DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

CIN: A-04-00-01209

APR 11 2001

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Ms. Karen Kallen-Zury
Chief Executive Officer
Hollywood Pavilion Hospital
1201 N. 37th Avenue
Hollywood, Florida 33021

Dear Ms. Kallen-Zury:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, ***Review of Outpatient Psychiatric Services Provided by Hollywood Pavilion Hospital for Fiscal Year Ending June 30, 1998***. A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determinations as to actions taken on all matters reported 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 (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 Code of Federal Regulations Part 5) As such, within 10 business days after the final report is issued, it will be posted on the world web at http://hhs.gov/proorg/org.

To facilitate identification, please refer to Common Identification Number (CIN) A-04-00-01209 in all correspondence relating to this report.

Sincerely yours,

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

Enclosures - as stated

Action Official
Dale Kendrick, Associate Regional Administrator
Division of Financial Management and Program Initiatives
Health Care Financing Administration
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY HOLLYWOOD PAVILION HOSPITAL FOR FISCAL YEAR ENDING JUNE 30, 1998

APRIL 2001
A-04-00-01209

EXECUTIVE SUMMARY

BACKGROUND

The Medicare program reimburses psychiatric care hospitals for the reasonable costs associated with providing outpatient psychiatric services. These services must be reasonable and necessary for the diagnosis or treatment of a patient's condition, and supported by sufficient documentation to justify the treatment provided. Claims are submitted for services rendered and are reimbursed on an interim basis. At year-end, the hospital submits a cost report to the Medicare Fiscal Intermediary (FI) for final settlement. Medicare requires costs claimed to the program to be reasonable, allowable, and related to patient care.

OBJECTIVE

The objectives of this audit were to determine: (1) whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicare requirements, and (2) the appropriateness of outpatient psychiatric costs claimed in the cost report.

SUMMARY OF FINDINGS

Outpatient psychiatric services were not billed for in accordance with Medicare requirements and inappropriate costs were claimed on the cost report. We estimate the Hospital overstated billings to Medicare for outpatient psychiatric services by $2.4 million. Additionally, the Fiscal Year (FY) 1998 cost report included $721,388 in outpatient psychiatric costs that were not allocable or reimbursable according to Medicare regulations. We also found that the hospital overstated Partial Hospitalization Program (PHP) square footage statistics in allocating indirect costs to the PHP operation. We will provide the FI with detail of the identified unallowable costs so that it can apply the appropriate adjustment to the Hospital's FY 1998 Medicare cost report.

Medical Record Review

Hollywood Pavilion Hospital (Hospital) submitted claims totaling $5.8 million for outpatient psychiatric services with dates of service during FY 1998. To determine whether controls were in place to ensure compliance with Medicare regulations and guidelines, we reviewed the medical records of 100 randomly selected claims totaling $463,593. Our analysis showed $227,640 (approximately 49 percent) of these charges did not meet Medicare criteria for reimbursement.

Specifically, we found:

- $195,150 for services which were not reasonable and necessary;
- $22,140 for services which were not covered or allowed;
- $5,400 for services which were undocumented; and
- $4,950 for services which were inadequately/insufficiently documented.

As a result, we estimate the Hospital overstated billings to Medicare for outpatient psychiatric services by $2,366,237.

Cost Report Review

The Hospital claimed $3.3 million in outpatient psychiatric service costs, after adjustments and reclassifications, on its FY 1998 cost report. We identified $721,388 of those costs that were not allocable or reimbursable according to Medicare regulations. The costs include:

- $436,240 for compensation improperly allocated to outpatient psychiatric services;

- $279,327 for transportation, which should have been charged to a non-reimbursable cost center; and

- $5,821 for diversionary activities, which are non-covered services.

Additionally, we noted the facility's square footage was overstated by 5,294 square feet.

We also noted $88,801 in costs not related to patient care were included in the Hospital's home office cost report. Additionally, $401,538 in officer's salaries were allocated functionally rather than using the pooled method.

We will provide the FI with detail of the identified unallowable costs so that it can apply the appropriate adjustment to the Hospital's FY 1998 Medicare cost report.

Recommendations

We recommend the Hospital:

1. strengthen its procedures to ensure charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements. We will provide the results of our review to the FI, so it can apply the appropriate adjustment of $2,366,287 for unallowable outpatient psychiatric services to the Hospital's FY 1998 Medicare cost report.

2. develop procedures to exclude costs related to non-covered services from its Medicare cost reports and to properly allocate costs. We will provide the FI with details of the unallowable and/or inappropriate costs claimed on the cost report, so that it can apply the appropriate adjustment to the Hospital's FY 1998 Medicare cost report and determine the effect of the findings.

The Hospital generally did not agree with our findings. Regarding the medical review, the Hospital believed that the PHP services reviewed were reasonable and necessary, documented and provided to eligible beneficiaries.

Regarding the cost report issues, the Hospital believed that the presentation of the report overstated the reimbursement impact of the findings. We have revised the report to clarify the impact of our cost report findings. However, we believe that our final audit determinations are correct and in accordance with Medicare rules and regulations. The basis for our position is discussed in detail beginning on page 2 of the attached report. The auditee's response, in its entirety, is included in Appendix B of this report.

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INTRODUCTION

BACKGROUND

The Hospital, located in Hollywood, Florida, provides outpatient psychiatric services to patients. These services are provided by the Hospital through its PHP. The Hospital submitted to Medicare for reimbursement 1,187 claims for outpatient psychiatric services valued at $5.8 million with dates of services during FY 1998.

According to the Hospital, the program operates from 10:00 a.m. to l 2:00 p.m., 5 days a week. The Hospital offered group therapy on a wide range of topics including life skills, creative expressions, art and music therapy, and occupational therapy.

The Medicare program reimburses psychiatric care hospitals for the reasonable costs associated with providing outpatient psychiatric services. These services must be reasonable and necessary for the diagnosis or treatment of a patient's condition, and supported by sufficient documentation to justify the treatment provided. Claims are submitted for services rendered and are reimbursed on an interim basis. At year-end, the hospital submits a cost report to the Medicare FI for final settlement. Medicare requires costs claimed to the program to be reasonable, allowable, and related to patient care.

The legislative authority for coverage of partial hospitalization benefit is contained in Section 1835 of the Social Security Act. Governing regulations are found in Title 42 of the Code of Federal Regulations (CFR); and the Health Care Financing Administration (HCFA) coverage guidelines are found in the Medicare Intermediary Manuals.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this audit were to determine: (1) whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicare requirements, and (2) the appropriateness of the outpatient psychiatric costs claimed in the cost report.

We conducted our audit during the period of December 1999 through October 2000 at the Hospital in Hollywood, Florida and at the FI in Omaha, Nebraska. The audit was conducted in accordance with generally accepted government auditing standards.

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

To determine whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicare requirements, we:

- reviewed criteria related to outpatient psychiatric services;

- obtained the Hospital's FY 1998 Provider Statistical and Reimbursement Report and used an unrestricted random sample approach to select 100 outpatient psychiatric claims for review;

- utilized the FI's medical review staff 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.

To determine the appropriateness of costs claimed on the FY 1998 cost report, we reviewed judgmentally selected costs and allocation statistics related to outpatient psychiatric services. Our findings were provided to the FI to assess the impact of our adjustments on the cost report. In addition, we reviewed judgmentally selected costs claimed on the FY 1998 home office cost report.

FINDINGS AND RECOMMENDATIONS

The FI's medical records review disclosed that outpatient psychiatric services were not billed for in accordance with Medicare requirements. We estimate the Hospital overstated billings to Medicare for outpatient psychiatric services by $2.4 million. In addition, we identified $721,388 on the cost report which the Hospital treated inappropriately.

MEDICAL RECORD REVIEW

The Hospital submitted claims totaling $5.8 million for outpatient psychiatric services with dates of service during FY 1998. To determine whether controls were in place to ensure compliance with Medicare regulations and guidelines, we reviewed the medical records of 100 randomly selected claims totaling $463,593 and representing 5,147 units of service. Our analysis showed $227,640 for 2,525 units of service did not meet Medicare criteria for reimbursement. Our results are as follows:

- $195,150 in charges where the services were not reasonable or necessary;

- $22,140 in charges where the services provided were not covered or allowed;

- $5,400 in charges for no documentation of any type received from provider; and

- $4,950 in charges for documentation is inadequate/insufficient to meet Medicare reimbursement criteria.

Services Not Reasonable or Necessary

The Medicare Intermediary Manual, Section 3112.7 Outpatient Psychiatric Services, identifies the range of services a hospital may provide to outpatients who need psychiatric care. For such services to be covered, they must be "... reasonable and necessary for the diagnosis and treatment of a patient's condition …."

Our review showed that $195,150 in charges for 2,164 units was for PHP services that in the opinion of the medical reviewers did not support that the patients had a mental condition that required the level of intensity of a PHP.

For example, a patient was not capable of actively participating and benefiting at the intensity of a PHP. She did not retain information and was not actively participating in her treatment in group therapies. Patients who are not capable of actively participating in a PHP are not eligible for coverage. A previous episode of care in this PHP was reviewed and the patient had these same symptoms and behaviors of poor memory, inability to concentrate, inability to learn, irrelevant and superficial responses and slow thought processes and these symptoms were not improved with PHP treatment. These were chronic for this patient and consistent with dementia or an organic process. There was not documentation of symptoms that would indicate she had an exacerbation of a chronic psychiatric condition or an acute psychiatric condition. Supervision and structured activities that are designed for the memory impaired to help them remain cognitively and physically stimulated at their optimal level are available at lower levels of care and in structured living environments. Treating her in a PHP was not reasonable and necessary.

Services Not Covered or Allowed

The Medicare Intermediary Manual, Section 3112.7 Outpatient Psychiatric Services, identifies the range of services a hospital may provide to outpatients who need psychiatric care. For such services to be covered, they must be "... reasonable and necessary for the diagnosis and treatment of a patient's condition...".

Our review showed $22,140 in charges for 246 units were for PHP services that in the opinion of the medical reviewers were for services for which there is a Medicare law, regulation or policy which prohibits coverage or a local practice that clearly establishes non-coverage.

For example, the services provided one patient included music and occupational therapy. The services were recreational and diversionary in nature and not closely related to patient's clinical needs. Therefore, the Medicare program would not cover these services.

No Documentation

Title 42 CFR 482.24 states that, "A medical record must be maintained for every individual evaluated or treated in the hospital...."

Our review showed that $5,400 in charges for 60 units was for PHP services that in the opinion of the medical reviewers did not have any documentation to support the services rendered.

For one patient, there was no documentation to support that services were ordered, reasonable and necessary and provided as billed.

Inadequate/Insufficient Documentation

Title 42 CFR 482.24 states that, "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."

Our review showed that $4,950 in charges for 55 units was for PHP services that in the opinion of the medical reviewers did not have adequate/sufficient supporting documentation to meet Medicare reimbursement criteria.

For example, the goals in the treatment plan for one patient were not addressed and documentation was not provided to support all the services were provided as billed.

COST REPORT REVIEW

The Hospital claimed $3.3 million in outpatient psychiatric service costs, after adjustments and reclassifications, on its FY 1998 cost report. We identified $721,388 on the cost report which the Hospital treated inappropriately. The costs include:

1. $436,240 for compensation improperly allocated to outpatient psychiatric services;

2. $279,327 for transportation, which should have been charged to a non-reimbursable cost center; and

3. $5,821 for diversionary activities, which are non-covered services.

Additionally, we noted 5,294 square footage overstated the facility's square feet.

We also noted $88,801 in costs not related to patient care were included in the Hospital's home office cost report. Additionally, $401,538 in officer's salaries were allocated functionally rather than using the pooled method. We did not determine the effect of the home office cost report findings.

Compensation Improperly Allocated

The Hospital inappropriately allocated to the PHP the Medical Director's fees and the salaries for Hospital office staff. Title 42 CFR 413.24 (d)(1) recognizes that "all costs of non-revenue producing centers are allocated to all centers they serve, whether or not these centers produce revenue." The cost should have been allocated to the Hospital's various programs based on the benefit received. The allocations included:

- $148,500 for the Medical Director
- $287,740 for the office staff

The Medial Director diagnoses, examines and prepares the plan of treatment for each individual patient. Because time logs supporting allocation based on time spent performing various functions were not available, we treated the Medical Director as professional component rather than provider component. The professional component of provider-based physician's services pertains to that part of the physician's activities which is directly related to the medical care of the individual patient.

The Hospital allocated the office staff 100 percent to the PHP. We treated the office staff as Hospital Administrative and General for allocation purposes. On Provider Reimbursement Manual (PRMI) 2 2110 Worksheet B - Cost Allocation and Worksheet B-1 Cost Allocation - Statistical, the instructions for Column 10, Administrative and General (A&G) state that: "The A&G costs are allocated to revenue-producing and non-reimbursable cost centers based on accumulated costs."

Patient Transportation

The Medicare Intermediary Manual, Section 3112.7 states transportation costs are not reimbursable.

The Hospital charged $279,327 to the PHP for transportation. The costs included:

- $154,025 in salaries for the transportation coordinator and van driver/riders;
- $52,033 for the lease expense;
- $49,579 for fuel and repairs; and
- $23,690 in insurance expense.

Because these costs are not reimbursable by Medicare, they should have been allocated to a non-reimbursable cost center.

Recreation and Diversional Activities

Title 42 CFR 413.9(c) defines reasonable costs as "... all necessary and proper expenses incurred in furnishing services ..." The PRMI, Section 2102.2 defines costs related to patient care as those which "... include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities ..." Medicare Intermediary Manual, Section 3112.7 states that non-covered outpatient psychiatric services include services and programs which are primarily recreational or diversional in nature.

The Hospital charged the PHP for $5,821 in unallowable recreation and diversional activity costs. For example, some of these costs included fast food for the patients, craft supplies and video rentals.

Square Footage

The PRM, Section 3617 states, "There can be no deviation of the prescribed statistics and it must be utilized for all the following cost centers: Square Footage for Buildings and Fixtures, Movable Equipment, Maintenance and Repairs, and Operation of Plant."

Based on measures of the Hospital's blueprints, space not related to outpatient care was included in the PHP square footage. The Hospital overstated the PHP square footage by 5,294 square feet in the cost report. Because square footage is used as a basis for allocation, the PHP received more than its appropriate share of allocated costs.

Home Office Costs

The PRM, Section 2150.2(A) defines allowable home office costs as "... home office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.) are allowable to the extent they are reasonable."

Herlee, Inc., is the home office for the Hospital. It is also the home office for a nursing home and two convalescent homes.

For FY 1998, the home office had costs totaling $613,812. We identified $88,801 in costs not related to patient care. This included $68,701 in legal fees and $20,100 in meals and entertainment expenses which lacked sufficient documentation to make a determination. Additionally, $401,538 in officer's salaries were allocated functionally rather than using the pooled method. We did not determine the effect of the home office cost report findings.

CONCLUSION

The Hospital submitted claims totaling $5.8 million for outpatient psychiatric services with dates of service during FY 1998. Our audit of randomly selected claims totaling $463,593 disclosed that $227,640 should have been rejected by the Medicare program. Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident the Hospital billed at least $2,366,237 in error for FY 1998. For the details of our sample results see **Appendix A**.

In support of the above claimed charges, the Hospital claimed about $3.3 million in costs for these outpatient psychiatric services, after reclassifications and adjustments, on its FY 1998 Medicare cost report. We identified $753,327 of those costs which the Hospital treated inappropriately. Additionally, we noted 5,294 square footage overstated the facility's square feet. Accordingly, the FI would need to utilize the results of this review to adjust the FY 1998 cost report.

RECOMMENDATIONS

We recommend the Hospital:

1. strengthen its procedures to ensure charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements. We will provide the results of our review to the FI, so it can apply the adjustment of $2,366,287 for unallowable outpatient psychiatric services to the Hospital's FY 1998 Medicare cost report.

2. develop procedures to exclude costs related to non-covered services from its Medicare cost reports and to properly allocate costs. We will provide the FI with details of the unallowable and/or inappropriate costs claimed on the cost report, so it can determine the effect of the cost report findings.

AUDITEE RESPONSE AND ADDITIONAL OIG COMMENTS

The Hospital, in its January 5, 2001 response to our draft report (APPENDIX B), believed that the outpatient psychiatric services the OIG reviewed were reasonable and necessary, provided to eligible beneficiaries and sufficiently documented. Regarding the cost report issues, the Hospital generally took exception to the impact of the adjustments from a presentation standpoint.

The following is a detailed discussion of specific points made in the Hospital's comments to our findings.

Medical Record Review

The Hospital's Comments

1. Services Not Reasonable or Necessary

The Hospital stated that in each instance, the treating physician certified to the necessity of partial hospitalization services which were needed to avoid inpatient psychiatric care. The hospital believes that the treating physician was in the best position to determine appropriate care.

2. Services Not Covered or Allowed

The Hospital stated that according to the OIG report services were questioned because they were recreational and diversionary in nature and not closely related to the patient's clinical needs. The Hospital believes that their occupational and music therapy services are recognized treatment modalities and were administered by qualified individuals. In addition, the Hospital believed that a number of claims in this category were denied because the reviewer required documentation of a patient interview to satisfy the conditions of coverage and also because the reviewer took exception to the manner in which the physician developed his weekly progress notes.

3. Documentation and Inadequate/Insufficient Documentation

The Hospital believes the reviewers either overlooked the available documentation or sought specific documentation in the medical record that may have been identified elsewhere in the progress notes. The Hospital states that Medicare regulation provides for flexibility in meeting specific required contents of medical records by requiring the items only, as appropriate.

Additional OIG Comments

The OIG auditors are not medical experts and all medical issues, including the sample review, were referred to medical experts. In this case, the claims were reviewed by qualified staff provided by the FI. Medicare claims have always been subject to review for reasonableness and necessity. The reviewer's examination included: (1) intake forms and admission information, including medical history; (2) nursing assessments; (3) treatment plans; (4) certification and re-certification for the continued need for PHP services; (5) clinical/progress notes; (6) physician notes; and (7) group notes/treatment summaries. As we discussed in our report, we believe the medical record of the services claimed did not support the Medicare claim. We will provide the results of our review and the documentation submitted by the Hospital to the FI.

Cost Report Review

Auditee Response Regarding Medical Director Fees

The Hospital treated these fees as a provider component because the relationship between the Hospital and each of the physicians supports a one hundred percent (100%) allocation of compensation for provider services and does not include compensation for direct patient care which is separately billable by each of the Hospital's physicians. Therefore, the Hospital believes that the $148,500 fee for the Medical Director fees are hospital only expenses and should be allocated based on the accumulated costs of the PHP versus the inpatient unit resulting in 86% of these costs allocated to the PHP.

Additional OIG Comments

We reviewed the Hospital's response that the fees for the Medical Director fees should be treated as provider component. Provider component services include teaching, research conducted in conjunction or as part of patient care, administration, general supervision of professional or technical personnel, laboratory quality control activities. However, the Medical Director, when interviewed, stated that he examines, evaluates, diagnoses and prescribes the plan of treatment for each patient in the PHP program.

The 42 CFR 415.60(g) addresses the type of record keeping requirements. It states in part that "... each provider that claims payment for physicians under this subpart must meet all of the following requirements: (1) maintain the time records or other information it used to allocate physician compensation..." (2) "Report the information on which the physician compensation is based to the intermediary ..." (3) retain each physician compensation allocation, and the information on which it is based ..."

The Medical Director informed us that he did not maintain logs or similar documentation to account for time spent with patients. Accordingly, we still believe that the Medical Director's fees should not be included in the provider component.

Auditee Response Regarding Office Staff Costs

The Hospital contends that it is inappropriate to allocate office staff cost employed solely by the Hospital to the nursing home operation in that it allocates costs to cost centers not served. The Hospital believes the office staff cost of $237,202 should be allocated 86% to the PHP, based on the accumulated cost statistic of the Hospital. The remaining office cost of $50,538 should be allocated 45% to the PHP through the general G&A allocation of the entire health care complex.

Additional OIG Comments

Originally, the Hospital allocated these costs 100 percent to the PHP. Their position now agrees with ours.

Auditee Response Regarding Salaries Pertaining to Patient Transportation

The Hospital agrees that transportation costs are not reimbursable. However, the Hospital believes that our 50 percent adjustment for salaries is based solely on our interview of the Chief Operating Officer and that actual drivers' schedules more accurately reflect transportation as a 37.5 percent unallowable allocation. Further, the Hospital also states that the associate administrator's time should also be allocated the same as the drivers' times. He serves as director of transportation, payroll and other administrative tasks. Accordingly, based on these percentages, the $191,785 proposed adjustment for salaries would be reduced to $115,620.

Additional OIG Comments

We developed our 50 percent adjustment for salaries based on interviews with the mental health technicians, a transportation driver and the Hospital's chief operating officer. These interviews were necessary because the Hospital did not maintain time logs or schedules. We requested time logs or similar documentation in order to properly allocate their time but both the Hospital's chief operating officer and the mental health technicians stated that no documentation was kept as to when they departed the Hospital and the time returned.

While the Hospital now proposes to base the allocation of 37.5 percent on drivers' actual schedules, the Hospital does not provide any documentation for us to verify that these schedules were in effect and actually reflect transportation time during the period of our review. Accordingly, our adjustment for transportation salaries for drivers remains at 50 percent.

While we originally eliminated the associate administrator's salary 100 percent, we agree to allocate the administrator's salary the same as the drivers' times, or 50 percent. Accordingly, we have reduced our adjustment from the $191,785 to $154,025.

Auditee Response Regarding Lease and Insurance Expense Related to Patient Transportation

The Hospital uses one of its vehicles to specifically transport employees from offsite parking. These costs are appropriate and helpful in maintaining the operation of patient care facilities and activities. As a result, the proposed OIG adjustment should be modified to reflect the allowable costs for one vehicle.

Additional OIG Comments

The Hospital has a total of eight vehicles which its uses for transportation. While one of these vehicles is used for employee transportation, the Hospital cannot provide records to support an allocation to employee use. We requested time logs, schedules, or similar documentation in order to properly allocate this vehicle's costs. We were told that no records were kept of the time spent performing these functions. Even though the transportation of Hospital employees from an offsite parking facility is a reasonable cost incurred in furnishing services, this cost cannot be quantified because of lack of adequate documentation by the Hospital.

Auditee Response Regarding Square Footage

The Hospital agreed with OIG that there was a clerical error in the square footage determination of the PHP and that it was undertaking a review to ensure that accurate cost allocations are made in future cost reports.

Additional OIG Comments

None

Auditee Response Regarding Home Office Costs

The Hospital contends that the $68,701 in legal fees are allowable because they are reasonable and necessary expenditures and related to patient care. The reasonable cost of any service shall be the cost actually incurred in the official delivery of health care services determined with regulations. The legal costs are appropriate and helpful in developing and maintaining the operation of patient care activities and facilities. The Hospital's legal counsel met on an ongoing basis with executive management and officers of the Hospital regarding operational issues. The home office disallowed $6,000 of legal fees not related to patient care.

Additional OIG Comments

We found numerous legal costs not appropriate and helpful in developing and maintaining the operation of patient care activities and facilities. These included such costs as the Hospital paying for legal counsel's leased vehicle, review of living wills, Hospital officers' condominium purchase, a conference at the Jupiter, Florida police department in reference to the Hospital officers' grandchildren, a boat closing and similar expenditures which are obviously of a personal nature. The greater portion of the legal costs that we disallowed as not reasonable or necessary expenditures and not related to patient care were for weekly meetings

with the Hospital's executives and officers where no agenda, minutes, or similar were kept by the parties involved. It is important to document the purpose of meetings in light of the numerous legal expenses that were personal in nature.

As to the $6,000 in legal fees which were disallowed by the home office in its cost report, this amount was an arbitrary amount not based on any specific legal work performed. No schedules, documentation or similar documentation was provided as to how this amount was computed. We believe that our original audit determination was correct.

APPENDIX A

Review of Outpatient Psychiatric Services Provided by Hollywood Pavilion Hospital

Statistical Sample Information

POPULATION	SAMPLE ERRORS
Items: 1,187 Claims	Items: 100 Claims
	Items: 83 Claims
Dollars: $5,776,592	Dollars: $463,593
	Dollars: $227,640

The sample projection was obtained using the RAT-STATS unrestricted variable appraisal program. We reported the lower limit of the 90% [1] confidence interval. Details of our projection appear below:

Projection of Sample Results
90[1] Percent Confidence Interval

	Point
Estimate:	$2,702,087
	Precision
Amount:	$ 335,850
Lower Limit:	$2,366,237

[1] 90% two-sided confidence level, which is the 95% one-sided confidence level.

Hollywood Pavilion
1201 N. 37th AVENUE
HOLLYWOOD, FLORIDA 33021-54981

TELEPHONE (954) 962-1355

January 5, 2001
Charles J. Curtis
Regional Inspector General for Audit Services
Region IV
61 Forsythe Street, S.W., Room 3T41
Atlanta, GA 30303-8909

RE: Common Identification Number (CIN) A-04-00-01209

Dear Mr. Curtis:

Pursuant to the Office of the Inspector Generals ("OIG") draft report entitled "Review of Outpatient Psychiatric Services Provided by Hollywood Pavilion Hospital for Fiscal Year Ending June 30, 1998" ("Draft OIG Report"), dated October 2000, we wish to respond and provide additional information with respect to partial hospitalization program ("PHP") services provided by Hollywood Pavilion ("Hollywood") during fiscal year 1998 ("Audit Period"). Further, we request a meeting with you at your earliest convenience to discuss the Draft OIG Report and the additional information being submitted. Since 1992 Hollywood has been well recognized by the community for providing PHP services to an underserved, indigent population. It has been commended by the JCAHO for doing an outstanding job providing services to a population that few providers have been willing to serve.

The Summary of Findings of the Draft OIG Report states that outpatient psychiatric services were not billed in accordance with Medicare requirements. It estimated that Hollywood overstated billings to Medicare for outpatient psychiatric services by $2.4 million. The Draft OIG Report also claims that Hollywoods Fiscal Year (FY) 1998 cost report reimbursement was overstated by $919,945.

Specifically, the Draft OIG Report claims as part of the medical record review that certain services were not (1) reasonable and necessary, (2) covered or allowed, (3) documented, and (4) adequately or sufficiently documented. Moreover, the Draft OIG Report claims as part of the cost report review that certain costs claimed were not allowable or reimbursable under Medicare regulations. Each of these areas will be separately addressed.

A. Medical Record Review

1. Services Not Reasonable or Necessary

The Draft OIG Report states that $195,150 in charges for 2,164 units were "for PHP services that in the opinion of the medical reviewers did not support that the patients had a mental condition that required the level of intensity of a PHP." As an example. the Draft OIG Report cites a patient who "was not capable of actively participating and benefiting at the intensity of a PHP. She did not retain information and was not actively participating in her treatment in group therapies." It cites a previous episode of care where "the patient had these same symptoms and behaviors of poor memory, inability to concentrate, inability to learn, irrelevant and superficial responses and slow thought processes and these symptoms were not improved with PHP treatment." The OIG Draft Report states that "these were chronic for this patient and consistent with dementia or an organic process." ... [that] "there was no documentation of symptoms that would indicate she had an exacerbation of a chronic psychiatric condition or an acute psychiatric condition" and that "treating her in a PHP was not reasonable and necessary."

Response: Medicare regulations require a certification from the physician that the beneficiary is (a) able to benefit from a coordinated program of services; and (b) that the physician certify that the beneficiary must be able to benefit from a coordinated program of services".[1] All patient records reviewed by the reviewers contained physician certifications as required by Medicare regulations. In each instance the treating physician certified that the patient would require inpatient psychiatric care in the absence of partial hospitalization services.

Hollywood appropriately relied upon certification by its physicians that its patients met these requirements. Further, Hollywood relied upon the response of the patients as observed and documented by its clinicians in the medical record as well as the treatment plan and therapist documentation in support of the physicians certification. Although some of the patients may have cognitive impairments, such impairment does not mean that these patients are not able to benefit from structured, intensive services.

Medicare Intermediary Manual section 3112.7 states that:

> "Services must be for the purpose of diagnostic study or reasonably be expected to improve the patients condition. The treatment must, at a minimum, be designed to reduce or control the patients psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patients level of functioning. It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness,

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1 see program memorandum, HCFA-Pub. 60A, Transmittal NO. A-95-8, June 1,1995

> although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement."

Consequently, patients with chronic conditions may qualify for PHP services as described in the Medicare Intermediary Manual. Nonetheless, the medical reviewer faults a number of claims because the patients have chronic conditions. For example, the patient referenced in the Draft OIG Report concludes that the patient was not capable of actively participating and benefiting at the intensity of the PHP because a previous episode of care in the PHP for this patient showed that the patient had these same symptoms and behaviors of poor memory, inability to concentrate, inability to learn, irrelevant and superficial responses and slow thought processes that were not improved. Even though the patient may have a long-term chronic condition, in each instance the patients condition had been exacerbated by a crisis and the patients attending physician documented the need for PHP services consistent with the section 3112.7 of the Medicare Intermediary Manual.

At Hollywood the patients are well known to the attending physicians who certify that the patients are "able to benefit from a coordinated program of services." Unlike the reviewer who must confine his or her review to discreet past events, the attending physician has an opportunity to examine the patient at the time of admission into the PHP and must exercise future judgment on the probable future course of the patient, such as whether the patient could reasonably be expected to benefit from participation in PHP activities. In many cases the attending physician has been caring for the patient for a number of years and recognizes the progress of the patient and the benefit of PHP that may not be readily apparent to the reviewer.

Further, the reviewer has the benefit of hindsight in reviewing these cases retrospectively. However, the physician must determine at the time of admission to the PHP whether there is a reasonable expectation that the patient can benefit from PHP services. An appropriate physician certification was obtained for all patients, consistent with Medicare regulations and ongoing treatment resulted in control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization.

In numerous instances, such as in claim # 6, 57, 62, 64, 83, 84 and 85, it appears the reviewer interprets the prescribing of a low dosage of Mellaril as negating the medical necessity for PHP services. However, the use of Mellaril for the aging psychiatric patient is supported by current literature (See Exhibit 1) and should not bias the reviewer in making a medical necessity determination.

Services rendered by Hollywood complied with 42 CFR §410.43. Patients accepted into the program were eligible for such services, were properly certified by the patients physician, and received intensive, multidisciplinary services based on the patients individualized needs. Attached as Exhibit 2 is additional documentation to support the services rendered to patients identified as

claim # 7, 9, 12, 15, 16, 28, 36, 45, 46, 53, 71, 80, 84, 89, 99, and 100. Therefore, we respectfully request that the amount denied for each of these claims be reversed.

2.Services Not Covered or Allowed

The Draft OIG Report claims that charges for 246 units were for PHP services "for which there is a Medicare law, regulation or policy which prohibits coverage or a local practice that clearly establishes non-coverage." As an example, the OIG cites services for one patient which included music and occupational therapy. According to the Draft OIG Report these services were recreational and diversionary in nature and not closely related to the patients clinical needs, and, therefore, not covered by Medicare.

Response: Pursuant to 42 CFR §410.43 Partial hospitalization services are services that -

(1) Are reasonable and necessary for the diagnosis or active treatment of the individuals condition;
(2) Are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization; and
(3) Include any of the following:

(i) Individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law.

(ii) Occupational therapy requiring the skills of a qualified occupational therapist.

(iii) Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients.

(iv) Drugs and biologicals furnished for therapeutic purposes, subject to the limitations specified in §410.29.

(v) Individualized activity therapies that are not primarily recreational or diversionary.

(vi) Family counseling, the primary purpose of which is treatment of the individual's condition.

(vii) Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment.

(viii) Diagnostic services.

Hollywood's occupational therapy and music therapy services were administered by professionals with certification and degrees in these treatment modalities. Specifically, Janice Cohen Ribiero and Russell Hilliard served as music therapists during the Audit Period. Mrs. Ribiero has a bachelor's and a master's degree in Music Therapy and is board certified by the Certification Board for Music Therapists, Inc. See Exhibit 3. Mr. Hilliard has a bachelor's degree in music therapy and is also board certified by the Certification Board for Music Therapists, Inc. See Exhibit 4. In addition, during the Audit Period, Barbara Kotaska Gruber and George Kurien were employed by Hollywood as licensed occupational therapists. Both Mrs. Gruber and Mr. Kurien are licensed by the State of Florida and board certified by the American Occupational Therapist Certification Board, Inc. See Exhibit 5.

Music therapy is a research based health profession in which music activities are designed to accomplish non-musical therapeutic goals with patients in a non-threatening environment. Florida State University offers both an undergraduate and graduate degree in music therapy and recognizes that treatment involving the use of music may facilitate learning, healing and change in individuals' lives in the medical, rehabilitative, special education, geriatric and psychiatric settings. The goals and objectives of music therapy include stimulation, coping skills, mood elevation, anxiety reduction, and reality orientation, and, paired with physical or occupational therapy, can reduce anxiety, increase compliance and reinforce progress.

Both occupational and music therapy are recognized treatment modalities and were administered by qualified individuals. Although these treatment modalities might at times appear to be recreational or diversional in nature, at Hollywood they were utilized for specific treatment objectives as documented in the treatment plans and progress notes and based upon observations on the part of qualified professionals. These therapies are therapeutic and are incorporated into a patient's treatment plan when indicated. These therapies were not primarily recreational or diversionary but were a therapeutic part of the Hollywood patient's treatment plan and as such should be covered services in accordance with 42 CFR §410.43. Unfortunately, we were unable to specifically identify the patient in the example cited by the OIG Draft Report. We would appreciate your assistance in this matter so that we can provide you with specific documentation.

In addition to the one example cited, it appears that a number of claims in this category were denied because the reviewer required documentation of a patient interview in order to satisfy the conditions of coverage. Medicare regulations require that PHP services be certified by a physician and that an individualized plan of treatment be established and periodically reviewed by a physician in consultation with appropriate staff participating in the program. See 42 CFR §424.24(e). Similarly, program memorandums issued by the Health Care Financing Administration ("HCFA") in both 1995 ands 1996 have the same requirement. See Program

Memorandum (Intermediaries) No. A-95-8, June 01, 1995 and No. A-96-2, July 1, 1996.

Medicare regulations do not condition coverage upon specific documentation of a physician/patient interview. Rather, Hollywood maintains documentation which shows that the physician establishes the patient's treatment plan in consultation with appropriate staff as evidenced by the physician's order which implements the treatment plan, the treatment team minutes and the physician's weekly progress notes. See Exhibit 6 which includes specific documentation for claims # 4 and 55.

In addition, the reviewer appeared to take exception to the manner in which the physician developed his weekly progress notes. The Hollywood physicians directly observed patients enrolled in the PHP and participated in the development, monitoring and care of the patient. After a course of therapies generally over a five to seven day period, the physician would dictate his progress note for that period. The day of dictation may have occurred on a Saturday or Sunday but evidenced his observation, supervision and evaluation of the patient over the course of the week. Moreover, it is important to recognize that these patients were under the care of a physician and were routinely seen by the patient's attending physician. In most cases, the patient's attending physician was also the Hollywood physician.

With respect to claim # 4 and 55, the reviewer acknowledges that documentation supported that the patient's condition required the PHP level of care. The documentation submitted demonstrates that the PHP services were certified by the physician and that an individualized plan of treatment was established and periodically reviewed by the physician in consultation with appropriate staff participating in the program in accordance with Medicare regulations. Therefore, we respectfully request that the amount denied for each of these claims be reversed. With respect to claim # 47, an individualized plan of treatment was developed by each discipline participating in the treatment of the patient. See Exhibit 7. The reviewer, however, stated that the goal of art therapy did not relate to the patient's problem.

The patient was diagnosed with schizoaffective disorder, bipolar type. The patient was anxious and had a disorganized thought process for which art therapy was provided as one means of assisting the patient in more clearly expressing himself as evidenced by the treatment plan for art therapy See Exhibit 8. The reviewer also states that nursing did not note that the patient was on antidepressant or mood stabilizer and that absences in the program were not addressed. However, such information was so noted. See Exhibit 9. Again, we believe the documentation meets the conditions of coverage and request that the amount denied be reversed.

3. No Documentation

The Draft OIG Report cites Title 42 CFR §482.24 which states, "A medical record must be maintained for every individual evaluated or treated in the hospital..." It states that its review found "$5,400 in charges for 60 units were for PHP services that in the opinion of

the medical reviewers did not have any documentation to support the services rendered" and that "for one patient, there was no documentation to support that services were ordered, reasonable and necessary and provided as billed."

Response: Hollywood maintains patient information on all its patients which includes information required by Medicare regulations and Mutual of Omaha Medicare ("MOM") LMRP No. 94-I December, 1994 ("LMRP 94-1"). As stated in LMRP 94-1, "in addition to progress notes, other forms of documentation may be furnished to the intermediary to support the patient's need for intensified PHP services. The supporting documentation may include, but is not limited to, case management notes, treatment team notes, weekly progress notes and physician summaries." Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. Program Memorandum, HCFA-Pub. 60A, No. A-99-39, September 1, 1999 states that a provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the services, the patient's response to the therapeutic intervention, and its relation to the goals indicated in the treatment plan. Thus, for payment purposes the documentation required relates to the services provided by Hollywood.

There is ample evidence of documentation as shown in Exhibit 10 to support the services rendered for claims # 9, 70 and 96. It appears, however, that the reviewers either overlooked the documentation or sought specific documentation in the medical record that may have been identified elsewhere consistent with LMRP 94-1 . As a result of the documentation provided, we respectfully request that the denial of $5,400 for services not documented be reversed.

4. Inadequate/Insufficient Documentation

The Draft OIG Report that "$4,950 in charges for 55 units were for PHP services that in the opinion of the medical reviewers did not have adequate/sufficient supporting documentation to meet Medicare reimbursement criteria." The Draft OIG Report again cites Title 42 CFR §482.24 which states "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." As an example, the Draft OIG Report states "goals in the treatment plan for one patient were not address and documentation was not provided to support all the services were provided as billed."

Response: 42 CFR §482.24 describes medical record services required of hospitals as a condition of participation. Generally the requirements are equally applicable to inpatient and outpatient services. Regarding specific content of the record, 42 CFR §482.24 (c) (2) describes eight (8) items required in medical records, as appropriate. (Emphasis added). That section states: "All records must document the following, as appropriate:"

(i) Evidence of a physician examination,including a health history, performed no more than 7 days prior to admission or within 48 hours after admission.

(ii) Admitting diagnosis.

(iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.

(iv) Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.

(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.

(vi) All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.

(vii) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.

(viii) Final diagnosis with completion of medical records within 30 days following discharge.

Included in the Medicare regulation is the flexibility to include those items as appropriate. Clearly, in the outpatient setting in general, and specifically as appropriate in PHP services, many of the above eight (8) items are not appropriate at all, or may not be appropriately required in one physical record for an individual patient particularly where the patient is also undergoing care simultaneously with the attending physician.

Further, the preamble to the final regulations revising requirements that hospitals must meet in order to participate in the Medicare and Medicaid programs, states "The conditions and accompanying standards specified in the regulations are used by HCFA surveyors as a basis for determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid..." Another basis for making such a determination is accreditation by JCAHO. As stated at 42 CFR §488.5, Institutions accredited as hospitals by the JCAHO or AOA are deemed to meet all of the Medicare conditions of participation, except:

(1) The requirement for utilization review as specified in section 1861(e)(6) of the Act and in §482.30 of this chapter;

(2) The additional special staffing and medical records requirements that are

considered necessary for the provision of active treatment in psychiatric hospitals (section 1861 (f) of the Act and implementing regulations); and

(3) Any requirements under section 1861 (e) of the Act and implementing regulations that HCFA, after consulting with JCAHO or AOA, identifies as being higher or more precise than the requirements for accreditation (section 1865(a)(4) of the Act.

Hollywood is accredited by JCAHO and for the Audit Period was fully accredited *with commendation* by JCAHO. Accordingly, it is deemed to have met all of the Medicare conditions of participation. The JCAHO Hospital accreditation standards, at MS.6.3 states:

> "The medical staff determines those non-inpatient services (for example, ambulatory services), if any, for which a patient must have a medical history taken and an appropriate physician examination performed by a qualified physician who has... privileges..."

The JCAHO standard providing flexibility as to the need for medical history and physicals on non-inpatients is contrary to the interpretation that Medicare regulations require a history and physical on all patients, both outpatient or inpatient. Thus, the blanket application of 42 CFR §482.24 as to the required content of the medical record in the PHP setting appears inappropriate. Hollywood maintains information on all its patients which includes documentation specifically required by JCAHO, Medicare regulations and Mutual of Omaha Medicare ("MOM") LMRP No. 94-1 December, 1994 ("LMRP 94-1"). As stated in LMRP 94-1, "in addition to progress notes, other forms of documentation may be furnished to the intermediary to support the patient's need for intensified PHP services. The supporting documentation may include, but is not limited to, case management notes, treatment team notes, weekly progress notes and physician summaries." Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. Program Memorandum, HCFA-Pub. 60A, No. A-99-39, September 1, 1999 states that a provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the services, the patient's response to the therapeutic intervention, and its relation to the goals indicated in the treatment plan. Thus, for payment purposes the documentation required relates to the services provided by Hollywood.

With respect to claim # 58, there is ample evidence of documentation to support the services rendered. See Exhibit 11. The reviewer acknowledges that the patient's symptoms support that services provided were medically reasonable and necessary. However, the reviewer concluded that the services were not allowed because the provider did not provide active treatment intervention because there was no documented follow up to ensure the patient was adequately medicated to manage her symptoms, the patient was not improving and the patient's ability to participate and benefit was impaired by hallucinations. Further, the reviewer stated that the goals of the treatment plans were not addressed in documentation. However, the attached documentation reveals that there were seven attempts to follow up on the medication management

of the patient. Moreover, the attached documentation demonstrates that treatment was rendered consistent with the individualized treatment plan and the services were medically reasonable and necessary. Consequently, we respectfully request that the total amount denied be reversed.

B. Cost Report Review

The Draft OIG Report states that it identified $987,620 of $3.3 million in outpatient psychiatric service costs that were not allowable or reimbursable according to Medicare regulations. In general, our exceptions relate to the impact of the adjustments recommended in the Draft OIG Report. After the adjustments and reclassifications are made, the impact on the outpatient psychiatric services cost is substantially less than $987,620 and the effect of the reclassifications will improve the reimbursement for inpatient hospital services and the skilled nursing facility.

Hollywood believes the impact of the adjustments should be considered so as to not mislead the readers of this Draft OIG Report. The actual impact of any adjustment on the Health Care Complex's overall reimbursement is contingent on any other adjustment and on a number of other factors, such as program charges. Therefore, we have taken a "simplistic" approach on the individual adjustments described below to reflect an approximate reimbursement impact.

1. Improper Allocations

The OIG Draft Report costs of non-revenue producing states that Title 42 CFR §413.24(d)(1) recognizes that "all centers are allocated to all centers they serve, whether or not these centers produce revenue." It indicated that Hollywood "arbitrarily" allocated $664,712 to the PHP and that these costs should have been allocated to the hospital's various programs based on the benefit received. Moreover, because time logs were not available the Medical Director fees and Psychiatric Director fees were treated as professional component.

Medical Director and Psychiatric Director Fees

The $148,500 fee for the Medical Director (NO LONGER RELEVANT) are hospital only expenses and should be allocated based on the accumulated costs of the PHP versus the inpatient hospital unit resulting in eighty six percent (86%) of these costs allocated back to the PHP.

Per B-I, Column 6:

Line 25	Adults and Pediatrics	$ 391,290	14%
Line 63	Other Outpatient Services	2,395,912	86%
		$2,787,202	100%

Hollywood treated these fees as a provider component. Section 2101.1 of the PRM distinguishes between professional and provider components. The professional component of provider-based physician's services pertains to that part of the physician's activities which is directly

related to the medical care of the individual patient. It represents remuneration for the identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or to his treatment. The portion of the physician's activities representing services which are not directly related to an identifiable part of the medical care of the individual patient is the provider component. Reimbursement for provider component services can be made only to a provider on the basis of its allowable reasonable costs.

Provider services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physician's provider service activities.

The relationship between Hollywood and each of the physicians supports a one hundred percent (100%) allocation of compensation for provider services and does not include compensation for direct patient care services which are separately billable by each of the Hollywood physicians. Thus, these costs cannot be considered as professional component costs because the contract and services performed under the contract for which the cost relate are solely and specifically provider component costs. Therefore, these costs were correctly stated in Hollywood's FY 1998 cost report and the proposed adjustment is improper.

Office Staff Costs

(NO LONGER RELEVANT)

Medical Records Staff Cost

(NO LONGER RELEVANT)

2. Patient Transportation

The OIG Draft Report states that the Medicare Intermediary Manual, Section 3112.7 states transportation costs are not reimbursable.

Salaries

The proposed adjustment removes fifty percent (50%) of the drivers' compensation which was based on the reviewer's discussion with Hollywood's chief operating officer. The individuals who serve as drivers also serve as mental health technicians when not driving. Upon further study by the chief operating officer, we believe a more accurate reflection of the driving time would be thirty seven and one-half (37.5%) based on the drivers' actual schedules which is as

follows:

Report to hospital

Begin driving and pickups	8:15
Return to facility	9:45
Begin treatments	10:00
1/2 hour lunch	
End treatments	2:00
Begin driving and drop-offs	2:30
Return to facility	4:00
Leave hospital	4:30

As a result, only three (3) of the eight (8) hour days were related to nonallowable driving time. In addition, Hollywood's associate administrator has multiple administrative responsibilities which includes payroll and other administrative tasks related to the operation of Hollywood and he serves as the director of transportation. Based on the driver's time it would appear equitable to allow sixty two and one-half percent (62.5%) of the associate administrator's compensation as an allowable cost and disallow the remaining thirty seven and one-half (3 7.5%) as a nonallowable expense. These adjustments would reduce the $191,785 proposed adjustment to $115,620.

Lease and Insurance Expense

Hollywood utilized one of its vehicles specifically to transport employees from offsite parking. No credit was afforded Hollywood for this vehicle or the usage of the vehicles for the nursing home operation. Hollywood contends that the lease and insurance expenses for one of the eight vehicles is an allowable cost.

Under 42 U.S.C. §1395x(1)(A), the reasonable cost of any service shall be the cost actually incurred in the official delivery of health care services determined in accordance with regulations that establish the methodology to be used. Under 42 C.F.R. §4 13.9, reasonable costs are those that are necessary and proper costs incurred in furnishing services. Such costs are those that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Costs incurred by Hollywood to transport employees to offsite facilities are necessary and proper costs that directly relate to patient care. Such costs are not specifically excluded as unallowable costs related to patient care or unallowable costs not related to patient care. See HCFA Pub. 15-1 2102.3 - 2182. As a result, the proposed adjustment should be modified to reflect the allowable costs for one vehicle.

In addition, as clarification, Hollywood did not claim the fuel and repair expense of $49,579 as a PHP cost but rather as Administrative and General cost. As a result, only a percentage of

these costs were stepped down to the PHP.

3. Square Footage

The OIG Draft Report notes that based on measures of the hospital's blueprints, nursing home space was included in the PHP square footage. Hollywood concurs that there was a clerical error in the square footage determination of the PHP. Hollywood has undertaken an extensive review of the entire Health Care Complex square footage utilization to ensure accurate cost allocations are made in future cost reports

4. Home office Costs

The OIG Draft Report states that the home office had costs totaling $613,812 and that of these, the OIG identified $88,801 in costs not related to patient care.

Hollywood contends that $68,701 in legal fees are allowable. Legal costs of $68,701 are reasonable and necessary expenditures and related to patient care. Under 42 USC Sec. 1395x(1)(a), the reasonable cost of any service shall be the cost actually incurred in the official delivery of health care services determined in accordance with regulations that establish the methodology to be used. Under 42 CFR Sec. 413.9, reasonable costs are those that are necessary and proper costs incurred in furnishing services. Such costs are those that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. The legal fees incurred and claimed were not for legal expenses specifically excluded as unallowable costs not related to patient care. See HCFA Pub. 15-1, Sec.2183.

The legal costs were appropriate and helpful in developing and maintaining the operation of the patient care facilities and activities. Legal counsel for Hollywood met on an ongoing basis with executive management and officers of Hollywood regarding operational issues to include reimbursement, purchasing, patient care responsibilities and rights. The legal costs are supported by independent third party billings. The cost both ($68,701) and per hour ($250.00) is reasonable for the geographic region and the experience and expertise of the legal professional providing the service. Hollywood self-disallowed $6,000 in legal fees not related top patient care. The remaining $68,701 are reasonable, necessary and related to patient care in accordance with Medicare regulations and we request that the proposed adjustment be reversed.

In addition, Hollywood also requests a revision to the wording related to the meals and entertaining expenses of $20,100. The Draft OIG Draft Report indicates these costs are not related to patient care. However, $20,100 represents primarily expenses of meals with management personnel of the entities managed by the Home Office in Broward County, Florida or the locale of the northern facilities and therefore are costs related to patient care. We believe the underlying documentation to support the allowability of the costs may have been insufficient in the eyes of the auditors and the OIG Draft Report should reflect lack of adequate supporting documentation only.

In summary, we believe that the documentation attached supports both a reversal of a number of claims denied by HCFA reviewers and a reversal of certain proposed adjustments to Hollywood's FY 1998 cost report as discussed above. Further, we request a meeting with you at your earliest convenience to discuss the Draft OIG Report and the additional information being submitted.

Very truly yours,

Karen Kallen-Zury
Chief Executive Officer