

**Memorandum**

Date MAY 4 2000

From June Gibbs Brown  
Inspector General *June G Brown*

Subject Audit of the Medicare Partial Hospitalization Program at Mental Health Corporation of Denver (A-07-98-01263)

To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

This memorandum is to alert you to the issuance on Friday, May 5, 2000, of our final report entitled, "Audit of the Medicare Partial Hospitalization Program at Mental Health Corporation of Denver" for the Fiscal Year (FY) ended June 30, 1996. A copy of the report is attached. The objective of our review was to determine whether charges by Mental Health Corporation of Denver (MHCD) for partial hospitalization program (PHP) services met Medicare requirements. We determined that MHCD did not follow applicable Medicare requirements with regard to Medicare covered PHP services.

Our audit at MHCD determined that 100 percent of the services included on our 100 sampled claims should not have been paid by the Medicare program. Based on our review we believe the entire \$4,447,607 charged for PHP services for FY 1996 did not meet Medicare requirements.

We recommended that MHCD ensure that any future services submitted to Medicare for reimbursement are covered by and properly documented in accordance with Medicare requirements. We will provide the results of our review to Blue Cross Blue Shield (BCBS) of Texas, so that it can consider the \$4,447,607 in settling MHCD's FY 1996 Medicare cost report. We will also request that BCBS of Texas review PHP services provided by MHCD for other cost report periods. The results of our audit have also been shared with our Office of Investigations for their consideration of any further actions.

The MHCD, in its response dated July 13, 1999, claimed that they received conflicting and confusing material and verbal advice from two separate fiscal intermediaries (intermediaries) and that the intermediaries did not furnish accurate and timely provider education and assistance. The MHCD's response did not address or make reference to the Medicare criteria cited in the draft audit report. We believe MHCD should have followed the cited criteria during the audit period since the criteria was published in the intermediary's Medicare newsletter without change on October 1, 1994 and again on October 1, 1995.

Page 2 - Nancy-Ann Min DeParle

For further information, contact:

Barbara Bennett  
Regional Inspector General  
for Audit Services, Region VII  
(816) 426-3591

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**AUDIT OF THE MEDICARE  
PARTIAL HOSPITALIZATION  
PROGRAM AT MENTAL HEALTH  
CORPORATION OF DENVER**



**JUNE GIBBS BROWN  
Inspector General**

**MAY 2000  
A-07-98-01263**



Region VII  
601 East 12th Street  
Room 284A  
Kansas City, Missouri 64106

A-07-98-01263

**MAY 5 2000**

Mr. Roberto Quiroz  
Chief Executive Officer  
Mental Health Corporation of Denver  
4141 E. Dickenson Place  
Denver, Colorado 80222

Dear Mr. Quiroz:

This report provides you with the results of our "Audit of the Medicare Partial Hospitalization Program at Mental Health Corporation of Denver." The Medicare partial hospitalization program (PHP) covers partial hospitalization services that are reasonable and necessary for the diagnosis and treatment of a Medicare beneficiary's condition. The objective of our review was to determine whether charges by Mental Health Corporation of Denver (MHCD) for PHP services during the Fiscal Year (FY) ended June 30, 1996, met Medicare requirements.

### **EXECUTIVE SUMMARY**

The entire \$4,447,607 charged for PHP services (for which MHCD received interim payments of \$3,526,861) did not meet Medicare requirements. We found, through medical review, that 100 percent of charges for the services included on 100 randomly selected claims did not meet Medicare requirements for one or more reasons. We recommended that MHCD ensure that any future services submitted to Medicare for reimbursement are covered by and properly documented in accordance with Medicare requirements. We will provide the results of our review to the fiscal intermediary, so that the appropriate adjustment of \$4,447,607 can be applied to MHCD's FY 1996 Medicare cost report. We will also request that the fiscal intermediary review PHP services provided by MHCD for other cost report periods. During the course of our audit, MHCD discontinued billing Medicare for PHP services. MHCD disagreed with our recommendation. Their comments are presented in further detail later in this report and included as Appendix A.

### **BACKGROUND**

#### **Laws and Regulations**

Title XVIII of the Social Security Act (Act) authorizes the Medicare program to provide medical benefits to individuals 65 years of age and older, and certain individuals under age 65 who are disabled or suffer from end stage renal disease. Section 1832 of the Act established coverage of PHP services provided by community mental health centers (CMHC) to Medicare beneficiaries. Section 1861(ff)(2) of the Act generally defines PHP 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. Section 1835 of the Act requires physicians to certify that PHP patients would otherwise require inpatient psychiatric care.

Section 4162 of Public Law 101-508 (OBRA 1990) amended section 1861(ff) of the Act to extend Medicare coverage of PHP services to CMHCs. Section 1916(c)(4) of the Public Health Service (PHS) Act listed the services that must be provided by a CMHC. Section 1861(ff) defines a CMHC for Medicare as an entity that furnishes the services in section 1916(c)(4) of the PHS Act and meets applicable State licensure requirements. In 1992, the PHS Act was amended to require only four core services. The four core services are currently listed at section 1913(c)(1)(B) of the PHS Act which superseded section 1916(c)(4). The legislation states that any entity that provides 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 cost. 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 fiscal intermediary (intermediary) makes a settlement payment based on the reasonable costs incurred.

### **Mental Health Corporation of Denver**

In accordance with Medicare guidelines, MHCD obtained their Medicare provider number through a self-attestation process which required the applicant to attest that they complied with the requirements for a CMHC as defined by the PHS Act, and that they also provided the PHP core services required by the Act. A Medicare certified CMHC, such as MHCD, can either provide core services directly or under arrangement with other providers.

MHCD was incorporated as a private, not-for-profit (501)(c)(3) corporation in December 1987, and became operational July 1, 1989, with an administrative office in Denver, Colorado. The effective date of participation in the Medicare program was July 1, 1992. For the FY ended June 30, 1996, MHCD received interim payments of \$3,526,861 on the submitted charges of \$4,447,607.

### **Fiscal Intermediary Responsibilities**

The Health Care Financing Administration (HCFA) contracts with intermediaries, usually large insurance companies, to assist them in administering the Medicare program. The intermediaries for MHCD during our audit period were Blue Cross Blue Shield (BCBS) of New Mexico and BCBS of Texas. With respect to CMHCs, the intermediaries are responsible for:

- reviewing and processing claims for PHP services;
- making interim payments;

- conducting audits of cost reports;
- performing liaison activities between HCFA and CMHCs; and
- disseminating information and educational material.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

The objective of our review was to determine whether charges by, and payments to, MHCD for PHP services for the FY ended June 30, 1996 met Medicare requirements.

### **Scope**

To accomplish our objective, a sample of 100 claims was randomly selected from MHCD's universe of 8,015 PHP claims for the period July 1, 1995 through June 30, 1996. During this period MHCD received interim payments of \$3,526,861 for submitted charges of \$4,447,607. We used applicable Medicare laws, regulations, and guidelines to determine whether the services claimed by MHCD met Medicare requirements.

### **Methodology**

We performed our work in a cooperative effort with the HCFA Denver regional office and BCBS of Texas. The HCFA medical surveyors reviewed supporting medical records maintained by the provider for each of the services included on 100 paid PHP claims. The medical records were also reviewed by the intermediary's medical review personnel to determine whether the services claimed met Medicare requirements.

Our field work was performed at MHCD in Denver, Colorado, and the Office of Audit Services (OAS), Denver field office. The review was initiated by the Office of Inspector General (OIG) in cooperation with HCFA and the intermediary.

Our claims review was performed in accordance with generally accepted government auditing standards. Our review did not require an evaluation of internal controls. In addition to the claims review, we performed an audit of MHCD's costs as submitted on their FY 1996 cost report to determine whether they were reasonable and allowable. During this review, we found cost items that should not have been reported or were improperly classified on the cost report.

Results of this audit will be provided to MHCD's current fiscal intermediary, TrailBlazer Health Enterprises (TrailBlazer) for their consideration in the finalization of MHCD's FY 1996 cost report.

## **DETAILED RESULTS OF REVIEW**

Our review showed that none of the services on 100 randomly sampled PHP claims met Medicare requirements. The 100 claims contained 1,030 units of PHP services. For the services on the 100 claims, MHCD submitted charges of \$4,447,607 and received \$3,526,861 in interim payments. Since none of the sampled items were eligible for Medicare reimbursement for one or more reasons, we believe the entire universe of \$4,447,607 in charges is unallowable. We recommended that MHCD ensure that any future Medicare billings contain only services that meet Medicare requirements. We also will inform the intermediary so that our findings can be considered in settling MHCD's FY 1996 cost report.

### **CRITERIA**

The 42 CFR 410.2 defines PHP services as a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care. The PHP services are to provide acutely mentally ill individuals with intensive psychiatric services to prevent hospitalization. According to the Special Medicare Part A Newsletter No. 345-96, the PHP treatment is intended for clients who: (1) are likely to benefit from a coordinated program of services; (2) do not require 24-hour care; (3) have an adequate support system outside of the hospital; (4) have a diagnosis of mental illness; and (5) are not judged to be dangerous to self or others.

The 42 CFR 410.43 describes the services that must be provided and identifies the criteria for evaluating whether the PHP provider can be reimbursed for these services. Under 42 CFR 424.24, Medicare pays for PHP services only if a physician certifies (and recertifies, where such services are furnished over a period of time) that the beneficiary would otherwise require inpatient psychiatric care in the absence of such services. A physician must also establish and periodically review an individualized treatment plan for furnishing the services. The plan of care must include the physician diagnosis, the type, amount and duration of services, and the treatment goals. The PHP is meant to provide services to clients who require more than isolated sessions of outpatient treatment.

### **Ineligible Services**

Reviews of the medical records performed by the intermediary's medical review staff and HCFA's medical surveyors in Denver, Colorado, found that all of the 1,030 units of service contained in the 100 sampled claims did not meet Medicare requirements. There were multiple reasons for which units of service contained on the sampled claims should have been denied. The following denial reasons were most frequently identified during the medical review:

- 95 claims had no physician orders or inadequate physician orders.
- 94 claims had no physician certification or recertification that the beneficiary would otherwise require inpatient psychiatric care in the absence of PHP services.
- 87 claims had inadequate group and/or individual therapy notes so that medical necessity could not be determined. In order to claim therapy services, Medicare requires medical notes to identify frequency, duration, and amount of service for each client. The medical review revealed many of the medical records did not have adequate documentation of individual or group therapy. For 26 of the 87 claims, there were no therapy notes.
- 86 claims had an inadequate treatment plan. Elements such as the physician diagnosis, the type, amount and duration of services, and treatment goals were either missing or incomplete. For 13 of the 86 claims, there was no treatment plan.
- 79 claims were for patients who had achieved sufficient stabilization and no longer required the intense, frequent involvement of a PHP. These patients were chronic and not in an acute exacerbation of symptoms. For example, one client required medication management and psychotherapy on an intermittent basis, which could have been performed in an office setting. In another case, a relatively stable client in a nursing home could have had his needs met by the nursing home staff in consultation with mental health professionals.

Assessment of the medial records documentation revealed MHCD generally served a population who did not receive the intensive therapy required to be provided by a PHP, but were billed to Medicare as PHP services. Most clients required maintenance and were not acutely ill. In our opinion, it appeared that MHCD's philosophy was to bill Medicare because the patients had Medicare coverage, and not because the services provided would qualify as Medicare PHP services. The intermediary placed MHCD on 25 percent prepayment review effective October 16, 1996. Based on the results of the initial review, the intermediary increased prepayment review to 50 percent effective May 7, 1998. Effective July 1998, MHCD discontinued billing the Medicare program.

## **RECOMMENDATIONS**

Based on the results of our audit, we recommended that MHCD:

- Ensure that if they bill Medicare in the future that any claims submitted to Medicare for reimbursement contained only services that are covered and properly documented in accordance with Medicare requirements.

We will provide the results of our review to TrailBlazer, so that the appropriate adjustment of \$4,447,607 in ineligible charges to Medicare can be applied to MHCD's FY 1996 Medicare cost report. We will also request that BCBS of Texas review PHP services provided by MHCD for other cost report periods.

### **AUDITEE COMMENTS**

The MHCD did not agree with our recommendation that MHCD "pay the Federal Government the projected overpayment amount...." The MHCD cited multiple, and at times confusing, materials coupled with equally conflicting and confusing verbal advice provided by two intermediaries as their reasons for disagreement. They also responded that the intermediaries did not furnish accurate and timely provider education and assistance. Further, they stated that by failing to deny PHP claims for payment on a timely basis or provide instructive guidance, MHCD relied upon the intermediaries determination that the PHP services rendered were appropriate. The MHCD stated it was denied the opportunity to seek payment from Medicaid and other third party payors for reimbursable services provided. The full text of the response is found in Appendix A.

### **OIG COMMENTS**

The MHCD contended that it was often unable to obtain guidance from its intermediary, and that any guidance received was confusing and ambiguous. Rather, we believe the guidance was sufficiently clear as to the requirements for physician orders and certification/recertification, the need for adequate therapy notes and the condition of patients who required PHP services. And in fact, these were the bases for the medical reviewers' determinations to deny the 1,030 units of service contained in the 100 claims in our sample.

As outlined on page 5 of this report, any one of these reasons by itself would make the claim ineligible for reimbursement. However, many of the claims had multiple reasons for being unallowable. We believe during the audit period, July 1, 1995 through June 30, 1996, that MHCD should have followed the criteria cited since they were published without change on October 1, 1994 and again on October 1, 1995.

The MHCD's response generally addressed only physician certifications, and did not specifically address any of the other reasons given for the claims being unallowable for reimbursement. The MHCD's response also did not address or make reference to the regulatory criteria cited in the draft audit report.

We believe that it is the responsibility of individual entities to make use of available information to ensure that claims submitted are, in fact, reimbursable by Medicare and that entities bear the brunt of responsibility for ensuring that they receive reimbursement for services provided from the appropriate sources.

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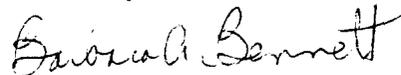
Page 7 - Mr. Roberto Quiroz

Final determinations as to actions to be taken on all matters reported will be made by the HHS action official named below. We request that you respond to the 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 the referenced Common Identification Number A-07-98-01263 in all correspondence relating to this report.

Sincerely,



Barbara A. Bennett  
Regional Inspector General  
for Audit Services, Region VII

Enclosure

HHS Action Official  
James Randolph Farris, M.D.  
Regional Administrator,  
HCFA Region VI  
1301 Young Street, Room 714  
Dallas, Texas 75202-4348



July 13, 1999

*Access Center*  
*Outpatient*  
*Residential*

Barbara A. Bennett  
Regional Inspector General  
for Audit Services, Region 7  
601 East 12<sup>th</sup> Street  
Room 284-A  
Kansas City, MO 64106

*Dual Diagnosis*      **Re:    CIN: A-07-98-01263**

*Assertive Community Treatment*

Dear Ms. Bennett:

*Rehabilitation*  
*Child, Adolescent & Family*  
*Older Adult*

Pursuant to the Office of the Inspector General's ("OIG") draft report and results of the OIG's audit of Medicare Partial Hospitalization Program ("PHP") services at Mental Health Corporation of Denver ("MHCD") dated May 14, 1999, we wish to respond and provide additional information with respect to PHP services rendered by MHCD from July 1, 1995 through June 30, 1996 (the "Audit Period"). Further, we would also like to request a meeting with you at your earliest convenience to discuss the OIG audit and the additional information being submitted.

*Housing Development*

Throughout this Audit Period, MHCD attempted, as a community mental health center ("CMHC"), to develop and implement internal guidelines and revised forms to ensure that PHP services met Medicare guidelines. Blue Cross/Blue Shield of New Mexico ("BC/BS of NM") failed repeatedly to respond timely to requests from MHCD for guidance and clarification. MHCD believed in good faith that what it developed met the Medicare criteria and was consistent with the delivery of services in a CMHC. However, because of the lack of clarity in the law, coupled with the lack of timely interpretation and guidance by BC/BS of NM and again later by Blue Cross/Blue Shield of Texas ("BC/BS of TX") and a general misunderstanding of the nature of a CMHC resulting in the application of standards not made clear during this Audit Period, certain PHP claims of MHCD are only now being retroactively denied for MHCD's fiscal year ending June 30, 1996.

Administrative Office  
4141 East Dickenson Place  
Denver, CO 80222  
(303) 757-7227  
(303) 757-8281 (FAX)

During the first portion of this Audit Period, the fiscal intermediary ("FI") for MHCD Medicare Part A claims was BC/BS of NM and inadequate guidance was provided by this FI regarding appropriate criteria for billing PHP services by CMHC's. Exhibit A to this letter is a chronological summary of both oral and written communications between MHCD, Colorado CMHC's and associations and BC/BS of NM and Blue Cross/Blue Shield of Texas ("BC/BS of TX") attempting to clarify the applicable PHP reimbursement requirements.

Roberto Quiroz, MSW  
CEO

Frank McGuirk, Ph.D.  
Deputy Director

Carl Clark, M.D.  
Medical/Clinical Director

July 13, 1999



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Section 4162 of the Omnibus Budget Reconciliation Act of 1990 ("OBRA") amended Sections 1861(ff) and 1832(a)(2), the Social Security Act, to extend Medicare coverage and payment to PHP services provided by CMHC's effective October 1, 1991 (the "OBRA Amendments"). Prior to the OBRA Amendments, PHP services were covered by Medicare only if provided by a hospital to its outpatients.<sup>1</sup>

In the Medicare Provider Reimbursement Manual, effective October 1, 1991, it states.

"It is not necessary that a course of treatment 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 systems 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 reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.

"Some patients may undergo a course of treatment which increases their level of functioning but then reach a point where further significant increase is not expected. Continued coverage may be possible even though the condition has stabilized or treatment is primarily for the purpose of maintaining the present level of functioning. Coverage is denied only where evidence shows that the criteria discussed above are not met. e.g., that stability can be maintained without further treatment or with less intensive treatment."

The majority of MHCD's PHP recipients were historically high users of inpatient services with major mental illnesses. Therefore, by providing continuing treatment that prevented the recipient's condition from deteriorating, relapsing further, or requiring hospitalization, MHCD believed that the services it provided met Medicare's criteria for PHP coverage as outlined above.

Federal regulations effective March 13, 1994 defining the coverage, criteria and payment methodology (the "1994 Regulations") were published in an interim final rule on February 11, 1994.<sup>2</sup> Pursuant to the Interim Final Rule published March 22, 1994, the definition of PHP services was clarified and the definition of a CMHC reiterated.

<sup>1</sup> Medicare coverage of partial hospital services provided by hospitals was effective December 22, 1987.

<sup>2</sup> 59 Fed. Reg. 6570 (February 11, 1994).

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Based on section 1861(ff)(2) of the OBRA Amendments, PHP services must (1) be reasonable and necessary for the diagnosis or active treatment of the individual's condition; and (2) 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:

- Individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law.
- Occupational therapy requiring the skills of a qualified occupational therapist
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients.
- Drugs and biologicals furnished for therapeutic purposes, subject to the limitations described in §410.29.
- Individualized activity therapies that are not primarily recreational or diversionary.
- Family counseling, the primary purpose of which is treatment of the individual's condition.
- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment.
- Diagnostic services.

Again, in the absence of any feedback, MHCD attempted to interpret the 1994 Regulation and believed the services it provided conformed to the above criteria.

Prior to the 1994 Regulation and Interim Final Rule, Medicare issued only two manual instructions covering PHP services, both issued in March, 1992, effective retroactively to October 1, 1991.<sup>3</sup> These instructions stated that, in general, for PHP services to be covered the services must be for the purpose of diagnostic study or they must be reasonably expected to improve or maintain the patient's condition and to prevent relapse or hospitalization. In neither of these transmittals nor in the Medicare Newsletter published by BC/BS of NM<sup>4</sup> was appropriate documentation described that would suffice as evidence of a physician's prescription or of a physician certification. Thus, CHMC's in Colorado were left to determine on their own what appropriate documentation might be in their particular setting.

Moreover, in the Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual, which includes Medicare guidelines for CMHC's, it

<sup>3</sup> See Tab 1 of Exhibit A; Transmittal No. IM-92-1 and Medicare Provider Reimbursement Manual, Part 1, Transmittal No. 366.

<sup>4</sup> Medicare Newsletter; Publication No. 92-7, July 20, 1992.



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is suggested that an evaluation be done on a regular basis by a physician, (i.e. at least every 90 days) and this review should be documented in the patient's record and be made available as requested for state or federal assessment purposes.<sup>5</sup> A letter dated March 28, 1994 from ██████████ of BC/BS of NM to ██████████ Chair of the Colorado Association of Community Mental Health Centers and Clinics ("CACMHCC"), Committee for Finance and Business, indicated that a 90 day review of the patient's progress notes by the physician would be appropriate for certification for PHP services.<sup>6</sup>

In addition, in a letter to the Honorable ██████████ from ██████████ Administrator of the Health Care Financing Administration ("HCFA"), dated September 26, 1994, six months after the issuance of the 1994 Regulations and Interim Final Rule, ██████████ acknowledged that HCFA's FI's were having difficulty evaluating claims for PHP services.<sup>7</sup> He acknowledged that PHP providers needed more specific guidance about coverage of PHP services. Thus, it is evident that even after issuance of the 1994 Regulations and Interim Final Rule, HCFA acknowledged that FI's lacked sufficient understanding or knowledge to help educate providers.

Not until January 19, 1995 did BC/BS of NM issue its draft local medical review policy ("LMRP") for PHP's in an outpatient and CMHC setting, requesting provider comments. MHCD, in conjunction with the CACMHCC, documented its concerns and comments in a response to BC/BS of NM's draft LMRP, dated March 2, 1995.<sup>8</sup> It is evident from the response of ██████████ President of Colorado Association of Community Mental Health Centers and Clinics, that even the draft LMRP was inconsistent with BC/BS of NM's previous guidance particularly with respect to patient eligibility and physician certification. The draft LMRP was never finalized by BC/BS of NM, thus leaving providers with no further FI guidance. Minutes from the CACMHCC Finance Committee, dated May 4, 1995, document that there was no response from BC/BS of NM, who did not want to be "pushed" to respond to the Association (CACMHCC).<sup>9</sup>

Only in June 1995, did HCFA issue Program Memorandum (PM) 95-8 to provide clarification of the requirements applicable to the Medicare PHP benefit.<sup>10</sup> In PM 95-8, the scope of services available under the PHP benefit were further defined. Of significance in this matter is the notion and definition of "active treatment".

<sup>5</sup> See Tab 2 of Exhibit A.

<sup>6</sup> See Tab 3 of Exhibit A.

<sup>7</sup> See Tab 4 of Exhibit A.

<sup>8</sup> See Tabs 5 and 6 of Exhibit A.

<sup>9</sup> See Tab 7 of Exhibit A.

<sup>10</sup> Program Memorandum (Intermediaries), No. A-95-3, June 1, 1995. Because PM 95-3 was due to expire on June 30, 1996, HCFA re-issued it in its entirety to make it clear that the information in PM 95-3 was still applicable. See Program Memorandum (Intermediaries), HCFA Pub. 90A, Transmittal No. A-96-2, July 01, 1996.

"Active treatment" was defined as the ongoing provision of clinically recognized therapeutic interventions which are goal-directed and based on a documented treatment plan. Examples given of active treatment include, but are not limited to, individual therapy, group therapy, and occupational therapy. In order to be considered "active treatment", PM 95-8 stated the following criteria must be met:

- 1) Treatment is directed toward the alleviation of the impairments that precipitated entrance in the program or which necessitate continued level of intervention;
- 2) Treatment enhances the patient's coping abilities; and
- 3) Treatment is individualized to address the specific clinical needs of the patient.

Active treatment was not intended to include service to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. Further, PM 95-8 stated that 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. Persons who require a low frequency of participation may indicate that PHP services are no longer reasonable and necessary and the beneficiary could be managed in an outpatient setting and should no longer be covered under the PHP benefit.

Most of the MHCD consumers would not fit this description because MHCD serves the highest number of seriously mentally ill in the state of Colorado. Our goal is to keep our consumers out of the hospital.

PM 95-8 also stated that the physician 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 PHP services are not substituted. PHP services may occur in lieu of either (1) admission to an inpatient hospital; or (2) a continued inpatient hospitalization. Moreover, a beneficiary must (a) be able to benefit from a coordinated program of services; (b) have an adequate support system outside the program and not require 24-hour care; (c) have an ICD-9 diagnosis of mental illness; and (d) not be dangerous to themselves or others. In short, eligible beneficiaries would require inpatient psychiatric treatment in the absence of PHP services. These requirements match the profile of most adult consumers served by MHCD.

BC/BS of NM did not provide any guidance with respect to the implementation of the 1994 Regulation, Interim Final Rule or HCFA's program memorandum. In the absence of guidance from BC/BS of NM, MHCD believed that they were still providing appropriate Medicare PHP services, since the services occurred in lieu of either (1) admission to an inpatient hospital, or (2) a continued inpatient hospitalization, as outlined in PM 95-8.



BC/BS of TX issued Medicare Part A Newsletter No. 318-95 ("Newsletter No. 318-95") dated September 1, 1995, which provided additional clarification regarding the PHP benefit but did not furnish the specific timing and manner of the physician certification and recertification.<sup>11</sup> BC/BS of TX was not, however, MHCD's FI when this Newsletter No. 318-95 was issued. BC/BS of NM was subsequently terminated as MHCD's FI on September 30, 1995, and replaced by BC/BS of TX effective December 1, 1995. In the absence of guidance from MHCD's FI, MHCD developed its own form of certification and recertification in an attempt to interpret the Medicare guidelines.<sup>12</sup> Additionally, Newsletter No. 318-95 did not specify the form of the physician prescription for PHP services provided by CMHC's. MHCD implemented its own certification and recertification form for PHP services in February, 1996.

BC/BS of TX did not provide training to Colorado providers of CMHC PHP services until October 1, 1996, one year after it was awarded the HCFA FI contract. One transition seminar was held by BC/BS of TX but only dealt with billing logistics and transitioning to this new FI.<sup>13</sup> Very little of the training pertained specifically to PHP services provided by CMHC's.

In a letter received by MHCD from BC/BS of TX on October 17, 1996, MHCD was notified of the results of a post-payment review and that they were being placed under Focused Medical Review ("FMR") effective immediately.<sup>14</sup> However, MHCD was reassured by BC/BS of TX that this prior post payment review would not result in repayment nor be punitive in nature because of the lack of prior guidance. This was the first feedback received by MHCD that the PHP services it was providing did not meet Medicare guidelines. In response to this review and notification, MHCD contacted BC/BS of TX for approval of the certification and recertification form developed in February, 1996. In November, 1996, [REDACTED] of BC/BS of TX provided verbal confirmation that MHCD's certification and recertification form met Medicare guidelines.

Throughout this period, MHCD developed and implemented internal guidelines and revised forms to ensure that PHP services met Medicare guidelines. For example, on January 31, 1996, MHCD issued an internal memorandum to PHP Program Directors with revised Certification/Recertification Forms and a PHP Program Part A Documentation Requirements Packet.

The lack of clarity in the law, the development of PHP review policies and applications of those standards by FI's in a frequently arbitrary manner, and a wide variance and implementation of both CMHC definitions and PHP's left MHCD during this period of time in a vulnerable position as it attempted to provide a

<sup>11</sup> See Tab 3 of Exhibit A.

<sup>12</sup> See Tab 9 of Exhibit A.

<sup>13</sup> See Tab 10 of Exhibit A.

<sup>14</sup> See Tab 11 of Exhibit A.



July 13, 1999

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legitimate and appropriately covered services to beneficiaries for which PHP was medically necessary.

Thus, without clearly articulated standards applicable to the Medicare CMHC PHP benefits, MHCD struggled with applying vague statutory standards intended to fit a health care system whose emphasis was on inpatient treatment. Specifically, the language used by Medicare and the FI pertained to inpatient practices and did not correspond to CMHC vocabulary. For example, CMHC's do not utilize the term "admission" to a program, as, by definition, patients reside in the community rather than an inpatient treatment center. Moreover, because of this lack of guidance and lack of effectiveness of the BC/BS of NM and BC/BS of TX, MHCD has been denied at a minimum (1) notice of the specific standards used to measure compliance, (2) opportunity for corrective action and (3) trained surveyors capable of performing reliable evaluations.

The multiple and at times confusing interpretative materials, coupled with equally conflicting and confusing verbal advice furnished by BC/BS of NM and BC/BS of TX and the lack of national standards has resulted in what we believe to be an unfair retrospective denial of claims for PHP services rendered by MHCD during the audit period. We have been subject to different standards by two different FI's. These differences are a source of legitimate provider and patient confusion. Our Medicare FI's did not furnish accurate and timely provider education and assistance.<sup>15</sup> We are willing to work expeditiously with the OIG to resolve any inappropriate claims, but we believe that the lack of clear and correct guidance from our FI should not be held against us.

Finally, by failing to timely deny PHP claims for payment or provide instructive guidance, MHCD relied on the FI's determination that the PHP services rendered were appropriate. Thus, MHCD was denied the opportunity to seek payment from Medicaid and other third party payors for reimbursable services provided by MHCD.

Please be assured that MHCD has sought to act at all times in good faith to maintain compliance with all applicable federal guidelines and regulations. We would appreciate the opportunity to provide this additional information to you for your consideration and would like to request a meeting at your earliest convenience to discuss more fully the issues at hand.

Very truly yours,

Roberto Quiroz, M.S.W.  
Chief Executive Officer

<sup>15</sup> 42 C.F.R. §421.103