



OPERATION RESTORE TRUST



December 8, 1997

Mr. Curtis Lord, VP Program Safeguards
Blue Cross/Blue Shield of Florida
532 Riverside Avenue
PO Box 2078
Jacksonville, FL 32231-0048

Dear Mr. Lord:

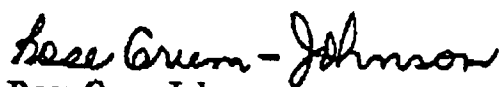
The enclosed report provides the results of the Operation Restore Trust (Wedge Project) review of the Community Outreach for the Recreation and Education of Seniors, Community Mental Health Center (Provider #10-4787) located in Miami, Florida. The objectives of this review were two-fold. First, to evaluate whether the provider met the certification requirements for a CMHC to provide Partial Hospitalization services in accordance with § 1861 ff of the Social Security Act and § 1916 (c)(4) of the Public Health Service Act. Secondly, to evaluate the payments made to the provider to ensure they were appropriate.


A sample of 20 beneficiaries was reviewed for the period January 1996 through December 1996. Our findings will require corrective actions by the Fiscal Intermediary, HCFA, and the OIG.

Please prepare and submit to the HCFA Miami ORT office, an action plan to implement recommendations made in this report that pertain to your organization.

If there are any questions regarding this report, please call Dewey Price at 305-536-6772 or Sheila Kanaly at 305-536-6588.

Sincerely,


Rose Crum-Johnson
HCFA Region IV Administrator


Charles Curtis
Region Inspector General-Audit

cc: Angela Bryce-Smith, HCFA CO
Mario Pelaez, OIG-OA
Dale Kendrick, HCFA Region IV
Eugene Grasser, HCFA Region IV
Barbara Bisno, AUSA

COMMUNITY OUTREACH BRANCH FOR THE RECREATION AND EDUCATION OF SENIORS

Provider No. 10-4681

I. INTRODUCTION

The Secretary of the Department of Health and Human Services and the President initiated Project Operation Restore Trust (ORT), an innovative, collaborative project designed to address growing concerns over rising health care costs. A review of departmental records indicated that over the last 10 years, many segments of the health care industry have experienced a surge in health care fraud and that the States of Texas, California, Illinois, New York, and Florida receive annually over 40 percent of all Medicare and Medicaid funds. As a result, these States were selected to participate in the ORT 23-month pilot project.

Within the Department of Health and Human Services, ORT has been a joint effort by the Health Care Financing Administration (HCFA), the Office of the Inspector General (OIG) - Office of Audit (OA), and the Administration on Aging. These components are focusing attention on program vulnerabilities identified through investigations and audits. In 1997, HCFA, its State agencies and contractors, and the OIG carried out various projects (commonly referred to as wedge projects). In the State of Florida, one of these projects involved onsite reviews of community mental health centers (CMHCs). Through analysis of HCFA Customer Information System (HCIS) billing data and review of complaints, ten CMHCs were selected for onsite review.

These onsite reviews were conducted by an ORT team consisting of representatives from HCFA, the Medicare contractor, the Florida Agency for Health Care Administration (Survey and Certification Staff), and the (OIG)- Office of Audit.

This report provides the results of the combined review of the Community Outreach Branch for the Recreation and Education of Seniors (COBRE) conducted on August 12, 1997 through August 15, 1997.

II. EXECUTIVE SUMMARY

The objectives of the review were to:

- 1) determine whether the provider met the certification criteria for a Community Mental Health Center;
- 2) determine whether the 20 sample Medicare beneficiaries met the eligibility requirements

for the Partial Hospitalization Program (PHP) benefit;

3) determine whether the Medicare coverage and reimbursement criteria were met for PHP services claimed by COBRE from 1/1/96 through 12/31/96 on behalf of 20 sample Medicare beneficiaries; and,

4) determine whether the costs claimed on COBRE's 1996 cost report were allowable, reasonable, and necessary.

The significant findings of our review were as follows.

1) The team determined that the facility did not meet certification requirements to operate as a CMHC under sections 1916(c)(4) of the Public Health Service Act and section 1861 of the Social Security Act. Specifically, the provider was unable to substantiate provision of any of the five required core services. Therefore, it is recommended that this provider's number be voided and that all payments made to the provider since its effective date of participation in the Medicare program be recouped (this amount approximates \$3,216,575, as per the Medicare Part A Provider Summary Report).

2) The team's medical review of the 20 sample beneficiaries found that none were eligible for PHP benefits.

3) The services provided to the sample 20 Medicare beneficiaries for whom COBRE submitted claims for PHP services for the period of January 1, 1996 through December 31, 1996 represented a net reimbursement in the amount of \$352,061. The medical review conducted by the Fiscal Intermediary (FI) staff and HCFA concluded that all of the services claimed during the reviewed period did not meet the Medicare coverage and reimbursement criteria and that the content of the group sessions was social, recreational, and diversionary, rather than of a psychotherapeutic nature.

4) The review concluded that COBRE had claimed costs in its 1996 Cost Report totaling \$185,237 that are unallowable.

On October 3, 1997, the Miami Satellite Office directed the fiscal intermediary to suspend without notice all Medicare payments to COBRE. This action was taken under the provision of 42 CFR 405.372(a)(4), as a result of the determinations by the team: that the provider did not meet the certification requirements for a CMHC; that the 20 beneficiaries did not meet the eligibility criteria for the PHP benefit; that the services were non-therapeutic in nature; and that there was more than \$180,000 in disallowed costs. Additionally, the Miami Satellite Office recommended to HCFA Region IV on October 30, 1997, that the provider agreement with COBRE be terminated.

III. BACKGROUND

Title XVIII of the Social Security Act (the Act) authorizes the Medicare program to provide medical benefits to individuals who are age 65 or over, and certain individuals under age 65 who are disabled or suffering from end-stage renal disease. Section 1835 of the Act established coverage of partial hospitalization services for Medicare beneficiaries. Section 1861(ff)(2) of the Act generally defines partial hospitalization services as those [mental health] services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary will by regulation establish. This benefit was designed to be a last step treatment for patients who had been diagnosed with mental illness and their condition was in an acute state. These services were supposed to be of limited duration and would be the last steps before inpatient hospitalization. Thus, it was perceived by Congress that this benefit would result in cost savings for treating the mentally ill and because it is limited to those beneficiaries whose mental illness is in an acute state, the expenditures for these services would be minimal.

Section 4162 of Public Law 101-508 (OBRA 1990) amended Section 1861 of the Act to include CMHCs as entities that are authorized to provide partial hospitalization services under Medicare. Section 1916(C)(4) of the PHS Act lists the services that must be provided by a CMHC. A Medicare-certified CMHC can either provide PHP services directly or under arrangement with other providers, in order to render CMHC services as required by the Public Health Service Act.

HCFA's definition of a CMHC is based on §1916(c)(4) of the Public Health Service (PHS) Act. The PHS definition of a CMHC is cross-referenced in section 1861(ff) of the Social Security Act. HCFA defines a CMHC as an entity that provides:

- ⇒ outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health services area who have been discharged from inpatient treatment at a mental health facility;
- ⇒ 24-hour a day emergency care services;
- ⇒ day treatment or other partial hospitalization services or psychosocial rehabilitation services;
- ⇒ screening for patients being considered for admission to State mental health facilities to determine the appropriateness for such admission; and

- ☞ consultation and education services.

In order for a Medicare patient to be eligible for a partial hospitalization program, a physician must certify (and recertify where such services are furnished over a period of time):

- 1) that the individual would require inpatient psychiatric care in the absence of such services, [This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted];
- 2) an individualized plan for furnishing such services has been established by a physician and is reviewed periodically by a physician; and
- 3) such services are or were furnished while the individual is or was under the care of a physician. [Physician certification is required under the procedures for payment of claims to providers of partial hospitalization services under §1835 (a)(2)(F) of the Act.]

A Medicare partial hospitalization program is an appropriate level of active treatment intervention for individuals who:

- are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment. Partial hospitalization is the level of intervention that falls between inpatient hospitalization and episodic treatment on the continuum of care for the mentally ill;
- do not require 24-hour care and have an adequate support system outside the hospital setting while not actively engaged in the program;
- have a diagnosis that falls within the range of ICD-9 codes for mental illness (i.e., 290 through 319). However, the diagnosis in itself is not the sole determining factor for coverage; and
- are not judged to be dangerous to self or others.

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

Community Outreach Branch for the Recreation and Education of Seniors (COBRE) is a for-profit corporation with its principal place of business in Miami, Florida. Its effective date of participation in the Medicare program was May 31, 1994. The provider number was granted based on a self-attestation statement certifying the facility's compliance with the Federal requirements in Section 1861 (ff)(3)(B) of the Social Security Act, and its conformance with the provisions concerning Medicare provider agreements. The provider chose Blue Cross/Blue Shield of Florida as the organization to serve as fiscal intermediary.

IV. SCOPE AND METHODOLOGY

In order to determine if the provider met the certification requirements for a CMHC, COBRE staff were interviewed and requested to provide documentation (including medical records) demonstrating their provision of the five required core services.

During the review, applicable laws, regulations, and Medicare guidelines were used to determine whether the sample beneficiaries and the services claimed met the Medicare eligibility and reimbursement guidelines. The medical review was performed using the criteria set forth in Title 42 CFR 424.24 which provides that Medicare pays for partial hospitalization services only if a physician certifies the content of the plan of care. The plan must include the physician's diagnosis, the type, frequency, and duration of services to be administered, and the goals of the treatment plan. In addition, the patient must meet eligibility criteria to receive PHP services.

The medical review was conducted by staff from HCFA and the fiscal intermediary. The review process consisted of a review of all claims submitted by COBRE for the 20 sample beneficiaries between January 1st and December 31st, 1996. The sample used for this review was not based upon a statistically valid random sample, and therefore, the results would not be extrapolated to the entire universe of the provider's claims.

The financial data, reports, and supporting documentation for fiscal year 1996 were requested to determine if costs claimed on the FY 1996 cost report were allowable, reasonable, and necessary. The cost report review was performed in accordance with generally accepted governmental auditing standards.

The field work was conducted at the COBRE corporate site in Miami, Florida, and the Miami field office. Our site visit began August 4, 1997, and concluded on August 8, 1997.

V. FINDINGS

1. Certification

In our review of COBRE, we met with and interviewed its owner who was asked to provide documentation substantiating COBRE's provision of the five required core services. An agreement with Outpatient Psychiatric Care was provided as evidence that the facility provides the five core services. It was noted that Outpatient Psychiatric Care is also owned by the same individual and has a separate Medicare Part B provider number, under which it bills Medicare Part B for services provided to COBRE's beneficiaries. An analysis was done by the team of the agreement between COBRE and Outpatient Psychiatric Care. The agreement failed to substantiate that the five core services were being provided. In addition, it did not meet Medicare's definition of "under arrangement," since the CMHC did not maintain oversight of the patients' care.

2. Patient Eligibility and Physician Certification

The medical review determined that payment for all of the services claimed by COBRE for the 20 beneficiaries should be denied because the beneficiaries did not meet the Medicare eligibility criteria for PHP services (see attached chart delineating the medical review results for the 20 beneficiaries in the sample). Specifically, the review determined that none of the beneficiaries required the intensive services of a partial hospitalization program, although the provider had physician certifications for PHP services in 19 of the 20 sample patient medical records. The documentation in the medical records did not show symptoms of severe psychiatric disorders which would have required inpatient hospitalization in the absence of PHP services.

3. Medical Necessity

The medical review also found the services to the 20 sample beneficiaries were not reasonable and necessary and that the content of the groups presented was social, recreational and diversionary, rather than of a psycho-therapeutic nature. The documentation in the medical records for the 20 beneficiaries contained identical statements i.e., they were not individualized according to each patient's treatment, progress, and diagnosis. The same group sessions were recommended for all patients. As a result of the medical review, \$352,061, which is the amount of the net reimbursement to COBRE on these 20 sample beneficiaries, is considered an overpayment.

4. Cost Report

Medicare cost principles limit reimbursement to the costs that would be incurred by a reasonable, prudent and cost-conscious management. 42 CFR 413.9 provides that all payments to providers must be based on the "reasonable cost" of services covered under Title XVIII of the Act and related to the care of the Medicare beneficiaries. The regulations at 42 CFR 413.9 state in part that costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

The review showed that COBRE claimed costs of \$101,491 that were unallowable and unreasonable. We disallowed an additional \$83,746 in costs that, based on salary and staffing patterns for CMHCs, were deemed to be excessive. Therefore, the total cost disallowances are \$185,237. A breakdown of these are as follows:

Unallowable

COBRE claimed \$101,491 for costs determined to be unallowable as follows:

- a. \$88,015 claimed for bad debts. This amount represents the 20% co-payment attributable to the net reimbursement received by the provider on behalf of the 20 beneficiaries in our sample. The provider Reimbursement Manual, Part I, Section 308 stipulates that a debt must meet the following criteria to be allowable:
 - ◆ the debt must be related to covered services and derived from deductible and coinsurance amounts;
 - ◆ the provider must be able to establish that reasonable collection efforts were made;
 - ◆ the debt was actually uncollectible when claimed as worthless; and,
 - ◆ sound business judgement established that there was no likelihood of recovery at any time in the future.

The HCFA and FI staff found that none of the services provided to the 20 beneficiaries met the Medicare coverage and reimbursement criteria for PHP services. Consequently, the bad debts claimed were not related to covered services and, therefore, unallowable.

- b. \$13,476 claimed for meals. This cost was included with the amount claimed for office expense by the provider in their FY 1996 cost report.

Not reasonable

COBRE claimed \$83,746 in costs that we determined to be not reasonable, as follows:

- ◆ \$83,746 in costs that, based on salary and staffing patterns for CMHCs, were determined to be excessive. Reasonable salaries were determined using a 1996 survey of CMHCs by the Association for Ambulatory Behavioral Healthcare;
- ◆ \$12,046 represents payments to the Medical Director; and,
- ◆ \$71,700 represents salary paid to the CEO/Administrator.

Recommendations

It is recommended that:

- the FI should maintain the suspension of payments to this provider, until advised otherwise by HCFA, and recoup all overpayments;
- HCFA should take action to void the provider agreement;
- the OIG-Office of Investigations consider further actions against this provider, including evaluating the provider for any civil/criminal action; and,
- the OIG should permissively exclude the owner of this provider from the Medicare Program due to a 1988 felony conviction for possession of illegal substances (see 42 CFR 489.53).

COMMUNITY OUTREACH BRANCH for the RECREATION and EDUCATION of SENIORS (C.O.B.R.E.-Provider No. 10-4681)

RECORD NO.	BENE HIC NO.	RESULTS OF MEDICAL REVIEW	REVIEW OUTCOME	AMOUNT PAID IN 1996	AMOUNT DENIED
1	265-72-4453M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet certification and eligibility criteria under § 1835 (a)(2)(F). 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$24,455.70	\$24,455.70
2	581-40-7326A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$21,966.96	\$21,966.96
3	553-96-6262A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$20,650.65	\$20,650.65
4	590-76-7679M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$19,743.90	\$19,743.90
5	101-44-6549M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$19,505.20	\$19,505.20
6	264-29-4018C3	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$18,698.60	\$18,698.60
7	589-23-2465M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$18,526.20	\$18,526.20
8	266-31-2546A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$16,829.90	\$16,829.90
9	152-50-8021A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$16,771.00	\$16,771.00

RECORD NO.	BENE HIC NO.	RESULTS OF MEDICAL REVIEW	REVIEW OUTCOME	AMOUNT PAID IN 1996	AMOUNT DENIED
10	264-14-1050D	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$16,501.80	\$16,501.80
11	265-76-6637A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$16,495.10	\$16,495.10
12	266-29-8012A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$16,442.80	\$16,442.80
13	266-70-5476A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$16,391.30	\$16,391.30
14	593-22-8148M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$16,226.70	\$16,226.70
15	583-74-0930A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$15,853.40	\$15,853.40
16	264-70-5998A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$15,636.40	\$15,636.40
17	265-95-4645M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A).	Deny all Services.	\$15,615.30	\$15,615.30

RECORD NO.	BENE HIC NO.	RESULTS OF MEDICAL REVIEW	REVIEW OUTCOME	AMOUNT PAID IN 1996	AMOUNT DENIED
18	110-46-4979A	<ol style="list-style-type: none"> 1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A). 	Deny all Services.	\$15,335.80	\$15,335.80
19	265-77-7154M	<ol style="list-style-type: none"> 1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A). 	Deny all Services.	\$15,331.10	\$15,331.10
20	262-97-7894M	<ol style="list-style-type: none"> 1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862(a)(1)(A). 	Deny all Services.	\$15,083.10	\$15,083.10
Total Amount Paid/Denied				\$352,060.91	\$352,060.91

Chart updated 12/07/97