DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date OCT - 1 1999

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Outpatient Psychiatric Services Provided by the Waterbury Hospital for the Fiscal Year Ending September 30, 1997 (A-01-99-00501)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on October 5, 1999, of our final report "Review of Outpatient Psychiatric Services Provided by the Waterbury Hospital for the Fiscal Year Ending September 30, 1997." 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 Waterbury Hospital (Hospital), located in Waterbury, Connecticut did not establish or follow existing procedures for the proper billing of outpatient psychiatric services.

This audit of hospital outpatient claims was conducted in conjunction with our review of Medicare's partial hospitalization programs at community mental health centers in which our office found significant error rates regarding provider compliance with Medicare requirements. Additional audits of hospital outpatient psychiatric services are in process and will be reported to you upon completion.

Our audit at the Hospital determined that a significant amount of the outpatient psychiatric charges claimed by the Hospital did not meet the Medicare criteria for reimbursement. Specifically, we identified charges for psychiatric care not properly supported by medical records or otherwise found medically unnecessary. Based on a statistical sample, we estimate that at least $1,909,961 in outpatient psychiatric charges were submitted by the Hospital yet did not meet Medicare criteria for reimbursement. We also identified $212,372 in costs ineligible for Medicare reimbursement claimed by the Hospital on its Fiscal Year (FY) 1997 cost report for outpatient psychiatric services. We recommended that the Hospital strengthen its procedures to ensure that charges for psychiatric services are covered and properly documented in accordance with Medicare requirements. We also recommended that the Hospital establish nonreimbursable cost centers or otherwise exclude costs related to noncovered services from its Medicare cost reports. We will also provide the results of our review to the fiscal intermediary (FI) so that it can apply the appropriate adjustments of $1,909,961 and $212,372 to the Hospital's FY 1997 Medicare cost report.

The Hospital, in its response dated June 22, 1999, believed that the Office of Inspector General (OIG): (1) should either accept its hired consultant's analysis of the OIG's sampled outpatient psychiatric claims or conduct a joint review with this consultant; (2) should not recommend disallowance of payment because the Hospital believed the guidance provided by the FI regarding documentation standards was confusing and ambiguous; (3) should remove examples of grant expenditures from its report and include a note that the Hospital informed the FI it would adjust its FY 1997 cost report based on the results of the OIG's audit; (4) should note in its report that additional information was added to the medical records sampled by the OIG without the Hospital's authorization; and (5) should reconsider its statistical sampling technique. We believe that our final audit determinations are correct and in accordance with Medicare rules and regulations. With regard to item 4 we have referred this matter to our Office of Investigations for further review. The basis of our position is discussed in detail starting on page 12 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 William J. Hornby, Regional Inspector General for Audit Services, Region I, at (617) 565-2689.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY THE WATERBURY HOSPITAL FOR FISCAL YEAR ENDING SEPTEMBER 30, 1997

JUNE GIBBS BROWN
Inspector General

OCTOBER 1999
A-01-99-00501

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

OCT - 5 1999

CIN A-01-99-00501

Mr. John Tobin
President
Waterbury Hospital
64 Robbins Street
Waterbury, Connecticut 06708

Dear Mr. Tobin:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Outpatient Psychiatric Services Provided by the Waterbury Hospital for Fiscal Year Ending September 30, 1997." A copy of this report will be forwarded to the action official noted below for his 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-01-99-00501 in all correspondence relating to this report.

Sincerely yours,

William J. Hornby

William J. Hornby
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. George F. Jacobs
Regional Administrator
Health Care Financing Administration
Room 2325, JFK Federal Building
Boston, Massachusetts 02203-0003

EXECUTIVE SUMMARY

Background

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. Medicare regulations define outpatient services as "Each examination, consultation or treatment received by an outpatient in any service department of a hospital...." Medicare regulations further require that charges reflect reasonable costs and such services be supported by medical records. These records must contain sufficient documentation to justify the treatment provided. Hospital costs for such services are generally facility costs for providing the services of 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 year end, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final reimbursement.

Objective

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.

Summary of Findings

In Fiscal Year (FY) 1997, the Waterbury Hospital (Hospital) submitted for reimbursement about $4.4 million in charges for outpatient psychiatric services. To determine whether controls were in place to ensure compliance with Medicare requirements, we reviewed the medical and billing records for 100 randomly selected claims totaling $64,216. These services were charged on behalf of patients in the Hospital's partial hospitalization program (PHP) and other outpatient programs. Our analysis showed that $53,585 of these charges did not meet Medicare criteria for reimbursement. Specifically, we found:

- $37,243 in charges for PHP services not properly supported in the medical records, not certified by a physician, lacking sufficient patient treatment plans, or found not reasonable and necessary.

- $16,342 in other outpatient psychiatric charges not properly supported in the medical records or lacking sufficient patient treatment plans.

During our audit, we discovered that the Hospital had added medical record documentation and supplied missing required signatures to patient medical record charts subsequent to our selection of the records for review. This questions the integrity of the information supplied to us.

Based on a statistical sample, we estimate that the Hospital had overstated its FY 1997 Medicare outpatient psychiatric charges by at least $1.9 million. Accordingly, we found that the Hospital did not establish or follow existing procedures for the proper billing of outpatient psychiatric services.

Medicare requires that costs claimed to the program to be reasonable, allowable, allocable, and related to patient care. Accordingly, we reviewed $695,138 in selected outpatient psychiatric costs reported on the Hospital's FY 1997 Medicare cost report. From our review, we identified $212,372 in costs ineligible for Medicare reimbursement. These costs included patient transportation, patient meals, and self-administered drugs. Also included were Medicare nonreimbursable costs found not directly related to patient care.

Recommendations

We recommend that the Hospital:

1. Strengthen its procedures to ensure that charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements. Accordingly, we will provide the results of our review to the FI, so that it can apply the appropriate adjustment of $1,909,961 to the Hospital's FY 1997 Medicare cost report.

2. Develop procedures to establish nonreimbursable cost centers or to otherwise exclude costs related to noncovered services from its Medicare cost reports. We will provide the FI with detail of the identified $212,372 in unallowable costs so that it can apply the appropriate adjustment to the Hospital's FY 1997 Medicare cost report.

In response to our draft report (see APPENDIX C), the Hospital believed that the Office of Inspector General (OIG): (1) should either accept its hired consultant's analysis of the OIG's sampled outpatient psychiatric claims or conduct a joint review with this consultant; (2) should not recommend disallowance of payment because the guidance provided by the FI regarding documentation standards was confusing and ambiguous; (3) should remove examples of grant expenditures from its report and include a note that the Hospital informed the FI it would adjust its FY 1997 cost report based on the results of the OIG's audit; (4) should note in its report that additional information was added to the medical records sampled by the OIG without the Hospital's authorization; and 5) should reconsider its statistical sampling technique.

We believe that our final audit determinations are correct and no further adjustments to our report are necessary. The basis for our position is discussed starting on page 12 of this report.

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INTRODUCTION

BACKGROUND

The Health Insurance for the Aged and Disabled Act (Medicare), Title XVIII of the Social Security Act, as amended, is a program of health insurance that is administered by the Health Care Financing Administration (HCFA). The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. Such services are generally provided by 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 year end, the hospital submits a cost report to the Medicare FI for final reimbursement. Medicare requires that for benefits to be paid:

- "...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 §482.24]

- Psychiatric "services must be...reasonable and necessary for the diagnosis or treatment of a 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." [HCFA Fiscal Intermediary Manual Section 3112.7]

In addition, for patients receiving PHP services,

- "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 every 31 days thereafter." [HCFA Program Memorandum, Publication 60A]

- in order for an individual's PHP to be covered, a physician must certify that "...The individual would require inpatient psychiatric care in the absence of such services..." Further, "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]

For costs claimed on a hospital's Medicare cost report, Medicare requirements define:

- reasonable costs as "...all necessary and proper expenses incurred in furnishing services...However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable...." [42 CFR 413.9(c)(3)]

- that "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 Section 2102.1]

- costs related to patient care as those which "...include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others...." [Provider Reimbursement Manual Section 2102.2]

- noncovered outpatient psychiatric services to include patient meals and patient transportation. It also limits drug coverage only to those which cannot be self-administered. [Medicare Fiscal Intermediary Manual §3112.7]

The Hospital, a 243 bed acute care facility in Waterbury, Connecticut, provides outpatient psychiatric services to patients in the greater Waterbury, Connecticut area. The Hospital provides these services through its PHPs and through other outpatient psychiatric programs. For FY 1997, the Hospital submitted for Medicare reimbursement 5,871 claims for outpatient psychiatric services valued at $4,355,173.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicare requirements. Our review included services provided and costs incurred during FY 1997.

We conducted our audit during the period of November 1998 through January 1999 at the Hospital in Waterbury, Connecticut in accordance with generally accepted government auditing standards. During the course of our field work, we discovered that the Hospital had added medical record documentation and supplied missing required signatures to patient medical record charts subsequent to our selection of the records for review.

We brought this to the attention of Hospital officials, who, in a written correspondence to us, confirmed that Hospital staff had added medical record documentation and supplied missing required signatures to patient medical record charts subsequent to our selection of the records for review. This included the addition of treatment plans, plan updates, and plan reviews to the requested patient charts and the obtaining of physician signatures to existing documents. The Hospital identified to us the added documents but stated that the extent of added signatures could not be determined, but estimated that records for 30 to 40 of the 100 cases we reviewed were changed after we selected them for review. The hospital stated that the purpose of the additions was to insure completeness and accuracy, and not to affect any billing and audit issues.

Because the objective of our audit was to determine whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicare requirements, the changing of medical records by adding additional information or supplying missing evidence of physician supervision could materially affect whether such services were allowable for Medicare reimbursement. This questions the integrity of information supplied to us.

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

To accomplish our objective, we:

- reviewed criteria related to outpatient psychiatric services,
- obtained an understanding of the Hospital's internal controls over Medicare claims submission,
- used the Provider Statistical and Reimbursement Report provided by the FI for the Hospital's FY 1997 to identify 5,871 outpatient psychiatric claims from the Hospital valued at $4,355,173,
- employed a simple random sample approach to randomly 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 Anthem Blue Cross/Blue Shield of Connecticut, the Medicare FI, and psychiatrists from Qualidigm, the Connecticut Peer Review Organization (PRO), to review each of the 100 outpatient psychiatric claims,

- used a variable appraisal program to estimate the dollar impact of improper charges in the total population, and

- reviewed Medicare Part B claims processed by the local Medicare Part B Carrier which correspond to our sampled claims processed by the FI.

In addition, we identified $4,279,289 in outpatient psychiatric costs, after reclassifications and adjustments, claimed by the Hospital on its FY 1997 Medicare cost report. We tested the allowability of a judgmental sample of $695,138 of these costs through review of supporting documentation.

The Hospital's response to the draft report is appended to this report (see APPENDIX C) and is addressed on pages 12 through 17. We deleted from the response certain sensitive information on Medicare beneficiaries and others that the OIG would not release under the Freedom of Information Act.

FINDINGS AND RECOMMENDATIONS

The Hospital provides outpatient psychotherapy services under several programs in the greater Waterbury, Connecticut area. Much of the services provided to Medicare beneficiaries are provided through the Hospital's Center for Geropsychiatry and Grandview Adult Behavioral Health Center. The Hospital operates PHPs within these centers as well as providing other outpatient psychiatric services.

In FY 1997 the Hospital submitted for Medicare reimbursement about $4.4 million in charges for outpatient psychiatric services. We reviewed the medical and billing records for 100 randomly selected claims comprising 744 individual services totaling $64,216 in charges. Our analysis disclosed that $53,585 of the sampled charges did not meet Medicare criteria for reimbursement. Based on a statistical sample, we estimate that the Hospital had overstated its FY 1997 Medicare outpatient psychiatric charges by at least $1.9 million. Charges found unallowable lacked sufficient medical record documentation, physician certification, sufficient treatment plans, or were found not reasonable and necessary.

The Hospital claimed about $4.3 million in costs for providing these outpatient psychiatric services, after reclassifications and adjustments, on its FY 1997 Medicare cost report. We reviewed a judgmental sample of $695,138 in nonsalary costs and found $212,372 of such costs were unallowable under Medicare requirements. These unallowable costs included patient meals, patient transportation, self administered drugs, respite care, and other costs not directly related to patient care.

Findings from our review of medical records and outpatient psychiatric costs are described in detail below.

MEDICAL RECORD REVIEW

PARTIAL HOSPITALIZATION PROGRAM

According to the Hospital, patients in the Hospital's PHPs attend four group therapy sessions per day, three to five days per week. The Hospital offers group therapy on a wide range of topics including assertiveness, life management, and social skills. From our sample of 100 outpatient psychiatric claims, 11 of these claims, representing 452 services and totaling $38,461 in charges, were for services provided to PHP patients. Our review showed that $37,243 for 439 services, did not meet Medicare criteria for reimbursement. Our results are as follows:

Services Not Certified By a Physician

Under HCFA Program Memorandum, Publication 60A, in order for an individual's PHP to be covered, a physician must certify that "...The individual would require inpatient psychiatric care in the absence of such services..." Further, "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."

We found that the Hospital did not have procedures in place for physicians to certify that patients placed into the intense treatment of a PHP would require inpatient psychiatric care in lieu of such services. From our review of the billing and medical records of the 11 PHP claims, we identified $17,354 in charges for 204 PHP services billed to the Medicare program which were not certified by a physician.

Specifically, we found cases for which a patient was receiving the intense level of care from the PHP but for whom a physician had not certified that the patient would require inpatient psychiatric care in lieu of such services. Without such a physician certification, the necessity of such an intense level of care is unclear.

Services Not Supported By Medical Records

The 42 CFR, §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."

Our audit disclosed a weakness in the Hospital's system of internal controls regarding medical record documentation supporting the charge. Our review of a statistical sample of claims disclosed that $14,483 in PHP charges were not properly supported in the medical records.

We examined the billing and medical records for the 11 PHP claims in our sample. In addition, we requested the assistance of medical review personnel from the FI and PRO. Based on our analysis, we identified:

- $12,475 for charges not sufficiently documented in accordance with Medicare requirements. These charges included $11,737 for 140 group therapy sessions documented by "flowsheets." Such PHP flowsheets provide little more than the patient's current mental status on a numerical scale and "checkmarks" to indicate the type and number of groups attended that day. These records did not record what took place in each group, including the patient's interaction with group members, his/her progress compared to the treatment plan goals, or future plans for treatment. We found an additional $738 in charges for eight other services not showing sufficient documentation. Examples of such errors included the billing for 2 days of PHP therapy - a total of seven group therapy sessions over the 2 days. A single progress note for each day states that the patient attended the specified number of sessions but no write up was provided by the individual group therapists for each session billed.

- $2,008 in charges for 24 PHP services which Hospital staff were unable to locate in the patient's chart. For example, we found a 1 day PHP billing for six group sessions for which only three sessions were recorded on the PHP flowsheet.

Without complete medical record documentation, including a description of what took place in a therapy session, including the patient's interaction with group members, his/her progress compared to the treatment plan goals, and future plans of treatment, the appropriateness of the patient's level of care is unclear. Further, inadequate documentation of patient therapies and treatments provides little guidance to physicians and therapists to guide future treatment. The lack of required documentation, as shown above, precluded us from determining whether those services were indeed reasonable and necessary.

Services Not Reasonable And Necessary

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

The Hospital did not have adequate procedures in place for ensuring that services billed to the Medicare program are reasonable and necessary for the treatment of a patient's condition.

With the assistance of medical reviewers from the FI and PRO, we found $4,719 in erroneous charges for services determined not to be reasonable and necessary. These charges were from one PHP claim containing 55 group therapy services for which medical record documentation did not demonstrate this level of treatment as reasonable and necessary.

Outdated Patient Treatment Plans

HCFA Program Memorandum, Publication 60A states, "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 every 31 days thereafter."

We found that the Hospital did not have adequate procedures in place for keeping current treatment plans for each patient receiving PHP psychiatric care. With the assistance of medical review personnel from the FI and PRO, we examined the billing and medical records for the 11 PHP claims in our sample. Based on our analysis, we identified $686 for charges for eight PHP services where the predominant error was patient treatment plans outdated in excess of 31 days.

Without a current treatment plan prescribed to identify the type, amount, frequency, and duration of services to be furnished to the patient, we could not determine with any certainty that the above services were indeed reasonable and necessary.

OTHER OUTPATIENT PSYCHIATRIC SERVICES

In addition to its PHP, the Hospital provides other, less intensive outpatient psychiatric services. These services include periodic psychotherapy, medication monitoring, and other psychiatric care. Most prevalent examples found in our review were weekly group therapy sessions and monthly medication reviews. Our sample of 100 claims contained 89 such claims for 292 services valued at $25,755. We found that charges for $16,342, representing 194 services, did not meet Medicare criteria for reimbursement as detailed below.

Services Not Supported By Medical Records

The 42 CFR, §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."

Our audit disclosed a weakness in the Hospital's system of internal controls regarding medical record documentation supporting the charge. Our review of the 89 outpatient psychiatric claims disclosed that $11,280 in charges representing 133 services were not properly supported in the medical records. Based on our analysis, we identified:

- $9,352 in charges for 108 services not sufficiently documented in accordance with Medicare requirements. Ninety-nine services, totaling $8,620, were mainly group therapy sessions documented by "flowsheets." Such weekly or monthly flowsheets, similar to the PHP flowsheets, provide little more than the patient's current mental status on a numerical scale and "checkmarks" to indicate the group(s) attended that day. These records did not record what took place in each

group, including the patient's interaction with group members, his/her progress compared to the treatment plan goals, or future plans for treatment. In addition, we identified $732 for charges for nine other services determined by the medical reviewers as also not showing sufficient documentation to support the care rendered to the patient. For example, we found a progress note written by a clinician which stated, "Pt. attended Cognitive Therapy."

- $1,928 in charges for 25 services for which Hospital staff was unable to locate a corresponding progress note in the patient's chart.

As a result, we concluded that $11,280 in other outpatient psychiatric charges did not have adequate documentation required for Medicare billing and, therefore, did not meet Medicare's criteria for reimbursement. Without complete medical record documentation, including a description of what took place in a therapy session, including the patient's interaction with group members, his/her progress compared to the treatment plan goals, and future plans of treatment, the appropriateness of the patient's level of care is unclear. Further, inadequate documentation of patient therapies and treatments provides little guidance to physicians and therapists to guide future treatment. In this regard, the lack of required documentation, as described above, precluded us from determining whether those services were indeed reasonable and necessary.

Insufficient Patient Treatment Plans

The HCFA Fiscal Intermediary Manual section 3112.7(B) states that for outpatient hospital psychiatric services to be covered, "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...."

Section 3112.7 continues by stating, "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."

We found that the Hospital did not have adequate procedures in place for preparing individualized treatment plans for each patient receiving ongoing psychiatric care. From our review of the billing and medical records for the 89 other outpatient psychiatric claims in our sample, we identified $5,062 in charges for 61 services to patients who had treatment plans not complying with Medicare requirements or otherwise missing. With the assistance of medical review personnel from the FI and PRO, we identified:

- $3,992 in charges for 48 services to patients whose treatment plan was outdated. We found that about 60 percent of these outpatient services had treatment plans

dated over 1 year old. For one sampled service, the Hospital identified the patient's most recent treatment plan as dated in 1991, over 5 years prior to the date of service.

- $761 in charges for nine services to patients whose existing treatment plan was not signed by a physician, and

- $309 in charges for four services to patients who did not have an individualized treatment plan.

Without an up-to-date and proper treatment plan prescribed by a physician to identify the type, amount, frequency, and duration of services to be furnished to the patient, we could not determine with any certainty that the above services were indeed reasonable and necessary.

REVIEW OF OUTPATIENT PSYCHIATRIC COSTS

The Hospital claimed $4,279,289 in costs for outpatient psychiatric services, after reclassification and adjustments, on its FY 1997 Medicare cost report. From this amount, we judgmentally selected nonsalary costs of $695,138 for review. Our analysis showed that $212,372 (about 30 percent) of these outpatient costs reviewed were unallowable. Descriptions for these unallowable costs are shown below.

Nonreimbursable Costs

The 42 CFR 413.9(c)(3) defines reasonable costs as "...all necessary and proper expenses incurred in furnishing services...However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable...."

The Provider Reimbursement Manual section 2102.1 states that "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 section 2102.2 defines costs related to patient care as those which "...include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others...."

We found that the Hospital did not have adequate controls established in the preparation of its FY 1997 Medicare cost report to exclude all nonreimbursable costs or to otherwise establish nonreimbursable cost centers for such costs.

Based on our analysis, we found that $64,925 of the $695,138 in Hospital outpatient psychiatric costs reviewed were not allowable, reasonable, allocable, or otherwise directly related to patient care. This resulted in an overstatement of the Hospital's FY 1997 Medicare cost report. Specifically, we found that the Hospital had claimed costs associated with respite care provided through the Hospital's crisis center. These costs included rent for an apartment, furnishings, groceries, cable television, and newspaper delivery. Further, we also found that the Hospital had claimed costs associated with State grant programs which were not directly related to the medical treatment of Medicare beneficiaries. For example, we found costs for program clients associated with their burial expenses, travel to conferences in Washington, DC and Albuquerque, NM, and storage facilities for personal belongings. These costs are not allowable, reasonable, or allocable to the Medicare program. The Hospital believed that its treatment of the costs associated with the State grants was correct.

Costs Related To Noncovered Services

Medicare Fiscal Intermediary Manual section 3112.7 states that noncovered outpatient psychiatric services include meals and transportation. It also limits drug coverage only to those which cannot be self-administered.

We found that the Hospital did not have adequate procedures in place to establish nonreimbursable cost centers or to otherwise exclude costs related to noncovered services from its FY 1997 Medicare cost report.

As part of the Hospital's outpatient psychiatry programs, the Hospital provided patients with transportation to treatment facilities via vehicles leased or provided under contract with an ambulance company. Additionally, the Hospital also provided meals and in some instances self-administered drugs to the beneficiaries participating in these outpatient services. These costs are not covered under the Medicare program. Our analysis showed that $147,447 of the outpatient costs reviewed were noncovered because they were 1) related to patient transportation ($129,676), 2) related to patient meals ($16,383), or 3) for self-administered drugs ($1,388). As a result, we believe that the Hospital overstated its FY 1997 Medicare cost report by $147,447. During the course of our audit, the Hospital acknowledged that it had inadvertently included patient transportation costs in its FY 1997 Medicare cost report and would notify the FI of this error. The Hospital did not comment on the other costs found in error.

CONCLUSION

For FY 1997, the Hospital submitted for reimbursement $4,355,173 in charges for outpatient psychiatric services. Our audit of 100 randomly selected claims totaling $64,216 disclosed that $53,585 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 billed at least $1,909,961 in error for FY 1997. We attained our estimate by using a single stage appraisal program. The details of our sample appraisal can be found in APPENDIX A.

In support of the above claimed charges, the Hospital claimed about $4.3 million in costs for these outpatient psychiatric services, after reclassification and adjustments, on its FY 1997 Medicare cost report. We judgmentally reviewed $695,138 of such nonsalary costs and found $212,372 unallowable.

RECOMMENDATIONS

We recommend that the Hospital:

1. Strengthen its procedures to ensure that charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements. Accordingly, we will provide the results of our review to the FI, so that it can apply the appropriate adjustment of $1,909,961 to the Hospital's FY 1997 Medicare cost report.

2. Develop procedures to establish nonreimbursable cost centers or to otherwise exclude costs related to noncovered services from its Medicare cost reports. We will provide the FI with detail of the identified $212,372 in unallowable costs so that it can apply the appropriate adjustment to the Hospital's FY 1997 Medicare cost report.

AUDITEE RESPONSE AND OIG COMMENTS

The Hospital, in its response dated June 22, 1999 (see APPENDIX C) believed that the OIG: (1) should either accept its consultant's analysis of the OIG's sampled outpatient psychiatric claims or conduct a joint review with its consultant; (2) should not recommend disallowance of payment because the guidance provided by the FI regarding documentation standards was confusing and ambiguous; (3) should remove examples of grant expenditures from its report and include a note that the Hospital informed the FI it would adjust its FY 1997 cost report based on the results of the OIG's audit; (4) should note in its report that additional information was added to the medical records sampled by the OIG without the Hospital's authorization; and 5) should reconsider its statistical sampling technique.

We believe that our final audit determinations are correct and no further adjustments to our draft report are necessary. We have summarized the auditee's relevant responses and provide our additional comments below.

Auditee Response Regarding Its Consultant's Analysis of OIG Results

The Hospital hired a consultant, PricewaterhouseCoopers (PWC) to review the OIG's results in order to determine whether or not the proposed disallowances of $1.9 million were appropriate. PWC determined that 38 percent of the claims submitted by the Hospital were in error, resulting in its proposed disallowance of $877,350. The PWC results differed from the OIG's in issues pertaining to; (1) insufficient flowsheet documentation, (2) PHP services not certified by a physician, and (3) services not reasonable and necessary. Accordingly, the Hospital believed that the OIG should either accept its consultant's analysis of the Hospital's sampled claims or conduct a joint review with PWC.

OIG Comments

The PWC reviewers concurred with the OIG on a material portion of our finding. Specifically, of the $64,216 sampled by the OIG, we determined that $53,585 was in error, while PWC believes that $24,498 was in error. Regarding the finding difference, we have reviewed PWC's analysis and disagree with its interpretation and application of Medicare criteria for determining the sufficiency of documentation to support claims for payment by Medicare. The Hospital, in an appendix to its response to our draft report, provided a table comparing the above differences in findings (see APPENDIX C). We have addressed the central issues of discrepancy below.

Insufficient Flowsheet Documentation: The most significant difference (51 percent of the total difference) between the OIG and PWC results stems from the appropriateness of the Hospital's flowsheets used to document group therapy sessions for both PHP and other outpatient services. As stated on Page 6 and 8 of this report, such flowsheets provide little more than the patient's current mental status on a numerical scale and "checkmarks" to indicate the type and number of groups attended that day. These records did not record what took place in each group, including the patient's interaction with group members, his/her progress compared to the treatment plan goals, or future plans for treatment. An example of a Hospital flowsheet is shown in APPENDIX B. The OIG agrees with the Hospital that the use of activity checklists or flowsheets can, in part, be an acceptable form of documentation. However, as a condition for participation in the Medicare Program, the Hospital should recognize 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." (42 CFR §482.24) Further, the HCFA Program Memorandum addressing PHP states that chart entries should contain an observation of the patient's status and responses in the course of therapeutic contact and the patient's response to treatment as it relates to the individualized active treatment goals. According to the FI and psychiatrists from the PRO, the Hospital's flowsheets did not meet these standards and they were unable to determine the medical reasonableness and necessity of the claimed services. These services were therefore denied.

PHP Services Not Certified by a Physician: (34 percent of the total difference) Subsequent to the completion of our review, PWC provided us with inpatient discharge summaries identifying these documents as physician certifications. We reviewed the Hospital documentation and

found that it did not clearly articulate the physician certification requirements set forth in 42 CFR 424.24 and HCFA Program Memorandum A-96-2. Specifically, both of these references cite that the physician must certify that the patient would require inpatient psychiatric care if the partial hospitalization services were not provided. The determination that such services be denied remain unchanged.

Services Not Reasonable and Necessary: (17 percent of the total difference) The medical reviewer's determination that certain services were medically unreasonable was based on an apparent overutilization of services. In the sampled case in question, the psychiatrist from the PRO stated that the volume of services provided for that monthly billing was "a case of overkill." The psychiatrist also stated, "There is virtually no description of what these 55 group meetings were about, accomplished or how they helped." Further, on an individual basis, the services claimed by the Hospital were not supported by documentation sufficient to determine their necessity and, therefore, their determination that such services be denied remains unchanged.

In regard to the Hospital's comment that the OIG did not consider the entire medical record in its review, the OIG believes it reviewed all relevant medical record documentation for the sampled services. During our exit conference with the Hospital, we asked PWC reviewers whether they utilized any other medical record documentation not considered by the OIG. PWC reviewers informed us that they had not except for two documents it had retrieved from the patients' inpatient charts. Upon review of these records, we determined such services remain ineligible for Medicare reimbursement. We also noted that one of the supplied documents was indeed copied by the OIG. We noted that the OIG's copy was not signed by a physician. However, the copy subsequently supplied by the Hospital was signed. In regard to a related Hospital comment questioning the OIG's medical reviewers' qualifications, the Hospital is well aware that both the FI and PRO have had long standing contracts with the Medicare program in Connecticut, part of which requires them to perform medical reviews, such as this review, on a day-to-day basis.

The OIG cannot accept the Hospital's recommendation of a joint re-review of the sampled claims. The OIG has presented the Hospital with detailed schedules of our findings on a service-by-service basis as well as copies of all medical reviewer notes from the FI and PRO psychiatrists. Our findings have been fully articulated to the Hospital. Likewise, the Hospital has stated its positions through its outside legal counsel and provided us with its consultant's work product. We have discussed the Hospital's positions with the FI and find no basis for changing the results of our review.

The OIG will therefore not accept the Hospital's recommendation of either accepting PWC's results or conducting a joint re-review of the sampled claims.

Auditee Response Regarding Guidance for Documentation Requirements

The Hospital believed that the guidance provided by the FI regarding these documentation standards was confusing and ambiguous. In this regard, the Hospital maintains that as HCFA did not issue Program Memorandum A-96-2 directly to individual providers, there is no evidence that shows that the Hospital received these requirements and they should not be held to the

requirements transmitted by it. Further, subsequent statements issued to the Hospital by its new FI, Empire Medical Services, specifically recognizes the continuing need for clarification of existing requirements. Under the limitation of liability provision set forth in section 1879 of the Social Security Act, the Hospital states that it is entitled to reimbursement for services found to be unreasonable and unnecessary if the Hospital did not know, and could not have been reasonably expected to know, payment would not be made for the services. Given the confusion which existed regarding the documentation standards, the Hospital believed it is still entitled to payment for these services.

OIG Comments

As one of the top 10 acute care hospitals in the nation (based on Medicare charges in FY 1997) providing outpatient psychiatric services to Medicare beneficiaries, we would expect the Hospital to keep abreast with Medicare requirements. HCFA Program Memorandum, Publication 60A, which was re-transmitted by HCFA via Program Memorandum A-96-2, was originally distributed by the FI to all hospital administrators via Bulletin H 95-54 on July 19, 1995. Critical elements with respect to treatment plans and physician certifications from these documents were drawn from Title 42 CFR 424.24. It is the Hospital's responsibility, not the Medicare program, to ensure that Program Memoranda and other criteria are distributed to relevant staff within the Hospital. Further, the OIG maintains that the applicable regulations and guidelines used in our report to support our findings are clear. However, if the Hospital believes that these billing instructions are not clear, it is the Hospital's responsibility as a Medicare provider to obtain guidance from the applicable Medicare carrier, FI, and HCFA regional office prior to the submission of any claim or the acceptance of payment for any questionable service. We do not believe that the Hospital is entitled to payment for these services and will therefore not change our recommendation for recoupment of these payments.

Auditee Response Regarding Grant Expenditures

The Hospital agrees that its FY 1997 cost report should be adjusted to eliminate $212,372 in unallowable costs. However, the OIG's audit report contains examples of unallowable costs which seem to sensationalize the audit finding. The Hospital notes that these were "approved" grant expenditures and requests this paragraph be removed from the audit report. Further, the Hospital believed that the OIG's report should reflect more precisely that the Hospital immediately notified the FI that it would be making adjustments to the cost report as a result of the OIG audit.

OIG Comments

The OIG appreciates the Hospital's concurrence in this matter. However, the examples of unallowable costs used in the audit report are accurate and correct. These examples describe unallowable costs the Hospital charged to the Medicare program and were subsequently found by the OIG. The OIG did not determine whether these costs were "approved" or that the granting agencies had any knowledge of their true nature. Further, our report indicates that the Hospital would notify the FI of its inadvertent inclusion of unallowable patient transportation charges in

its FY 1997 Medicare cost report. The Hospital did not, however, mention the other costs found in error. The OIG will therefore not change this section of the audit report.

Auditee Response Regarding Alteration of Medical Records

The Hospital believes that the OIG report should note that the Hospital did not authorize or condone the alteration of medical records under OIG review and cooperated fully in identifying the information added to the medical records.

OIG Comments

The OIG report does note that the Hospital identified some of the records which had been altered after they were notified of the problem by the OIG. We cannot comment on whether the alteration of medical records for service dates in 1996 and 1997 was done with or without authorization from the Hospital as it remains outside the scope of this audit report. The OIG will therefore not change this section of the audit report.

Auditee Response Regarding the OIG's Extrapolation of Sample Results

The Hospital believed that the OIG improperly extrapolated the alleged overpayments in the claims reviewed across all outpatient psychiatric services provided by the Hospital during the period reviewed. In this regard, the Hospital believed that the OIG's sample did not meet the minimum standards contained in the Medicare Carriers Manual Sampling Guidelines Appendix. For example, these guidelines recommend the use of stratification where stratification will result in greater precision. The OIG sample was not stratified despite the fact that the PHP services have distinctly different requirements for reimbursement from other outpatient services and the OIG report clearly treats the two types of services as separate groups. The Hospital also believed that it has not received adequate information regarding the selection of the sample to determine whether the claims reviewed were selected at random, although this information was previously requested.

In addition, the Hospital believed that the extrapolation of overpayments unfairly restricts its right to seek reimbursement directly from patients. The Hospital believed it has the right to do this unless the service was denied by Medicare based on lack of medical necessity.

OIG Comments

The minimum standards for statistical sampling applicable to reviews of providers (as cited by the Hospital in the Medicare Carriers Manual Sampling Guidelines Appendix) applies to provider reviews which formulate a conclusion based on the point estimate. These minimum standards advocate the use of stratification to optimize the accuracy of the point estimate because the point estimate is the basis for conclusion. However, the OIG policy for questioning costs is not based on the point estimate. Instead, in instances of costs questioned, the OIG policy dictates the use of the more conservative lower confidence limit of the point estimate. When stratification is not used, the lower confidence limit becomes even more conservative because the

lesser precision resulting from not stratifying further reduces the lower confidence limit of the point estimate. All statistical calculations used in the OIG sample appraisals conform with accepted standard statistical theory. The OIG statistical software and user guide (RAT-STATS), including the random number generator software is available on the world wide web at http://www.hhs.gov/progorg/oig/.

In regard to stratification, we were unable to stratify the population of outpatient psychiatric services because the Hospital failed to identify PHP services on its Medicare billings. The Medicare Hospital Manual section HO 452 (A) requires hospitals to use condition code "41" when billing Medicare to indicate that the claim is for partial hospitalization services. Without this required identifier on the billing records, we were unable to perform the computer applications needed for stratification. Identifying whether a claim was for PHP services or not could only be determined by reviewing the medical records for each sampled case.

Also, the Hospital erroneously believes that the use of sampling unfairly restricts its right to seek reimbursement directly from patients. Under Medicare limitations of liability, a beneficiary can only be billed directly for services denied by Medicare if the beneficiary knew or should have known that the services in question may not be covered by the Medicare program. Without notification in writing by the provider, FI, or PRO regarding possible non-coverage for these services, the Hospital cannot seek reimbursement from the beneficiaries in question.

The OIG will therefore not alter its statistical sampling technique or recommend that beneficiaries be liable for the services found in error.

APPENDICES

APPENDIX A

REVIEW OF
OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY THE
WATERBURY HOSPITAL

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 5,871 Claims	Items: 100 Claims	Items: 70
Dollars: $4,355,173 Charges	Dollars: $64,216 Charges	Dollars: $53,585

PROJECTION OF SAMPLE RESULTS[1]

Point Estimate: $3,145,973
Lower Limit: $1,909,961
Upper Limit: $4,381,985

[1]Based on our sample appraisal methodology, we are 90 percent confident that the point estimate of the dollar value of errors was $3,145,973. Further appropriate appraisal of these sample results shows that we are 95 percent confident that the lower limit of the errors are valued at $1,909,961.

Waterbury Hospital Psychiatric Service
Partial Hospital Program Flow Sheet
- Progress Notes -

[redacted]

Week/Year 12-9-96

Prob.	TARGETS OF TREATMENT	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
	Date:	9	10	11	12	13
	DANGEROUSNESS					
	Suicidal Ideation					
	Homicidal Ideation					
	AFFECTIVE DISORDER					
	Depression	2	2	1	1	1
	Anxiety					
	Mood Lability					
	PSYCHOSIS					
	Paranoia	1	1	1	1	1
	Hallucinations	1	1	1	1	1
	Delusional Thinking					
	NEGATIVE SYMPTOMS					
	Anergia	1	1	1	1	1
	Amotivation	1	1	1	1	1
	Poor Hygiene					
	Social Deficit	2	2	2	2	2
	Substance Abuse					

CODE: 0 = *No Evidence* 1 = *Present* 2 = *Markedly Present* 3 = *Severe* 4 = *Extreme*

[redacted] Elements of Service					
Attendance (P, A, Ex)	P	P	P	P	P
Supportive Group	✓✓✓	✓	✓	✓	✓✓
Insight Oriented Group		✓			
Activation Group				✓	
Skill Building	✓		✓✓✓✓	✓	✓✓
Patient / Family Teaching					
Medication Review					
Medication Services					
Individual Session / Assessment					
Collateral Contact					
Staff Initials	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Staff Signature		Initials	Staff Signature		Initials
[redacted]		[redacted]	[redacted]		[redacted]

CN 3854 - REV 10-94

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June 22, 1999

By Hand Delivery

Mr. Michael Armstrong
Office of Audit Services
Office of Inspector General
John F. Kennedy Building
Boston, Massachusetts 02203

Re: Draft Report on Review of Outpatient Psychiatric Services at Waterbury Hospital

Dear Mr. Armstrong:

This letter constitutes the views and suggestions of Waterbury Hospital (the "Hospital") in connection with the United States Department of Health and Human Services, Office of Inspector General, Office of Audit Services' draft report entitled "Review of Psychiatric Services Provided By Waterbury Hospital for Fiscal Year Ending September 30, 1997." We understand your draft is subject to further review and revision. Based on our comments and suggestions, we respectfully urge revision to conform the findings to the results of an independent review done by PricewaterhouseCoopers ("PWC").

The draft report resulted from a review undertaken by the Office of the Inspector General ("OIG") of 100 psychiatric outpatient claims submitted by the Hospital in fiscal year ending September 30, 1997. The OIG review was accomplished with the assistance of a coder from the fiscal intermediary and a psychiatrist from the Peer Review Organization. In the draft report, you do not generally contest that the services were actually provided. You do find, however, that approximately eighty-three percent of the charges associated with these claims did not qualify for reimbursement under Medicare. According to your report, most of the claims did not qualify for reimbursement because there was insufficient documentation in the medical records maintained by the Hospital to determine whether the services provided were reasonable and necessary. Extrapolating the findings of the statistical sample, you estimate that Medicare overpaid the Hospital approximately $1.9 million for outpatient psychiatric charges. You therefore propose that the fiscal intermediary disallow $1.9 million in claims by adjusting the Hospital's cost report for fiscal year 1997. In addition, based on your review of the Hospital's 1997 cost report, you concluded that costs totaling $212,372 were not allowable.

Mr. Michael Armstrong
Office of Audit Services
Office of Inspector General -2- June 22, 1999

I. Review Approach By Hospital

In order to verify the findings suggested by the OIG in its review of these claims, the Hospital engaged PWC to conduct an independent review of the 100 claims reviewed by the OIG. On June 1, 1999, we met with your staff, the coders from PWC and representatives from the Hospital and reviewed fully a draft of PWC's findings as well as the documentation criteria utilized by PWC to conduct the audit of the relevant medical records. PWC's final report is appended hereto as Attachment A. We thank you for that opportunity and sincerely believe that PWC's review more accurately reflects the appropriate adjustment that should be made to the charges for outpatient services. To that end, and as follow-up to our June 1, 1999 meeting, we respectfully request that you either (1) accept the PWC analysis and adopt its findings for transmittal to the fiscal intermediary, or (2) prior to forwarding your recommendations to the fiscal intermediary, allow the coders from PWC to review with the coder that you used each of the claims where there was a difference in the final conclusion with respect to the particular service. As a matter of fundamental fairness and appropriate process to arrive at a correct result, we sincerely believe that, at a minimum, a joint review should occur.

II. The Review By PricewaterhouseCoopers

As mentioned, we engaged the independent auditing firm of PWC to conduct an independent review of the 100 claims already reviewed by the OIG. This review sought to ascertain whether or not the proposed disallowances were appropriate. As indicated in its report, PWC determined that only thirty-eight percent of the claims submitted by the Hospital lacked sufficient documentation to support the reasonableness and medical necessity of the services provided. PWC did not make any determination regarding whether the Hospital knew or should have known that its documentation of the services was not sufficient to demonstrate that services were reasonable and necessary. PWC did, however, conduct a review of available guidance from the Hospital's fiscal intermediary and found that during the relevant period there was significant confusion and ambiguity over what degree of documentation would be required by Medicare. An extrapolation of the charges that were insufficiently documented as determined by PWC would yield a proposed disallowance based on your extrapolation methodology of $877,350. See Attachment B.

The independent review by PWC calls into question the appropriateness of the standards utilized by the fiscal intermediary's coder as a basis for disallowing claims. In determining the appropriate documentation standards to support the reasonableness and medical necessity of the services provided, PWC relied on the specific documentation requirements for partial hospitalization program and outpatient program services set forth in (1) Section 1835(f)

of the Social Security Act, (2) 42 C.F.R. § 424.24 (which codifies Section 1835(f) of the Social Security Act), (3) Medicare Manual Guidance (Hospital Manual §230.5 and Intermediary Manual §§3112.7 and 3920) and (4) HCFA Publication 60A - Program Memorandum A-96-2. PWC utilized the specific standards set forth in the statutory, regulatory and manual guidance. PWC also interpreted the standards suggested in Program Memorandum A-96-2 in the context of the particular services provided and patients treated at the Hospital. The program memorandum standards were therefore applied flexibly based on the specific facts and circumstances of each case. The more flexible use of the standards included in Program Memorandum A-96-2 accords with the instructions from HCFA set forth in that memorandum. HCFA there asserts that "[t]o the extent this instruction contains specific references to guidelines or frequency of services, these references are based on professional consultation and are offered as benchmarks for review of medical necessity and not as absolute coverage denials."

With regard to criteria for documentation, none of the statutory, regulatory or administrative guidance established or even suggested inflexible, specific standards. For example, guidance regarding updates to a treatment plan for outpatient psychiatric services states only that services must be "periodically evaluated" by a physician. *See*, Hospital Manual §230.5 and Intermediary Manual §3112.7. This is, of course, appropriate because the degree of specificity or timing for an appropriate reevaluation of a treatment plan will often depend on the nature of the medical condition and the patient's progress. In such instances, PWC determined and applied specific review standards based on its review of the particular services provided and patients treated at the Hospital as well as on the clinical experience of its reviewers. For example, PWC generally required an evaluation of a treatment plan every twelve months for outpatient services (although some variation was permitted when warranted by the severity of a patient's condition and the intensity of the therapy).

By contrast, the OIG reviewer did not appear to apply the documentation standards specific to partial hospitalization program and outpatient program services set forth in Section 1835(f) of the Social Security Act and 42 C.F.R. § 424.24. The OIG reviewer relied instead on the very general medical record requirements set forth in 42 C.F.R. § 482.24. These general requirements are the requirements a hospital must meet as a condition of participation in Medicare and in no way constitute requirements for coverage of a particular service. In addition, the language of the requirements (with its references to "hospitalization" and "discharge") strongly suggests that these requirements are more appropriately applied to the provision of inpatient services. The OIG reviewer also, in contravention of HCFA's own explicit instructions, appears to have strictly applied as absolute standards the benchmarks merely suggested in Program Memorandum A-96-2. Moreover, the OIG reviewer did not clearly define the standards applied where the statutory, regulatory or administrative guidance did not establish or even suggest specific standards.

The independent review also calls into question the accuracy with which the OIG reviewer applied documentation standards. In its review, PWC examined the entire patient record related to the most recent treatment plan and therefore based its findings on all available documentation relating to the claims under review. The review was conducted by experienced coders with substantial experience in the review of psychiatric services. By contrast, the OIG review focused on limited documentation copied from the medical records from a narrow time period. The selected documentation was forwarded to a coder from the intermediary temporarily engaged by the OIG for the review. The qualifications of the intermediary's coders have not been revealed. The coder at the intermediary then examined only those documents selected from the medical records in order to reach a determination. In addition, in reaching a determination, the intermediary's coder appears to have focused principally on the form of the documentation maintained by the Hospital rather than the substance of the information documented.

The more limited focus of the OIG review seriously affects the accuracy of the proposed findings. For example, statutory and regulatory guidance requires certification from a physician that partial hospitalization program services are necessary. *See*, Section 1835(2)(f) of the Social Security Act and 42 C.F.R. § 424.24(e). A review that considered only documentation relating to a limited time period in which some such services were provided might overlook a physician certification included earlier in the patient's medical record. The review by PWC clearly indicates that some physician certifications were overlooked. For certain claims, PWC reviewed inpatient hospital discharge summaries completed prior to the dates of service reviewed by the OIG reviewers that included all of the required elements for physician certification (*e.g.*, signed physician statement ordering partial hospitalization program services that indicated that if the patient care was not continued in the PHP then hospitalization would have continued and establishing an individualized written plan for furnishing those services). The portions of the medical records not considered by your reviewers were forwarded to [redacted] of your office by PWC on June 7, 1999 and should be considered by your reviewers prior to finalization of your report.

As another example, the Hospital might document a treatment plan update for a particular patient in the notes for a monthly or a biannual case review. These notes would meet all the requirements for a treatment plan by documenting the patient's diagnosis, the patient's response to current treatment, the future treatment to be provided and the objectives of the treatment. Because the treatment plan was not set forth on a specific form designated "treatment plan", the coder used by the OIG apparently overlooked the existence of the treatment plan.

The proposed disallowance of claims for services provided to patient No. 41 exemplifies the incorrect determinations reached by the OIG. In its report, the OIG proposed

to disallow approximately $4,900 in claims for partial hospitalization program services provided to this one patient in November and December of 1996 on the grounds that the services were not reasonable and necessary. Comments in the review materials maintained by the OIG medical review staff indicate that a physician reviewing the documentation for the claims found the services provided excessive. PWC, reviewing the entire treatment period in question, found the documentation more than adequate to justify the need for the intensity of services provided. As indicated by the medical record, this patient is a chronically ill individual who has been under psychiatric treatment at the Hospital since at least November 6, 1995. The patient suffers from a schizo-affective disorder and has a history of suicide attempts. A sudden worsening of her condition precipitated an admission to the inpatient treatment unit at the Hospital in October of 1996. After she demonstrated some improvement in her condition, her physician discharged her to the partial hospitalization program in November of 1996. The medical record clearly indicates that this patient would have required inpatient care if she had not received the partial hospitalization program services during the period in question, the services were furnished to the patient while she was under the care of a physician and that physician established and periodically reviewed an individualized, written plan for providing the services. The medical record also indicates that the Hospital promptly discharged this patient to the intensive outpatient program as soon as her condition permitted a less intense level of care. A statement from her treating physician, Dr [redacted] enclosed as Attachment C, summarizes the supporting documentation contained in the medical record and attests to the reasonableness and medical necessity of those services. We request that this particular case be reviewed again by the psychiatrist you used, and, if necessary, have him speak with Dr [redacted]

III. Even Assuming Sufficient Documentation Was Not Maintained, Waterbury Hospital Had No Knowledge that the Services Were Not Reasonable and Necessary

Even assuming that there was insufficient documentation to support the reasonableness and medical necessity of certain services provided by the Hospital, payment for those services should not necessarily be disallowed. Under the limitation of liability provision set forth in Section 1879 of the Social Security Act, the Hospital is entitled to reimbursement for services found to be unreasonable and unnecessary if the Hospital did not know, and could not have been reasonably expected to know, payment would not be made for the services. The facts strongly suggest that the Hospital had no reason to question whether its documentation practices were sufficient to support the reasonableness and medical necessity of the services.

The Behavioral Health Program at the Hospital had no notice of the main documentation requirements applied by the OIG in its review of claims. A majority of the proposed disallowances by the OIG results from a strict application of HCFA Publication 60A - Program Memorandum A-96-2. Program Memorandum A-96-2 was issued in July of 1996 to

fiscal intermediaries. HCFA did not issue Program Memorandum A-96-2 directly to individual providers. A provider therefore could not have received notice of the guidelines unless its fiscal intermediary passed on the new guidelines. The OIG did not indicate, however, that the fiscal intermediary had passed on to hospitals the new Program Memorandum A-96-2. Nor has PWC been able to confirm, through an independent investigation, that the fiscal intermediary provided the Behavioral Health Program at Waterbury Hospital with Program Memorandum A-96-2. According to certain statements made by the OIG at the exit conference on June 1, 1999, the fiscal intermediary for the Hospital during the period reviewed, Anthem Blue Cross/Blue Shield of Connecticut, apparently passed on to certain hospitals in Connecticut an earlier program memorandum containing the same guidelines in 1995. Based on our own conversations with the Hospital, there is no indication that the Behavioral Health Program at Waterbury Hospital received a copy of or information about the guidelines from its fiscal intermediary. [redacted], Director of Administrative Services for the Behavioral Health Program at the Hospital, has stated that she first received notice of the existence of Program Memorandum A-96-2 at the time of the OIG review. After hearing audit personnel refer to the guidelines, she actively sought further information on the guidelines from professional associations and other hospitals. Eventually, she obtained a copy of Program Memorandum A-96-2, but not before discovering that many other hospitals were also unaware of the existence of the memorandum.

Whether or not Program Memorandum A-96-2 and its predecessor were distributed to Connecticut hospitals, it is clear that a substantial amount of confusion and uncertainty regarding the applicable documentation requirements for outpatient psychiatric services nonetheless existed during the period reviewed by the OIG. Correspondence at the time, as documented in detail by PWC, see Attachment A, verifies that there was significant, ongoing confusion over the degree of specificity of documentation required during that period. We call your attention in particular to the position paper submitted to Medicare fiscal intermediaries by the Partial Hospitalization Association of Connecticut on October 12, 1995 which directly addresses the "widespread confusion, dissension, and misunderstanding amongst providers, intermediaries, and associations, at the national, state, and local level" concerning documentation requirements for partial hospitalization program services. According to the position paper, professional organizations at both the national and local level were working with Medicare representatives to clarify the requirements. There is no indication, however, that the requirements were clarified during the period of the OIG review. Correspondence and updates from professional associations throughout the period reviewed confirm the ongoing lack of clear guidance. The only communications from the fiscal intermediary or its agents on the issue of documentation found in the files at the Hospital were drafts of proposed guidance on documentation requirements. That particular guidance appears to support the legitimacy of the Hospital's documentation practices during 1997. The comprehensive statement and explanation of outpatient psychiatric services requirements issued by Empire Medical Services

in February of 1999, well after the time period reviewed by the OIG, specifically recognizes the continuing need for clarification and seeks to respond to provider concerns by providing new information and clarification of existing requirements.

We are particularly troubled by the apparent utilization by your coder of a standard of documentation that assumed that the use of flowsheets was insufficient to document medical necessity. Depending on the nature of the patient's illness and other documentation, this approach is not correct. Indeed, the information and guidance that the Hospital did receive from HCFA or the fiscal intermediary or its agents during the period reviewed explicitly supported the use of activity sheets and flowsheets. For example, the OIG proposes to disallow $11,737 in claims for partial hospitalization services alone on the grounds that the services provided were only documented by flowsheets. Information received by Waterbury Hospital from HCFA and its fiscal intermediary during the period reviewed, however, generally supports the use of such flowsheets to document the medical necessity of services. In particular, the information approves the use of flowsheets to meet the daily chart entry requirement set forth in Program Memorandum 96-A-2. We call your attention, in particular, to three administrative issuances received by the Hospital.

First, Medicare Intermediary Manual §3920(K) describes the medical record notes required in order for a psychiatric outpatient service to be covered. The manual guidance clearly indicates that medical record documentation may take many forms. According to the manual guidance, such medical record documentation "may include, but is not limited to, daily outpatient logs, activity checklists, case management, nurse's, therapist's and physician's notes." (emphasis added). The manual guidance thus not only emphasizes the substance of the information recorded, rather than the form of the documentation, but also explicitly approves the use of activity checklists.

Second, on April 12, 1996, the Connecticut Peer Review Organization, Inc., on behalf of Anthem Blue Cross/Blue Shield of Connecticut, issued to all partial hospitalization program providers specific guidance to clarify certain partial hospitalization program requirements. This guidance discusses the medical record documentation required to establish that services provided were reasonable and necessary. According to the guidance, the requirement for daily medical record entries may be met by a checklist. Documentation in the form of a checklist which refers to the services rendered as well as the patient's clinical status and response to treatment is sufficient daily documentation so long as the checklist is part of the patient's medical record.

Third, on December 5, 1996, Anthem Blue Cross/Blue Shield of Connecticut issued draft local medical review policy to all partial hospitalization program providers. The draft policy addresses daily recordkeeping requirements and explicitly states that a "flowsheet or

grid may be utilized which identifies the date, service rendered (specific group, individual therapy) and clinician's initials." The draft policy also indicates that only "significant events, responses, and/or reactions" need be noted. The flowsheets used by Waterbury Hospital document the services rendered, the patient's current mental state (on a scale of 0-4) and include additional notes on any significant events or responses. It should be noted that, given the medical condition of many patients, no significant response to a particular group therapy may have occurred and, therefore, none would be documented.

IV. Unallowable Costs and Other Issues

As explained during our meeting on June 1, 1999, the Hospital agrees that its 1997 cost report should be adjusted to eliminate $212.372 in unallowable costs. The Hospital has communicated with its fiscal intermediary with respect to such an adjustment. However, as explained at the June 1 conference, we believe your articulation of the basis for the adjustment should be modified, given the circumstances that caused the error, i.e. the treatment of grant expenditures on the cost report.

The last paragraph on page ten details specific costs that were deemed nonallowable as a result of the change in the treatment of grants in the cost report. All of the costs specified in this paragraph were "approved" grant expenditures. This paragraph seems to sensationalize the audit findings and we would request that this paragraph be eliminated from the final report.

On page eleven, third paragraph, the last two sentences should reflect more precisely that the Hospital immediately notified the fiscal intermediary that it would be making adjustments to the cost report as a result of the OIG audit, specifically for transportation and meals, as well as any other items found in the audit process. The Hospital did question the adjustments for the State grants within the cost report. There had been no change in the way the Hospital reported its grant funding and the fiscal intermediary had never questioned the Hospital's methodology in previous audits.

In addition, on page three of the draft report, the report references the addition of certain information to the medical records reviewed. As explained by Mr. John Tobin, President of the Hospital, the Hospital's investigation of the information added concluded that certain Hospital staff had sought (without the knowledge or authorization of the Hospital) not to fraudulently add information, but rather merely to assure completeness of the records for review. Upon learning of this, the Hospital promptly investigated what occurred and fully disclosed what it found. The fact that the Hospital did not authorize or condone what happened and cooperated fully in identifying the additional information should be noted in the report.

V. Extrapolation of the Results of Review

We also have concerns that the OIG improperly extrapolated the alleged overpayments in the claims reviewed across all outpatient psychiatric services provided by Waterbury Hospital during the period reviewed. Based on the information provided, the statistical sampling undertaken by the OIG does not appear to meet the minimum standards for statistical sampling applicable to reviews of providers. *See*, Medicare Carriers Manual Sampling Guidelines Appendix (rendered applicable to reviews of providers by Medicare Intermediary Manual §2229). For example, the sampling guidelines advocate the use of stratification (or grouping of the units reviewed) where stratification will result in greater precision in an extrapolation. In the OIG review of the Hospital, claims were not stratified despite the fact that partial hospitalization services have distinctly different requirements for reimbursement than other outpatient services and the OIG draft report clearly treats the two types of services as separate groups. Also, we have not yet received adequate information regarding the selection of the sample to determine whether the claims reviewed were selected at random. We have previously requested this information.

A mere extrapolation of overpayments may also unfairly restrict the rights of the Hospital to seek reimbursement directly from patients. The Hospital would have the right to charge a Medicare beneficiary for services provided if Medicare denies payment for any reason other than medical necessity. Unless the specific claims for which payment is being denied are clearly identified, however, the Hospital cannot exercise its rights.

Please call me to discuss the issues presented above. We believe these issues are significant and require further discussion before any final decision is made regarding the proposed disallowances. As we indicated in the exit conference on June 1, 1999, we are ready and willing to have the medical review personnel who participated in the PWC review discuss and resolve with the medical review staff who participated in the OIG review any differences in determinations. Given the expertise and the fact-specific analysis required for a medical record review, such a discussion may prove the only method of ensuring correct determinations. We believe that, especially given the magnitude of the proposed adjustment, fundamental fairness suggests strongly that a joint review between the PWC coders and your coders is appropriate with respect to those claims where different conclusions were reached.

Mr. Michael Armstrong
Office of Audit Services
Office of Inspector General

June 22, 1999

Thank you for the opportunity to respond to your draft. We look forward to expeditiously reviewing with you the issues raised and we appreciate your highly professional courtesy and approach to this significant matter. Please call me to discuss the next steps that should be taken to come to a proper finalization of your draft report. Thank you.

Sincerely,

Richard P. Ward

Richard P. Ward

RPW/ezb:MHODMA.Active;8011135;5
cc: William J. Hornby,
Regional Inspector General
for Audit Services
John Tobin
[redacted]

PricewaterhouseCoopers Review of Hospital Based Outpatient Psychiatric Services at Waterbury Hospital (FY 1997)

PricewaterhouseCoopers LLP (PwC) was engaged on behalf of Ropes & Gray for Waterbury Hospital (the "Hospital") to perform a documentation review of certain psychiatric services for 100 outpatient psychiatric claims for the Fiscal Year ended September 30, 1997 (FY '97). The purpose of the review was to compare our results to the audit performed by the Office of the Inspector General (OIG) in December of 1998. The OIG documentation review was based on the following regulatory guidance: Title 42 Code of Federal Regulations (CFR) § 482.24, HCFA Fiscal Intermediary Manual § 3112.7, HCFA Hospital Manual § 230.5, HCFA Hospital Manual § 452 and HCFA Publication 60 A- Program Memorandum A-96-2. The results of our review are set forth in Appendix A.

The following regulatory guidance was evaluated and considered by PricewaterhouseCoopers during the review of outpatient psychiatric records:

I. Outpatient Psychiatric Services

A. Certification and Recertification of Outpatient Psychiatric Services

Section 424.24 of the Code of Federal Regulations: "Certification is not required for the following:

> (1) Hospital services and supplies incident to physicians' services furnished to outpatients. This exemption applies to drugs and biological that cannot be self-administered, but not to partial hospitalization services, as set forth in paragraph (e) of this section...."[1]

Outpatient Psychiatric Services are discussed further in Section 230.5 of the Hospital Manual and Section 3112.7 of the Intermediary Manual.[2]

> "Outpatient Hospital Psychiatric Services
>
> A. General.--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; from intensive treatment programs to those that provide primarily supportive, protective, or social activities. Because of this diversity, it must be ensured that payment is made only for covered services that meet the requirements of the outpatient hospital benefit.
> In general, to be covered, these services, must be 1) incident to a physician's service (see 230.4.A), and 2) reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the service must be for the purpose of diagnostic study or the service must reasonable and be expected to improve the patient's condition."

B. Individualized Treatment Plan

[1] Section (e) of this regulation went on to identify the content of certification and plan of treatment requirements for partial hospitalization services.

[2] This information is stated with the same verbiage in both Section(s) 230.5 of the Hospital Manual and Section 3112.7 of the Intermediary Manual. For purposes of this document, Section 230.5 of the Hospital Manual is directly excerpted.

The coverage criteria for outpatient psychiatric services is discussed in Section 230.5 of the Hospital Manual and Section 3112.7 of the Intermediary Manual.[3]

"B. Coverage Criteria.--The services must meet the following criteria:

1. Individualized Treatment Plan.-- 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 diagnosed and anticipated goals. (A plan is not required if only a few brief services will be furnished).

2. Physician Supervision and Evaluation.-- 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 the medical record must support this involvement. The physician must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed."

Section 3920K of the Intermediary Manual discusses the coverage criteria for outpatient psychiatric services.

"K. Review of Outpatient Hospital Psychiatric Services.--Ensure that the psychiatric services are reasonable and necessary.

1. Psychiatric Coverage Criteria.--Services are covered if they are prescribed by a physician and the following conditions are met:

- Individualized plan of treatment (a plan is not required for a few brief services); and
- A plan of care must include the type, amount, frequency, and duration of services, including goals and diagnoses."

C. *Medical Record Documentation*

Section 482.24 of the Code of Federal Regulations ("Conditions of Participation: Medical record services") discusses the hospital's responsibility for maintaining and keeping of medical records.

"...A medical record must be maintained for every individual evaluated and treated in the hospital:

(b) Standard: Form and retention of record. The hospital must maintain medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained and accessible...

(c) *Standard: Content of record.* 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:

(1) All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

(i) The author of each entry must be identified and must authenticate his or her entry.

[3] Ibid

(ii) Authentication may include signature, written initials or computer entry.

(2) All records must document the following, as appropriate:

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

Section(s) 230.5 of the Hospital Manual and 3112.7 of the Intermediary Manual also provide guidelines on medical record documentation requirements.[4]

" 2. Physician Supervision and Evaluation.--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 the medical records must support this involvement...."

Section 3920K of the Intermediary Manual details the specific documentation for outpatient hospital psychiatric services:

" 2. Documentation includes:

- Facility and patient identification (provider name, patient name, provider number, HICN, age);
- Physician referral and date; and
- Date of last certification.
- Diagnosis - this is the primary diagnosis for which outpatient hospital psychiatric services were rendered. Indicate other diagnoses or those that influence the primary diagnosis.
- Duration - the total length of time the services have been rendered (in days) from the date initiated. Includes the last day in the current billing period.
- Number of visits - the total number of patient visits completed since services were initiated. Includes the last visit in the billing period.
- Date of onset - the date of the primary diagnosis.
- Date treatment started - the date services were initiated.
- Billing period - when services began and ended in the billing period (from-through dates).
- Medical history - should include a brief description of the patient's psycho-functional status prior to the onset of the condition requiring services and any pertinent history prior to treatment.
- Initial evaluation and date - the initial evaluation performed at the facility.
- Plan of treatment and date established - should include specific goals and a reasonable estimate of when they are excepted to be reached (e.g., 3-6 months). Includes specific therapies, e.g. creative art, music, movement, recreation therapy. Services must be prescribed by a physician and be individualized. There is no requirement that the physician who establishes or certifies the plan of care (POC) be the one who reviews the plan.
- Physician progress notes - should provide information on periodic evaluation, consultation, conferences with staff, and patient interviews. Notes should include a diagnosis, an estimate of the duration of treatment and a description of how treatment goals are being realized and as well as POC changes.
- Medical record notes - should include a discussion of the individual's symptoms and present behavior, for example:
  --Thoughts ...
  --Perception ...

[4] Ibid

--Anxiety...
--Activity ...
--Self care
--Nutrition
--Sleep
--Family processes.[5] –

Medical documentation may include, but is not limited to, daily outpatient logs, activity checklists, case management, nurse's, therapist's, and physician's notes. Documentation should include medication changes as well as therapy changes.

- Frequency and Duration - there are no specific time limits. Medical documentation should support the frequency and duration of services provided. When considered reducing the frequency of services provided, consider how their reduction may lead to relapse or rehospitalization.
- Goals should describe the control of symptoms and how they will maintain behavioral/functional level.
  --Need not be restorative;
  --Should be reasonable and relate to the individuals' treatment need; and
  --Diagnostic studies should relate to the individual treatment needs.

NOTE: Improvement is measured by comparing the effect of continuing treatment versus discontinuing it. Do not deny services because a therapeutic condition has stabilized or because treatment is primarily for maintiaining the present level of functioning.

Determine when it is established that the coverage criteria not met; for example, that stability can be maintained without further treatment or with less intensive treatment."

II. Outpatient Partial Hospitalization Services

A. Patient Eligibility and Certification/Recertification of Outpatient Psychiatric services

Section 424.24 of the Code of Federal Regulations ("Requirement for medical and other health services furnished by providers under Medicare Part B") discusses Partial Hospitalization services.

"(e) Partial hospitalization services: Content of certification and plan of treatment requirements--(1) Content of certification.
(i) The individual would require inpatient psychiatric care if the partial hospitalization services were not provided.
(ii) The services are or were furnished while the individual was under the care of a physician.
(iii) The services were furnished under a written plan of treatment that meets the requirements of paragraph (e) (2) of this section.

(2) Plan of treatment requirements. (i) The plan is an individualized plan that is established and is periodically reviewed by a physician in consultation with appropriate staff participating in the program, and that sets forth--

(A) The physician's diagnosis;
(B) The type, amount, duration, and frequency of the services; and
(C) The treatment goals under the plan.
(ii) The physician determines the frequency and duration of the services taking into account accepted norms of medical practice and a reasonable expectation of improvement in the patient's condition."

[5] All of the above are defined further in the regulations.

HCFA Pub 60A Program Memorandum A-96-2 defines the eligibility requirements for partial hospitalization services.

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

1)That the individual would require inpatient psychiatric care in the absence of such services.

This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted.

2) An individual plan for furnishing such services has been established by a physician and is reviewed periodically by a physician, and

3) Such services are or where furnished while the individual is or was under the care of a physician. (Physician certification is required under the procedures for payment of claims to providers of partial hospitalization services under 1835 (a) (2) (f) of the Act.)

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

Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment. Partial hospitalization is the level of intervention that falls in between inpatient hospitalization and episodic treatment on the continuum of care for the mentally ill;

Do not require 24-hour care and have an adequate support system outside the hospital setting while not actively engaged in the program;

Have a diagnosis that falls within the range of ICD-9 codes for mental illness (i.e., 290 through 319). However, the diagnosis is not the sole determining factor for coverage; and

Are not judged to be dangerous to self or others".

B. Individualized Treatment Plan

Section 230.5 of the Hospital Manual and Section 3112.7(C) of the Intermediary Manual as well discusses partial hospitalization.[6]

"C. Partial Hospitalization.-- Partial hospitalization is a general term that encompasses a variety of outpatient psychiatric programs; each of which can vary in their functions, the populations that they serve, their treatment goals and the services that they provide. Depending on their functions, they may also be called day hospital/day treatment centers, or day care/night care centers. Within the same facility, there may be a number of programs operating, each of which may be aimed at a different population with a different level-of-care treatment program.

The Medicare law does not provide for the coverage of partial hospitalization programs per se. However, under the outpatient hospital benefit, those portions of the programs that fall within the requirements of the law may be covered. For coverage purposes, the key to whether a particular type or group of services and activities may be covered will depend primarily on the services provided in the program, and how the services are being used in the care of patients."

Section 3112.7 identified the coverage criteria for PHP services.[7]

"B. Coverage Criteria.--The services must meet the following criteria:

1. Individualized Treatment Plan.-- 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 diagnosed and anticipated goals. (A plan is not required if only a few brief services will be furnished).

2. Physician Supervision and Evaluation.-- 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 the medical records must support this involvement. The physician must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

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 of 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 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 a 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.

[6] See Note 2.

[7] See Note 2. In this section, Section 3112.7 is excerpted.

Some patients may undergo a course of treatment which increases their level of function, but then reach a point where further significant increase is not expected. Do not deny claims automatically because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining a present level of functioning. Rather, evaluate each case in terms of the criteria as discussed above, and deny only where the evidence clearly established that the criteria are not met: for example, that stability can be maintained without further treatment or with less intensive treatment."

Section 424.24 of the Code of Federal Regulations discusses the specific requirements for the PHP treatment plan..

" 2) Plan of treatment requirements. (i) The plan is an individualized plan that is established and is periodically reviewed by a physician in consultation with appropriate staff participating in the program, and that sets forth--

(A) The physician's diagnosis;
(B) The type, amount, duration, and frequency of the services; and
(C) The treatment goals under the plan.
(ii) The physician determines the frequency and duration of the services taking into account accepted norms of medical practice and a reasonable expectation of improvement in the patient's condition."

Section 3920K of the Intermediary Manual also defines PHP services and the coverage criteria:

" 3. Partial Hospitalization Services.-- Partial hospitalization encompasses a variety of outpatient psychiatric programs each of which can vary in its function, the population served, the treatment goals, and the services provided.

Partial hospitalization programs must meet the documentation criteria outlined in 3112.7(C).[8]"

The coverage criteria for outpatient psychiatric services is also identified in Section 3920K.

"K. Review of Outpatient Hospital Psychiatric Services.--Ensure that the psychiatric services are reasonable and necessary.

1. Psychiatric Coverage Criteria.--Services are covered if they are prescribed by a physician and the following conditions are met:

   - Individualized plan of treatment (a plan is not required for a few brief services); and
   - A plan of care must include the type, amount, frequency, and duration of services, including goals and diagnoses."

C. *Medical Record Documentation*

Section 482.24 of the Code of Federal Regulations ("Conditions of Participation: Medical Record Services") discusses the hospital's responsibility for maintaining and keeping of medical records.

"...A medical record must be maintained for every individual evaluated and treated in the hospital:

(b) Standard: Form and retention of record. The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written,

[8] The documentation criteria for section 3112.7 (C) is identified on page 5 under Section B of this document " Individualized Treatment Plan."

promptly completed, properly filed and retained and accessible..."

(c) *Standard: Content of record.* 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.

(1) All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

(i) The author of each entry must be identified and must authenticate his or her entry.

(ii) Authentication may include signatures, written initials or computer entry.

(2) All records must document the following, as appropriate:

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

Section(s) 230.5 of the Hospital Manual and 3112.7 of the Intermediary Manual define medical record documentation requirements[9].

1. "Physician Supervision and Evaluation.--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 the medical records must support this involvement...."

Section 3920K of the Intermediary Manual details the specifics of medical review for outpatient hospital psychiatric services:

"...2. Documentation includes:

- Facility and patient identification (provider name, patient name, provider number, HICN, age);
- Physician referral and date; and
- Date of last certification.
- Diagnosis - this is the primary diagnosis for which outpatient hospital psychiatric services were rendered. Indicate other diagnoses or those that influence the primary diagnosis.
- Duration - the total length of time the services have been rendered (in days) from the date initiated. Includes the last day in the current billing period.
- Number of visits - the total number of patient visits completed since services were initiated. Includes the last visit in the billing period.
- Date of onset - the date of the primary diagnosis.
- Date treatment started - the date services were initiated.
- Billing period - When services began and ended in the billing period (from-through dates).
- Medical history - should include a brief description of the patient's psycho-functional status prior to the onset of the condition requiring services and any pertinent history prior to treatment.
- Initial evaluation and date - the initial evaluation performed at the facility.
- Plan of treatment and date established - should include specific goals and a reasonable estimate of when they are excepted to be reached (e.g., 3-6 months).

[9] Ibid

Includes specific therapies, e.g., creative art, music, movement, recreation therapy. Services must be prescribed by a physician and be individualized. There is no requirement that the physician who establishes or certifies the plan of care (POC) be the one who reviews the plan.

- Physician progress notes - should provide information on periodic evaluation, consultation, conferences with staff and patient interviews. Notes should include diagnoses, an estimate of the duration of treatment and a description of how treatment goals are being realized and as well as POC changes.
- Medical record notes- should include a discussion of the individual's symptoms and present behavior, for example:
  - --Thoughts ...
  - --Perception ...
  - --Anxiety...
  - --Activity ...
  - --Self care
  - --Nutrition
  - --Sleep
  - --Family processes .[10]

Medical documentation may include, but is not limited to daily outpatient logs, activity checklists, case management, nurse's, therapist's, and physician's notes. Documentation should include medication changes as well as therapy changes.

- Frequency and Duration- there are no specific time limits. Medical documentation should support the frequency and duration of services provided. When considering reducing the frequency of services provided, consider how their reduction may lead to relapse or rehospitalization.
- Goals should describe the control of symptoms and how they will maintain behavioral/functional levels.
  - --Need not be restorative;
  - --Should be reasonable and relate to the individual's treatment need; and
  - --Diagnostic studies should relate to the individual's treatment needs.

NOTE: Improvement is measured by comparing the effect of continuing treatment versus discontinuing it. Do not deny services because a therapeutic condition has stabilized or because treatment is primarily for maintaining the present level of functioning.

Determine when it is established that the coverage criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment."

III. Review of Guidance Relating to Documentation of Psychiatric Services

PricewaterhouseCoopers conducted a review of Medicare Bulletins distributed by Anthem Blue Cross, the Fiscal Intermediary for Waterbury Hospital, interviewed Waterbury Outpatient Psychiatric department management, physicians and staff, and had several general discussions with the Local and National Ambulatory Behavioral Health Associations. This review showed that, prior to and during FY 97, there had been inconsistencies and ambiguity with respect to documentation requirements for outpatient and partial hospital services. It is clear that there are still many different interpretations of the documentation requirements depending on fiscal intermediary medical review policies, proposed national policies and opinions of professionals in the field both in 1997 and today.

A. Fiscal Intermediary Guidance

Fiscal Intermediary interpretation of national laws and regulations are usually communicated through the use of locally published Medicare Bulletins and the development of Local Medical Review

[10] All of the above symptoms are defined further in the regulations.

Policies. Additionally, intermediaries have also provided feedback to providers through the use of medical record reviews.

B. Medicare Bulletins

A review of Medicare Bulletins distributed by Anthem did not reveal any clear guidance with respect to documentation requirements or interpretations of national regulations or laws.

C. Local Medical Review Policy

Partial Hospitalization Services have never been clearly defined by Anthem Blue Cross in the form of a Local Medical Review Policy. In 1996, a draft Local Medical Review Policy was created but was never finalized.

D. Medical Review

There is no evidence that Waterbury Hospital has ever received consistent denials for outpatient psychiatric services based on insufficient medical record documentation revealed during a medical review. Both, the State of Connecticut, Department of Public Health and Anthem Blue Cross Blue Shield have reviewed services for the period in question and had not made any recommendations that the services required more appropriate documentation. Additionally, Waterbury Hospital went through a Behavioral Health Accreditation Survey with the Joint Commission for the Accreditation of Healthcare Organizations and received a score of 97 out of 100. The review period for this survey was January 1997 to January 1998. No deficiencies were noted for outpatient services.

E. Interviews with Waterbury Hospital Psychiatric Department Staff

As a result of conducting interviews with the Director of Waterbury Hospital's Outpatient Psychiatric Programs, a staff Physician and other department managers, it appears that the guidance provided locally and nationally was inconsistent and indecisive. Results of the interviews showed some of the guidances, such as Program Memorandum 60-A, were never received and reviewed by the Director of Administrative Services, Behavioral Health. In the absence of clear guidance, policies, procedures and guidelines for treatment and documentation were collectively created by the professional staff at Waterbury Hospital that were in accordance with professional practice standards and based on their interpretation of the guidance.

F. Connecticut Association for Ambulatory Behavioral Healthcare (Formerly Partial Hospital Association of Connecticut (PHAC))

The Connecticut Association for Ambulatory Behavioral Healthcare, on behalf of partial hospital providers in the state of Connecticut, has maintained ongoing communication with Anthem Blue Cross since 1993, attempting to clarify documentation criteria that would be appropriate to document that the services provided were reasonable and necessary. Other than the development of the Draft Local Medical Review Policy and an attempted coordinated medical review with the Connecticut Peer Review Organization, very little has been documented and published as guidance by Anthem.

The efforts to clarify documentation requirements for Partial Hospitalization services have been evident nationally, in Washington and locally, in Connecticut. Below are some of the key correspondences between the AABH (Association for Ambulatory Behavioral Healthcare), PHAC (Partial Hospital Association of Connecticut) and BC BS of Connecticut (Fiscal Intermediary) which demonstrate the intense communication efforts to develop a consistent documentation process.

1. September 13, 1995, Memo to PHAC Board Members from [redacted], President PHAC

A letter to schedule a meeting to discuss the issues pertaining to Partial Hospitalization Documentation.

2. October 12, 1995 Draft Position Paper from the Partial Hospitalization Association of Connecticut

"During the last 2 years, there has been widespread confusion, dissension and misunderstanding amongst providers, intermediaries and associations, at the national state and local level. The area of confusion has been the implementation and review of documentation requirements for partial hospitalization programs, as this modality has become increasingly figural and utilized in the managed care environment. There are HCFA requirements that are interpretations of the federal legislation regarding reimbursement for this modality; these guidelines have left many opportunities for confusion.
It is the earnest hope of PHAC that our association and the Connecticut Fiscal Intermediaries can agree on some guiding principles, so that our separate cultures can learn a common language."

Draft Position Paper and letter sent to members of PHAC, stating that clarification has been requested in regards to the issues including documentation requirements. This position paper was drafted after Program Memorandum (PM) 95-8 was issued by HCFA in June of 1995.

3. October 23,1995, Letter to AABH from PHAC (CAABH)

A letter was sent requesting comments from the AABH on the above referenced draft letter.

4. December 12, 1995 Letter to [redacted], Anthem BC BS of CT, from [redacted] PHAC (CAABH)

"The PHAC created a subcommittee to study and resolve the issue related to Medicare documentation, as we had discussed at a much earlier date. Enclosed is the Position Paper of the Partial Hospitalization Association of Connecticut, as we struggled to fully address this issue. Thanks for your help in distributing this document to the other fiscal intermediaries, and the other appropriate people who may need to review and comment on this, and we can then know how to proceed."

5. April 12, 1996, Memo to Partial Hospitalization Program Providers from CPRO

A proposal of documentation and review guidelines effective May 15, 1996. "For the purposes of supporting PHP services, there must be daily documentation which refers to therapies/services rendered as well as reference to the patient's clinical status and response to treatment as it relates to the patient's individualized treatment plan. This documentation can be in the form of a checklist which would part of the patient's medical record."

6. May 23, 1996 Letter to AABH from PHAC (CAABH)

"PHP Attendance Documentation Checklist/Tx Plan Update"

"This 2 sided form was reviewed with our FI, Blue Cross/Blue Shield, and approved for documentation of group attendance. Medication Reviews, significant clinical events are separately documented in the progress notes. The group attendance is documented for one week. On Friday, the completed form is shared by the clinical staff, who reviews this form as part of their weekly tx plan review-side 2 of the form. In our Tuesday clinical review, all disciplines sign off and make appropriate changes on tx plan review form."

"In a follow up meeting, all the items raised in this memo, (a memo from CPRO), were resolved to the satisfaction of PHAC board members who followed up and educated/collaborated with CPRO and Medicare as to what are the appropriate

standards and guidelines. Again, the documentation checklist system was acceptable for fulfilling the requirement of daily chart entries."

7. December 1996, Draft Medical Review Policy was issued by BC BS of Connecticut

This draft was never finalized but did indicate that use of checklists were acceptable forms of documentation.

8. January 24, 1997, a letter was sent to [redacted] Administrator, Medicare Medical Review from CAABH

Requesting feedback on the Draft policy of December 1996. The documentation requirements noted were.

"Many providers noted the extraordinary difficulties with summarizing each specific intervention and what was done in each group. Not every clinician is in every group, so many, many separate chart entries could be required for a single day and then in the weekly summary. Many providers would be willing to work as a subgroup of the CAABH to provide samples of documentation that would not be onerous. Please address."

IV. Project Staff

The coding and documentation specialists who conducted the review were:

[redacted]

V. Summary

When PricewaterhouseCoopers performed the documentation review, PricewaterhouseCoopers reviewed services being audited in the context of the patient's entire course of treatment as applicable to the date of service chosen by the OIG for the documentation review. Therefore, PricewaterhouseCoopers looked at the entire medical record, based on our knowledge of the regulatory criteria and benchmarks as discussed above, to determine if services were reasonable and necessary.

PricewaterhouseCoopers utilized all of the regulatory and other published guidance relating to coverage and documentation of medical necessity. We also considered Program Memorandum A-96-2, which sets forth various "benchmarks" for medical necessity. In that memorandum, HCFA stated that "[t]o the extent this instruction contains specific references to guidelines for frequency of services, these references are based on professional consultation and are offered as benchmarks for review of medical necessity and not as absolute coverage denials. PricewaterhouseCoopers was informed by the Hospital's Director of Administrative Services, Behavioral Health, [redacted] that this

memorandum was not brought to her attention during FY 1997. Given the lack of regulatory clarity during 1997, PricewaterhouseCoopers determined that it would be inappropriate to disallow services based solely on a single date of services' documentation and on the lack of clear documentation guidelines.

Given the documentation methodologies in place during the FY1997 at the Hospital, PricewaterhouseCoopers' nurse coders, and other professionals with experience in psychiatric illness and treatment, reviewed the entire medical record of the patient to assure that all relevant documentation was considered to evaluate the reasonableness and necessity for any particular service. An examination of the portions of the medical records considered by the OIG indicated that in many instances its review did not include a review of the entire treatment period for the date-of service being reviewed. PricewaterhouseCoopers reviewers also considered the particular psychiatric conditions of the various patients to determine whether the course of treatment involved patients with long-term chronic conditions where the objective was to avoid further deterioration or inpatient hospitalization. This type of treatment, is recognized in Section 3112.7 of the Intermediary Manual. Many of the Hospital's patients fell into this treatment modality for which there would, for example, be no occasion for the recording in the medical record of a specific "response" to a single daily service. For such patients medical necessity determinations relating to individual, daily services are properly made by reviewing the documentation of the entire course of treatment as set forth in the treatment plan and as documented over weeks or sometimes months of therapy.

PricewaterhouseCoopers therefore reviewed specific services based on a review of the entire course of treatment as established by the treatment plan and reflected in the entire medical record. As a result of this approach, we concluded that many of the services disallowed by the OIG were services where the medical record, in fact, supported the medical necessity of the individual services. Attached as Appendix B are the criteria that PricewaterhouseCoopers generally applied in its review of the medical record.

APPENDIX

Appendix A1

Comparison of OIG and PwC Findings

Analysis by Primary and Secondary Disposition Codes

		OIG Findings				PwC Findings			
		Total Services	Charges	OIG Charges as % Subtotal	OIG Charges as % Total Charges	Total Services	Charges	PwC Charges as % Subtotal	PwC Charges as % Total Charges
No Errors (Disposition Code 1)									
	Outpatient	98	$ 9,413	88.5%	14.7%	190	$ 17,187	43.3%	26.8%
	PHP	13	1,218	11.5%	1.9%	265	22,531	56.7%	35.1%
	Total - No Errors	111	$ 10,631	100.0%	16.6%	455	$ 39,718	100%	61.9%
Disposition Code 2 - 9 Analysis									
Disposition Code	**Disposition Code Description**								
Outpatient									
2	No medical record documentation found for service	25	$ 1,928	11.8%	3.0%	18	$ 1,413	17.0%	2.2%
4	No treatment plan for patient care	4	309	1.9%	0.5%	4	309	3.7%	0.5%
5	Treatment plan outdated	48	3,993	24.4%	6.2%	73	5,983	72.0%	9.3%
6	Treatment plan not prescribed by physician	9	761	4.7%	1.2%	2	172	2.1%	0.3%
7	Insufficient flow sheet documentation	99	8,620	52.7%	13.4%				
9	Documentation otherwise insufficient	9	732	4.5%	1.1%	5	429	5.2%	0.7%
	Total Outpatient	194	$ 16,342	100.0%	25.4%	102	$ 8,306	100%	12.9%
PHP									
2	No medical record documentation found for service	24	$ 2,008	5.4%	3.1%	15	$ 1,236	7.6%	1.9%
3	No recertification by physician	204	17,217	46.2%	26.8%	83	7,173	44.3%	11.2%
5	Treatment plan outdated	8	686	1.8%	1.1%	5	429	2.6%	0.7%
7	Insufficient flow sheet documentation	140	11,737	31.5%	18.3%	65	5,478	33.8%	8.5%
8	Service not reasonable and necessary	55	4,856	13.0%	7.6%				
9	Documentation otherwise insufficient	8	738	2.0%	1.1%	19	1,876	11.6%	2.9%
	Total PHP	439	$ 37,243	100.0%	58.0%	187	$ 16,192	100%	25.2%
	Total (Disp Code 2-9 Analysis)	633	$ 53,585			289	24,498		38.1%
	TOTALS	744	$ 64,216			744 *	64,216		
	Findings Rate (%)		83.4%				38.1%		

* Some units were not verified. OIG figures were used for these claims.