DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

July 26, 2001

CIN: A-02-00-01032

Ms. Mildred Allen
President, CEO
Fordham-Tremont Community Mental Health Center
2021 Grand Concourse, 7th Floor
Bronx, New York 10453

Dear Ms. Allen:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Medicaid Outpatient Psychiatric Services Provided by Saint Barnabas Hospital, Fordham-Tremont Community Mental Health Center for Fiscal Year Ended September 30, 1999." 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.

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To facilitate identification, please refer to Common Identification Number A-02-00-01032 in all correspondence relating to this report.

Sincerely yours,

Timothy J. Horgan
Regional Inspector General
for Audit Services

2 Enclosures

Direct Reply to HHS Action Official:

Mr. Peter Reisman
Associate Regional Administrator
Division of Financial Management
Centers for Medicare and Medicaid Services, Region II
U.S. Department of Health and Human Services
26 Federal Plaza, Room 38-130
New York, New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY SAINT BARNABAS HOSPITAL, FORDHAM-TREMONT COMMUNITY MENTAL HEALTH CENTER FOR FISCAL YEAR ENDED SEPTEMBER 30, 1999

JULY 2001
A-02-00-01032

Office of Inspector General

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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.

EXECUTIVE SUMMARY

Background

The Medicaid program covers outpatient hospital services, physician services, clinic services, and prescription drugs pursuant to an approved State program. The Federal government and the States share in the cost of the program. In New York State (NYS), the Federal share is 50 percent. The NYS Medicaid requirements cover outpatient programs for adults with a diagnosis of mental illness and children with a diagnosis of emotional disturbance.

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 Medicaid requirements.

Summary of Findings

During Federal Fiscal Year (FY) ended September 30, 1999, Saint Barnabas Hospital, Fordham-Tremont Community Mental Health Center (Hospital) received reimbursement for 81,918 Medicaid outpatient psychiatric claims totaling $12,374,449 (Federal share $6,186,815). To determine whether controls were in place to ensure compliance with Medicaid regulations and guidelines, we reviewed the medical and billing records for 100 statistically selected claims totaling $15,225 (Federal share $7,612). These claims were made on behalf of patients who received services in the Hospital's outpatient psychiatric department.

Generally, we found that the Hospital received reimbursement for claims that were reasonable, necessary, and adequately supported by medical records. However, our analysis showed that $1,181 (Federal share $591) of the sampled claims did not meet Medicaid criteria for reimbursement. Claims found unallowable were for services with insufficient treatment plans or not properly supported by medical record documentation.

We found for the most part the Hospital had adequate procedures for the proper billing of Medicaid outpatient psychiatric services. However, in limited instances, procedures were not established. In addition, staff did not always follow existing Hospital procedures.

We extrapolated our sample results to the population of claims reimbursed to the Hospital for services provided during FY 1999 and estimated that the Hospital was overpaid by Medicaid $410,200 (Federal share $205,100).

Recommendations

We recommend that the Hospital strengthen its procedures to ensure that claims for outpatient psychiatric services are properly documented in accordance with Medicaid regulations. In addition, we recommend the Hospital refund $410,200 (Federal share $205,100) to Medicaid. Accordingly, we will share this report with NYS Department of Health (DOH) so that it can monitor the recovery of the overpayment.

In responses to our draft report (see APPENDIX B and APPENDIX C), Hospital officials indicated that 4 of the 8 claims questioned by the OIG were allowable and asked that the claims be reconsidered in light of specific comments it was supplying. Based on the comments made by the Hospital and reviewed by the medical reviewers, we believe that our final audit determinations are correct and no further adjustment to our report is necessary. The basis for our position is discussed starting on page 10 of this report.

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INTRODUCTION

Background

The Medicaid program, established by Title XIX of the Social Security Act (the Act), is a cooperative venture jointly funded by the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America=s poorest people. The Centers for Medicare and Medicaid Services (CMS)[1] has issued general regulations for the Medicaid program.

Within the broad national guidelines provided by CMS, each of the States: (1) establishes its own eligibility standards, (2) determines the type, amount, duration, and scope of services, (3) sets the rate of payment for services, and (4) administers its own program.

The State of New York initiated its Medicaid program on May 1, 1966. The NYS DOH is the Single State Agency for Medicaid. The DOH delegates certain of its responsibilities to other State agencies. One such agency is the Office of Mental Health (OMH), which is responsible for the overall administration of inpatient and outpatient psychiatric services.

Title XIX of the Act requires that in order to receive Federal-matching funds, certain basic services must be offered to the categorically needy population in any State program. Outpatient hospital services and physician services are included in the required basic services. Many states also include clinic services and prescribed drugs as optional services covered under the Medicaid program.

The amount of total Federal outlays for Medicaid has no set limit; rather, the Federal government must match whatever the individual State decides to provide, within the law, for its eligible recipients. The FY 1999 Federal share for New York State Medicaid services was 50 percent. Providers participating in Medicaid must accept Medicaid payment rates as payment in full.

The Code of Federal Regulations (CFR) at 42 CFR 482.1(a)(5) requires hospitals that receive payments under Medicaid to meet the requirements for participation in Medicare. Part 482.24 of the 42 CFR requires that a medical record be maintained for every individual evaluated or treated in a 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.

Part 587 of Title 14 of the Official Compilation of Codes, Rules and Regulations of the State of New York (14 NYSCRR) establishes and sets certification standards for six categories of outpatient programs: Clinic Treatment programs for Adults, Clinic Treatment programs for Children, Continuing Day Treatment, Day Treatment programs for Children, Intensive

[1] Prior to June 2001, the CMS was known as the Health Care Financing Administration (HCFA).

Psychiatric Rehabilitation Treatment, and Partial Hospitalization. Part 587 also provides treatment planning guidance for the programs, including:

- Treatment planning shall be based on an assessment of the recipient's psychiatric, physical, social, and/or psychiatric rehabilitation needs which result in the identification of the following: (1) the recipient's designated mental illness diagnosis, (2) the recipient's problems and strengths, (3) the recipient's treatment goals consistent with the purpose and intent of the program, and (4) the specific objectives and services necessary to accomplish goals.

  The treatment plan shall include, but need not be limited to, the following: (1) the signature of the physician involved in the treatment, (2) the recipient's designated mental illness diagnosis, (3) the recipient's treatment goals, objectives and related services, (4) plan for the provision of additional services to support the recipient outside of the program, and (5) criteria for discharge planning…A periodic review of the treatment plan shall include the following: (1) input of all staff involved in treatment of the recipient, (2) the recipient, his or her family and/or other collaterals, as appropriate, (3) assessment of the progress of the recipient in regard to the mutually agreed upon goals in the treatment plan, (4) adjustment of goals, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate, and (5) the signature of the physician involved in the treatment. [14 NYSCRR Part 587.16]

- Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient. Such notes shall identify the particular services provided and the changes in goals, objectives and services, as appropriate. Progress notes shall be recorded within the following intervals: (1) Clinic treatment programs - each visit and/or contact, (2) Continuing day treatment programs - at least every two weeks, (3) Partial hospitalization programs - each visit and/or contact, (4) Day treatment programs - at least every week. [14 NYSCRR Part 587.16]

- The case record shall be available to all staff of the outpatient program who are participating in the treatment of the recipient and shall include the following information…(11) dated and signed records of all medications prescribed. [14 NYSCRR Part 587.18]

Part 588 of 14 NYSCRR establishes standards for reimbursement of outpatient programs for adults with a diagnosis of mental illness and children with a diagnosis of emotional disturbance, including:

- Reimbursement shall only be made for services identified and provided in accordance with an individual treatment plan or psychiatric rehabilitation service plan. [14 NYSCRR Part 588.5]
- For Clinic Treatment services, the treatment plan shall be developed prior to the fourth visit after admission or within 30 days of admission, whichever comes first. Review of the treatment plan shall be every three months, unless the individual is discharged and readmitted, in which case the review cycle begins again. [14 NYSCRR Part 588.6]
- For Continuing Day Treatment services, the treatment plan shall be completed prior to the twelfth visit after admission or within 30 days of admission, whichever occurs first. Review of the treatment plan shall be every three months. [14 NYSCRR Part 588.7]

In NYS, Medicaid reimbursement is based on face-to-face encounters between clinical staff and patient(s) or collateral(s) for the provision of services identified and provided in accordance with a treatment plan and documented in the patient's record. For each program type, visits must meet a specified minimum duration to be billed. The date, type of service and duration must also be recorded in the case record. Reimbursement is limited to one mental health program visit, not including crisis visits, and one collateral visit or group collateral visit per patient per day, regardless of the number of collaterals involved in the visit.

Fordham-Tremont Community Mental Health Center, an affiliation of Saint Barnabas Hospital, provides outpatient psychiatric services for ten outpatient programs. The outpatient programs, licensed by New York State Office of Mental Health (OMH), New York City Department of Mental Health, Mental Retardation, and Alcoholism Services, and Joint Commission on the Accreditation of Health Care Organizations, include: 1) Adult Outpatient Services, 2) Continuing Care Clinic, 3) Mentally Ill Chemical Abusers (MICA) Continuing Day Treatment Program,
4) Continuing Day Treatment Unit, 5) David Cassella Children Services, 6) School-based Mental Health Program, 7) Child, Adolescent, and Family Services Unit, 8) Family Violence/Crisis Services, 9) Latin American Immigrant Services, and 10) Assertive Community Treatment Team. These programs are located at four sites in the Bronx, New York.

Objective, Scope and Methodology

The objective of this audit was to determine whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicaid regulations. Our review included services provided during FY 1999.

To accomplish our objective, we:

- Reviewed Medicaid criteria related to outpatient psychiatric services.
- Used computer programming to identify the universe of 81,918 claims valued at $12,374,449 (Federal share $6,186,815) from the Medicaid Management Information System.
- employed a simple random sample approach to select a statistical sample of 100 outpatient psychiatric claims valued at $15,225 (Federal share $7,612).
- interviewed appropriate Hospital administrative personnel to obtain an understanding of how medical records were maintained and how outpatient psychiatric services were documented and billed.
- performed detailed audit testing on the medical and billing records for the claims selected in the sample.
- Utilized medical review staff (a psychiatrist and registered nurses) at the Island Peer Review Organization to analyze the medical records supporting the claims.
- used a variables appraisal program to estimate the dollar impact of improper claims in the total population.
- Discussed the audit methodology and results with officials from CMS, NYS DOH and NYS OMH.

We limited consideration of the internal control structure to those controls related to the submission of claims to Medicaid because the objective of our review did not require an understanding or assessment of the entire internal control structure at the Hospital. Our review was made in accordance with generally accepted government auditing standards. Our fieldwork was performed from June 2000 through February 2001 at the Hospital facilities located in the Bronx, New York, and at the Island Peer Review Organization, located in Lake Success, New York.

The Hospital's response to the draft report is appended to this report (see APPENDIX B and APPENDIX C), and is addressed on page 10**.** We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

FINDINGS AND RECOMMENDATIONS

In FY 1999, the Hospital received reimbursement for 81,918 Medicaid outpatient psychiatric claims totaling $12,374,449 (Federal share $6,186,815). We reviewed the medical and billing records for 100 statistically selected claims totaling $15,225 (Federal share $7,612). In general, we found that the Hospital received reimbursement for claims that were reasonable, necessary, and adequately supported by medical records. However, our analysis showed that eight of the sampled claims totaling $1,181 (Federal share $591) did not meet Medicaid criteria for reimbursement. Based on an extrapolation of the statistical sample, we estimate that the Hospital received an overpayment of $410,200 (Federal share $205,100) for Medicaid outpatient psychiatric services provided during FY 1999. We determined the unallowable claims were for services with insufficient treatment plans or not properly supported by medical record documentation.

The findings from our review of Medicaid outpatient psychiatric claims are described in detail below.

INSUFFICIENT TREATMENT PLANS

From our review of the medical records for the 100 outpatient psychiatric claims in our sample, we identified five claims totaling $707 that had insufficient treatment plans. Specifically, we determined that two claims lacked current treatment plans, one claim had no patient participation and approval, and two claims had insufficient discharge planning.

Current Treatment Plans

Treatment planning is the process of developing, evaluating and revising an individualized course of treatment based on an assessment of the recipient's diagnosis, behavioral strengths and weaknesses, problems, and service needs. Treatment planning shall be an ongoing process carried out by the professional staff in cooperation with the recipient and his or her family and/or other collaterals, as appropriate, which results in a treatment plan. The treatment plan shall be updated or revised to document changes in the recipient's condition or needs and the services provided.

The time periods for developing initial treatment plans and subsequent reviews vary depending upon the program the patient is admitted into. Specifically, Part 588.6(g) of 14 NYSCRR requires that treatment plans for Clinic Treatment programs be developed prior to the fourth visit after admission or within 30 days of admission, whichever comes first. Subsequent review of the treatment plan shall be every three months. Part 588.7(d) requires that treatment plans for Continuing Day Treatment programs be completed prior to the twelfth visit after admission or within 30 days of admission, whichever occurs first. Subsequent review of the treatment plan shall be every three months.

Although we found that the Hospital's policies and procedures were consistent with State regulations, we determined that the Hospital did not always follow existing procedures for preparing individualized treatment plans for each patient receiving ongoing psychiatric care. From our review of the medical records for the 100 outpatient psychiatric claims in our sample, we identified two claims totaling $233 for patients who had treatment plans that did not comply with Medicaid regulations concerning time periods for developing treatment plans. An example of an error found to be lacking a current treatment plan follows:

The Hospital submitted a claim to Medicaid for a Continuing Day Treatment visit provided on August 16, 1999 and received reimbursement totaling $158. With the assistance of medical review personnel from the PRO, we determined the treatment plan was not prepared within a timely manner.

> According to the medical reviewers, "treatment plan noted to be outdated, as 12 visits occurred prior to completion of treatment plan."

Patient Participation and Approval

Part 587.16(c) of 14 NYSCRR requires patient participation in treatment planning and approval of the plan. This regulation also states that reasons for non-participation and/or approval by the patient shall be documented in the case record.

We found that the Hospital's policies and procedures provide for patient participation in the development of the treatment plan. In addition, the Hospital's treatment plan form provides a section to document patient participation, and a block for the patient's signature. From our review of the medical records for the 100 outpatient psychiatric claims in our sample, we identified one claim totaling $158, which was in error regarding patient participation and approval of the treatment plan, as described below:

The Hospital submitted a claim to Medicaid for a Clinic visit provided on July 29, 1999 and received reimbursement totaling $158. With the assistance of medical review personnel from the PRO, we determined that the medical records did not contain any documentation of patient participation in treatment planning and approval of the plan.

> According to the medical reviewers, "Treatment Plan (5/25/99) lacks patient signature and has no check mark in space provided to indicate that patient participated in the treatment planning. Documentation of patient participation in Treatment Plan inadequate."

Discharge Planning

Discharge planning is the process of planning for termination from a program or identifying the resources and supports needed for transition of an individual to another program and making the necessary referrals. Discharge planning includes linkages for treatment, rehabilitation and supportive services based on assessment of the recipient's current mental status, strengths, weaknesses, problems, service needs, the demands of the recipient's living, working and social environment, and the client's own goals, needs and desires.

Part 587.16(e) of 14 NYSCRR stipulates that the initial treatment plan shall include criteria for discharge planning. In addition, Part 587.16(g) of 14 NYSCRR requires periodic reviews of treatment plans to include intervention strategies or initiation of discharge planning, as appropriate.

We found that for the most part the Hospital had adequate procedures for ensuring that discharge planning was discussed on either initial treatment plans or periodic treatment plan reviews, as required by Medicaid regulations. However, we identified two claims totaling $316 for patients who had treatment plans that did not contain adequate discharge planning. An example of this type of error follows:

The Hospital submitted a claim to Medicaid for a Clinic visit provided on May 5, 1999 and received reimbursement totaling $158. With the assistance of medical review personnel from the PRO, we determined discharge planning was not sufficiently addressed in the treatment plan.

> According to the medical reviewers, "Discharge criteria section of treatment plan blank and no other documentation of discharge criteria found. Noted that discharge planning documented on next Treatment Plan (6/4/99) however not documented on previous Treatment Plans (9/4/98 and 12/4/98) or on Treatment Plan covering date of service (3/4/99). Documentation of discharge planning inadequate."

Without an up-to-date, physician-signed, proper treatment plan to identify the patient's diagnosis, problems and strengths, treatment goals, as well as objectives and services necessary to accomplish those goals, we could not determine with any certainty that the services were indeed reasonable and necessary.

SERVICES NOT SUPPORTED BY MEDICAL RECORDS

According to 42 CFR 482.24, the hospital must maintain a medical record for each inpatient and outpatient. The medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The medical records must be retained in their original or legally reproduced form for a period of at least 5 years. In addition, the medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Further, all records must document the following, as appropriate: (1) admitting diagnosis, (2) results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient, (3) 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, and (4) discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.

From our review of the medical records for the 100 outpatient psychiatric claims in our sample, we identified three claims totaling $474 that had services that were not supported by the medical records. Specifically, we determined that one claim did not have a progress note for the date of service and two claims had inadequate documentation supporting the service billed.

Progress Notes

The 14 NYSCRR Part 587.16(f) requires progress notes be completed by the clinical staff member(s) who provided services. The notes shall identify the particular services provided and the changes in goals, objectives and services, as appropriate. Progress notes shall be recorded at each visit and/or contact for clinic treatment programs and at least every two weeks for continuing day treatment programs.

Although we found that the Hospital's policies and procedures were consistent with Medicaid regulations, we determined that the Hospital did not always follow existing procedures for documenting services rendered. From our review of the medical records for the 100 outpatient psychiatric claims in our sample, we identified one claim totaling $158 for a patient in which the medical record did not contain documentation supporting the service billed, as described below:

The Hospital submitted a claim to Medicaid for a Clinic visit provided on March 30, 1999 and received reimbursement totaling $158. With the assistance of medical review personnel from the PRO, we determined there was no progress note for the date of service.

> According to the medical reviewers, "…no documented progress note or clinical documentation of patient participation in therapeutic group."

Medication Documentation

The 14 NYSCRR Part 587.4(c) defines medication therapy as the prescription and/or administration of medication, assessment of the appropriateness of the recipient's existing medication regimen through review of records and consultations with the recipient and/or family and monitoring the effects of the medication on the recipient's mental and physical health.

The 14 NYSCRR Part 587.18(b) requires the case record to be available to all staff of the outpatient program who are participating in the treatment of the recipient. The record shall include…dated and signed records of all medications prescribed. In addition, 42 CFR 482.24 requires the medical record to contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. The medical record must also document 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.

We found that for the most part the Hospital had adequate procedures for ensuring that medication prescriptions were documented in the case records, as required by Medicaid regulations. However, we identified two claims totaling $316 for patients in which the medical record did not contain sufficient documentation supporting the service billed. An example of an error found to be lacking adequate medication documentation follows:

The Hospital submitted a claim to Medicaid for a Clinic visit provided on November 18, 1998 and received reimbursement totaling $158. With the assistance of medical review personnel from the PRO, we determined that there was inadequate documentation of the medication prescribed.

> According to the medical reviewers, "Inadequate documentation of medications in progress notes and no documentation of medication on medication sheet, for date of service."

Without complete medical record documentation, including a description of what took place in a therapy session, the medication prescribed, 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 direct future treatment. In this regard, the lack of required documentation precluded us from determining whether those services were needed.

Conclusion

In FY 1999, the Hospital received reimbursement for 81,918 Medicaid outpatient psychiatric claims totaling $12,374,449 (Federal share $6,186,815). In general, our review showed that the Hospital received reimbursement for claims that were reasonable, necessary, and adequately supported by medical records. However, our audit of 100 statistically selected claims totaling $15,225 (Federal share $7,612) disclosed that eight claims totaling $1,181 (Federal share $591) should not have been billed to the Medicaid program. Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that the Hospital was overpaid at least $410,200 (Federal share $205,100) for FY 1999. We attained our estimate using a single stage appraisal program. The details of our sample appraisal can be found in APPENDIX A.

Recommendations

We recommend that the Hospital strengthen its procedures to ensure that claims for outpatient psychiatric services are properly documented in accordance with Medicaid regulations and guidelines. In addition, we recommend the Hospital refund $410,200 (Federal share $205,100) to Medicaid. Accordingly, we will share this report with NYS DOH so that it can monitor the recovery of the overpayment.

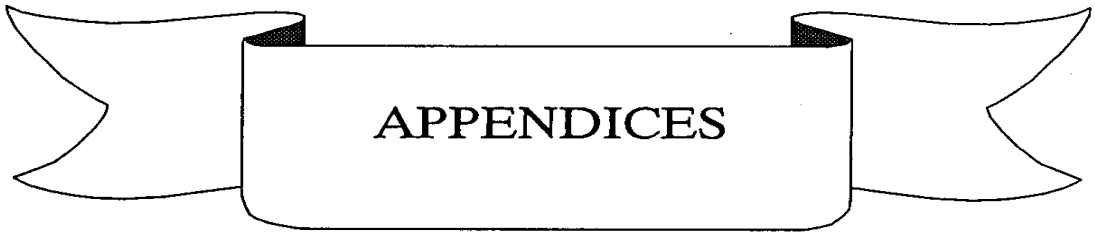
AUDITEE RESPONSE AND OIG COMMENTS

The Hospital, in its response dated May 24, 2001 (see APPENDIX B), believed that four of the eight claims questioned by the OIG were allowable and asked that the claims be reconsidered in light of specific comments it was supplying. The OIG had questioned $632 (Federal share $316) for these four claims. For each of the four claims, the Hospital provided a synopsis of the medical records we had already reviewed, and provided no new additional documentation.

The Hospital did not address in its response the remaining four claims questioned by the OIG, which totaled $549 (Federal share $275).

In a supplemental response dated June 7, 2001 (see APPENDIX C), the Hospital described how it believed it is currently engaged in an ongoing process of improving the effectiveness and efficiency of the outpatient mental health services it provides to the community.

We reviewed all relevant comments made by the Hospital and believe that our final audit determinations are correct and no further adjustment to our report is necessary. We found that the Hospital, in its response, had simply provided a synopsis of the medical records we had already reviewed, and provided no new additional supporting documentation. In addition, the medical reviewers were provided these responses, considered the information supplied, and found no basis to change the outcomes of the four claims presented for re-review.


APPENDICES

APPENDIX A

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY SAINT BARNABAS HOSPITAL, FORDHAM-TREMONT COMMUNITY MENTAL HEALTH CENTER FOR FISCAL YEAR ENDED SEPTEMBER 30, 1999

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 81,918 Claims	Items: 100 Claims	Items: 8 Claims
Claims: $12,374,449	Claims: $15,225	Claims: $1,181

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: $967,746
Lower Limit: $410,200
Upper Limit: $1,525,293

A Center For All People

FORDHAM-TREMONT
Community Mental Health Center
Affiliate of St Barnabas Hospital

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Rev. David Caselia
President, Governing Board

Mildred M. Allen, Ph.D.
Executive Director

Mr. James P. Edert
Dept. of Health and Human Services
Office of Inspector General
Office of Audit Services
26 Federal Plaza, Rm. 3900A
Jacob K. Javits Federal Bldg.
New York, N.Y. 10278

May 24th, 2001

CIN: A-02-00-01032

Dear Mr. Edert,

In response to your letter dated May 17th, 2001, regarding the US Department of Health and Human Services, Office of Inspector General, Office of Audit Services draft report entitled "Review of Medicaid Outpatient Psychiatric Services Provided by Saint Barnabas Hospital, Fordham-Tremont Community Mental Health Center for Fiscal Year Ended September 30th, 1999" we would like you to note the following response for four of the eight denied claims we feel should be reconsidered.

The following four claims have been cited for disallowance. Please note:

Claim #4: This claim was cited for "No discharge planning – Periodic treatment plan".

*See OIG Note Below

* Note: We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

Claim #18: This claim was cited for "No beneficiary signature on treatment plan and no explanation for omission".

*See OIG Note Below

Claim #61: This claim was cited for "inadequate documentation regarding medication and dosage".

*See OIG Note Below

* Note: We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

Claim #65: This claim was cited for "inadequate discharge criteria documented on treatment plan".

*See OIG Note Below

Please review the above listed claims regarding your recommendation of disallowance. Contact me at 718-960-0348 if you have any further questions.

Sincerely,

Mildred Allen

Mildred Allen, Ph.D.
CEO/President

Return Receipt Requested

* Note: We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

FORDHAM-TREMONT
Community Mental Health Center
Affiliate of St. Barnabas Hospital

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Mr. James P. Edert
Dept. of Health and Human Services
Office of Inspector General
Office of Audit Services
26 Federal Plaza, Rm. 3900A
Jacob K. Javits Federal Bldg.
New York, N.Y. 10278

June 7th, 2001

CIN: A-02-00-01032

Dear Mr. Edert,

In response to your letter dated May 17th, 2001, regarding the US Department of Health and Human Services, Office of Inspector General, Office of Audit Services draft report entitled "Review of Medicaid Outpatient Psychiatric Services Provided by Saint Barnabas Hospital, Fordham-Tremont Community Mental Health Center for Fiscal Year Ended September 30th, 1999" we would like to address the systemic recommendations made in this report. This letter will serve as an addendum to our letter of May 24th, 2001, in which we presented for reconsideration of disallowance four of the eight denied claims in the draft report. The draft report identifies three types of problems that resulted in insufficient treatment plan documentation in the fiscal year ending on September 30th, 1999; 2 Treatment Plan Reviews (TPRs) did not have sufficient documentation of discharge planning, 1 TPR showed no evidence of client participation in and approval of treatment and 2 TPRs were not completed in a timely manner. The report also recommends that Fordham-Tremont strengthen procedures to ensure proper documentation and billing of services.

Fordham-Tremont CMHC is engaged in an ongoing process of improving the effectiveness and efficiency of the outpatient mental health services it provides to the mid-Bronx community. In October of 1999 a revised treatment plan form was introduced in order to improve the treatment planning process. The new treatment plan integrated the assessment and treatment of functional impairments more clearly into treatment planning. Goals became more concrete, observable and measurable and therefore assessment of progress and plans for discharge are now more effectively and efficiently identified and documented.

In January of 2000, Fordham-Tremont CMHC completed a training initiative in Solution Focused Treatment. Unit Directors, Supervisors and Clinicians were involved in the training, so that this new treatment modality could be supported on all levels of treatment. This treatment approach was chosen to improve the clinical staff's ability to engage clients in the treatment process and develop concrete, realistic treatment goals that are strength based and client focused. The client is asked to describe, in concrete terms, how their symptoms interfere with their functioning and the client's self-report is incorporated into the treatment goals, which are continually addressed in the therapy process. Thus, treatment planning has become a consistently collaborative experience between client and clinician where client participation is encouraged and ensured.

The Center's Department of Management Information Systems transitioned onto Medical Manager, a new computer tracking system, in January of 2000. Medical Manager has improved the coordination of client information, clinical visit tracking and billing procedures significantly. This data management system has been used for performance improvement projects throughout the agency, including improved communication and coordination between the Clinical and Billing Departments.

Executive leadership has established the Integrated Clinical-Billing Meeting, a meeting with leaders from the Clinical and Billing Departments to set performance improvement priorities, monitor their implementation and to uphold accountability standards throughout the agency. Although many Treatment Units must meet a variety of different regulatory standards, the Center has worked to create multi-level tracking and verification systems that assure the validation and integration of clinical treatment, documentation and billing Center Wide. These efforts have resulted in a series of projects, trainings and coordinated initiatives, which are all designed to check, double check and triple check that all services are provided, documented and billed appropriately.

An ongoing performance improvement project has been to assess and confirm that all clinical treatment provided meets the standards of medical necessity. Training has been provided for Unit Directors, Supervisors, Psychiatrists and Clinicians on the clinical, documentation and billing standards involved in providing medically necessary treatment. Chart audits have been conducted to monitor progress in this area and any impediments to progress are addressed in the Integrated Clinical-Billing Meeting.

Executive leadership developed a policy to uphold accountability for the timely completion of TPRs, which is essential to the treatment process. Each Unit has redesigned their tracking system to ensure and verify timely completion of TPRs. The Center has also introduced a multi-level approach to double and triple check the timely completion of TPRs. The Supervisors check every chart regularly and complete a

verification form documenting that every TPR is completed. The Unit Directors conduct regular audits of each Supervisors' charts. The Medical Director, Director of Clinical and Preventive Services and the Clinical Program Analyst conduct random audits to confirm that the verification system on all Units is working effectively.

Fordham- Tremont Community Mental Health Center is committed to standards of excellence and will continue to assess and improve the Center's clinical services and the documentation and billing procedures that support these services.

Please contact me at 718-960-0348 if you have any further questions.

Sincerely,

Mildred Allen, Ph.D.
CEO/President

Return Receipt Requested