

**Memorandum**

Date • APR 16 2001
From Deputy Inspector General
for Audit Services

Subject Review of Outpatient Psychiatric Services Provided by College Hospital for the
Calendar Year Ended December 31, 1998 (A-09-00-00067)

To Mark E. Miller, Ph.D.
Acting Director
Center for Health Plans and Providers, HCFA

This memorandum is to alert you to the issuance on Wednesday, April 18, 2001 of our final report entitled, "Review of Outpatient Psychiatric Services Provided by College Hospital for the Calendar Year Ended December 31, 1998." A copy of the report is attached. The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements. We found that the College Hospital (Hospital), located in Cerritos, California, did not have adequate procedures in place to ensure that services billed to the Medicare program were reasonable and medically necessary for the treatment of the patient's condition. We believe our audit findings are significant in that over \$560,000 of the almost \$1.8 million of submitted charges from the Hospital, as outlined below, did not meet Medicare's reimbursement criteria.

This audit of hospital outpatient claims was conducted in conjunction with our review of outpatient psychiatric services at psychiatric hospitals, in which our office found significant error rates regarding provider compliance with Medicare requirements. We previously reported the results of several reviews of hospital specific outpatient services. Additional reviews of hospital specific outpatient psychiatric services are in process and the results will be reported to you upon completion of each review.

Our review at the Hospital determined that a significant amount of the outpatient psychiatric charges submitted by the Hospital did not meet the Medicare criteria for reimbursement. Specifically, we identified charges for psychiatric services that were either unreasonable or unnecessary for the treatment of the patient's condition, or were not adequately supported by the underlying medical records. Based on a statistical sample, we estimate that at least \$567,888 in outpatient psychiatric charges submitted by the Hospital did not meet Medicare criteria for reimbursement.

We recommended that the Hospital strengthen its procedures to ensure that 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 fiscal intermediary (FI) so that it can apply the appropriate adjustments of \$567,888 to the Hospital's Calendar Year 1998 Medicare cost report.

Page 2 - Mark E. Miller, Ph.D.

The Hospital, in its January 24, 2001 response to our draft report, disagreed with the findings and recommendations. In regard to our finding of \$567,888 in estimated overpayments, the Hospital stated that the Office of Inspector General's report reflected a fundamental misunderstanding and misapplication of the Medicare coverage criteria for partial hospitalization services.

We believe that our final audit determinations are correct and in accordance with Medicare requirements. The basis for our position is discussed in detail beginning on page 9 of the attached report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Lori Ahlstrand, Regional Inspector General for Audit Services, Region IX, (415) 437-8360.


Thomas D. Roslewicz

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT
PSYCHIATRIC SERVICES PROVIDED BY
COLLEGE HOSPITAL FOR THE
CALENDAR YEAR ENDED
DECEMBER 31, 1998**



**APRIL 2001
A-09-00-00067**



Region IX
Office of Audit Services
50 United Nations Plaza
Room 171
San Francisco, CA 94102

CIN A-09-00-00067

Mr. Stephen Witt,
Chief Executive Officer
College Hospital
10802 College Place
Cerritos, California 90703

Dear Mr. Witt:

Enclosed are two copies of the 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 College Hospital for the Calendar Year Ended December 31, 1998." A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

Final determination 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 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-09-00-00067 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Ahlstrand".

Lori Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Page 2 - Mr. Stephen Witt

Direct Reply to HHS Action Official:

Ms. Elizabeth C. Abbott
Regional Administrator
Health Care Financing Administration
75 Hawthorne Street, 4th Floor
San Francisco, California 94105-3901

EXECUTIVE SUMMARY

BACKGROUND

The College Hospital (Hospital) in Cerritos, California, provides outpatient psychiatric services, through its partial hospitalization program (PHP), to patients of the greater Los Angeles area. The Hospital submitted for Medicare reimbursement 1,216 claims for outpatient psychiatric services provided through its PHP valued at \$1,796,666 during Calendar Year (CY) 1998.

The Medicare Intermediary Manual, section 3112.7, identifies a wide range of services a hospital may provide to patients who need outpatient psychiatric care. For such services to be covered, they must be "...reasonable and necessary for the diagnosis or treatment of the patient's condition." Further, 42 CFR section 482.24 states that, "A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services." Further, Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care.

OBJECTIVES OF REVIEW

The objectives of our review were to determine whether outpatient psychiatric services were billed and reimbursed in accordance with Medicare requirements, and to test the reasonableness of selected expenses reported on the related cost report.

SUMMARY OF OIG REVIEW

Our review of 100 claims submitted to Medicare for outpatient psychiatric services by the Hospital showed that 44 claims included charges for services that were either unreasonable or unnecessary for the treatment of the patient's condition, or were not adequately supported by the underlying medical records. The charges which did not meet Medicare criteria on the 44 claims represented \$63,504 of the \$157,164 reviewed, or 40 percent. We also reviewed selected expense accounts relating to outpatient psychiatric services on the Hospital's CY 1998 Medicare cost report, and found no indication of any unallowable or unreasonable costs under Medicare guidelines.

Based on an extrapolation of the statistical sample, we estimate that the Hospital overstated its CY 1998 Medicare outpatient psychiatric charges by at least \$567,888. This occurred because the Hospital did not have adequate procedures in place to ensure that services billed to Medicare were reasonable and medically necessary or to ensure that the services billed were sufficiently documented.

Unreasonable and Unnecessary Charges. With the assistance of medical reviewers from the Health Care Financing Administration's (HCFA) contracted peer review organization (PRO) and the Medicare fiscal intermediary (FI), we determined that \$62,706 of total charges reviewed were unreasonable or medically unnecessary due to the patient's inability to:

- (1) actively participate or comply with the active treatment process, or
- (2) benefit from the level of treatment or intensity of the PHP services.

We concluded that the Hospital did not have adequate procedures in place to ensure that services billed to the Medicare program were reasonable and medically necessary for the treatment of the patient's condition.

Insufficient Medical Record Documentation. We also determined that \$798 in outpatient psychiatric charges were not properly supported by medical record documentation. Our review showed a weakness in the Hospital's system of internal controls regarding medical record documentation supporting some of the services.

RECOMMENDATIONS

We recommend that the Hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are covered under Medicare and properly documented in accordance with Medicare regulations and guidelines. In addition, we will provide the FI with the results of our review, so that it can apply the appropriate adjustment of \$567,888 to the Hospital's CY 1998 Medicare cost report.

The Hospital disagreed with our findings and recommendations. Their response is included in APPENDIX B of this report.

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INTRODUCTION

BACKGROUND

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

There is a wide range of services and programs that a hospital may provide to its outpatients who need psychiatric care, ranging from a few individual services to comprehensive, full-day programs, such as PHP and from intensive treatment programs to those that provide primarily supportive, protective, or social activities. To be reimbursable under Medicare:

- ◇ Outpatient hospital psychiatric services must be "...reasonable and necessary for the diagnosis or treatment of the patient's condition...Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized...The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed." [Medicare Intermediary Manual section 3112.7]
- ◇ The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment. Noncovered services include activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. [Medicare Intermediary Manual section 3112.7]

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

In addition, for patients receiving a PHP level-of-care, the following requirements also apply:

- ⇒ “It is reasonable to expect the plan of treatment to be established within the first 7 days of a patient’s participation in the program, and periodic reviews to be performed at least 31 days thereafter.” [HCFA Program Memorandum, Publication 60A]
- ⇒ A physician must also certify and recertify 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.” [HCFA Program Memorandum, Publication 60A]

Medicare reimbursement is based on reasonable costs. “It is the intent of the program that providers are reimbursed the actual costs of providing high quality care...Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service...If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.” [Provider Reimbursement Manual, part 1, section 2102.1]

The Hospital in Cerritos, California, provided outpatient psychiatric services, through its PHP, to patients of the greater Los Angeles area. The Hospital submitted for Medicare reimbursement 1,216 claims for outpatient psychiatric services provided through its PHP valued at \$1,796,666 during CY 1998.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of our review was to determine whether outpatient psychiatric services were billed and reimbursed in accordance with Medicare requirements. We also tested the reasonableness of selected expenses reported on the related Medicare cost report. Our review included claims with dates of service during CY 1998. We conducted our review during the period of December 1999 through September 2000 at the Hospital in Cerritos, California, 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 the review did not require an understanding or assessment of the complete internal control structure at the Hospital.

To accomplish our objective, we:

- ⇒ reviewed Medicare criteria related to outpatient psychiatric services;
- ⇒ obtained an understanding of the Hospital's internal control over Medicare claims submission;
- ⇒ used the Hospital's CY 1998 Provider Statistical and Reimbursement Report provided by the FI to identify the 1,216 claims for outpatient psychiatric services submitted by the Hospital valued at \$1,796,666;
- ⇒ employed a simple random sample approach to select a statistical sample of 100 outpatient psychiatric claims;
- ⇒ performed detailed audit testing on the billing and medical records for the claims selected in the sample;
- ⇒ utilized medical review staff from the California PRO and from Mutual of Omaha, the Medicare FI, to review the 100 claims for outpatient psychiatric services;
- ⇒ used a variable appraisal program to estimate the dollar impact of improper payments in the total population; and
- ⇒ provided the FI with the results of our claims review for their review and adjudication.

In addition, we tested the appropriateness and reasonableness of selected expenses on the CY 1998 Medicare cost report through a review of supporting documentation.

FINDINGS AND RECOMMENDATIONS

In CY 1998, the Hospital submitted to Medicare for reimbursement \$1,796,666 in outpatient psychiatric charges. We reviewed the medical and billing records for 100 statistically selected claims which included 3,742 individual services totaling \$157,164 in billed charges. Our analysis showed that \$63,504 of the sampled charges did not meet Medicare criteria for reimbursement. Specifically:

- (1) \$62,706 of the sampled charges were for services that were not reasonable or medically necessary; and
- (2) \$798 of the sampled charges were for services not sufficiently documented in the medical record.

Based on an extrapolation of the statistical sample, we estimate that the Hospital overstated its CY 1998 Medicare outpatient psychiatric charges by at least \$567,888. This occurred because the Hospital did not have adequate procedures in place to ensure that services billed to Medicare were reasonable and medically necessary or to ensure that the services billed were sufficiently documented.

Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We reviewed selected expense accounts relating to outpatient psychiatric services on the Hospital's CY 1998 Medicare cost report, and found no indication of unallowable or unreasonable costs under Medicare guidelines.

Findings from our review of medical records are described in detail below.

MEDICAL RECORDS REVIEW

Unreasonable and Medically Unnecessary Services

During the course of the review, we found that the Hospital claimed \$62,706 in outpatient psychiatric charges for PHP services that were unreasonable and unnecessary for the treatment of the patient's condition. Based on documentation in the medical records, reviewers concluded that the psychiatric services were unreasonable and medically unnecessary.

The Medicare Intermediary Manual, section 3112.7 identifies a wide range of services a hospital may provide to patients who need outpatient psychiatric care. For such services to be covered, they must be "...reasonable and necessary for the diagnosis or treatment of the patient's condition."

With the assistance of medical reviewers from the PRO and FI, we determined that \$62,706 of total charges reviewed were unreasonable or medically unnecessary due to the patient's inability to:

- (1) actively participate or comply with the active treatment process (\$28,098); and
- (2) benefit from the level of treatment or intensity of the PHP services (\$34,608).

In the first situation, the PRO and FI determined that \$28,098 of the \$62,706 in unreasonable and unnecessary charges were for services in which the patient was unable to actively participate. The HCFA Program Memorandum, Publication 60A specifically states that "Patients who refuse or who cannot participate (due to their behavioral, cognitive, or emotional status) with the active treatment process...." would not benefit from the intense level of care provided under the Medicare PHP.

Examples from the medical reviewers' results include:

In the review of 1 claim for 32 group sessions totaling \$1,344 in charges, the medical reviewer noted:

"The documentation clearly shows the patient was not able to actively participate and benefit in the program. He had to be readmitted to the in-patient unit during this course of treatment, and had been in and out of the program frequently in the past. The staff had occasion to know this patient's inability to participate and benefit from this type of program. Services denied as this type of program was not appropriate to treat this patient's mental condition."

In the review of 1 claim for 19 group sessions totaling \$798 in charges, the medical reviewer noted:

"Her consistent record of non-compliance and non-attendance does not support a willingness to actively participate in the program. The documentation does not support that the services were reasonable and necessary for the patient's mental condition."

In the review of 1 claim for 12 group sessions totaling \$504 in charges, the medical reviewer noted:

“Group documentation on 8/7/98 stated that [the patient] laughed frequently to himself and made several off topic remarks. He had a poor ability to focus and concentrate on task. The Physician Weekly Progress Note on 8/3-8/7/98 stated the patient had been non-compliant with attendance and had been wandering off during the day. Services are denied as the patient was non-compliant with the program.”

In the review of 1 claim for 16 group sessions totaling \$672 in charges, the medical reviewer noted:

“It was obvious that for whatever reason this patient was unable to participate or benefit from the program and attended only four days during May. There were no changes ordered in his plan of care or medication. This patient required a more structured living environment to monitor his medication compliance. Services denied as not medically appropriate for his mental condition.”

In the second situation, the PRO and FI determined that \$34,608 of the \$62,706 in charges were for services which did not benefit the patient due to the patient’s condition. For Medicare purposes, PHPs provide a comprehensive structured program of services that are specified in an individualized treatment plan, which is formulated by a physician and the multidisciplinary team with the patient’s involvement. However, patients who require a low frequency of participation may be managed in an outpatient or office setting on a less intense and frequent basis. Thus, the PHP services are no longer reasonable and necessary.

Examples from the medical reviewer’s results include:

In the review of 1 claim for 39 group sessions totaling \$1,638 in charges, the medical reviewer noted:

“The documentation supports that the focus of his therapy was on alcohol abuse and he was attending AA daily. The intensity of a PHP was not medically necessary or appropriate to treat depression due to alcohol abuse.”

In the review of 1 claim for 29 group sessions totaling \$1,218 in charges, the medical reviewer noted:

“During December [the patient] attended the program only one or two days a week. Documentation does not support a need for the intensity of a PHP to monitor drug compliance. With this decreased attendance drug compliance could have been monitored through occasional outpatient visits.”

In the review of 1 claim for 32 group sessions totaling \$1,344 in charges, the medical reviewer noted:

“Documentation does not support that this patient required the intensity of a PHP in order to function. Structure and activities could be furnished in a less intensive program or outpatient therapy.”

In the review of 1 claim for 64 group sessions totaling \$2,688 in charges, the medical reviewer noted:

“The documentation supported that this patient had a chronic psychosis with marked impairment of attention and concentration. The intensity of a PHP was not an appropriate placement for him. His medication adjustment could have been managed on an outpatient basis.”

Accordingly, we have concluded that the Hospital did not have adequate procedures in place to ensure that services billed to the Medicare program were reasonable and medically necessary for the treatment of the patient’s condition.

Insufficient Medical Record Documentation

Our review also showed a weakness in the Hospital’s system of internal controls regarding medical record documentation supporting some of the services. The 42 CFR section 482.24 states that, “A medical record must be maintained for every individual evaluated or treated in the hospital. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.”

With the assistance of medical reviewers from the PRO and FI, we determined that \$798 in outpatient psychiatric charges were not properly supported by medical record documentation. This was mainly due to missing progress notes in 8 of the 100 outpatient psychiatric claims reviewed.

Examples of insufficient documentation errors include:

In the review of one claim for five group sessions totaling \$210 in charges, one session totaling \$42 was disallowed. The medical reviewer noted:

“...the provider billed for 5 groups and the documentation supports only 4.”

In the review of 1 claim for 42 group sessions totaling \$1,764 in charges, 3 sessions totaling \$126 were disallowed. The medical reviewer noted:

“The provider billed for 42 groups but the documentation supports she attended only 39.”

In the review of 1 claim for 19 group sessions totaling \$798 in charges, 2 sessions totaling \$84 were disallowed. The medical reviewer noted:

“The provider billed for 2 groups during 2/23-2/28/98 that were not supported by documentation and are disallowed.”

As a result, we concluded that the Hospital needs to strengthen its procedures for ensuring that services billed to the Medicare program are sufficiently documented in the medical records in accordance with Medicare requirements.

OUTPATIENT PSYCHIATRIC COSTS

Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We reviewed selected expense accounts relating to outpatient psychiatric services on the Hospital's CY 1998 Medicare cost report, and found no indication of any unallowable or unreasonable costs under Medicare guidelines.

CONCLUSION

For CY 1998, the Hospital submitted to Medicare for reimbursement \$1,796,666 in charges for outpatient psychiatric services. Our review of 100 statistically selected claims totaling \$157,164 showed that \$63,504 should not have been billed to the Medicare program. Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that the Hospital overcharged Medicare at least \$567,888 for services during CY 1998. The details of our sample appraisal can be found in APPENDIX A.

We also tested the appropriateness and reasonableness of selected expenses totaling \$767,289 on the Hospital's CY 1998 Medicare cost report and found no indication of any unallowable or unreasonable costs.

RECOMMENDATIONS

We recommend that the Hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are covered under Medicare and properly documented in accordance with Medicare regulations and guidelines. In addition, we will provide the FI with the results of our review, so that it can apply the appropriate adjustment of \$567,888 to the Hospital's CY 1998 Medicare cost report.

HOSPITAL COMMENTS AND OIG RESPONSES

In a letter dated January 24, 2001, the Hospital disagreed with our findings and recommendations, questioning the fairness and adequacy of the review process used to evaluate the medical necessity of its outpatient psychiatric services.

The Hospital's comments are summarized below and included in their entirety as APPENDIX B.

Hospital Comment #1

The Medicare Intermediary Manual reflects that partial hospitalization services are reasonable and necessary if they will improve the patient's functionality, or they will lead to a control of the patient's symptoms and maintenance of the patient's functional level to avoid further deterioration or hospitalization. The patient does not have to "get better;" rather, services are covered if they are needed to avoid deterioration in the patient's condition.

OIG Response

For coverage purposes, the key to whether the services and activities may be covered will depend primarily on the services provided by the program and how the services are used in the care of the patient. There are no specific limits set on the length of coverage for these services.

Pursuant to the Medicare Intermediary Manual section 3112.7, coverage for services should be continued "[A]s long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice..." The HCFA Program Memorandum, Publication 60A further states "Treatment may continue until the patient has improved sufficiently to be maintained in the outpatient or office setting on a less intense and less frequent basis." at which point further PHP services become unnecessary and unreasonable.

Hospital Comment #2

The reviewers failed to take into account the entire course of the patient's treatment and condition. Rather, the reviewers generally examined a small snapshot of the patient's treatment, and determined that, during the short period reviewed, the patient appeared either to be unable to comply with the active treatment process or to benefit from the PHP services.

OIG Response

The Hospital requested that it take responsibility for the copying process. Accordingly, we provided the Hospital with general guidelines to complete the task. The Hospital was initially instructed to provide a copy of the entire medical record for each of the beneficiaries selected. However, due to the volume of documents in some medical records, we requested, as a minimum, that documentation be provided for a period of no less than 30 days prior and 30 days after the sample dates of service.

The Hospital was instructed to provide enough supporting documentation to illustrate the patient's condition and reasonableness of the services rendered. In addition, we provided a checklist of suggested types of documentation to be included with each medical record. The checklist included information pertaining to the patient's prior history and assessment, intake and admission forms, psychiatric history and evaluations, psychological history and evaluations, social worker and nursing assessments, treatment plan(s) with intended goals and duration of treatment, progress notes, and other relevant information needed to support medical necessity and reasonableness of the service(s) rendered.

The reviewers made their determinations based on the documentation provided by the Hospital in accordance with our request.

Hospital Comment #3

Any recoupment of the payments from the Hospital would be barred under the related concepts of waiver of liability and without fault. Pursuant to section 1879 of the Social Security Act, providers are entitled to be reimbursed for services rendered when the provider did not know, and could not reasonably be expected to know, that payment would not be made. Similarly, under the Medicare Intermediary Manual section 3708, *et. seq.*, a provider is not liable for overpayments if it is "without fault" with respect to the overpayments. In other words, if an intermediary discovered that a provider was incorrectly paid, the intermediary is not to automatically assume that the provider is not entitled to the reimbursement. Rather, the intermediary must determine whether a provider was without fault.

OIG Response

Section 1862 of the Social Security Act states that no payment may be made for items or services that are not considered reasonable or necessary for the diagnosis or treatment of injury or illness. The determinations of medical necessity made by the FI's medical reviewers were made in accordance with Medicare law, regulations, and guidelines.

In addition, the FI stated that a waiver of liability analysis was not required for this review. A waiver of liability applies specifically to a review of skilled nursing facilities and was not applicable to the claims in this review. Furthermore, the FI stated that the provider is liable if the services rendered are unnecessary.

Hospital Comment #4

The Hospital's reviewers, in good faith, concluded that the services at issue were all medically necessary. In each instance the patient's treating physician concluded and certified that the services were medically necessary. We believe that the above discussion, and the discussion in the enclosures, demonstrate at the very least that reasonable minds could differ concerning the medical necessity of the services under review. Accordingly, it cannot be said that the Hospital knew or should have known that these services were not medically necessary.

OIG Response

The determination for medical necessity was left to the discretion of the PRO and the FI, who are both well-versed with Medicare laws, regulations, and guidelines.

We provided all 100 claims to the PRO who made the initial determination for medical necessity and reasonableness of the services rendered. The claims were reviewed by their staff of physicians, registered nurses, and other licensed professionals. Based on their professional opinion they found service(s) provided on 57 of the claims were not medically necessary and/or adequately documented.

The 57 questioned claims were forwarded to the FI along with the patients' medical records for a final review. The FI's medical reviewers agreed with the PRO psychiatrists' findings on 44 of the 57 claims which were recommended for disallowance. Ultimately, the FI overruled the PRO psychiatrists' findings in the Hospital's favor on the remaining 13 claims, and the services on these claims were allowed.

Hospital Comment #5

If the PRO and the FI cannot agree, and the current intermediary reviewers cannot agree with the prior intermediary reviewers, the Hospital cannot be deemed to have know[n] that the services would be denied as not medically necessary.

APPENDICES

**REVIEW OF PSYCHIATRIC OUTPATIENT SERVICES
PROVIDED BY COLLEGE HOSPITAL**

STATISTICAL SAMPLE INFORMATION

POPULATION

Items: 1,216 Claims
Dollars: \$1,796,666 Charges

SAMPLE

Items: 100 Claims
Dollars: \$157,164 Charges

ERRORS

Items: 44 Claims
Dollars: \$63,504

**PROJECTION OF SAMPLE RESULTS
at the 90 Percent Confidence Interval**

Point Estimate: \$772,209
Lower Limit: \$567,888
Upper Limit: \$976,529

ROBERT W. LUNDY, JR.
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January 24, 2001

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VIA FEDERAL EXPRESS

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and Human Services
OIG Office of Audit Services
1055 Corporate Center Drive, Suite 110
Monterey Park, CA 95174

Attn: Jerry McGee, Sr. Auditor

Re: College Hospital - - CINA-09-00-00067

Dear Mr. McGee:

This office represents College Hospital. We are writing on behalf of the Hospital in response to the draft report prepared by the Office of Inspector General ("OIG") entitled "Review of Outpatient Psychiatric Services Provided by College Hospital for Calendar Year Ended December 31, 1998" ("Draft Report").

College Hospital is an acute psychiatric hospital located in Cerritos, California. For the past twenty-five years, the Hospital has furnished a wide range of inpatient and outpatient mental health services to its community. The Hospital's outpatient adult programs have been treating mentally ill Medicare patients since January, 1991. The Hospital provides care that is critically needed in its community in a manner it believes is both highly ethical and efficient.

The Hospital has carefully reviewed the Draft Report. We appreciate the Draft Report's conclusion that the auditors found no indication of any unallowable or unreasonable costs claimed in the Hospital's Medicare cost report. We strenuously disagree, however, with the Draft Report's findings and recommendations concerning the medical record review. We believe that the Draft Report reflects a fundamental misunderstanding and misapplication of the Medicare coverage

HOOPER, LUNDY & BOOKMAN, INC.
HEALTH CARE LAWYERS

United States Department of Health and Human Services
January 24, 2001
Page 2

criteria for partial hospitalization services. We also believe that there are substantial flaws in the review methodology which bring into serious question the entirety of the review findings. These issues are discussed below.

Application of Coverage Criteria

The Medicare Act covers under Part B of the Medicare program partial hospitalization services furnished in hospital outpatient departments. These services must be furnished in a program which is a distinct and organized intensive ambulatory treatment service offering less than twenty-four hour daily care, and must be furnished under the supervision of a physician pursuant to an individualized written plan of treatment. 42 U.S.C. § 1395x(ff). Covered partial hospitalization services include a wide range of outpatient mental health services, provided such services 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 related to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted forms of medical practice and reasonable expectation of patient improvement).”

42 U.S.C. § 1395x(ff)(2).

The Draft Report reflects that the auditors reviewed a sample of the Hospital’s outpatient mental health services furnished to Medicare beneficiaries during 1998, involving \$157,164 of the \$1,796,666 of total charges submitted by the Hospital to Medicare. Of this amount, the Draft Report indicates that \$64,504 of the sample charges did not meet Medicare criteria for reimbursement. The overwhelming bulk of these disallowed charges were disallowed on the ground that the services were not reasonable or medically necessary. The Report reflects that, with the exception of a minor disallowance, the Hospital maintained adequate documentation in the patients’ medical records.

The applicable Medicare guideline, § 3112.7 of the Medicare Intermediary Manual, explains that partial hospitalization services are reasonable and necessary for the treatment of the patient’s condition if the services are reasonably expected to improve the patient’s condition. This means that the treatment must be “designed to reduce or control the patient’s psychiatric systems, so as to prevent relapse or hospitalization, and improve or maintain the patient’s level of functioning.” The Manual states:

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3. Reasonable Expectation of Improvement. -- Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's 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, 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 functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

Thus, the Manual reflects that partial hospitalization services are reasonable and necessary if they will improve the patient's functionality, or they will lead to a control of the patient's symptoms and maintenance of the patient's functional level to avoid further deterioration or hospitalization. The patient does not have to "get better;" rather, services are covered if they are needed to avoid deterioration in the patient's condition.

Of the \$62,706 of charges reviewed and disallowed as unreasonable or medically unnecessary, the Draft Report states that the reviewers determined that \$28,098 was disallowed due to the patient's inability "to actively participate or comply with the active treatment process." The balance, \$34,608, was disallowed because the reviewers determined that the patient was unable "to benefit from the level of treatment or intensity of the PHP services."

In applying both of these criteria, the reviewers failed to take into account the entire course of the patient's treatment and condition. Rather, the reviewers generally examined a small snapshot of the patient's treatment, and determined that, during the short period reviewed, the patient appeared either to be unable to comply with the active treatment process or to benefit from the PHP services.

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Such an approach is entirely inappropriate in view of the types of patients treated in the Hospital's PHP program. These patients suffer with serious and persistent mental disorders that often show only small, or potentially no, incremental changes over short periods of time. However when the entire course of the patients' treatment is evaluated, improvements that would not have occurred in the absence of the program are evident which might be less obvious from a brief sampling of care. For the type of chronically ill patient population treated by the Hospital's partial hospitalization program ("PHP"), evaluation of whether the patient can actively participate and benefit from the program must be made over a much longer period of time than examined by the reviewers.

The Draft Report's findings concerning medical necessity also amount to an after-the-fact second-guessing of the attending physician's medical judgment. The services disallowed were furnished pursuant to an individualized treatment plan formulated for the patient by the patient's attending physician, with multi-disciplinary input from a team of mental health professionals. These individuals concluded in advance of the provision of care that the patient could actively participate in and would benefit from the PHP services.

The Hospital has reviewed the records relating to the charges that were denied on the ground that the services were unreasonable or medically unnecessary, including the records relating to the entire course of the patient's care. The Hospital has found in each instance that the services were necessary for the patient's functionality or to avoid a deterioration in the patient's condition that would have necessitated inpatient treatment. The results of these reviews are enclosed.

We note that the Draft Report discusses several examples to illustrate each of the two bases for disallowance based on medical necessity. Each of these examples is addressed in detail in the enclosures. The Hospital disagrees with the findings with respect to each of the examples. We briefly discuss each of them below.

Draft Report Examples of Patients Unable to Participate in the Program

The following examples were included in the Draft Report of Patients unable to participate actively in the PHP program, and are discussed in the order presented in the Draft Report:

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1. Sample Number 25

The Draft Report denied services furnished to this patient based on the conclusion that it was not appropriate to treat the patient's condition. The Draft Report emphasized that the patient had to be readmitted during the course of treatment.

The Hospital's reviewers concluded that this patient did participate in and benefit from the program. An examination of the entire course of treatment prior to the inpatient stay reflected that the patient was making progress. However, the patient experienced an increase in symptoms due to the death of his grandmother and an uncle who was terminally ill, necessitating a two-day inpatient stay. He was readmitted to the PHP program to decrease the risk that he would need further inpatient treatment. The medical records indicated that the patient was able to follow group content and made on target statements. The physician notes indicated that the patient was making progress to a baseline level of stabilization and was beginning the process of transitioning to adult day care.

Clearly, an inpatient admission during the course of treatment does not indicate a patient did not benefit from PHP services, particularly where the inpatient admission was occasioned by a significant event. Indeed, in the absence of the PHP program it appears that this patient would have to have spent even more time in the hospital as an inpatient.

2. Sample number 15.

The Draft Report indicates that this patient had a history of non-attendance and non-compliance with the PHP program, and that the documentation does not support the conclusion that the services were reasonable and necessary.

The Hospital's reviewers concluded that the services were reasonable and necessary as they enabled the patient to move to a lower level of care. The medical record reflects that the patient was working hard to be medication compliant and was gaining insight into her patterns of decompensation. Although she initially expressed suicidal ideation, during the course of treatment she became less hopeless and helpless. Additionally, her attendance and focus on treatment improved during the course of the program. Upon discharge there was noted improvement, including denial of suicidal thoughts, improved medication compliance and a decrease in self-medicating behavior. It appears that the patient was both benefitting from and participating in the PHP program.

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3. **Sample number 64.**

The Draft Report indicates that the services were denied because the patient was non-compliant with the program.

The Hospital's reviewers concluded that the patient benefitted from the program. The patient was admitted with acute symptoms of schizophrenia, paranoid type. The symptoms included auditory hallucinations and delusions which resulted in the patient wandering the streets and unable to care for himself. Although the patient struggled with compliance, his participation kept him out of the hospital for six months due to the intense treatment interventions provided by the PHP.

4. **Sample number 32.**

The Draft Report denied this claim, concluding that the patient was unable to participate or benefit from the program, pointing out that the patient attended only four days during May.

The Hospital's reviewer completely disagrees with this determination, concluding that the patient participated in and benefitted from treatment. The medical record reflected that it was essential that this patient be treated in a PHP as he had been discharged from a two-week inpatient stay because he had been extremely psychotic and incoherent, with subsequent violent behavior. The medical record reflects that the patient did benefit from the program, as he was more medication compliant, became less fragmented and more coherent, was able to maintain on tasks in groups, and showed improvement in self-care. The reason that the patient attended only one day per week was that the patient's estate conservator indicated that she would only support treatment for the patient one day per week due to her share of cost. This is clearly not evidence that the patient did not participate in the program or did not benefit from it.

Draft Report Examples of Patients unable to Benefit from the Program

The following examples were included in the Draft Report of patients unable to participate actively in the PHP program, and are discussed in the order presented in the Draft Report:

1. **Sample number 55.**

The Draft Report indicates that the intensity of a PHP was not medically necessary to treat the patient's depression due to alcohol abuse, as the focus of the patient's therapy was on his alcohol abuse and the patient was attending AA daily.

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The Hospital's reviewer concluded that the patient did require the services of a PHP. The patient was admitted to the program post discharge from an inpatient psychiatric hospitalization for severe depressive symptoms, suicide ideation and self-medication of these symptoms with alcohol. The focus of the treatment was to provide interventions for his depressive symptoms, functional impairments, clinical needs, and difficulties with achieving stabilization. This patient also suffered periods of increased agitation and hostility. During this time, the patient required adjustments in his antidepressant and sleeping medication. The patient's attending psychiatrist also certified that without this level of care, the patient was at an imminent risk of need for inpatient hospitalization to treat his depression.

2. Sample number 34.

This claim was denied because the reviewer determined that there was not a need for the intensity of a PHP to monitor drug compliance. The reviewer noted that the patient was attending the program only two days per week.

The Hospital's reviewer concluded that the patient did require the services of a PHP, and that drug monitoring was only one aspect of the patient's care. The patient was initially admitted to the program five days per week with the focus of treatment on his depressive symptoms associated with Axis I diagnosis of Major Depressive Disorder, Recurrent, Severe, without Psychosis. The patient had been discharged from an inpatient admission for a suicide attempt. The focus of treatment was to provide various therapy interventions and medication, and to help him establish a support network in the community and to provide for his safety. The patient's days in treatment had begun to be reduced during the period reviewed as the patient began the process of attempting to establish community based support systems, his mother had become ill, and he had to attend court.

This appears to be a clear instance of the reviewers focusing myopically on the period reviewed and not the prior period which demonstrated the clear need for and benefit of PHP for the patient.

3. Sample number 59.

The Draft Report states that the patient did not require the intensity of a PHP, and that the structure and activities could have been provided in a less intensive program or outpatient therapy.

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The Hospital reviewer concluded that the documentation did support a PHP level of care. The patient was admitted to PHP with grandiose delusions, agitation, and racing thoughts. The patient stated that the devil and a ghost were directing him to start fires and to kill his son and wife. The physician assessed that the patient's admitting diagnosis was Schizoaffective Disorder and that he need PHP to reduce his risk of inpatient admission. During the period reviewed, the patient's physician noted an increase in symptoms of delusions and isolation with the need to carefully monitor the patient's status.

4. Sample number 56.

The Draft Report states that the intensity of PHP was not an appropriate placement for this patient, as the patient had chronic psychosis with marked impairment of attention and concentration, and that the patient's medication adjustment could have been managed on an outpatient basis.

The Hospital's reviewer concluded that the documentation clearly validates that PHP was an appropriate level of treatment for this patient, as his symptoms were acute in nature. Upon admission, the patient had manifested an acute increase in paranoid ideation and agitation. He had a significant recent history of becoming so agitated that he would make threatening behaviors such as holding his fist to others in an aggressive manner. Treatment was necessary to help him better manage his paranoia in a more adaptive way. The treating physician concluded that without the PHP the patient would have required inpatient admission.

In summary, we believe that a careful review of the eight samples discussed in the Draft Report demonstrates that the services furnished by the Hospital's PHP were medically necessary and appropriate. The patients all benefitted from the program, as reflected by evidence of improved functionality in each instance. Further, each of the patients did participate in the PHP at a level that permitted the patient to benefit from the program.

Finally, even if it could be concluded that some of the services at issue were not medically necessary, any recoupment of the payments from the Hospital would be barred under the related concepts of waiver of liability and without fault. Pursuant to Section 1879 of the Social Security Act, providers are entitled to be reimbursed for services rendered when the provider did not know, and could not reasonably have been expected to know, that payment would not be made. Similarly, under the Medicare Intermediary Manual ("MIM") section 3708 *et. seq.*, a provider is not liable for overpayments if it is "without fault" with respect to the overpayments. As explained in MIM section 3708, intermediaries are *required* to determine whether the provider is liable for any overpayment before instituting any action to collect the overpayment from the provider. In other

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words, if an intermediary discovered that a provider was incorrectly paid, the intermediary is not to automatically assume that the provider is not entitled to the reimbursement. Rather, the intermediary must determine whether a provider was without fault. Under section 3708.1 of the MIM:

A provider is without fault if it exercised reasonable care in billing for, and accepting, the payment; *i.e.*, . . . On the basis of the information available to it, including, but not limited to , the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct. . . .

There is absolutely no discussion in the Draft Report that a waiver of liability or without fault analysis was performed. Without such an analysis, the Medicare program may not recover any amount from the Hospital.

Further, under the circumstances here, even if it were ultimately determined that the findings of the Draft Report are substantively correct, it is clear that the Hospital was without fault concerning the medical necessity of the claims. As discussed above, the Hospital's reviewers in good faith concluded that the services at issue were all medically necessary. In each instance the patient's treating physician concluded and certified that the services were medically necessary. We believe that the above discussion, and the discussion in the enclosures demonstrate at the very least that reasonable minds could differ concerning the medical necessity of the services under review. Accordingly, it cannot be said that the Hospital knew or should have known that these services were not medically necessary.

Additionally, as discussed below, the PRO and the fiscal intermediary disagreed concerning the medical necessity of many of the services that were denied by the fiscal intermediary. Moreover, the fiscal intermediary had previously allowed some of the services that it now would deny upon appeal by the provider. If the PRO and the fiscal intermediary cannot agree, and the current intermediary reviewers cannot agree with the prior intermediary reviewers, the Hospital certainly cannot be deemed to have know that the services would be denied as not medically necessary. As a result, no recovery of reimbursement already paid to the Hospital may be made.

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Methodological Problems

There are substantial issues raised by the methodology that underlies the Draft Report that we believe completely undermines the report findings. First, the report findings are dramatically different than the Hospital's ongoing review experience with its fiscal intermediary, Mutual of Omaha ("Mutual"). According to the Draft Report, one-hundred claims from 1998, representing 8.2% of the total claims submitted, and 8.7% of the total amounts billed were reviewed, and the results of this review were extrapolated to the entire universe of 1998 claims. Of this sample, the auditors determined that \$63,504 of the total of \$157,164 in billed charges in the sample, or about 40%, should be disallowed. These results are dramatically different from the Hospital's experience with Mutual during 1998.

Throughout 1998, Mutual audited random samples of the Hospital's charges for PHP patients. During the year, Mutual reviewed 270 claims (in contrast to the 100 claims reviewed in conjunction with the Draft Report), and initially denied only 20% of the claims audited (as compared to 40% in the Draft Report). Further, the Hospital has appealed most of Mutual's denials, and many of those denials have been overturned. Mutual applied the very same criteria that the PRO and Mutual applied in its review discussed in the Draft Report. The substantial disparity between Mutual's findings and the findings described in the Draft Report, in our view, brings the entire report into question.

Additionally, our review of the sample claims disallowed in the Draft Report reflects that several of the claims had previously been specifically reviewed for coverage by Mutual, and paid upon Mutual's determination that the services were medically necessary. These claims involved \$ 7,686 in charges. Thus, approximately 12% of the \$63,504 of claims in the sample that are proposed to be disallowed are highly questionable, even prior to reviewing the individual cases for medical necessity. We believe that this analysis undermines the validity of the entire sample findings and the extrapolation of those findings to the universe of all claims.

Finally, we are very concerned with the statistical sampling and extrapolation procedures used by the OIG. We believe the procedures used are fundamentally flawed and cannot validly be used as a basis for determining an overpayment. Among other factors, our concerns with the accuracy of the review and the methodological problems discussed above makes it invalid to extrapolate from the small sample reviewed by the PRO and Mutual.

In conclusion, the Hospital wishes to reiterate its commitment to providing the highest quality care to patients in its partial hospitalization program in an ethical and efficient manner. We urge the OIG to consider these comments and the enclosures before finalizing the Draft Report. As

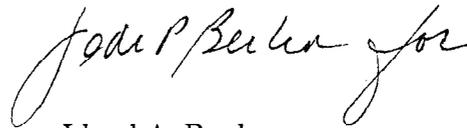
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discussed above, we believe that the Draft Report is seriously flawed in numerous respects. It would be highly inequitable to recover any amount from the Hospital based upon the Draft Report findings.

We wish to thank you in advance for the careful consideration you will give the issues raised by our letter. Please contact the undersigned if you would like to discuss any of the issues addressed in this letter further.

Sincerely,



Lloyd A. Bookman

LAB/ss
Enclosures