Memorandum

Date NOV 15 1999

From for June Gibbs Brown
Inspector General

Subject Review of Outpatient Psychiatric Services Provided by the Elliot Hospital for the Fiscal Year Ending June 30, 1998 (A-01-99-00502)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on Wednesday, November 17, 1999. of our final report "Review of Outpatient Psychiatric Services Provided by the Elliot Hospital for the Fiscal Year Ending June 30, 1998." A copy of the report is attached. The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements. We found that the Elliot Hospital (Hospital), located in Manchester, New Hampshire did not establish or follow existing procedures for the proper billing of outpatient psychiatric services.

This audit was conducted in conjunction with our review of Medicare's partial hospitalization programs at community mental health centers in which our office found significant errors regarding provider compliance with Medicare requirements. Additional audits of hospital outpatient psychiatric services are planned.

Our audit at the Hospital determined that many of the outpatient psychiatric services claimed by the Hospital did not meet the Medicare criteria for reimbursement. Specifically, we identified charges for psychiatric care which were found medically unnecessary or not properly supported by medical records. Based on a statistical sample, we estimate that at least $314,359 in outpatient psychiatric charges were submitted by the Hospital yet did not meet Medicare criteria for reimbursement. We also identified $11,315 in costs ineligible for Medicare reimbursement claimed by the Hospital on its Fiscal Year (FY) 1998 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 so that it can apply the appropriate adjustments of $314,359 and $11,315 to the Hospital's FY 1998 Medicare cost report.

The Hospital, in its response dated August 17, 1999 (see APPENDIX B), believed that the services questioned by the Office of Inspector General (OIG) were medically reasonable and necessary and were sufficiently documented. The Hospital concurred with the OIG that food and dietary costs claimed on the FY 1998 cost report are unallowable. We believe that our final audit determinations are correct and no further adjustments to our draft report are necessary.

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, (617) 565-2689.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1999
A-01-99-00502

NOTICES

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://www.hhs.gov/progorg/oig/

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

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

CIN A-01-99-00502

Mr. Douglas Dean
President and CEO
Elliot Hospital
1 Elliot Way
Manchester, New Hampshire 03102

Dear Mr. Dean:

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 Elliot Hospital for Fiscal Year Ending June 30, 1998." 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-01-99-00502 in all correspondence relating to this report.

Sincerely yours,

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 requirements define outpatient services as "Each examination, consultation or treatment received by an outpatient in any service department of a hospital...." Medicare further requires that charges reflect reasonable costs and services provided 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) 1998, the Elliot Hospital (Hospital) submitted for reimbursement $1,087,164 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 $250,635. These services were charged on behalf of patients in the Hospital's partial hospitalization program (PHP). Our analysis showed that $102,641 of these charges did not meet Medicare criteria for reimbursement. Specifically, we found:

- $99,715 in charges for PHP services that were not reasonable and necessary.
- $2,926 in charges for PHP services that were insufficiently documented.

We extrapolated these results to the population of claims at the Hospital during FY 1998 and estimated that the Hospital overstated billings to Medicare by $314,359. Accordingly, we found that the Hospital did not either establish or follow existing procedures for the proper billing of outpatient psychiatric services.

Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We judgementally selected cost centers, totaling $241,737, from the Hospital's FY 1998 Medicare cost report and found that $11,315 in Food and Dietary Function costs were ineligible for reimbursement under the Medicare program for outpatient psychiatric services.

Recommendations

We recommend 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 recommend that the Hospital develop procedures to establish nonreimbursable cost centers from its FY 1998 Medicare cost report.

In response to our draft report (see APPENDIX B), the Hospital believed that the services questioned by the Office of Inspector General (OIG) were medically reasonable and necessary and were sufficiently documented. The Hospital concurred with OIG that food and dietary costs are unallowable.

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 8 of this report.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

The Medicare program established by Title XVIII of the Social Security Act (Act) provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Health Care Financing Administration (HCFA). Under section 1862 (a)(1)(A), the Act provides coverage for services, including outpatient psychiatric services, which are medically reasonable and necessary for the diagnosis or treatment of illness or injury. Outpatient psychiatric services are generally provided by hospital employees such as staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis based on submitted charges. At 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]

- services must be "...reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." [Social Security Act, §1862(a)(1)(A)]

- 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, §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 program 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, §2102.1]

- costs related to patient care are 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, §2102.2]

- non-covered 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, located in Manchester, New Hampshire, provides outpatient psychiatric services through its PHP to patients in the greater Manchester area. During FY 1998, the Hospital was part of Optima Healthcare, Inc., a management corporation for Elliot Hospital. For FY 1998, the

Hospital submitted for Medicare reimbursement 395 claims for outpatient psychiatric services valued at $1,087,164.

OBJECTIVES, 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 1998.

We conducted our audit during the period of January 1999 through March 1999 at the Optima Healthcare, Inc. Corporate office in Bedford, New Hampshire in accordance with generally accepted government auditing standards.

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

To accomplish our objective, we:

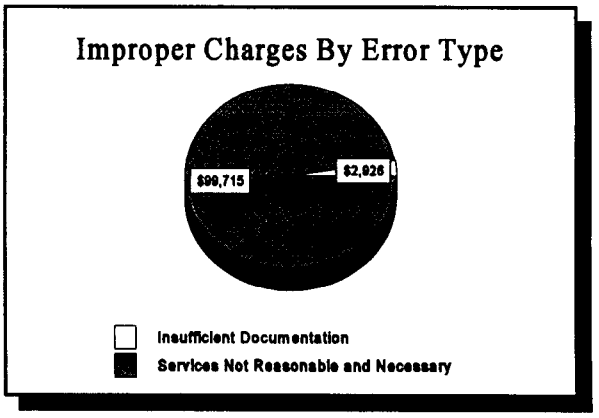
- reviewed criteria related to outpatient psychiatric services;
- obtained an understanding of the Hospital's internal controls over Medicare claims submission;
- used the Provider Statistical and Reimbursement Report provided by the FI for the Hospital's FY 1998 to identify 100 outpatient psychiatric claims from the Hospital valued at $250,635;
- 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 the FI and psychiatrists from the Northeast Health Care Quality Foundation, the New Hampshire 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;
- reviewed Medicare Part B claims processed by the local Medicare Part B Carrier which correspond to our sampled claims processed by the FI; and

- identified $413,165 in outpatient psychiatric services, after reclassifications and adjustments, claimed by the Hospital on its FY 1998 Medicare cost report. We reviewed supporting documentation for a judgmental sample of $241,737 of such costs.

The Hospital's response to the draft report is appended to this report (see APPENDIX B) and is addressed on pages 8 through 10. 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 psychiatric services through its Folkways Geropsychiatric Partial Hospitalization Program. The PHP offers more than 20 different group therapies to its patients in the greater Manchester, New Hampshire area. The Hospital's PHP offers an intensive level of treatment for patients in acute crisis that may require diagnostic, medical, psychiatric, psycho-social, occupational therapy, and pre-vocational treatment modalities usually found in a comprehensive program. The program is structured to offer an intensive milieu of various clinical services that would apply to clients transitioning to community living following an inpatient hospitalization for acute psychiatric illness or to provide intensive therapeutic modalities to those where traditional outpatient clinic or office visits are not meeting their needs.



In FY 1998, the Hospital submitted for Medicare reimbursement $1,087,164 in charges for outpatient psychiatric services. We reviewed the medical and billing records for 100 randomly selected claims totaling $250,635. Our analysis disclosed that $102,641 of the sampled charges did not meet the Medicare criteria for reimbursement. Based on a statistical sample, we estimate that the Hospital had overstated its FY 1998 Medicare outpatient psychiatric charges by at least $314,359.

In addition, the Hospital claimed $413,165 in costs for outpatient psychiatric services, after reclassifications and adjustments, on its FY 1998 Medicare cost report. We reviewed a judgementally selected sample of $241,737 in costs and found $11,315 of such costs to be unallowable under Medicare requirements. Findings from our review of medical records and outpatient psychiatric costs are described in detail on the following page.

MEDICAL RECORD REVIEW

Services Not Reasonable And Necessary

During the course of our review, we found that the Hospital had claimed $99,715 for PHP services that were not reasonable and necessary for the treatment of the beneficiaries' conditions. Errors in this category include situations where there was sufficient documentation in the medical record to allow the medical reviewers to make an informed decision that the medical services or products were not medically necessary.

The Social Security Act, §1862(a)(1)(A) states that no payment shall be made for any services which "...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

The HCFA Program Memorandum, Publication 60A, states that 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."

With the assistance of medical reviewers from the FI and PRO, we found $99,715 in erroneous charges for services determined not to be reasonable and necessary. Examples of errors that were found not reasonable and necessary include:

A claim for 7 days of group therapy totaling $1,925. The medical reviewer noted that:

> "...level of PHP was helpful but not necessary to prevent hospitalization. All groups except "focus group" were nonessential. Groups appear to be nonessential, more along the line of a day center...e.g...recreational discussion. "Focus group" is individualized. Some of the therapies that she was involved in do not appear essential or focused on a skill development for her. Current events group (...did not even record a progress note), exercise group, self esteem."

A claim for 1 day of group therapy totaling $385. The medical reviewer noted that:

> the exercise group, included as part of the claim for $77, was recreational in nature. In addition, the medical reviewer noted "Definitely, exercise group is recreational. This is globally true...instructing demented patients on warm up and cool down?"

In this regard, activity therapies or group activities, such as current event and exercise groups, which are not clearly justified and individualized in a beneficiary's treatment plan, would be considered recreational or diversional in nature. Any outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered under Medicare for outpatient psychiatric services. Furthermore, these types of therapies are not considered reasonable and necessary for the diagnosis and treatment of a patient's condition.

Insufficient Documentation

This category includes situations where the medical record includes some documentation for the claim in the sample, but such documentation is determined to be inconclusive to support the rendered services. With the assistance of medical reviewers from the FI and PRO, we found two claims totaling $2,926 in error due to insufficient documentation.

These two claims are discussed below:

A claim for 9 days of group therapy totaling $2,541. The medical reviewer noted that:

> there was "no re-certification for this period until 11/26", which was the 9th day in a series of dates (11/5, 11/6, 11/10, 11/12, 11/13, 11/19, 11/20, 11/24 & 11/26) for group therapy. The medical record for this claim was missing a re-certification for the PHP services selected in our sample.

A claim with a date of service of 8/12, was billed twice with the same revenue and procedure codes, but with different charge amounts of $462 and $385, respectively. The medical reviewer noted that:

> "8/12 listed twice on claim - both revenue code 915, both procedure code 90853."

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." With respect to the "missing re-certification", the lack of required documentation precluded the medical reviewers from determining whether those particular services were indeed reasonable and necessary.

REVIEW OF OUTPATIENT PSYCHIATRIC COSTS

The Hospital claimed $413,165 in costs for outpatient psychiatric services, after reclassification and adjustments, on its FY 1998 Medicare cost report. To determine whether these costs were allowable, reasonable, and allocable, we judgmentally reviewed $241,737 of these expenses. Our analysis showed that $11,315 of the outpatient charges reviewed were unallowable.

According to the Medicare Fiscal Intermediary Manual, §3112.7, non-covered outpatient psychiatric services include food and meal costs.

We found that the Hospital did not have adequate policies and procedures in place to establish non-reimbursable cost centers or to otherwise exclude costs related to non-covered services from its FY 1998 Medicare cost report. In this regard, we identified $11,315 for unallowable dietary and food costs. Specifically, we found dietary function costs, totaling $9,028 and food costs, totaling $2,287 charged to the Hospital's Medicare cost report for FY 1998. These costs represent lunches, snacks, and drinks provided daily to the PHP patients.

CONCLUSION

For FY 1998, the Hospital submitted for reimbursement $1,087,164 in charges for outpatient psychiatric services. Our audit of 100 randomly selected claims totaling $250,635 disclosed that $102,641 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 $314,359 in error for FY 1998. We attained our estimate by using a single stage appraisal program. The details of our sample appraisal can be found in APPENDIX A.

The Hospital also claimed $413,165 in costs for outpatient psychiatric services, after reclassification and adjustments, on its FY 1998 Medicare cost report. We judgmentally reviewed $241,737 of these costs and found $11,315 to be unallowable.

RECOMMENDATIONS

We recommend that the Hospital:

1. Strengthen its procedures to ensure that charges for psychiatric services are covered and properly documented in accordance with Medicare requirements.

2. Develop procedures to establish non-reimbursable cost centers from its Medicare cost report. We will provide the FI with details of the $314,359 in estimated overpayments for outpatient psychiatric services and the $11,315 in unallowable costs, so that it can apply the appropriate adjustments to the Hospital's FY 1998 Medicare cost report.

AUDITEE RESPONSE AND OIG COMMENTS

The Hospital, in its response dated August 17, 1999 (see APPENDIX B), believed that the services questioned by the OIG were medically reasonable and necessary and were sufficiently documented. The Hospital concurred with the OIG that food and dietary costs are unallowable. 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 Services Found Not Reasonable and Necessary

The Hospital had two major concerns regarding the OIG's finding that $99,715 in charges for PHP services were not reasonable and necessary. In this regard, the Hospital differed in its interpretation of HCFA and FI documents which define the scope and eligibility of PHP for Medicare beneficiaries. Specifically, the Hospital believed that applicable Medicare requirements provide coverage for PHP services for the diagnosis or active treatment of the individual's condition and to improve or maintain the individual's condition and functional level to prevent relapse or hospitalization. The Hospital therefore believed that the services questioned were reasonable and necessary because they improved or maintained the individual's condition and functional level to prevent a relapse and were not required to prevent hospitalization.

The Hospital also believed that issues related to the documentation of services, treatment plans, and therapies influenced the OIG's finding. In this regard, the Hospital believed that the volume of documentation contained in the medical records reviewed may have contributed to the medical reviewers' difficulty in locating relevant clinical documentation. Further, the Hospital also believed that in some instances progress notes may have emphasized changes in symptoms and interventions, not ongoing symptoms and treatment modalities which also may have led to the medical reviewers' confusion. The Hospital also believed that all of the group therapies it provided were necessary and reasonable given the individual beneficiaries' conditions and the subject matter of the groups in question. Further, if there were problems with the subject matter

of individual groups, then the FI should have informed the Hospital of this prior to the opening of the PHP, as the Hospital requested at that time.

OIG Comments

We have reviewed the Hospital's response and its two concerns regarding services found not reasonable and necessary and believe that no changes in the report are warranted. Specifically, the Hospital believed that maintaining an individual's condition and functional level to prevent relapse is a Medicare PHP coverage requirement separate from the PHP coverage requirement for the prevention of hospitalization. However, the HCFA Program Memorandum, Publication 60A clearly states:

> "Partial hospitalization may occur in lieu of either:
> * Admission to an inpatient hospital; or
> * A continued inpatient hospitalization."

Accordingly, we believe that treatment preventing a relapse would be covered in instances in which the beneficiary would otherwise require inpatient psychiatric treatment.

The Hospital also believed that issues related to the documentation of services, treatment plans, and therapies may have negatively influenced the medical reviewers' decisions when determining the reasonableness and necessity of the services reviewed. In this regard, the medical reviewers only classified errors as unreasonable and unnecessary when there was sufficient documentation to make this determination. If there were problems in locating relevant documentation, then the services would have been classified as insufficiently documented. Further, the medical reviewers did not categorically deny group therapies based on the subject matter of the group. Each service was reviewed independently based on the documentation contained in the beneficiary's medical record and a determination made accordingly.

Therefore, our conclusion, based on the medical reviewers' initial determinations, will remain unchanged and no further adjustments to our draft report made.

Auditee Response Regarding Services Insufficiently Documented

The Hospital believed that of the $2,926 in charges for PHP services insufficiently documented, $2,541 was in fact sufficiently documented. In this regard, the services in question were not supported by a physician's recertification of the necessity of ongoing PHP services. The Hospital maintains that this recertification was completed, but was somehow missing from the medical record. However, the Hospital believed that the presence of subsequent recertifications and physician notes indicating that the patient's condition was still present for the dates of service in question support the basis of the recertification and the services were therefore sufficiently documented.

The Hospital further noted that procedural and documenting processes at the Hospital's PHP have been substantially revised as a direct result of the OIG report. In this regard, all physician progress notes are now dictated and transcribed, thereby providing enhanced capability for greater detail and legibility. Further, the physician and nurse comment form within the medical record has been reformatted for greater capacity and ease of access. Hospital policies have also been revised concerning documentation guidelines and staff supervision.

OIG Comments

We believe that the Hospital documentation supporting these services does not meet the physician certification requirements set forth in 42 CFR §424.24 and HCFA Program Memorandum, Publication 60A. 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. Without this specific language, medical reviewers cannot determine if in fact PHP services were necessary in lieu of inpatient care or if a less intense milieu of care such as non-PHP outpatient psychiatric would have been sufficient for the dates of service in question. The FI subsequently reviewed this claim and did not change its original determination that these services should be denied.

Auditee Response Regarding Review of Outpatient Psychiatric Costs

The Hospital concurred with the OIG's finding that food and dietary costs are unallowable and will exclude these costs from its FY 1998 and subsequent cost reports.

APPENDICES

APPENDIX A

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY THE ELLIOT HOSPITAL

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 395 Claims	Items: 100 Claims	Items: 40
Dollars: $1,087,164 Charges	Dollars: $250,635 Charges	Dollars: $102,641

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: $405,432
Lower Limit: $314,359
Upper Limit: $496,505

Elliot Hospital

August 17, 1999

CIN: A01-99-00502

Mr. William J. Hornby
Regional Inspector General for Audit Services
Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203

Re: DRAFT REPORT "REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY THE ELLIOT HOSPITAL FOR FISCAL YEAR ENDING JUNE 30, 1998"

Dear Mr. Hornby:

We have reviewed the July 1999 Draft Report referenced above. We note that a substantial portion of the findings are based upon reviewers' abstract and retrospective evaluation of the medical necessity and reasonableness of PHP services. Clinical conclusions such as these are most appropriately the purview of individuals possessing specialized expert medical knowledge. As such, we present an appendix of clinically-focuses attachments stating our views relative to the facts and recommendations presented in the Draft Report. The review was completed by Betty Welch, Program Coordinator of the Partial Hospitalization Program at Elliot Hospital, and Dr. Vadalia, the Medical Director of the Program. Their respective credentials are also included as part of Appendix B.

Interpretation of the language present in HCFA and FI guideline documents bears substantially on the findings of this Draft Report. We present an enhanced discussion on this topic in an overview appendix.

As per your request, we submit a summary of actions taken as a direct result of this audit. As you have stated, this Draft Report is subject to further review and revision. We await your evaluation of this additional information. If you have additional questions, please call Patricia A. Hayward, General Counsel. at 603-663-8940.

Sincerely,

Douglas Dean
President and CEO
Elliot Hospital

One Elliot Way
Manchester, NH 03103-3599
Phone 603.669.5300
Fax 603.647.4420

CIN:A-01-99-00592 **August 17, 1999**

Elliot Hospital

OVERVIEW

Elliot Hospital has two major concerns regarding the OIG's finding that $99,715 in charges for PHP services were not reasonable and necessary:

1.

Differing interpretations of HCFA and FI documents which define the scope and eligibility of PHP for Medicare beneficiaries bear directly on the OIG finding .

The OIG draft report states that there was *"sufficient documentation in the medical record to allow the medical reviewers to make an informed decision that the medical services or products were not medically necessary."* The OIG draft report then references the *HCFA Program Memorandum, Publication 60A* indicating that this publication "*states that 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."* While the above statement is within HCFA Publication 60A, there are many other statements in the same bulletin that must be reviewed before deciding eligibility for PHP benefits.

HCFA Publication 60A also states: "To be considered eligible for payment under the Medicare partial hospitalization benefit, the services must be

- Reasonable and necessary for the diagnosis or active treatment of the individual's condition, and (emphasis added)
- Reasonably expected to improve or maintain (emphasis added) the individual's condition and functional level to prevent relapse or hospitalization (emphasis added)."

The second bullet is directly relevant to many of the cases of concern in the OIG draft report.

Most of the patients in the audit needed PHP for the active treatment for their respective conditions ***and*** to prevent hospitalization . The Individual patient summaries in Appendix B will attest to that fact. However, according to HCFA Publication 60A, these patients would also qualify for PHP if such treatment were to maintain their respective conditions and functional levels to prevent relapse. In light of this interpretation, Elliot Hospital respectfully requests reconsideration of those cases in which the denial criteria was stated simply as "PHP not necessary to prevent hospitalization".

The Local Medical Policy for PHP, Bulletin 517, Issued February 1997, makes clear statements regarding "indications and limitations on coverage," as follows: "The Medicare Program provides benefits for partial hospitalization services when the following criteria are met:

- The services are reasonable and necessary for the active treatment of the patient's condition;
- There is a reasonable expectation that the patient will improve or be maintained at a functional level to prevent relapse or hospitalization;
- The services must be prescribed by a physician and provided under an individualized written plan of treatment....
- The services must also be under the supervision of a physician and periodically evaluated by this physician to determine the extent to which treatment goals are being realized.
- The patient's diagnosed mental disorder must meet the DSM-IV criteria, with emphasis on Axis I and Axis II.

A later section on certification, notes: "Treatment may continue until the patient has improved sufficiently to be maintained in the outpatient or office setting on a less intense and less frequent basis." The bulletin later gives an example of this latter point as follows: "e.g., a patient who needs only one day a week on an ongoing basis would not need Medicare covered PHP services." Bulletin 517 thereby acknowledges the critical relapse prevention and maintenance function of PHP, sanctioning continued PCP

treatment until such time as the clinician can be assured that the patient will manage in a lower intensity of treatment.

2.

Issues related to the documentation of services, treatment plans and therapies.
The plethora of clinical information contained in each patient records may have made it difficult for the reviewer to focus on the truly relevant documentation of medical necessity. In addition, the physical nature of the medical record may have contributed to reviewer difficulty in locating relevant clinical documentation. This could be partially due to multiple disciplines documenting at different places in the medical record. To assist reviewers, we are enclosing quotes and data from the medical records of each individual beneficiary in chronological order.

While reviewing records ourselves and understanding what part of documentation might be missed by the reviewers, we recognized many areas of documentation we can improve upon. Daily physician and nurses notes could emphasize more ongoing symptoms and treatment modalities, thereby replacing the current trend of only mentioning changes in symptoms and interventions. For example, if the patient continues to be severely depressed with poor appetite, poor sleep and total lack of interest and presents with a new complaint of an upset stomach, the nurses and physicians would have written mostly about stomach problems and not described other ongoing problems. We have already started to address some of these issues and are finalizing our definitive plan to improve and streamline documentation.

Geriatric psychiatry has been recognized as a specialty for more than 25 years, with fellowship programs and qualifying exams by the Board of Psychiatry and Neurology. Our PRO and FI do not always utilize geriatric psychiatrists as review physicians. Geriatric psychiatry is a specialty where the patients have very distinct symptomatology, psychopathology and psychosocial issues. Treatment approaches and outcome expectations are very much different than in younger patients. In recognition of the

subtleties and special expertise required by this discipline, we would request these cases be reviewed by geriatric psychiatrists, if feasible.

We offer the following insight into our focus in group therapies. In one example noted on page 5 of the OIG draft report, a reviewer notes: *"level of PHP was helpful but not necessary to prevent hospitalization. All groups except focus group were nonessential. Groups appear to be nonessential, more along the line of a day enter...e.g...recreational discussion. Focus group is individualized."*, "Supportive Therapy" was not mentioned. This group is held on a daily basis. It is by far the most individualized group offered, with targeted focus on emotional issues facing the patient. This particular patient was admitted to PHP with significant caregiver burden resulting in major depression, with obesity, decreased engagement in any pleasurable activities and extremely low self-esteem contributing to her depression (more detail follows in the individual case presentation). The groups are appropriate to address her clinical needs, which were outlined in the treatment plan, and assist the patient in re-engaging in the activities of daily living.

Another reviewer comments: *"the exercise group, included as part of the claim for $77, was recreational in nature....Definitely exercise group is recreational. This is globally true...instructing demented patients on warm up and cool down*?" The American Association of Geriatric Psychiatry, the American Psychiatric Association and current trends in geriatric psychiatry in general opine that, by definition, nothing in a PHP program is "globally true". In fact, each patient has a different gain to achieve from each group. In reading the note for this patient it identifies that this particular patient does better with increased structure and that the occupational therapist utilized the time to help the patient understand the value of exercise in improving her mood and her need to continue this after discharge (which occurred on that particular day).

A number of studies have found that exercise not only improves anxiety and depression, but also may slow decline in memory. It is a very effective coping skill. Research has shown that moderate exercise regimens can result in a wide array of

physiological and psychosocial benefits and can help improve as well as maintain functional health in older people. Furthermore, selected sensorimotor activities can provide nervous system stimulation through tactile, proprioception, kinesthetic and vibratory senses.

The OIG draft report states: "*Any outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered under Medicare regulations for outpatient psychiatric services....*" None of our groups are recreational or diversional in nature. There have been occasions, for example, around holidays, where there was a party or a special video shown. In those instances, the medical record will reflect that the group time was not billed to the patient. Elliot Hospital has made great efforts to ensure that our interventions are individualized, goal directed and specific to the patient's treatment plan. Our interventions are based on sound therapeutic interventions. Staff members continually update their skills and knowledge to ensure that we continue to provide the most efficient and effective interventions to our patients.

Prior to opening the PHP program Elliot Hospital sent detailed group descriptions to the FI on May 17, 1996. In the correspondence, we specifically asked the FI to "review the enclosed program material (including group descriptions) for approval for Medicare coverage" The FI never verbally or in writing indicated that the groups were not appropriate for the types of patients we treat.. In a follow-up telephone conversation, we invited the FI to come to our facility and do an initial review, to ensure that we were meeting all guidelines and expectations put forth by HCFA. We were told that we did not need a review before we started the program, and, that if there were any problems, they would contact us.

Elliot Hospital has one major concern regarding the OIG's finding that $2,926 in charges for PHP services were insufficiently documented.

1.

(I can put this in if you want, but I do not believe they make a creditable case.)
There is one instance, in a patient's chart, that the recertification has been misplaced. We believe that the recertification was completed, but somehow missing from the medical record. Given that all other recertifications are present, this is the most likely explanation.

However, this raises the question as to the formality of the recertification. While we currently try to have a separate form for recertification, one could infer that the physician wanted treatment continued based on the following factors:

1. There are recertifications which follow the missing recertification.
2. The physician note on 10/29 (when recertification was expected) states: "Patient extremely anxious...experiencing chest pain....EKG negative....will consider GPU [inpatient] admit."
3. The physician signed a 10/22 treatment plan which under the section "Clinical Need for Continued Stay" states: "Patient continues to present with anxiety, limited coping skills and depressed mood. Involvement in IADLs continues to be quite limited."

Items 2 and 3 above support the basis of the recertification clause: That the partial hospitalization is in lieu of inpatient treatment and the patient needs continued treatment.

CIN:A-01-99-00502
Elliot Hospital

Summary of Actions Taken:

A detailed medical record review was undertaken for the twenty two (22) Partial Hospitalization Patients noted to have "Error Amount" totals listed in the "Review of 100 GPHP Claims" report. An overview (Appendix A) details Elliot Hospital's global concerns in the cases where the OIG has deemed patients to have received services which are not reasonable and necessary and/or have insufficient supporting documentation. Individual summaries (Appendix B) are enclosed for each patient in question, including "History of presenting illness", "Treatment plan", detailed clinical discussion, and "Summary and Conclusions". The conclusions in these summaries are corroborated by verbatim medical record excerpts from the dates of concern listed in the Draft OIG Report. It is the Elliot Hospital's position that each medical record, in total, substantiates the reasonable and necessary criteria set forth in the Medicare criteria.

Procedural and documenting processes in Elliot Hospital's Partial Hospitalization Program have been substantially revised as a direct result of the OIG report. All physician progress notes are now dictated and transcribed, thereby providing enhanced capability for greater detail and legibility. A reformatted "MD Notes/Nursing Comments" medical record form has been put into use as of August 1, 1999. This form provides for greater capacity and ease of access within the medical record. Revised internal policies related to new physician orientation to the Partial Hospitalization Program have been instituted. These policies emphasize specific guidelines for appropriate documentation and require close supervision and ongoing monitoring of new staff members. As of September 1, 1999 each non-physician staff member is required to conduct a monthly medical record audit and present his/her findings at a staff meeting. This audit's focus is complete and appropriate documentation for all medical record contributors.

In FY1998, Elliot Hospital configured the Folkways Partial Hospitalization Program as reimbursable cost center. Through the experience of this audit, Elliot Hospital will exclude the accounting for Food and Dietary Costs in the Folkways cost center. Elliot Hospital will notify the Medicare Auditors during the FY98 Medicare Cost Report audit for proper disallowance of these costs. FY99 and subsequent years, the Food and Dietary Costs will be properly disallowed on the submitted Medicare Cost Reports to the fiscal intermediary.