DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services
REGION IV
61 Forsyth Street, Room 3T41
Atlanta, GA 30303-8909

# Memorandum

Date: April 28, 1998

From: Regional Inspector General
for Audit Services, Region IV

Subject: Final Report - Review of Florida Adult Care Enterprise
Partial Hospitalization Program (CIN: A-04-97-02130)

To: Rose Crum-Johnson
Regional Administrator
Health Care Financing Administration

This report provides you with the results of our review of the Florida Adult Care Enterprise (FACE) partial hospitalization program (PHP). Medicare covers partial hospitalization services that are reasonable and necessary for the diagnosis and treatment of the individual's mental condition, and reasonably expected to improve or maintain the individual's condition and functional level to prevent relapse or hospitalization.

## EXECUTIVE SUMMARY

The objective of our review was to determine whether the PHP services claimed by FACE on behalf of 40 beneficiaries met the Medicare eligibility and reimbursement guidelines.

### SUMMARY OF FINDINGS

We reviewed the services provided to 40 Medicare beneficiaries for whom FACE submitted claims for PHP services for the period of October 1995 through March 1997 representing net reimbursement of $1,709,245. The medical review conducted by the fiscal intermediary (FI) personnel concluded that none of the services claimed during the reviewed period met the Medicare reimbursement criteria.

- The FI medical review staff determined that all of the services claimed by the provider for the 40 beneficiaries should be denied because the services were not considered medically necessary. The determination was based on the results of a review of the medical records by the FI for each of the beneficiaries. The review of medical records showed that services provided were not ordered by a physician, were not reasonable and necessary, were provided to ineligible beneficiaries, and lack the required documentation.

- The FI medical review staff redetermined that all of the services for the 40 beneficiaries should be denied after reviewing additional documentation requested from the provider.

From October 1995 through March 1997, the provider claimed gross charges totaling $3,197,369 on behalf of the 40 beneficiaries, and was reimbursed $1,709,245. We determined that the $1,709,245 reimbursed for these beneficiaries did not meet the Medicare reimbursement guidelines and, therefore, constitute overpayments.

Our review showed the provider was not familiar with Medicare guidelines for PHP services. Also, the provider did not conduct monitoring activities to ensure that the services were medically necessary and were provided to eligible Medicare beneficiaries. The provider established business relationships with assisted living facilities (ALF) operators to assist in identifying and enrolling beneficiaries into the PHP. Neither FACE nor the ALFs were cognizant of the eligibility rules.

We recommended that the Health Care Financing Administration (HCFA) instruct the FI to recover the amount of the overpayment and consider whether or not additional claims should be reviewed to identify additional overpayments.

The FI agreed with our audit findings and placed the provider on a complete suspension of payments until the amount of overpayment was recovered. The Miami Health Care Financing Administration/Operation Restore Trust (ORT) satellite office also agreed with our findings and recommended the suspension and termination of the provider from the Medicare program. The HCFA regional office responded to our draft report indicating their agreement with our findings and recommendations. The HCFA regional office's response is attached to this report as Appendix B.

The HCFA terminated the provider from the Medicare program effective August 15, 1997. The HCFA's decision was communicated in a letter to the provider dated July 24, 1997.

## Background

### The Florida Adult Care Enterprise

The FACE is a for-profit corporation with a principal place of business in Hollywood, Florida. The effective date of participation in the Medicare program was June 29, 1995.

The FACE was granted a Medicare provider number based on a self-attestation statement certifying compliance with the Federal requirements in section 1861(ff)(3)(B) of the Social Security Act and in conformance with provisions of section 1866 concerning Medicare provider agreements. The self-attestation process requires the applicant to attest that they

comply with the requirements of a Community Mental Health Center (CMHC) as defined by the Public Health Service (PHS) Act and that they provide the services required by the Act.

A Medicare certified CMHC can either provide PHP services directly or under arrangement with other providers to render the services. The majority of the services claimed by FACE were provided by independent contractors at ALFs. The FACE directly and indirectly employs psychiatrists, nurses, therapists, and administrative personnel in Broward County.

From October 1995 through March 1997, FACE received interim payments totaling $3,648,808 representing 245 Medicare beneficiaries. These payments are adjusted to actual cost based on annual cost reports.

**Fiscal Intermediary Responsibilities**

The HCFA contracts with FIs, usually large insurance companies, to assist them in administering the PHP benefit program. The FI for FACE is Mutual of Omaha Insurance Company in Omaha, Nebraska. The FIs are responsible for the following functions:

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

**Laws**

Title XVIII of the Social Security Act authorizes the Medicare program to provide medical benefits to individuals who are age 65 or over, and certain individuals under age 65 who are disabled or suffer end stage renal disease. Section 1832 of the Act established coverage of partial hospitalization services for Medicare beneficiaries. Section 1861(ff)(2) of the Act generally defines partial hospitalization services as those (mental health) services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish.

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. The PHS has primary responsibility for regulating CMHCs. Section 1916(C)4 of the PHS Act lists the services that must be provided by a CMHC. The legislation states that any entity that provided these services would be considered a CMHC for purposes of the Act.

Section 1833 (a)(2)(b) of the Act provides that CMHCs will be paid for 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 Medicare cost report for the year, the FI makes a settlement payment based on the reasonable costs incurred.

## OBJECTIVE, SCOPE, & METHODOLOGY

### Objective

The objective of our review was to determine whether the services claimed by FACE met the Medicare eligibility and reimbursement guidelines.

### Scope and Methodology

Our review was performed in accordance with generally accepted governmental auditing standards. We reviewed services claimed by FACE for 40 beneficiaries who received services between October 1995 and March 1997. We limited our review to the 40 beneficiaries for whom FACE had received the largest amount of reimbursement for services.

The claims reviewed were submitted during the period October 1995 through March 1997. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed met the Medicare eligibility and reimbursement guidelines.

Generally, for each of the 40 beneficiaries, we interviewed the following:

- the beneficiary or a close relative;
- the physician who signed the plan of care;
- the beneficiary's personal physician, if one was identified; and
- the ALF operator of the facility where the beneficiaries resided.

We obtained and reviewed the medical records maintained by the provider for each of the 40 beneficiaries. The medical records were also reviewed by the FI's medical review staff to determine whether the services claimed met the Medicare eligibility and reimbursement requirements.

Our field work was conducted at the CMHC in Hollywood, Florida, ALF facilities in Broward County, and the Miami field office. The interviews were conducted at the ALFs, the physicians' offices, and the CMHC. Our field work was started in March 1997 and completed in April 1997. Our field work was assisted by a FI field representative whose conclusions are considered relevant and, therefore, included in our report.

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

## DETAILED RESULTS OF REVIEW

Our review showed that all of the services claimed by FACE for the 40 beneficiaries were unallowable because the services were not medically necessary. The review of medical records showed that services provided were not ordered by a physician, were not reasonable and necessary, were provided to ineligible beneficiaries, and lacked the required documentation.

Although FACE submitted supplemental documentation in an attempt to reverse the unallowable determinations, the FI medical review staff concluded the supplemental records did not support the services claimed. For the 40 beneficiaries reviewed, FACE was reimbursed $1,709,245 between October 1995 and March 1997.

Additionally, the FI concluded that the services claimed for 37 of the 40 beneficiaries were not ordered by a physician. Title 42 CFR 410.110(a) requires that partial hospitalization services be prescribed by a physician and furnished under the general supervision of a physician. In addition, physician certification is required under the procedures for payment established by section 1835(a)(2)(F) of the Act.

### Medical Necessity

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

The medical review by the FI's medical review staff showed that services provided were not ordered by a physician, not medically necessary, lacked the required documentation, and were provided to ineligible beneficiaries.

**Cause**

Our review showed the provider was not familiar with the Medicare guidelines for PHP services. Also, the provider did not conduct monitoring activities to ensure that the services were provided to eligible Medicare beneficiaries and that the services were medically necessary. The provider established business relationships with operators of ALFs. Our review showed that all 40 beneficiaries reviewed resided in ALFs. They were approached by a provider representative who enrolled them in the PHP program and most of the services were provided at the ALF facilities. Although beneficiaries living in adult facilities are not specifically precluded from receiving PHP services, we do think it is inappropriate for the provider to target individuals living in these facilities and pursue referrals through provider representatives.

During an interview with the owners of the CMHC, they admitted that they were not familiar with the level of services that CMHCs are required to offer. In addition, we found that approximately 30 of the 34 therapists who conducted group therapy sessions at the ALFs did not possess the required State licenses.

The owners also indicated that they did not pursue collection of the 20 percent copay not covered by Medicare. The copayment acts as a control to ensure that the beneficiary received and needed the services provided.

**Effect**

Our review showed that all of the services claimed by FACE for the 40 beneficiaries from October 1995 through March 1997, representing net reimbursement of $1,709,245 should be denied because the beneficiaries did not meet the Medicare eligibility criteria, services were not reasonable and necessary, and the supporting documentation did not meet the reimbursement guidelines.

**Recommendations**

We recommend that HCFA:

- instruct the FI to recover the overpayment,
- consider decertification actions against the provider, and

- determine whether additional claims should be reviewed to identify additional overpayments.

On November 17, 1997, HCFA agreed with our recommendations and stated that they placed the provider on payment suspension effective April 8, 1997. On August 15, 1997, this provider was terminated from the Medicare program.

Charles J. Curtis

2 Attachments

**APPENDIX A**

MAJOR CONTRIBUTORS TO THIS REPORT

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|---|---|
| HHS OIG Office of Audit Services, Region IV | Gerald Dunham, HCFA Audit Manager<br>(404) 331-2446, ext. 107 |
| | Mario E. Pelaez, Senior Auditor<br>(305) 536-5309, ext. 15 |
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APPENDIX B

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★ ★ ★ OPERATION RESTORE TRUST ★ ★ ★

November 17, 1997

Jerry Dunham
Office of the Investigator General
P.O. Box 2047
Atalanta, Georgia 30301

RE: Florida Adult Care Enterprises (Provider number 10-4759)

Dear Mr. Dunham:

This letter is to inform you that the Health Care Financing Administration is in agreement with the findings and recommendations offered by the Office of the Inspector General on the above mentioned provider. Due to this provider's failure to meet federal requirements for participation in the Medicare program as a Community Mental Health Center, HCFA terminated this provider's Medicare participation agreement on August 15, 1997. HCFA has also placed the provider on payment suspension. Should you have any questions please call me at (305) 536-6540. Thank you.

Sincerely,

W Dewey Price

William Dewey Price, Team Leader
HCFA Miami Satellite Office