. *The use of revenue code 900 instead of 944 or 945 has no impact on Medicare reimbursement.*

OIG Response

Improper coding of claims often results in a technical denial of the claim. JHBMC did not indicate why the revenue code 900 was used.

3. *The OIG mistakenly assumed that ATS type services were by definition not covered by Medicare.*

OIG Response

The ATS claims were denied by medical reviewers because the services billed on the claims were not supported by documentation contained in the patients' records.

4. *The ATS claims should not have been included in our sample.*

OIG Response

The JHBMC included the ATS claims in its FY 1997 outpatient psychiatric service claims, therefore, we included the ATS claims in the scope of our audit. All claims billed by JHBMC during FY 97 under outpatient psychiatric revenue billing codes had an equal chance of being selected. The ATS claims were included in this universe of psychiatric claims because that is how JHBMC identified them in its billing submissions.

CONCLUSION

During FY 1997, JHBMC was reimbursed $1,139,893 for 2,935 Medicare claims submitted to the FI totaling $1,558,231 in charges. We selected a statistical sample of 100 FY 1997 paid claims totaling $57,179 in charges and had the claims medically reviewed by a team of experts. The medical reviewers determined that 59 of the 100 claims sampled included unallowable services based on Medicare requirements.

Based on the results of the medical review, for the 100 claims in our sample, we calculated that $44,799 of the $57,179 in charges were unallowable. We used a variable appraisal program to estimate the dollar impact of unallowable charges to the total population. Based on our statistical sample, we estimate that JHBMC overstated the FY 1997 Medicare outpatient psychiatric charges by at least $957,458.

RECOMMENDATION

We recommended that JHBMC strengthen procedures to ensure that charges for outpatient psychiatric services are for covered services and are properly documented in accordance with Medicare requirements. We will provide the results of our audit to CareFirst, the FI, so that they can recover the estimated overpayment and also ensure that the FY 1997 Medicare cost report is updated to accurately reflect allowable Medicare charges for outpatient psychiatric services rendered.

JHBMC COMMENTS

Statistical Sampling Methodology

In summary, JHBMC believed that in light of the issues regarding sample size, lack of stratification and high tolerance level measurement, all of which JHBMC felt were in violation of "applicable guidelines" or "generally accepted principles and procedures," the estimated overpayments must be set aside and the audit findings must be applied only to the claims actually reviewed. Specifically JHBMC contends that:

1. ***The sample size of 100 claims was inadequate.*** The JHBMC stated that during FY 1997, CMS required a minimum sample size of 400 and OIG required a minimum of 200. The JHBMC contended that the sample is not a representative

sample due to the inadequate sample size and, therefore, concluded that the sample results can only be applied to the specific claims reviewed and not extrapolated to the universe of claims.

2. ***The sample should have been stratified.*** The JHBMC contended that the sample should have been stratified into at least three different strata based on the differences among the outpatient program tracts such as Variety Program, ATS, etc. Stratification was necessary, according to JHBMC, to "avoid an unacceptable level of precision."

3. ***The overpayment estimate did not "achieve the required tolerance level."*** The JHBMC stated that "the estimates did not achieve the required tolerance level, as measured by the estimated relative error." The JHBMC calculated that the estimated relative error for the OIG sample is too high, yielding an "unacceptable level of imprecision."

OIG RESPONSE

A statistically valid, very conservative, method was used to calculate the estimated overpayment of $957,458. If anything, it is possible that $957,458 understated the true amount of the overpayment. We agree that stratification might have reduced the margin of error for the point estimate. However, we did not use the point estimate of $1,314,841. Rather, we used the lower limit of a 90 percent confidence level which yielded a figure of $957,458. Therefore, the fact that we did not stratify may have worked to the advantage of JHBMC because stratification could have resulted in a lower confidence limit that was higher than $957,458. Although the sample did not yield a coefficient of variation as small as some might desire for an expression of uncertainty concerning the point estimate, $1,314,841, it was large enough to produce a valid and precise estimate of the standard error, the basic ingredient of the confidence interval estimate. The use of a sample size of 100 in no way makes the sample invalid. Our simple random sampling approach is unbiased and is as valid as a stratified approach. The use of the lower limit of a 90 percent confidence interval takes the sampling precision into account, and results in a conservative, statistically valid estimate. In reporting an estimated total overpayment of $957,458, one's confidence is 95 percent that the true total overpayment is at least as large as that figure. For most observers, 95 percent is a powerful and compelling level of confidence.

APPENDIX A

REVIEW OF
OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY
JOHN HOPKINS BAYVIEW MEDICAL CENTER
BALTIMORE, MARYLAND

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 2935 Claims	Items: 100 Claims	Items: 59
Dollars: $1,558,231	Dollars: $57,179	Dollars: $44,799

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: $1,314,841

Lower Limit: $957,458

Upper Limit: $1,672,224

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JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

MAR 15 2001

March 14, 2001

VIA FEDERAL EXPRESS

David M. Long, Regional Inspector General
for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
150 S. Independence Mall West, Suite 316
Philadelphia, Pennsylvania 19106-3499

Your Reference: Common Identification No. A-03-99-00012

Dear Mr. Long:

This letter is submitted on behalf of Johns Hopkins Bayview Medical Center in response to the draft report of the Office of Inspector General, Office of Audit Services ("OAS"), entitled "Review of Outpatient Psychiatric Services Provided by the Johns Hopkins Bayview Medical Center (JHBMC) During Fiscal Year (FY) 1997" ("Draft Report").

EXECUTIVE SUMMARY

The Draft Report is replete with factual inaccuracies; utilizes invalid statistical methodologies that, in some instances, are directly contrary to the requirements of the Medicare Program Integrity, Hospital, and Intermediary Manuals; makes erroneous conclusions of law; and, in some cases, arbitrarily disregards the findings of OAS' expert medical reviewers and substitutes, without explanation, the medical judgment of OAS' auditors. Accordingly, most of the claims that were disallowed by OAS were properly paid by the Medicare Program. Further, to the extent that OAS identified technical issues that would justify the disallowance of a small number of claims, because of fatal flaws in OAS' statistical methodology, only those claims may be disallowed and the results may not be extrapolated to the broader universe of claims submitted by JHBMC for the programs that were audited for FY 97.

In addition, the approach of the audit team to JHBMC during this audit and the wholesale denial of all claims for two of the five programs (seemingly without the benefit of a medical review) call into serious question the objectivity of the audit. Contrary to the conclusions reached in the Draft Report, the expert medical reviewer engaged by

JHBMC to review the claims included in OAS' sample concluded that "JHBMC operates excellent and thorough programs...to provide necessary services to seriously mentally ill patients" and that "[t]he documentation in the charts is generally excellent, thorough and timely". For these reasons, JHBMC respectfully requests that your office reconsider its draft audit findings in light of the comments and additional information provided herein.

1. BACKGROUND

JHBMC is a wholly-owned not-for-profit subsidiary of The Johns Hopkins Health System Corporation. It has no common parent entity with The Johns Hopkins University. Located in eastern Baltimore City, JHBMC is a separately licensed acute care hospital that provides a broad array of inpatient and outpatient services, including a variety of outpatient psychiatric programs. Five separate JHBMC outpatient psychiatric programs were subject to OAS review, to varying degrees, in the audit and Draft Report. These programs serve a very sick and vulnerable population of Baltimore area residents on a medical campus that provides intensive psychiatric services - a fact seemingly overlooked in the Draft Report.

Four of these outpatient psychiatric programs are operated under the auspices of the JHBMC Community Psychiatry Program. In order to provide a context for the discussion that follows, we are providing a brief overview of these programs below. A more detailed description may be found in Section 8 of this response.

The Variety Program provides a full range of psychiatric rehabilitation services to adults 55 and older. Priority for admission is given to patients who have a major mental illness, schizophrenia, bi-polar disorder, major depression, or psychotic disorder, and have had a history of inpatient psychiatric treatment. The Variety Program is a psychiatric rehabilitation program approved by the State of Maryland's Department of Health and Mental Hygiene (DHMH) pursuant to the Code of Maryland Regulations (COMAR) at section 10.21.16. The goal of the Variety Program is to promote an optimal level of functioning in order to maintain program patients in the community, as well as to prevent patients with long-term, chronic mental illnesses from deteriorating to a non-functioning level.

The Intensive Psychiatric Services Program (IPS) provides comprehensive psychiatric outpatient diagnostic and treatment services for patients in acute distress or in crisis experiencing increased symptoms. The goals of the IPS are to prevent further decompensation and avoid psychiatric hospitalizations by providing urgent and intensive treatment in a less restrictive setting. Services are provided by a multidisciplinary staff

comprised of a psychiatrist, a psychiatric nurse, two social workers and a mental health professional.

The Mental Illness and Substance Abuse Program (MISA) provides psychiatric and substance abuse services to adults who have a primary diagnosis of major mental illness; schizophrenia, bi-polar disorder, major depression, or psychotic disorder; and an active alcohol or substance abuse problem. Services are provided by a multidisciplinary team comprised of psychiatrists, social workers, mental health therapists, addiction counselors, and nurses.

The Adult Outpatient Program (AOP) at JHBMC provides comprehensive outpatient mental health services to adults 18 years of age and older. Services are provided by a multidisciplinary team comprised of psychiatrists, psychologists, psychiatric nurses, social workers, and mental health therapists. Patients having either a primary major mental health diagnosis (*e.g.*, schizophrenia, bi-polar disorder, major depression) or psychotic disorder and being discharged from a psychiatric facility are given priority for admission.

The fifth program included in the audit was Addiction Treatment Services (ATS), an administratively separate program providing treatment to patients with alcohol and/or drug addictions. ATS is a JHBMC Department of Psychiatry program offering a wide range of clinical services directed and supervised by full-time faculty members in the Department. The faculty responsible for directing the program include psychiatrists (ATS Medical Directors) and licensed clinical psychologists (ATS Director and Associate Directors). The program serves an ethnic, racial, socioeconomic, and clinically diverse population of people who share in common a moderate to severe substance use disorder. Admission is available to adults (*i.e.*, persons 18 years or older) seeking treatment for an alcohol or other drug use disorder.

2. AUDIT PROCESS

JHBMC believes that the audit team demonstrated a bias from the beginning of the audit that predetermined the outcome.

At the February 22, 1999, entrance conference, the audit team advised JHBMC that it would be hand-delivering a list of patients whose records would be audited and immediately thereafter would follow JHBMC staff charged with retrieving those records as they located the patients' charts. OAS staff offered the explanation that this process was intended to assure "the integrity of the patient record". OAS explained that records had been altered in other audits. JHBMC feels strongly that this behavior demonstrated a

bias and was inconsistent with the long-established approach employed by numerous other government agencies, including the Department of Health and Human Services, and by the federal courts. The implication that JHBMC could not be trusted to produce records without altering them clearly demonstrated a bias by the auditors. It was only after consultation with OIG legal counsel that the audit team reluctantly agreed to abandon this approach.

When it became apparent later in the process that OAS had concerns about the sampled claims, rising to the level that OAS believed whole categories of services were billed improperly, JHBMC did not have an opportunity to respond to these concerns meaningfully. In fact, OAS cancelled the exit conference that had been scheduled for November 15, 1999. When this meeting was rescheduled almost three months later, there was no substantive discussion of the issues arising from the audit. JHBMC continues to believe that many of the concerns expressed in the Draft Report could have been ameliorated if JHBMC and OAS had established better lines of communication. JHBMC continues to be willing to establish a dialogue with OAS that will result in reasoned conclusions that are reflective of the actual situation with respect to the five programs being reviewed.

3. OAS Applied Invalid Statistical Sampling and Extrapolation Methods

JHBMC believes it is undisputed that (i) the government may apply appropriate statistical methods in estimating overpayments and (ii) providers may challenge the statistical validity of the government's sampling and extrapolation methodology. *See* HCFA Ruling 86-1 "Use of Statistical Sampling to Project Overpayments to Medicare Providers and Suppliers" (February 20, 1986). The HCFA Ruling further provided expressly for the right of a provider to appeal overpayment determinations by challenging the statistical validity of the sample and/or the correctness of the determination in specific cases identified in the sample. This ruling was reaffirmed in *Chaves County Home Health Services, Inc. v. Sullivan*, 931 F.2d 914, 916 (D.C. Cir. 1991), *cert. denied*, 502 U.S. 1091 (1992). These authorities make it clear that the application of faulty statistical methods in determining overpayments results in a deprivation of due process. JHBMC asserts that the statistical approaches in this audit were sufficiently flawed in several key respects, including but not limited to those issues outlined immediately below, to deprive it of due process if they were to be applied to calculate overpayments for all FY 97 claims submitted by JHBMC to Medicare for the audited programs.

Inadequate Sample Size

The sample size of 100 claims used by OAS complies with neither HCFA criteria nor generally accepted statistical principles and procedures.

According to the HCFA "Sampling Guidelines Appendix" of the Medicare Carriers Manual[1] governing sample size requirements, a sample of 400 would be required in a case such as this, in which stratification was not used and the expected overpayment would be $25,000 or more. In addition, under OAS "Audit Policies and Procedures" applicable during the time in question, at least 200 sampling units (claims) are usually necessary "to assure that a sufficient number of items exist in the sample with the desired characteristics." OAS Audit Policies and Procedures, 20-02-50-05, p. 9.

It does not appear that OAS used a sample size estimator program which would have allowed a determination of the proper sample size. Failure to use such a program constitutes another shortcoming in OAS' statistical procedures. JHBMC recognizes that HCFA has modified certain Manual provisions in recent years, in an apparent effort to provide support for the use of smaller samples (*e.g.*, 100 claims). However, the recent revisions to HCFA's manual provisions were not in effect during the audit year, nor do they obviate the underlying requirement that the government's sampling and extrapolation methodologies be *statistically valid.*

JHBMC has retained the services of a nationally-recognized expert in statistics to review the methodologies utilized in this audit. This expert's preliminary review confirms the invalidity of the sampling and extrapolation methods applied in the review. In addition to the shortcomings noted above, JHBMC's expert has concluded that the sample size was not large enough to achieve the required level of precision according to standard references on sampling, which reflect generally accepted statistical principles. In the context of the requirement of the *Chaves* case that various statistical approaches are permitted "so long as the extrapolation is made from a representative sample and is statistically significant," JHBMC's expert has concluded that the sampling in this instance violates many of the government's own standards and, further, does not reflect generally accepted minimum requirements for statistical principles and procedures. Because the review utilized these faulty sampling techniques, it is not a "representative sample" and any extrapolation using such a sample is therefore fundamentally flawed.

[1] HCFA has recently "obsoleted" this Appendix, by virtue of a Program Memorandum dated January 8, 2001. But see, Section 2229B of the Intermediary Manual which specifically references the Sampling Guidelines Appendix and cites with approval three standard texts on the subject. Plainly, the Appendix was still in force at the time the audit in question was conducted.

Accordingly, the results of this audit only may be applied to the specific claims included in the sample and may not be extrapolated to the broader universe of claims for FY 97.

Lack of Stratification

Where the universe of claims is heterogeneous, *i.e.*, where diverse types of services or claims are included, improper results may occur if the universe is not stratified into sub-groups. In the case of these five programs, the claims were heterogeneous and OAS used a simple random sample rather than one that was stratified according to types of claims, total charges, or any other factor. There is no evidence that OAS made *any* effort to determine whether, and how, the sample should have been stratified. JHBMC submits that stratification of this heterogeneous universe of claims might have significantly improved the precision of the resulting estimates, which are not at acceptable levels (as explained in more detail below).

In this case, the simple random sample employed by OAS failed to take into account the qualitative differences among the services and programs captured in the sample. The five outpatient tracks identified in the Draft Report's "Summary of Sampled Claims" (discussed in detail below) immediately suggest that the heterogeneous sample should have been stratified in accordance with these different tracks. As is plain from the program summaries set forth below, the Medicare beneficiaries involved in the sample were not similarly situated with respect to services, diagnosis, location, etc. While five or more strata may have been appropriate, a *minimum* of three strata were required in order to avoid an unacceptable level of imprecision. The Variety Program, regulated under Maryland law as a "psychiatric rehabilitation" program, represents one such distinct sub-group of services. It is even more obvious that the ATS claims required stratification. These services were provided to patients with a different primary diagnosis. ATS was administered separately from the other community psychiatry programs and employed a separate clinical staff. Equally significant is the fact that the ATS claims involve, on average, much larger dollar amounts. Given the higher average value of the ATS claims, any audit errors relating to such claims will have a disproportionate impact on the overpayment calculation. This is true both with respect to claim-by-claim determinations as to the allowability of the services, as well as error resulting from the failure to stratify the ATS claims.[2]

[2] This discussion assumes that it was proper to include ATS services, in some fashion, in the present audit. As discussed below, JHBMC's primary contention in this regard is that inclusion of ATS in the sample was improper *per se*.

After it has been determined that stratification is appropriate, the sample must be constructed so that each stratum contains a statistically appropriate number of claims. As the Medicare Program Integrity Manual indicates at § 5.3.2.2:

> "For stratified random sampling, the recommended minimum sample size is 100 sampling units [claims] with a minimum of 30 sampling units per stratum." (Emphasis added).

Accordingly, it is clear that the ATS and Variety Program claims were heterogeneous and should have been stratified, and that the groups of ATS and Variety claims in the sample do not contain enough units to satisfy the government's own standards.

The Estimates Did Not Achieve the Required Tolerance Level, As Measured by the Estimated Relative Error

It is undisputed that in any statistical study, tolerance levels must be met to ensure confidence in the results. The "estimated relative error," which is the ratio of the standard error to the mean of the estimated overpayment (also termed the "co-efficient of variation"), is a measure of the accuracy or inaccuracy of the estimates. While the most recent HCFA pronouncements are silent on this point, HCFA guidelines historically required the estimated relative error to have a "tolerance level" not exceeding 12% for a non-stratified sample of 100 claims. It is important to note that standard statistical references on sampling dictate an even lower value of 8% to be an acceptable tolerance level.[3] JHBMC believes that no analyses of any nature were performed by OAS with respect to either the standard deviation or the estimated relative error for this sample. However, using information JHBMC obtained from OAS, JHBMC's expert has calculated an estimated relative error in this instance of more than 16%, which would be an unacceptably high level of imprecision, particularly for a study involving such a large population and such significant payments.

[3] Hansen, Hurwitz and Madow, "Sample Methods and Theory", New York: John Wiley and Sons, 1953. Note that this text is cited as authoritative in both the Intermediary Manual and the Program Integrity Manual.

In summary, because the statistical sampling procedures used in this audit were not in compliance with applicable guidelines or with generally accepted statistical principles and procedures, the resulting overpayment extrapolation is not statistically valid. The methodological flaws are so significant that the estimated overpayment of $957,458 must be set aside and the audit findings be applied only to the claims actually reviewed.

4. APPLICABLE LAWS, REGULATIONS AND POLICIES

The Draft Report cites only minimal regulatory authority in support of its findings. The principal authority relied upon appears to be the Medicare Intermediary Manual, § 3112.7. JHBMC contends, as more fully explained below, that the large majority of services at issue satisfy the coverage criteria set forth in this Manual provision, as well as other applicable standards published in Medicare regulations and manuals. JHBMC further notes that the services in question were provided, and documented, in accordance with applicable JCAHO and state survey standards.

Because of the absence of specific regulatory support for the audit findings, it is sometimes difficult to ascertain the standard of review actually applied to the claims in question. Nevertheless, it seems clear that OAS applied different standards of claims review than those that were in effect during the audit period. Accordingly, the bulk of the adverse findings should be rejected for the additional reason that they constitute an improper retroactive application of a reimbursement standard.

Moreover, Medicare intermediaries are authorized to establish their own medical review policies for specific types of services. It is undisputed that JHBMC's Intermediary has never promulgated such a written policy applicable to outpatient psychiatric services. In addition, JHBMC's Intermediary has on numerous occasions in the past reviewed the types of services at issue in this audit, and has never raised issues as to the medical necessity of the services or the related documentation. (The Intermediary's position concerning the applicable standard of review is discussed in more detail below.)

Review by Delmarva

Delmarva Foundation for Medical Care, Inc. ("Delmarva") is the Peer Review Organization for the State of Maryland. Delmarva assisted OAS in its review of JHBMC's Hospital Outpatient Psychiatric Services. Peer Review Organizations are authorized under the Medicare statute to enter into contracts with the Secretary of the Department of Health and Human Services to review professional activities of providers

in the provision of health care services for which payment may be made under Medicare. 42 U.S.C.A. § 1320c-3.

In its report to OAS, Delmarva stated that "[t]he focus of the review was to determine if the provision of services was in accordance with Medicare requirements, *according to the Local Medical Review Policy employed by the Fiscal Intermediary.*" (Emphasis added.) (Delmarva Report, p. 1.) Although the Intermediary had never issued in writing a defined local medical review policy specific to outpatient psychiatric services, when Delmarva attempted to conduct its review in accordance with the policy that the Intermediary had established by *actual practice* in the past, it was arbitrarily directed by OAS to use a standard that was more stringent, and without a basis in law or policy, resulting in inappropriate determinations that some claims should be denied.

According to a memorandum dated August 4, 1999 from Jack Kahriger, OAS Senior Auditor, to David Long, Regional Inspector General for Audit Services, there was a "lack of a clearly defined local medical review policy covering outpatient psychiatric services." (Kahriger Memorandum, p. 2.) In fact, Delmarva specifically acknowledged the related problems in its August 13, 1999, letter to Mr. Kahriger, stating that "(f)urther discussion is needed regarding what documentation should be considered in determining the review outcomes. . . . Written instructions clarifying documentation requirements necessary for the review determination process would provide consistency as these reviews are performed in other projects." Thus, it is plain that Delmarva believed that the review process was impaired by virtue of the absence of clear written policy.

Apparently, the lack of a "clearly defined local medical review policy" prompted the OIG to meet with the Intermediary and Delmarva. This meeting was held to discuss the Intermediary's and Delmarva's acceptance of what OAS has sometimes referred to as "clump notes"[4] as appropriate documentation for the services rendered. The minutes of the meeting were documented in Mr. Kahriger's August 4, 1999 memorandum to David Long. According to the memorandum, Dottie Sewell (Intermediary) stated that "if the note was comprehensive enough then the FI would pay the claim . . . the FI wants to pay claims and does not necessarily look for reasons not to pay." (Kahriger Memorandum, p. 3.) Donna Horsey (Delmarva) stated that "in her opinion the monthly notes were comprehensive enough to support the services billed." (Kahriger Memorandum, p. 3.) Despite the fact that both the Intermediary and Delmarva had reviewed the claims and

[4] The term "clump notes" appears to be a characterization of periodic progress notes summarizing a patient's participation in groups and services authorized under his or her treatment plan, and noting any relevant change in the patient's status. This term seems pejorative and is in any event not used or otherwise endorsed by JHBMC.

found the monthly notes acceptable, apparently applying the unwritten Local Medical Review Policy, the Draft Report indicated that monthly notes were *not* acceptable, reflecting a medical review standard at odds with this unwritten standard, *i.e.*, the standard previously accepted by the Intermediary and the Peer Review Organization.

This method of documentation was accepted by JHBMC's Intermediary for many years, and JHBMC reasonably relied upon the Intermediary's favorable treatment of claims based on monthly progress notes. Accordingly, this documentation method is in fact consistent with the unwritten Local Medical Review Policy employed by the Intermediary.

Additionally, the review process described by Delmarva in its final report to OAS was inconsistent with the review as presented in the audit record (Delmarva's individual case summary reports). The Draft Report states that the 100 sample claims "were reviewed by a team of medical experts who determined that 59 of the 100 sample claims included unallowable services . . . [and that these claims] contained 570 units of service of which 443 units (78%) were denied by medical reviewers." Draft Report, p. 3. In other words, OAS takes the position that the denials are based solely on the conclusions of the medical reviewers. The audit records tell a different story.

In its report to OAS, Delmarva described the review process as follows:

> The initial review screen was performed by Registered Nurses. . . . All cases which failed the initial screen, that is, obtained a finding other than "1" (services allowable, reasonable, necessary, supported by the medical record) were reviewed by DFMC Expert Reviewers, who are licensed, practicing psychiatrists. (Delmarva Report, p. 5.)

In many instances, it appears that the findings of the expert medical reviewers were actually overruled by the auditors. In numerous other cases, the reviewers were not permitted to utilize their expertise in performing their review, but rather were required to apply a documentation standard dictated by OAS that is unsupported by applicable Medicare provisions. In the case of ATS, the audit records do not indicate *any* expert review, although *all* of the claims were denied. No explanation has been offered by OAS for its decision to substitute its own "medical" judgment for the medical judgment of its expert reviewers.

5. MEDICARE STANDARDS FOR DOCUMENTATION

Both the Intermediary Manual and the Hospital Manual contain coverage provisions for outpatient hospital psychiatric services. Section 230.5 of the Hospital Manual and § 3112.7 of the Intermediary Manual require that outpatient psychiatric services meet the following criteria: (a) individualized treatment plan; (b) physician supervision and evaluation; and (c) reasonable expectation of improvement. These criteria must be supported by documentation. Specifically, these manual provisions require the physician to provide a written plan of treatment stating "the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals." In addition, entries in the medical record must support the physician's involvement, including "periodic consultation and conference with therapists and staff, review of medical records and patient interviews."

Section 3920 of the Intermediary Manual[5] sets forth guidelines for hospital outpatient services in the context of a medical review. These guidelines instruct the Intermediary to look at particular items that should be included in the supporting documentation to support a claim for outpatient psychiatric services. The manual states: "medical documentation may include, but is not limited to, daily outpatient logs, activity checklists, case management, nurse's, therapist's, and physician's notes". The "checklist" for documentation requirements includes: (a) facility and patient identification; (b) physician referral and date; (c) date of last certification; (d) diagnosis; (e) duration of services; (f) number of visits; (g) date of onset; (h) date treatment started; (i) billing period; (j) medical history; (k) initial evaluation and date; (l) plan of treatment and date established ("should include specific goals and a reasonable estimate of when they are expected to be reached; includes specific therapies, *e.g.*, creative art, music movement, recreation therapy"); (m) physician progress notes ("should provide information on periodic evaluations, consultation, conferences with staff, and patient interviews"); and (n) medical record notes (should include a discussion of the individual's symptoms and present behavior).

The Medical Records, Viewed in Their Entirety, Satisfied Applicable Standards

As noted above, there are few *specific* standards applicable to medical record documentation for outpatient psychiatric services. The requirements of Intermediary Manual § 3112.7 and Hospital Manual § 230.5 pertaining to individual treatment plans

[5] This section was removed from the Intermediary Manual in June of 2000 and placed in the Program Integrity Manual at section 11.1.9 in September of 2000.

and physician oversight, have been discussed above. These manual provisions also set forth a general requirement that the documentation in the record be sufficient to permit a reviewing physician to evaluate the patient's status and make decisions concerning the ongoing course of treatment. These provisions make it quite clear that the medical records should be reviewed holistically.

In this case, OAS has attempted to apply documentation standards that are set forth nowhere in applicable provisions of Medicare regulations and manuals. This is particularly problematic with respect to the Draft Report's position (and the standard of review imposed upon Delmarva) that a detailed progress note is required in each instance of an outpatient encounter. OAS' position is rendered invalid by the absence of a written local medical review policy notifying providers of any additional standards applicable to the types of services at issue, and the actual local review policy established by practice by the Intermediary.

6. REVIEW BY OTHER GOVERNMENT AGENCIES

All five of the program tracks included in this review are subject to regular reviews by the Maryland Department of Health and Mental Hygiene's Office of Health Care Quality (OHCQ) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) on a three-year cycle. JHBMC's Community Psychiatric Programs were surveyed by the Department of Health and Mental Hygiene Office of Licensing and Certification Programs (OLCP) in May of 1994.[6] As a result of the survey, the programs were granted general approval for a period of two years. This approval period was later extended until January of 1998. In no instance have these surveys identified any problems relating to the quality and appropriateness of the services offered through these programs.[7] The 1994 survey revealed documentation for the surveyed programs to be timely, complete and accurate. (*See* additional discussion of Variety Program surveys below.)

[6] The approval letter pertaining to this survey refers to the Francis Scott Key Medical Center, the former name of JHBMC. As of 1996, Francis Scott Key had been part of the Johns Hopkins System for ten years.

[7] ATS is, like the other four programs, subject to both OHCQ and JCAHO review. However, because of the inherent differences between ATS and the other programs, ATS is reviewed by different survey teams. This is one more clear illustration of the inappropriateness of OAS's decision to include ATS in the sample. *See* discussion below.

7. OAS REVIEW OF JHBMC OUTPATIENT PSYCHIATRIC SERVICES

Summary of OAS Claim Denials

The Draft Report indicates that 58 out of 100 claims in the sample contained one or more units of service purported to be non-allowable.[8] OAS has further found that 443 of the 570 (78%) total units of service within the 100 claims are non-allowable. The vast majority of the denials were based on allegedly inadequate documentation.[9] OAS identified four units of service for which there was allegedly "no documentation" that the services were provided. Finally, two claims involving a total of 34 units of service were denied as lacking "medical necessity." As the comments set forth below will demonstrate, OAS' findings are riddled with inaccuracies and inconsistencies, and are not supported by any defined Medicare standards applicable to the services at issue or, in many instances, the views of OAS' medical reviewers (Delmarva).

It also is significant that OAS has proposed the disallowance of 100% of the claims relating to the Variety Program and ATS. Although this result is purported to be the outcome of a "medical review" process, it in fact represents a *categorical* rejection by OAS of the services offered through these two programs, and as such amounts to a nullification of the medical review process.

Review of Outside Expert

JHBMC engaged an outside medical expert to review the claims in the sample. JHBMC's medical expert was asked to determine whether the services at issue were reasonable and necessary for the diagnosis or treatment of a patient's condition, in accordance with applicable standards, and whether the services were adequately documented in the medical record. JHBMC's expert found that, in most instances, the services were both medically necessary and adequately documented.

In general, the expert found the patient records to contain detailed and thorough documentation, reflecting a staff that clearly remains connected to patients and does excellent follow-up after patients have left the program. JHBMC's expert consistently found sufficient clinical information to justify the claims, noting that in many instances

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[8] The Draft Report stated that 59 of the 100 sample claims included "unallowable" services; however, JHBMC believes that the supplemental schedules provided by OAS reflect only 58 such claims.

[9] Although inadequate documentation is the stated basis for OAS denial of 100% of the ATS claims, the records relating to the audit suggest that the ATS claims may have been denied for other reasons, as discussed more fully below.

critical information was found in different areas such as progress notes, group service notes, and occupational therapy sheets. The expert emphasized that the use of periodic progress notes ("clump notes" in OAS' terminology) used to summarize multiple patient visits was appropriate for patients with long-term and chronic conditions. The expert found that in many instances Delmarva seemed to focus on minor inconsistencies (*e.g.*, obvious errors regarding a date of service which is explained by review of the entire record). The expert disagreed with Delmarva's finding of lack of medical necessity in most instances, and noted that medical necessity was adequately documented based on diagnosis, history, current symptoms, treatment plan and medications. Overall, JHBMC's expert found the quality of the JHBMC's programs excellent and the documentation in the charts generally accurate, thorough, and timely.

8. PROGRAM DESCRIPTIONS AND PROGRAM-SPECIFIC ISSUES

As part of the process of addressing OAS' more specific adverse findings, relating to particular categories of audited services, JHBMC believes it will be helpful to set forth detailed descriptions of the programs under review. These descriptions will provide a useful context in which to review the services at issue. This context becomes important in light of the Draft Report's tendency to minimize the "medical" aspects of JHBMC's outpatient programs.

Variety Psychiatric Rehabilitation Program ("Variety Program")

The Variety Program provides[10] a full range of psychiatric rehabilitation services to adults 55 and older. Priority for admission is given to patients who have a major mental illness, schizophrenia, bi-polar disorder, major depression, or psychotic disorder, and have had a history of inpatient psychiatric treatment.

The Variety Program at JHBMC is a psychiatric rehabilitation program approved by DHMH pursuant to COMAR 10.21.16. JHBMC's Variety Program is routinely surveyed by DHMH and received full approval from the DHMH OLCP in March of 1994. This approval remained effective through the audit period.

The goal of the Variety Program is to promote an optimal level of functioning in order to maintain program participants in the community, as well as to prevent participants with long-term, chronic mental illness from deteriorating to a non-functioning level. Services are provided by a multi-disciplinary team comprised of a

[10] JHBMC notes that the present tense is used for editorial consistency. The services at issue were provided in 1996-97 and the program descriptions summarize them as they existed at that time.

psychiatrist, social worker, rehabilitation therapists and a clinical supervisor. The psychiatrist is Board-certified or Board-eligible and is credentialed through the Medical Center. All other mental health professionals are credentialed through the Community Psychiatric Program and comply with licensure and/or certification requirements.

All patients must have an outpatient mental health provider prior to being accepted into the Program. All referrals are screened for medical necessity. Upon entry into this program, patients receive a comprehensive rehabilitation assessment in which their strengths, skills, and needs are assessed in the following areas:

a. Independent living,

b. Self administration and management of medications,

c. Housing,

d. Mobility,

e. Social relationships, recreational activities, social support,

f. Activities of daily living.

Each patient meets with the Program psychiatrist, who determines the appropriateness of rehabilitation services. An admission decision is made by the psychiatrist and documented in the chart. If accepted into the program, based upon the needs identified in the evaluation and under the direction and supervision of the psychiatrist, an individualized rehabilitation plan is developed with each patient. The rehabilitation plan addresses the patient's functional needs/problems, strengths, and goals. The rehabilitation plan specifies the type, amount and frequency of the services provided. The services provided by the Variety Program and required under Maryland regulations at COMAR 10.21.21.06 include:

a. Rehabilitation activities directed toward the development, restoration, or maintenance of independent living skills including: self care skills, social skills, and independent living skills.

b. Medication services including monitoring the ability of the patient to self-administer medications.

c. Health Promotion and Training including providing basic instruction and training. Training is provided in nutrition, exercise, dental care, substance abuse prevention, and prevention of injury and illness in the home and in the community.

d. Crisis services.

e. Case management/access to necessary entitlements.

f. Development, coordination, and maintenance of a social support system by the patient in order to maintain independent community functioning.

Each patient's progress in achieving his/her rehabilitation goals is routinely reviewed by the psychiatrist, the rehabilitation team, and the patient. Services are modified in response to the changing needs of the patient, and such modifications are reflected in the medical record.

By providing structured rehabilitation services, Variety Program patients are able to maintain their independence and autonomy in the community, thus minimizing the possibility of recurrent hospitalizations caused by a deterioration of functional abilities. Group activities are an important part of this structure and are therapeutically critical in preventing deterioration in the status of these patients, many of whom are schizophrenic or chronically depressed. This approach is consistent with Medicare coverage provisions authorizing psychiatric services for patients with chronic conditions when "control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement." Intermediary Manual § 3112.7B.3. The provision of activities for these patients is also consistent with Medicare coverage rules, in that the activities are "essential" for treating the patient's condition and are not *primarily* recreational or diversional in nature. *Id.* at §§ 3112.7D.1.e. and 2.b. The audit report is directly in conflict with this position and concludes, without explanation, that the Variety Program services were in fact "primarily recreational or diversional." A more careful consideration of the Variety Program services belies such a conclusion.

Additional State Regulatory Oversight

The State of Maryland regulates Psychiatric Rehabilitation programs under the Maryland Code of Regulations at Title 10, Subtitle 21 (COMAR 10.21. *et seq.*). The Variety Program at JHBMC has been surveyed and approved by the Maryland Department of Health and Mental Hygiene. These regulations set forth the types of rehabilitation and support services provided in these programs, including: (1) rehabilitation activities (self-care, social and independent living skills); (2) medication services (administration and monitoring); (3) health promotion and training (nutrition, exercise, dental care, substance abuse prevention and prevention of injury and illness at home and in the community); (4) crisis services; and (5) emergency care. (*See* COMAR 10.21.21.06.) The regulations require the program director to "[f]acilitate the development of an individual's independent living and social skills" and to "[p]romote the use of community resources to integrate the individual into the community."

COMAR 10.21.21.04. For each patient, the program must include a physical examination, rehabilitation assessment, individual rehabilitation plan, and continuing evaluation. COMAR 21.21.21.05.

Documentation requirements for services provided under these state-approved programs include: (1) contact notes (notes documenting "all relevant contacts with or about the individual, including the dates, locations and types of contacts"); and (2) progress summary notes ("at a minimum, each month the rehabilitation coordinator shall record in the individual's medical record a progress summary note regarding: (a) the delivery of services; (b) changes in the individual's status; and (c) suggested changes in rehabilitation goals and services delivered."). COMAR 10.21.21.05.D. JHBMC has consistently met the standards set forth under Maryland's regulations and its psychiatric rehabilitation programs have been continuously approved by the state since the mid-1980s. The relevant survey records were provided to OAS during the audit, but have apparently been ignored.

Given the absence of specific Medicare standards, at either the national or the local level, OAS should have given consideration to the state survey history instead of going out of its way to refer several times in the Draft Report to "bingo-playing." This appears to be an effort to trivialize some of the therapeutic activities offered to Variety Program patients. It is significant that Maryland Medicaid reimbursed these services throughout the period in question. Medicaid, like Medicare, does not cover services which are completely social or recreational in nature. Medicaid relied on the State licensing and survey process to confirm that the Variety Program's services were *medical* in nature, not merely social or recreational.

Variety Program Denials

The Variety Program claims included in the audit sample were denied in their entirety. Although the Draft Report cites documentation issues as the basis for denials for all but two claims, JHBMC contends that the denials were more likely based upon an OAS bias against this program. Throughout the audit process and the audit record, OAS alluded to the recreational nature of Variety Program services in a context suggesting that these types of services are not covered by Medicare.

The use of so-called "clump notes" is the most prevalent reason for denials appearing in the case summaries. JHBMC contends that not only are these periodic progress notes permitted under Medicare guidelines, they are particularly appropriate for this type of service. Patients in the Variety Program are an extremely vulnerable population with severe and chronic mental illness. Most patients are not expected to ever

reach a normal level of functioning. Instead, the program is designed to provide services that increase – or in some cases, simply maintain – the patient's ability to function at home and in the community. Typically, these goals are long-term and in some instances, may simply be to prevent the patient's condition from deteriorating to a point where an inpatient hospital admission is necessary. The use of periodic progress notes to document a patient's progress, then, is a method of documentation suitable to the progressive and long-term nature of the Variety Program course of treatment. Furthermore, JHBMC's intermediary was familiar with and accepted this method of documentation.

Another frequently cited reason for denial of Variety Program claims is the use of CPT Code 90853 code (individual group psychotherapy led by a physician). Again, JHBMC contends that the use of this code is appropriate for the reasons stated below.

The Draft Report contains the following statement, at p. 7:

> We also found that the billing documents included the wrong CPT code. The CPT code listed indicates the group therapy service was rendered by a physician.

The CPT Code referred to by OAS in this instance is 90853, which, according to OAS, describes a service of group therapy 'by a physician.' Because the medical records did not indicate that the Variety Program groups were led by physicians (as opposed to other clinicians), OAS concluded that the services were billed erroneously based on the above-quoted CPT reference. Delmarva applied the same rationale in a number of instances in recommending that services be disallowed whenever the 90853 and 90841 (*see* discussion below concerning AOP claims) codes were used and the medical record indicated that the services were rendered by a professional other than a physician.

OAS' conclusion concerning the CPT Code is another example of its failure to correctly consider the provisions applicable to hospital-based outpatient psychiatric services. OAS and Delmarva overlooked the specific direction of the Medicare Hospital Manual in this regard. The Manual states, at § 442.7:

> HCPCS codes for diagnostic services and medical services. – The following instructions apply to reporting medical and additional diagnostic services other than radiology . . . These reporting requirements apply to hospital services provided in clinics, emergency departments, and other outpatient departments. . . . In most cases, CPT-4 codes are used to code hospital services. . . .

> CPT-4 codes are used by physicians to report physician services, and do not necessarily reflect the technical component of a service furnished by the hospital. Therefore, ignore any wording in the CPT-4 codes that indicates that the service must be performed by a physician. (Emphasis added.)

CPT Code 90853, when used by a hospital outpatient department, is therefore not conditioned upon the performance of the service by a physician. Once again, it appears that OAS was all too willing to disallow claims without a complete and careful consideration of the circumstances.

Finally, many of the Variety Program claims were denied without physician review (12 of 22 claims received a reason code of "2" without any indication of further review by the expert reviewer). Three of the denied Variety Program claims received a response from the expert reviewer that appeared inconsistent with the ultimate conclusion by Delmarva and denial by OAS. JHBMC believes that the audit findings must be reconsidered to take into consideration the information set forth above.

Intensive Psychiatric Services Program ("IPS")

IPS provides comprehensive psychiatric outpatient diagnostic and treatment services for patients in acute distress or in crisis experiencing increased symptoms. The goals of the IPS are to prevent further decompensation and avoid psychiatric hospitalizations by providing urgent and intensive treatment in a less restrictive setting.

Services are provided by a multidisciplinary staff comprised of a psychiatrist, a psychiatric nurse, two social workers and a mental health professional. The psychiatrist is Board certified and credentialed by the Medical Center. All other mental health professionals are credentialed through the Community Psychiatry Program and comply with licensure and/or certification requirements.

Upon entry into the IPS program, each patient sees a psychiatrist and receives a comprehensive psychiatric evaluation. Each patient is assigned an individual master's level therapist. The patient is exposed to see a therapist daily and sees the psychiatrist two or more times each week. Patients may be scheduled for four to twenty hours of treatment per week.

Based upon the needs identified in the evaluation and under the direction and supervision of the psychiatrist, an individualized treatment plan is developed with the patient. The treatment plan identifies the patient's diagnosis and treatment goals, and

outlines the type, amount, frequency and duration of services to be provided. Services provided by IPS include: crisis intervention for rapid stabilization, individual therapy, group therapy, medication management and monitoring, illness education, stress management, service coordination, aftercare planning, and referral. Each patient's progress is regularly reviewed by the psychiatrist. Treatment is modified as the patient progresses towards discharge. Any treatment modifications are noted in the medical record.

IPS Denials

Of the four IPS claims included in the audit sample, 2 claims for 26 units of service were denied. (Draft Report, p. 6). The Draft Report states, "one claim for which the documentation provided was not adequate to support that the services were rendered. The medical reviewers found twenty-three services totaling $1,550 were billed for this claim. They found twenty-one services totaling $1,510 were unallowable." (Draft Report, p. 6.) The case summary created by Delmarva, however, indicates that the "expert" reviewer found both medical necessity and adequate documentation for these services. The expert reviewer's response stated, "the patient needed day hospital treatment for the period in question and documentation supports the medical necessity for the services provided." Notwithstanding the conclusions of Delmarva's expert physician reviewer, the Delmarva report stated, "even though the expert reviewer has determined medical necessity of the services rendered, there is inadequate documentation to determine that the patient received the services billed." (Delmarva Case Summary, Claim 85.) We believe that this is a conclusion that is contrary to the evidence in the record and must be reversed.

Mental Illness and Substance Abuse ("MISA")

MISA provides psychiatric and substance abuse services to adults who have a primary diagnosis of major mental illness; schizophrenia, bi-polar disorder, major depression, or psychotic disorder; and an active alcohol or substance abuse problem. Services are provided by a multidisciplinary team comprised of psychiatrists, social workers, mental health therapists, addiction counselors, and nurses. All psychiatrists are Board-certified or Board-eligible and are credentialed through the Medical Center. All other mental health professionals are credentialed through the Community Psychiatry Program and comply with licensure and/or certification requirements.

Upon entry into MISA, each patient sees a psychiatrist and receives a comprehensive psychiatric evaluation. Based upon the needs identified in the evaluation and under the direction and supervision of the psychiatrist, an individualized treatment

plan is developed with each patient. The treatment plan identifies the patient's diagnosis and treatment goals, and outlines the type, amount, frequency and duration of services to be provided. The MISA program is able to coordinate services to treat both the psychiatric and substance abuse disorders. Services offered include: individual therapy, medication management, group therapy, illness education, and case management. Random urine tests and breathalyzer tests are also performed. The MISA program coordinates its treatment efforts with rehabilitation services to improve each patient's level of functioning.

Periodically, each patient's progress will be evaluated by the psychiatrist and the other members of the treatment team. Services may be intensified if patients' experience decompensation. Any treatment modifications are noted in the medical record.

MISA Denial

Of the three MISA claims included in the audit, only one claim (for 18 services) was denied. The Draft Report stated that this claim "was unallowable because the documentation supporting the therapies was inadequate." (Draft Report, p. 7). Again, Delmarva's final report appeared to be at odds with its own expert physician reviewer who found, "medical necessity criteria is met for each of the services of group therapy." (Delmarva Case Summary, Claim 50.) Thus, we believe that this conclusion is contrary to the evidence in the record and must be reversed.

Adult Outpatient Program ("AOP")

The AOP at the JHBMC provides comprehensive outpatient mental health services to adults 18 years of age and older. Services are provided by a multidisciplinary team comprised of psychiatrists, psychologists, psychiatric nurses, social workers, and mental health therapists. All psychiatrists are Board certified or Board eligible and are credentialed through the Medical Center. All mental health professionals are credentialed through the Community Psychiatry Program and comply with licensure and/or certification requirements.

Patients having either a primary major mental health diagnosis: schizophrenia, bi-polar disorder, major depression or psychotic disorder, and being discharged from a psychiatric facility are given priority for admission. Upon entry into the program, each patient sees a psychiatrist and receives a comprehensive psychiatric evaluation. Based upon the needs identified in the evaluation and under the direction and supervision of the physician, an individualized treatment plan is developed in collaboration with the patient. The treatment plan identifies the patient's diagnosis and treatment goals, and outlines the

type, amount, frequency and duration of services to be provided. Services provided by the Program included: individual psychotherapy; marital, family and group therapy; and prescribing medications, if indicated. Periodically, a patient's progress will be reviewed by the physician and other members of the treatment team. Services will be modified and changed in response to the changing needs of the patient. Any treatment modifications are noted in the medical record.

AOP Denials

Delmarva's Case Summaries for the denied AOP claims reveal that (a) the patients' diagnoses support the medical necessity for treatment; (b) individualized treatment plans were authorized by the physician and kept up to date; and (c) the record was supported by progress notes and contact/attendance sheets. Routinely, these records noted any change in the patient's condition and subsequent changes to the patient's individualized treatment plan. The Delmarva review frequently noted physician signatures on the treatment plans, and did not appear to find fault with physician supervision and evaluation of the patient's treatment. Nevertheless, most of the 20 denied AOP claims were denied on the basis of either "no documentation" or insufficient documentation.

In many cases, the denials were based on the use of the CPT Code 90841, which refers to individual therapy services "by a physician." As noted above in the discussion of the Variety Program denials, the use of this code to describe individual therapy services with health care professionals other than physicians is accurate in the outpatient hospital setting and therefore does not preclude Medicare payment.

Despite the fact that the Delmarva review process, as described in its report to OAS, required an "expert review" of any claim not receiving a "Code 1" (a determination that the services are allowable, reasonable, necessary and supported by the medical record) twelve of the twenty denied claims received no expert review. (Delmarva Report, p. 5.) Several of the denied claims appeared to be denied because the record contained "clump notes" (monthly progress notes) as opposed to daily progress notes, despite the fact that there is no regulatory requirement that the record contain daily notes. Finally, for at least three of the claims, Delmarva's "expert reviewer" determined that documentation supported the services as medically necessary; yet OAS recommended denial of the claims. We believe that this conclusion is contrary to the evidence in the record and must be reversed.

Addiction Treatment Services ("ATS")

Addiction Treatment Services (ATS) is a Department of Psychiatry program at JHBMC. ATS provides a wide range of clinical services directed and supervised by full-time faculty members in the Department of Psychiatry. The faculty responsible for directing the program include psychiatrists (ATS Medical Directors) and licensed clinical psychologists (ATS Director and Associate Directors). Medical supervision and services are provided by the psychiatrists from ATS, and physician assistants or physicians from the Comprehensive Care Practice (an internal medicine practice based at JHBMC). Nursing services are provided by LPN's and RN's, supervised by a Nursing Unit Manager who reports jointly to the Department of Nursing and the ATS Medical Directors. Counseling services are supervised by the ATS Director and Associate Directors. The general services offered in the program include substance abuse, psychiatric, and medical evaluations at admission, varying weekly intensities of individual and manual-guided group counseling, pharmacotherapy for substance use and other psychiatric disorders, and primary health care when indicated. Services are typically provided on an ambulatory basis but some patients reside on the 16-bed intermediate care residential unit while participating in the early phase of treatment. The goals of ATS are to help patients: (a) achieve and maintain abstinence; (b) eliminate or reduce drug use and sexual behaviors associated with transmission of HIV and other infectious diseases; (c) stabilize and improve general psychiatric functioning; (d) stabilize and improve overall psychosocial functioning; and (e) identify and reduce associated health problems.

The program serves an ethnic, racial, socioeconomic, and clinically diverse population of people who share in common a moderate to severe substance use disorder. Admission is available to adults (*i.e.*, 18 years or older) seeking treatment for an alcohol or other drug use disorder. All patients are seeking care for a substance use problem. Virtually all of the patients have severe problems across multiple substances, many are unemployed and socially disenfranchised, and a substantial number have other forms of psychiatric disorder (*e.g.* mood disorder, personality disorder). ATS offers four interdependent STEPs/levels of treatment intensity for patients with alcohol and drug use disorders. The multi-step system of care offered by the program was developed to provide the least intensive and invasive treatment necessary to rapidly stabilize patients and maintain good clinical response. The program is certified by the DHMH OLCP, accredited by JCAHO, and operates pursuant to the COMAR Title 10.23 (Drug Abuse Administration) and Title 10.47 (Certification of Alcohol Abuse and Alcoholism Treatment Facilities). The program's clinical and administrative operations are monitored on a monthly schedule by Baltimore Substance Abuse Systems, Inc., a quasi-

public, non-profit corporation of the State of Maryland responsible for the administrative, fiscal, and clinical oversight of substance abuse treatment programs in the greater Baltimore area that receive city, state, or federal funding.

New admissions begin treatment at one of four discrete STEPS of weekly counseling intensity (*i.e.*, Standard Outpatient, Fresh Start, IOP, Residential). Patients begin treatment at the STEP of care deemed most appropriate based on review of all medical and psychosocial data obtained during the initial evaluation. The weekly intensity of treatment is systematically reduced for patients responding well to treatment, and systematically increased for those responding poorly to the existing intensity of service. Poor adherence to scheduled treatment services is the most frequent reason why patients were referred to higher intensities of care, followed by objective or self-reported evidence of continued use of alcohol and other drugs. All changes in weekly counseling intensity follow guidelines established by the medical director, director, and associate directors. Adherence to these clinical guidelines is monitored by the psychiatrists and psychologists through daily (residential unit) or weekly clinical rounds (non-residential), individual patient evaluations, review and approval of the initial treatment plan and subsequent treatment plan reviews, weekly individual and group supervision of nursing and other clinical staff.

Counseling services follow the principles of individual drug abuse counseling, cognitive-behavioral and motivational therapies. All of these services are organized, reviewed, and supervised by the medical director (psychiatrist) and the program directors (licensed clinical psychologists). Comprehensive psychiatric evaluations, medical evaluations, pharmacotherapies for drug use and other psychiatric problems, and some of the group-based therapies for unstable patients are provided by the psychiatrist, psychologists, physician assistants, and internists.

All patients receive a comprehensive initial assessment that includes medical evaluation, structured assessment of drug and alcohol use severity (*e.g.*, Addiction Severity Index), a semi-structured psychosocial evaluation, a standardized mental state examination, and screening behavioral/psychiatric symptom checklist. Evidence of major psychiatric distress or impairment is further assessed by the program's psychiatrists and psychologists. All patients provide urine specimens and a random schedule for drug testing, and random breath intoximeter testing is routinely performed for patients with any evidence of alcohol problems. Clinical progress is monitored regularly in the multi-disciplinary clinical rounds directed by the psychiatrist and psychologists.

The four therapeutic components in place during the audit period were: (a) intermediate care residential unit (ICF), formerly called the ARC House, a 16-bed unit for patients in need of drug abuse services in a highly controlled environment with 24-hour medical and nursing supervision; (b) the Intensive Outpatient Program (IOP), which provided daily medical, general rehabilitative, and educational services to ARC House residents and others requiring highly structured and intensive ambulatory care; (c) the Fresh Start Program, which provides a partial day of clinical rehabilitative and educational services for ambulatory patients requiring moderate levels of structure and monitoring; and (d) the Standard Outpatient component, which provided one or two hours per week of individual and group-based counseling and aftercare. The overall expected duration of care is six months.

A dispute between representatives of OAS and JHBMC arose early in the audit process relating to the fourteen ATS claims in the sample. The ATS claims were captured in the sampling process because they were billed using Medicare revenue code 900, the same revenue code used for most of the Community Psychiatry Program services. Because nothing in the OAS audit plan (or even in the statements of OAS representatives) indicated any intention to include substance abuse psychiatric programs in the audit, JHBMC initially questioned providing the fourteen ATS records. OAS stated that if the records were not provided, the ATS claims "would be counted as errors and also be projected as such." OAS Audit Workpaper E-4, p. 2, December 10, 1999. Unfortunately, the OAS' team's approach to this issue appears to have undermined the validity of the entire audit.

Apparently, OAS was concerned that JHBMC was improperly using the 900 revenue code for billing ATS services that would otherwise be non-reimbursable under Medicare. This concern reflects a misunderstanding of both revenue codes and Medicare coverage criteria. Again, OAS workpapers are instructive in this regard. OAS asked the Maryland Medicare intermediary "if the system would allow payment of the '900' code that was used for the alcohol and drug rehab programs provided by ATS." *Id.* at p. 3. That workpaper later contains the following statement:

> The ATS program was also denied in its entirety because Medicare does not cover substance abuse recovery efforts, especially as psychiatric services. (Emphasis added.)

Id. JHBMC believes there is no dispute that the auditors did not intend to capture addiction-related services in the audit. JHBMC has reviewed other OIG audits of outpatient psychiatric services conducted throughout the country, and believes that addiction-related psychiatric services were not the focus of any of those reviews. It

appears that OAS insisted on keeping the ATS claims in the audit because of its belief that the services were improperly coded and billed in the first place.

Thus, the auditors objected to the ATS claims based on (i) JHBMC's use of the 900 revenue code, and (ii) the purported non-coverage of addiction treatment services. JHMBC disagrees with both these assumptions. The revenue code issue is a classic red herring. OAS repeatedly expressed concern that ATS services were billed utilizing UB-92 revenue code 900 (psychiatric treatment instead of more specific codes such as 944 and 945 (drug and alcohol rehabilitation). Even if OAS is correct that the 944 and 945 codes were more appropriate, this variation would have had no impact on Medicare reimbursement. As OAS has correctly pointed out, acute care hospitals in Maryland "operate under a 'waiver' from Medicare's hospital reimbursement methodology." Draft Report, p. 1.[11] In Maryland, while Medicare cost reports must still be filed, they are not the actual vehicle for determining Medicare reimbursement. Only unregulated hospital-based services are reimbursed in whole or in part through the cost report. Otherwise stated, the services in question were regulated by the Maryland Health Services Cost Review Commission ("HSCRC"), with reimbursement determined through JHBMC's rate structure rather than through the cost report. JHBMC's outpatient psychiatric services (including ATS) were included within the regulated rate for clinic services, upon which approved charges were determined by multiplying HSCRC-approved relative value units by the hospital-specific clinic rate. Under this system, the use of an incorrect or imprecise revenue code has no material reimbursement impact and therefore cannot provide an independent basis for denial of a Medicare claim.[12]

As to OAS' second erroneous assumption, Medicare does, in fact, cover addiction treatment services. The Medicare Coverage Issues Manual addresses outpatient hospital services for the treatment of alcoholism at § 35-22.1 and treatment of drug abuse (chemical dependency) at § 35-22.2. Services for the treatment of alcoholism and drug abuse in an outpatient setting are subject to the same rules as described in § 3112.7 and § 230.5 of the Medicare Intermediary Manual. For treatment of alcoholism, the manual

[11] It is not clear from the Draft Report what, if any, impact the revenue code issue would have in a state other than Maryland. Under the Medicare reimbursement principles applicable in other states at the time in question, addiction-related outpatient psychiatric services and other types of covered outpatient psychiatric services were classified in the same category for reimbursement purposes. In other words, the costs and charges associated with both types of services would normally have been grouped on the same line of the cost report, which suggests that there would have been no difference with respect to Medicare payment.

[12] In any event, JHBMC's charges for outpatient psychiatric services in FY 1997 were in compliance with applicable HSCRC policies.

states that the services may include "drug therapy, psychotherapy, and patient education and may be furnished by physicians, psychologists, nurses, and alcoholism counselors." The services must be "reasonable and necessary for diagnosis or treatment of the patient's condition . . . educational services and family counseling would only be covered where they are directly related to treatment of the patient's condition." For the treatment of drug abuse the manual requires that the services be "reasonable and necessary for treatment of the individual's condition." The manual also states, "decisions regarding reasonableness and necessity of treatment . . . and length of treatment should be made by intermediaries based on accepted medical practice with the advice of their medical consultant."

JHBMC submits that these two misunderstandings on the part of OAS (*i.e.*, the revenue code "red herring" and the mistaken assumption that the ATS services were, by definition, non-covered) irrevocably biased the review of the ATS claims. This bias is demonstrated by the fact that the Draft Report does not even attempt to explain why the use of an incorrect (or imprecise) revenue code would result in non-coverage of the services. Equally significant is the fact that the medical review of the ATS claims was virtually non-existent. In fact, OAS violated its own audit requirement in failing to submit the conclusions of the Delmarva nurses to physician review. This unexplained failure, JHBMC submits, has compromised the validity of the audit process. Taken together, OAS' erroneous conclusions and lack of expert review invalidate this portion of the Draft Report.

9. AVAILABILITY OF ADDITIONAL DOCUMENTATION

Since the time that OAS obtained the medical records for the sampled claims, JHBMC has located additional documentation pertaining to a small number of cases. These documents provide additional support for the denied claims. JHBMC confirmed on February 5, 2001 that OAS will accept these additional documents prior to making any final determinations, consistent with the assurance OAS provided to JHBMC staff on February 8, 2000. JHBMC appreciates OAS' cooperation in this regard, and is providing these materials under separate cover.

CONCLUSION

For the reasons set forth above, the results of this audit may not be extrapolated into the total universe of claims submitted by JHBMC to Medicare for FY 97 for the five programs that were the subject of this audit. In addition, individual claims that were disallowed must be re-reviewed in accordance with applicable coverage criteria, local medical review policy as evidenced by the actual practice of the Fiscal Intermediary during FY 97, and applicable Medicare standards for documentation. In addition,

determinations by OAS' expert medical reviewer that claims should be allowed must not arbitrarily be overruled by OAS auditors. Further, denials based on an erroneous legal position with respect to CPT coding must be reversed. After OAS has completed this process, JHBMC wishes to have the opportunity to discuss any remaining issues with OAS on a claim by claim basis.

Very truly yours,

Gregory F. Schaffer
President