DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

OCT 4 2000

Memorandum

Date

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Outpatient Psychiatric Services Provided by Saint Vincent's Hospital for Calendar Year Ended December 31, 1997 (A-02-99-01010)

To

Michael Hash
Acting Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on Friday, October 6, 2000, of our final report entitled, "Review of Outpatient Psychiatric Services Provided by Saint Vincent's Hospital for Calendar Year Ended December 31, 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 Saint Vincent's Hospital (Hospital), located in New York, NY, did not establish or follow existing procedures for the proper billing of outpatient psychiatric services.

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 outpatient psychiatric services which lacked sufficient patient treatment plans, sufficient medical record documentation, and/or were not reasonable and necessary. Based on a statistical sample, we estimate that at least $2,261,155 in outpatient psychiatric charges were submitted by the Hospital, yet did not meet Medicare criteria for reimbursement. We recommended that the Hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are reasonable and necessary and properly documented in accordance with Medicare regulations and guidelines. We will also provide the results of our review to the fiscal intermediary so that it can apply the appropriate adjustment of $2,261,155 to the Hospital's Calendar Year 1997 Medicare cost report.

The Hospital, in its response to our report, believed that certain services questioned by the Office of Inspector General were sufficiently documented and were medically reasonable and necessary. Based on additional documentation provided by the Hospital and reviewed by the fiscal intermediary and Island Peer Review Organization, we allowed $730 of our previously denied determinations. 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 Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, (212) 264-4620.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY SAINT VINCENT'S HOSPITAL FOR CALENDAR YEAR ENDED DECEMBER 31, 1997

JUNE GIBBS BROWN
Inspector General

OCTOBER 2000
A-02-99-01010

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region II
26 Federal Plaza
Room 3900-A
New York, NY 10278

CIN A-02-99-01010

Mr. Gary Zuar
Chief Financial Officer
Saint Vincent's Hospital
130 West 12th Street, Room 6J
New York, New York 10011

Dear Mr. Zuar:

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 Outpatient Psychiatric Services Provided by Saint Vincent's Hospital for Calendar Year Ended December 31, 1997." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determinations 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-02-99-01010 in all correspondence relating to this report.

Sincerely,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

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, predicated on submitted charges. At year end, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final settlement.

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. We also tested the reasonableness of selected expenses reported on the related cost report.

Summary of Findings

In Calendar Year (CY) 1997, Saint Vincent's Hospital (Hospital) submitted for reimbursement about $3.1 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 statistically selected claims totaling $78,040. These charges were made on behalf of patients who received services in the Hospital's outpatient psychiatric department. Our analysis showed that $63,765 of these charges did not meet Medicare criteria for reimbursement. Charges found unallowable were for services which lacked sufficient treatment plans, sufficient medical record documentation, and/or were not reasonable and necessary.

We extrapolated these results to the population of claims submitted by the Hospital during CY 1997 and estimated that the Hospital overstated its billings to Medicare by $2,261,155. We found that the Hospital staff did not establish and/or follow existing Medicare requirements 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 also judgmentally selected cost centers relating to outpatient psychiatric services, totaling $102,843, from the Hospital's CY 1997 Medicare cost report and found the costs to be appropriate.

Recommendations

We recommended that the Hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are reasonable and necessary and are properly documented in accordance with Medicare requirements. In addition, we will provide the results of our review to Empire Medicare Services (Empire), the Medicare FI, so that it can apply the appropriate adjustment of approximately $2.3 million during the settlement of the Hospital's CY 1997 Medicare cost report.

In response to our draft report (see APPENDIX B), Hospital officials believed that certain services questioned by the OIG were sufficiently documented and were medically reasonable and necessary. Based on additional documentation provided by the Hospital and reviewed by the FI and Island Peer Review Organization (IPRO), we allowed $730 of our previously denied determinations.

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.

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INTRODUCTION

BACKGROUND

The Medicare program established by Title XVIII of the Social Security Act (Act) provides health insurance coverage to people 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 excludes coverage for services, including outpatient psychiatric services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury. Outpatient psychiatric services are generally provided by hospital employees such as staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis predicated on submitted charges. At year end, the hospital submits a cost report to the Medicare FI for final settlement. 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 the patient's condition...Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed." [Medicare Intermediary Manual section 3112.7]

- "Documentation must show reevaluation of the course of treatment (at least every six months) identifying the patient's response to treatment and specifically noting changes in clinical status and/or treatment plan." [Empire's Medicare Part A Medical Review Policy for Outpatient Psychiatric Services - dated October 1993]

In addition, for patients receiving partial hospitalization program (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 stipulate:

- 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)]

Saint Vincent's Hospital is a not-for-profit organization which provides, among other services, non-PHP outpatient psychiatric services at its facility in New York, NY, and both PHP and non-PHP outpatient psychiatric services at its facility in Harrison, NY. For CY 1997, the Hospital submitted for Medicare reimbursement 4,915 outpatient psychiatric claims valued at $3,109,821.

Objective, Scope, and Methodology

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 regulations and guidelines. We also tested the reasonableness of selected expenses reported on the related cost report. Our review included services provided during CY 1997.

To accomplish our objective, we:

- reviewed criteria related to outpatient psychiatric services.

- interviewed appropriate Hospital staff concerning internal controls over Medicare claims submission.

- used the Hospital's CY 1997 Provider Statistical and Reimbursement Report, which was provided by the FI, to identify 4,915 outpatient psychiatric claims valued at $3,109,821.

- employed a simple random sample approach to select a statistical sample of 100 outpatient psychiatric claims.

- performed detailed audit testing on the billing and medical records for the claims selected in the sample.

- utilized medical review staff from the FI and a psychiatrist and registered nurses from IPRO, the New York peer review organization (PRO), to review the selected claims.

- used a variables appraisal program to estimate the dollar impact of improper charges in the total population.

- reviewed Medicare Part B claims processed by Empire, the Medicare Part B carrier, which corresponded to our sampled claims.

In addition, the Hospital claimed $3,875,106 in outpatient psychiatric costs after reclassifications and adjustments on its CY 1997 Medicare cost report. We tested the appropriateness of a judgmental sample of $102,843 of these costs through review of supporting documentation.

We limited consideration of the internal control structure to those controls relating to the submission of claims to Medicare 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 field work was performed at the Hospital facilities located in New York, NY, and Harrison, NY.

FINDINGS AND RECOMMENDATIONS

In CY 1997, the Hospital submitted for Medicare reimbursement approximately $3.1 million in charges for outpatient psychiatric services. We reviewed the medical and billing records for 100 statistically selected claims comprising 782 services totaling $78,040 in charges. Our analysis showed that $63,765 of the sampled charges did not meet the Medicare criteria for reimbursement. Based on an extrapolation of the statistical sample, we estimate that the Hospital overstated its CY 1997 Medicare outpatient psychiatric charges by approximately $2.3 million. Charges found unallowable were for services which lacked sufficient treatment plans, sufficient medical record documentation, and/or were not reasonable and necessary.

The Hospital claimed about $3.9 million in costs for providing these outpatient psychiatric services, after reclassifications and adjustments, on its CY 1997 Medicare cost report. Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We reviewed a judgmental sample of $102,843 in selected outpatient psychiatric costs on the Hospital's CY 1997 Medicare cost report, and found these costs to be appropriate.

Findings from our review of the outpatient psychiatric charges and costs are described in detail below.

OUTPATIENT PSYCHIATRIC SERVICES

Other Outpatient Psychiatric Services (Non-PHP)

The Hospital provides outpatient psychiatric services (non-PHP) including psychiatric evaluation and diagnosis, pharmacotherapy, individual psychotherapy, group therapy, couple therapy, family therapy, and psychiatric rehabilitation readiness determination. In addition to group therapy on general mental health issues, the program also offers long-term specialized groups, such as Dual Diagnosis and Pain Management. Ninety-nine of the 100 outpatient psychiatric claims in our sample were for non-PHP services. We found that $60,765 for 642 of these services on 59 claims did not meet Medicare criteria for reimbursement as detailed below. Further, services on 6 of the 59 claims were denied for more than one reason.

Insufficient Patient Treatment Plans

The Medicare 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."

In addition, according to Empire's Medicare Part A Medical Review Policy for Outpatient Psychiatric Services, dated October 1993, "Documentation must show reevaluation of the course of treatment (at least every six months) identifying the patient's response to treatment and specifically noting changes in clinical status and/or treatment plan."

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 100 outpatient psychiatric claims in our sample, we identified 41 claims with $42,450 in charges for 470 services provided to patients who had treatment plans that did not comply with Medicare guidelines or were otherwise missing. With the assistance of medical review personnel from the FI and IPRO, we identified:

- $39,210 in charges for 437 services provided to patients whose treatment plan did not indicate the service modality, frequency, or duration.

- $1,860 in charges for 12 services provided to patients where the treatment was not ordered by the physician.

- $900 in charges for 18 services provided to a patient whose existing treatment plan was signed by a physician subsequent to treatment.

- $480 in charges for three services provided to a patient whose treatment plan was outdated by 13 months.

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 services were indeed reasonable and necessary.

Services Not Properly 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 showed a weakness in the Hospital's system of internal controls regarding medical record documentation supporting services. Our review of the 100 outpatient psychiatric claims showed that 20 claims with $11,920 in charges representing 145 services were not properly supported in the medical records. With the assistance of medical review personnel from the FI and IPRO, we noted that progress notes were either missing or insufficient (e.g., no group names, modalities, or signatures) for those 20 claims. In addition, we noted that the Hospital could not locate medical records for two claims representing two services with charges totaling $190. Examples of services that were found to be insufficiently documented follow:

On one claim disallowed for 15 sessions of group therapy totaling $1,210, the medical reviewer noted:

> "...Progress notes unclear. Patient only marginally cooperative -- continues to drink. It is unclear whether this treatment is medically necessary and whether the setting is appropriate. Claim is also technically denied: Assessment dated 8/15/97 does not include treatment plan frequency/duration groups/individual not listed."

On one claim with two services, the medical reviewers disallowed one individual session totaling $95, and noted:

> "...Records show 10/7/97 - 1 visit is an MD visit, 10/7/97 2nd visit is for an IM injection. MD note refers to IM injection so would take this as an order. However, injection for same date of service of MD visit not payable as it is incident to the physician's visit."

As a result, we concluded that $11,920 in 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, 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, as described above, precluded us from determining whether those services were needed.

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 the patient's condition...."

The Hospital did not have adequate procedures in place for ensuring that services billed to the Medicare program were reasonable and necessary for the treatment of a patient's condition. With the assistance of medical reviewers from the FI and IPRO, we found $6,395 in charges for 27 services determined not to be reasonable and necessary. These charges were from 4 claims for 27 therapy services for which the medical record documentation did not demonstrate that the level of treatment was reasonable and necessary. An example of services that were found to be not medically reasonable and necessary follows:

On one claim disallowed for one individual and six group therapy sessions totaling $1,660, the medical reviewer noted:

> "...Patient has a history of missing therapy frequently due to part time job. Patient states he attends AA on the outside. As per the IPRO physician reviewer, the progress notes do not allow assessment of the patient's condition or progress. Patient did not attend a majority of the scheduled sessions. This would indicate a change of treatment plan is required. Therefore, both services and settings are not appropriate."

Partial Hospitalization Program Services

Patients in the Hospital's PHP can attend the program for 7 hours per day, and receive a full range of treatment services. The Hospital offers group therapy on a wide range of topics including general mental health issues as well as long-term specialized groups. From our sample of 100 outpatient psychiatric claims, one claim, representing 10 services and $3,000 in charges was for services provided to a PHP patient. We found that these services did not meet Medicare criteria for reimbursement because the treatment plan did not indicate frequency, modality, or the necessary physician's certification.

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

With the assistance of medical reviewers from the FI and IPRO, we determined that the treatment plan for the PHP claim did not contain the necessary physician's certification required to justify PHP services. In addition, the treatment plan did not clearly indicate the frequency or modality as required by the Medicare Intermediary Manual section 3112.7(B).

OUTPATIENT PSYCHIATRIC COSTS

The Hospital claimed about $3.9 million in costs for providing these outpatient psychiatric services, after reclassifications and adjustments, on its CY 1997 Medicare cost report. Medicare requires that costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We reviewed a judgmental sample of $102,843 in selected outpatient psychiatric costs on the Hospital's CY 1997 Medicare cost report and found these costs to be appropriate.

Conclusion

For CY 1997, the Hospital submitted for reimbursement $3,109,821 in charges for outpatient psychiatric services. Our audit of 100 statistically selected claims totaling $78,040 in charges showed that $63,765 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 $2,261,155 in error for CY 1997. 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 about $3.9 million in costs for providing these outpatient psychiatric services, after reclassifications and adjustments, on its CY 1997 Medicare cost report. We reviewed a judgmental sample of $102,843 in selected outpatient psychiatric costs on the Hospital's CY 1997 Medicare cost report, and found these costs to be appropriate.

Recommendations

We recommended that the Hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are for covered services and are properly documented in accordance with Medicare requirements. In addition, we will provide the results of our review to the FI, so that it can apply the appropriate adjustment of $2,261,155 to the Hospital's CY 1997 Medicare cost report.

AUDITEE RESPONSE AND OIG COMMENTS

The Hospital, in its response (see APPENDIX B), believed that certain services questioned by the OIG were sufficiently documented and were medically reasonable and necessary. Of the $64,495 in charges questioned by the OIG, the Hospital officials believed that $50,325 did in fact meet the Medicare criteria for reimbursement.

Specifically, the Hospital officials felt that certain of the disallowed claims had sufficient patient treatment plans, were adequately supported by medical records, and were reasonable and necessary.

Based on additional documentation provided by the Hospital and then reviewed by the medical reviewers, the following changes were made to the draft report:

- three previously denied claims totaling $380 were allowed
- the disallowed amount on two claims was reduced by $350
- 11 claims were re-categorized from one type of error to another.

As a result of these changes, we believe the determinations for the remaining 60 claims totaling $63,765 are correct and no further adjustments to our draft report are necessary. Further, services on 6 of the 60 claims were denied for more than one reason.

We have summarized the auditee's relevant responses and provide our additional comments below.

Auditee Response Regarding Insufficient Patient Treatment Plans

The Hospital officials believed that of the $48,370 in charges with improper treatment plans, $41,250 had in fact proper treatment plans. The Hospital presented the following issues in its response:

- Empire's Medicare Part A Medical Review Policy for Outpatient Psychiatric Services, dated October 1993, which stipulates that treatment plans be reevaluated every 6 months, should not be applied as criteria because it was not published as a rule or adopted by HCFA and incorporated in a HCFA manual as a formal interpretation of Medicare rules.
- Federal regulation 42 CFR 424.11 does not require specific procedures or forms, and if information is contained elsewhere in the provider medical records, it need not be repeated.

- Federal regulation 42 CFR 424.24 provides treatment plan requirements for partial hospitalization services and does not apply to other outpatient mental health services.

- The Administrative Procedure Act, 5 U.S.C. 706(2)(A), requires that any agency action that is arbitrary, capricious, or otherwise not in accordance with law must be set aside. Further, the Hospital officials believed that since the detailed elements of a treatment plan were not established in either applicable legislation or regulations, the guidelines cited by the OIG cannot be relied upon to disallow claims.

- The Hospital officials believed that New York State regulations 14 NYCRR 587 and 14 NYCRR 588 should be utilized in the absence of specific Federal law or regulation because the outpatient psychiatric programs are licensed by New York State. The Hospital officials further believed that these regulations are individualized for different treatment programs and provide specific criteria for treatment plans and the timing of when a treatment plan should be prepared and reviewed.

OIG Comments on Insufficient Patient Treatment Plans

We disagree with the Hospital's contention that our determinations should be changed. The OIG response to the specific issues presented by the Hospital follows:

- The HCFA Coverage Issues Manual (CIM) provides the Medicare contractors with the authority to make coverage decisions in consultation with its medical staff based on the law, regulations, rulings, and HCFA general program instructions. As such, Empire issued to all hospitals in New York on October 6, 1993, the Empire Medicare Part A Medical Review Policy for Outpatient Psychiatric Services. Also during December 1993, the FI met with various hospital liaison committee members to discuss the implementation of this policy. A representative of the Hospital was in attendance at that meeting. Therefore, we believe that this policy can and should be applied as criteria in this review.

- We agree that 42 CFR 424.11 requires the use of the entire medical record to determine if medical certification and recertification was obtained, and that the specific documentation need not be contained in any single document. Accordingly, the medical reviewers in our review did comply with this regulation and used the entire medical record in reaching their conclusions.

- We concur that 42 CFR 424.24 requires treatment plans for partial hospitalization services. However, as we cited in our report, the Medicare Intermediary Manual section 3112.7 requires services to be "provided under an individual written plan of treatment." Based upon the requirements of this section, all claims required treatment plans.

- We strongly believe the actions by the medical reviewers were not arbitrary or capricious, as described under the Administrative Procedure Act. The staff appropriately followed applicable laws, regulations, and guidelines in their review of the claims.

- The New York State regulations 14 NYCRR 587 and 588, cited by Hospital officials, establish reimbursement standards under the Medical Assistance Program (Medicaid). These State regulations do not relate to the Medicare program, and as such, have no relevance to our review.

Based on additional documentation provided by the Hospital and reviewed by the medical reviewers, we adjusted our determinations for 13 claims. Specifically, we reversed the disallowance entirely for one claim totaling $95, reduced a portion of the disallowance on two claims totaling $350, and re-categorized the type of error on eight claims totaling $4,730 from Insufficient Patient Treatment Plans to Services Not Properly Supported by Medical Records. In addition, we re-categorized two claims totaling $2,255 to Insufficient Patient Treatment Plans from Services Not Properly Supported by Medical Records. We maintain no further adjustments to our report are necessary for the remaining 42 claims totaling $45,450 (including 1 PHP claim for $3,000).

Auditee Response Regarding Services Not Properly Supported by Medical Records

The hospital officials believed that of the $8,425 in charges not supported by the medical records, $7,625 were in fact sufficiently supported by the medical records.

OIG Comments on Services Not Properly Supported by Medical Records

Although Hospital officials believed that certain of its services were adequately supported by medical records, we disagree. According to medical reviewers, the medical records provided by the Hospital did not properly support the Medicare claims.

However, based on the additional documentation provided by the Hospital and reviewed by the medical reviewers, we adjusted our determination for 12 claims. Specifically, we reversed the disallowance for one claim totaling $190 and re-categorized the type of error on two claims totaling $2,255 from Services Not Properly Supported by Medical Records to Insufficient Patient Treatment Plans. In addition, we re-categorized nine claims totaling $5,940 to Services Not Properly Supported by Medical Records from Insufficient Patient Treatment Plans and Services Not Reasonable and Necessary. We maintain no further adjustments to our report are necessary for the remaining 20 claims totaling $11,920.

Auditee Response Regarding Services Found Not Reasonable and Necessary

The Hospital officials believed that of the $7,700 in charges initially disallowed by the OIG as not reasonable and necessary, $1,450 were in fact appropriate. Specifically, the Hospital officials

believed these patients needed continuing treatment to stop further decompensation or to continue functioning in the community.

OIG Comments on Services Found Not Reasonable and Necessary

Although Hospital officials believe that certain of its services were reasonable and necessary, we disagree. According to the medical reviewers, the medical records provided by the Hospital did not support the need for services.

However, based on additional documentation provided by the Hospital and reviewed by the medical reviewers, we adjusted our determination for two claims. Specifically, we reversed the disallowance for one claim totaling $95 and re-categorized the type of error on one claim totaling $1,210 from Services Found Not Reasonable and Necessary to Services Not Properly Supported by Medical Records. The medical reviewers maintain that the services under the remaining claims were not reasonable or necessary. As a result, we maintain no further adjustments to our report are necessary for the remaining four claims totaling $6,395.

Auditee Response Regarding Diagnosis Code Errors

Hospital officials stated that the OIG disallowed claims because the diagnoses on the claims did not match the documentation in the medical records.

OIG Comments on Diagnosis Code Errors

We disagree. We did not take a disallowance when there was a difference between the diagnosis codes on the claim form and the diagnosis codes in the medical records.

Auditee Response Regarding Valid Statistical Methodology

Hospital officials questioned the validity of the statistical sampling methodology used by the OIG, and in particular the validity of the upper limit of $4,041,258 cited in our draft report. In addition, they requested a full statement of methodology so that it could be reviewed by their own expert.

OIG Comments on Valid Statistical Methodology

Our statistical sampling approach is statistically sound and has been used by the OIG, OAS for many years on audits, including audits involving hospital cost report recoveries. As explained in the report, based on an extrapolation of the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that the Hospital billed at least $2,261,155 in error for CY 1997. We attained our estimate by using simple random sampling techniques and applying a 90 percent confidence level. The precision of the point estimate at the 90 percent confidence level is plus or minus 27.85 percent, with a resulting lower limit of $2,261,155 and an upper limit of $4,006,945.

Further, we discussed this statistical sampling methodology with Hospital officials, and provided them access to our statistical sampling software and statistical sampling software users manual. We also provided them with a copy of the data file used to extrapolate our statistical projection.

APPENDIX A

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY SAINT VINCENT'S HOSPITAL FOR CALENDAR YEAR ENDED DECEMBER 31, 1997

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 4,915 Claims	Items: 100 Claims	Items: 60 Claims
Charges: $3,109,821	Charges: $78,040	Charges: $63,765

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: $3,134,050
Lower Limit: $2,261,155
Upper Limit: $4,006,945

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November 19, 1999

By Federal Express

Mr. Timothy J. Horgan
Regional Inspector General for Audit Services
Department of Health and Human Services
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900A
New York, NY 10278

Re: Common Identification Number A-02-99-01010:
Review of Medicare Outpatient Psychiatric Services, FYE 12/31/97
Saints Vincents Hospital and Medical Center of New York

Dear Mr. Horgan:

On behalf of Saint Vincents Hospital and Medical Center of New York ("Saint Vincents"), we are providing your office with an original and two courtesy copies of this letter and the enclosed Appendix in response to the draft audit report of Medicare outpatient psychiatric services for the year ending December 31, 1997, as supplemented by your letter dated October 13, 1999 (collectively, the "Draft Audit Report"). Saint Vincents respectfully requests the Office of Inspector General ("OIG") to reconsider the draft findings based on the information and supplemental materials provided herein.

Preliminary Statement

Saint Vincents is a not-for-profit acute care hospital with licensed facilities in Manhattan and Westchester. At both sites, Saint Vincents provides a wide range of psychiatric outpatient services, including adult clinic services and continuing day treatment programs. Each of these programs is licensed under New York State law.

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Federal and State Requirements for Treatment Plans

The majority of the disallowed claims in the Draft Audit Report are based allegedly on incomplete treatment plans under Medicare guidelines set forth in HCFA Fiscal Intermediary Manual §3112.7. Under this section, a written individualized treatment plan must be established for each patient stating the type, amount, frequency and duration of the services to be furnished, and the mental illness diagnoses and anticipated goals of treatment. The Draft Audit Report also cites Empire's Medicare Part A Medical Review Policy for Outpatient Psychiatric Services, dated October 1993, as the basis for the treatment plan to be reevaluated at least every six (6) months (the "1993 Empire Policy"). Initially, we object to the use of the 1993 Empire Policy as a basis for denying claims since it has not been published as a rule or adopted by HCFA and incorporated in an HCFA Manual as a formal interpretation of Medicare rules. The use by the OIG of local intermediary policies raises questions of due process and disparate application of federal policies and procedures.

As discussed more fully below, Saint Vincents objects to the claim that the treatment plans are incomplete or to the application of the 1993 Empire Policy in support of such a conclusion in the Draft Audit Report.

In this respect, the statutes and regulations cited by the OIG, (and based on our research) do **not** require specific contents in a treatment plan for mental health services, **except** in connection with partial hospitalization services. Under 42 CFR §424.11, a provider must obtain medical certification and recertification for services. This regulation states: "No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification." 42 CFR §424.11(b). The regulation further provides:

> (c) Required information. The succeeding sections of this subpart set forth specific information required for different types of services. If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found. (emphasis added)

The applicable succeeding section of the subpart, 42 CFR §424.24, only provides particular treatment plan requirements for outpatient physical therapy, speech-language pathology services and partial hospitalization services. Subparagraph (f), relating to all other covered medical and other health services, simply requires certification that the services were medically necessary and that "the certification be signed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant who has knowledge of the case." 42 CFR §424.24(f).

The Administrative Procedure Act, 5 U.S.C. §706(2)(A), requires that agency action that is arbitrary, capricious or otherwise not in accordance with law must be set aside. As the guidelines establishing detailed elements of a treatment plan for all outpatient psychiatric services other than partial hospitalization services are not found in either the applicable legislation or regulations, these guidelines are in excess of the implementing statute and regulations and their use are an ultra vires administrative action. Under these circumstances, such guidelines cannot be relied upon to disallow claims that are otherwise in full compliance with applicable Federal and State laws and duly promulgated regulations.

Each of the outpatient psychiatric programs operated by Saint Vincents is licensed by New York State. As such, in the absence of specific Federal law or regulation, the model for delivery of services, treatment planning and documentation is pursuant to State law and regulation. These State regulations, which are individualized for different treatment programs, such as clinic services and continuing day treatment programs, provide specific criteria for treatment plans and the timing of when a treatment plan should be prepared and reviewed. See 14 NYCRR §§587.16 and 588.7(d).

For example, State regulations provide that a written treatment plan for patients participating in a continuing day treatment program[1] must be contain 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.

14 NYCRR §587.16

New York State regulations further provide, in 14 NYCRR §588.7, that a treatment plan for patients participating in continuing day treatment programs must "be completed prior to the 12th visit after admission or within thirty days of admission whichever occurs first." Review of the treatment plan must occur every three (3) months. 14 NYCRR §588.7(d).

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[1] Continuing Day Treatment Programs are for chronically ill patients who need multiple treatment services daily, several times per week.

Saint Vincents has adopted policies requiring written treatment plans for all clinical services. (Saint Vincents policies for the Manhattan and Westchester campuses are annexed hereto as Exhibits A and B respectively.) While these policies also comply with federal law, the specific requirements applicable to each of the licensed programs, follow State regulations[2]. It is respectfully submitted that in the absence of specific federal regulations mandating specific contents for a treatment plan, Saint Vincents policies and practices in following State law is appropriate and cannot be sanctioned. Nevertheless, and as more fully discussed herein, many of the treatment plans under review by the OIG include all of the elements required in the Medicare Manuals.

We are providing as part of our response to the Draft Audit Report the attached Appendix. In many cases, the material is taken from the patient's medical record which should have been available to the OIG auditors. In other cases, we have provided relevant policies, regulations and additional documentary support, particularly where a question of medical necessity has been raised. We offer the following:

Non-Partial Hospitalization Programs, Manhattan Campus
Treatment Plan Errors (Exhibits 1-15)

Sample Patient # 4:

The OIG disallowed a $200 claim for four units of service rendered on 5/6/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 1, the Periodic Treatment Summaries dated 2/12/97 and 5/14/97 signed by the patient's attending physician, which show duration under "Time Course," and modality and frequency under "Psychosocial Therapies". The schedule referred to in the Treatment Summaries refers to the Continuing Day Treatment Program ("C.D.T.P.") Schedule for sample patient #4 dated 6/3/96, annexed as part of Exhibit 1. Under 42 CFR §424.11(c), the reference to the group schedule is acceptable for certification of the services provided. The Schedule, which was in effect during the time frame under review, shows the therapies planned (circled for the patient) and frequency. The May 1997 monthly attendance record and Treatment Planning Flow Sheet, annexed as part of Exhibit 1, further show modality and frequency.

[2] Because of specific federal regulations for alcohol and drug abuse programs, Saint Vincents' policies for its alcoholism and addictions outpatient program follow federal law.

Sample Patient #24:

The OIG disallowed a $1250 claim for 25 units of service rendered 7/1/97 - 7/31/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 2, the Periodic Treatment Summaries dated 5/2/97 and 8/2/97, which show duration under "Time Course," and modality and frequency under "Psychosocial Therapies". Please also see the Treatment Planning Flow Sheet, annexed as part of Exhibit 2, which shows modality and frequency.

In the original worksheet provided by Mr. James Cox at the exit conference, this claim was disallowed, in part, for the reason that the documentation does not support all services rendered. Please see History and Progress Notes for period 7/7/97-8/15/97, annexed as part of Exhibit 2, which show the patient's participation and responses to treatment services, and assessment of her condition. Contrary to the comments on the original worksheet that the coordinating therapists notes were written without the patient being seen, the notes reflect detail and assessments of the patient not found in other notes, thereby demonstrating that each note was written after the patient was personally seen.

Sample Patient #28:

The OIG disallowed a $2100 claim for 42 units of service rendered 2/4/97 - 2/28/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 3, the Periodic Treatment Summaries dated 2/4/97 and 5/28/97, which show duration under "Time Course", and modality and frequency under "Psychosocial Therapies." Please also see the C.D.T.P. Schedule for sample patient #28 dated April 12, 1996, and still in effect during the time frame under review, showing the therapies ordered (circled for the patient) and frequency of each, annexed as part of Exhibit 3.

While the time course stated in each of the treatment plans does not state a specific time frame, under New York State regulations and the policies of Saint Vincents, the stated need for "ongoing treatment" implies that treatment in accordance with the plan established should continue until the next assessment. State regulations and Saint Vincents policies applicable to patients participating in Continuing Day Treatment Programs, such as sample patient #28, require that the treatment plan be reviewed and updated every 3 months. Accordingly, unless otherwise specified, it is presumed that the time course for the treatment plan is at least 3 months.

In the original worksheet, this claim was also denied for lack of documentation for 15 units. Please see Attendance Sheets for group sessions attended by the patient in February 1997, annexed as part of Exhibit 3.

Sample Patient # 31:

The OIG disallowed an $800 claim for 16 units of service rendered 4/1/97 - 4/29/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 4, the Periodic Treatment Summaries dated 3/20/97 and 6/18/97, which show duration under "Time Course" and all modalities and frequency under "Psychosocial Therapies."

In the original worksheet, this claim also was denied because the treatment plan was not clearly dated by the physician and the nursing signature on 6/18/97 was after the dates of service. The 3/20/97 treatment plan, which shows the signatures of both the physician and nurse on 3/20/97, certified the need for services rendered during the claim period in April 1997. A comparison of the 3/20/97 and 6/18/97 Treatment Summaries (and the Treatment Summaries in Exhibits 5, 6 and 7) also reflect the mark of the physician's signature.

Sample Patient #36:

The OIG disallowed a $250 claim for 5 units of service rendered 7/7/97 - 7/30/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 5, Periodic Treatment Summaries dated 3/10/97 and 8/13/97, which show duration under "Time Course", and modality and frequency under "Psychosocial Therapies." The C.D.T.P. Schedule for sample patient #36 dated 10/22/96, which shows modality (circled for the patient) and frequency, is annexed as part of Exhibit 5.

Sample Patient #43:

The OIG disallowed a $2400 claim for 48 units of service rendered 3/3/97 - 3/31/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 6, the Treatment Summaries dated 1/10/97 and 4/2/97, which show duration under "Time Course" and modality and frequency under "Psychosocial Therapies." Please also see the Treatment Planning Flow Sheet, annexed as part of Exhibit 6, which shows all modalities ordered and frequency.

Sample Patient #52:

The OIG disallowed a $900 claim for 18 units of service rendered ½/97 - 1/31/97 for the reason that there was no valid treatment plan for the dates of service. Please see Exhibit 7, the Periodic Treatment Summaries dated 12/30/96 and 3/21/97 covering the period during which services were rendered. The Treatment Summaries show duration under "Time Course" and modality and frequency under "Psychosocial Therapies."

Sample Patient #59:

The OIG disallowed a $190 claim for 2 units of service rendered 2/3/97 - 2/19/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 8, the Periodic Treatment Summaries dated 12/31/96 and 6/10/97, which show duration under "Time Course" and the modality and frequency of treatment under "Psychosocial Therapies."

Sample Patient #61:

The OIG disallowed a $95 claim for 1 unit of service rendered on 2/7/97 for the reason that there was no valid treatment plan for the date of service. Please see Exhibit 9, the Periodic Treatment Summaries dated 1/14/97 and 3/21/97.

While the time course on both treatment plans show that treatment is "ongoing," under State regulations and Saint Vincents policies, "ongoing" implies that the treatment should continue until the next review of the treatment plan. New York State regulations and Saint Vincents policies require that for patients participating in adult psychiatry programs (clinic), the treatment plan must be reviewed and updated every 90 days. Accordingly, unless otherwise specified, it is presumed that the time course is at least 90 days.

Sample Patient #64:

The OIG disallowed a $650 claim for 13 units of service rendered 5/1/97 - 5/29/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 10, the Periodic Treatment Summaries dated 1/15/97 and 5/19/97, which show duration under "Time Course" and modality and frequency under "Psychosocial Therapies." Please also see the C.D.T.P. Schedules dated 8/96 and 7/97, annexed as part of Exhibit 10, which show the therapies ordered (circled for the patient) and frequency. The Treatment Planning Flow Sheet showing modality and frequency during the time frame under review is also annexed as part of Exhibit 10.

While the Time Course stated in each of the treatment plans does not state a specific time frame, the reference to the need for "long term" care implies that the time course should continue until the next review of the treatment plan. As a patient participating in a Continuing Day Treatment Program, the treatment plan for sample patient #64 must be reviewed and updated every three months. Accordingly, unless otherwise specified, it is presumed that the "long term" time course is at least three months.

Sample Patient #68:

The OIG disallowed a $95 claim for 1 unit of service rendered 6/23/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 11, the Periodic Treatment Summaries dated 6/18/97 and 9/8/97, which show duration under "Time Course" and the frequency and modality under "Psychosocial Therapies."

Sample Patient #70:

The OIG disallowed a $285 claim for 3 units of service rendered on 1/3/97 - 1/27/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 12, the Periodic Treatment Summaries dated 11/14/96 and 2/18/97, which show modality and frequency under "Psychosocial Therapies."

While the expected duration stated in each of the treatment plans is "indeterminate", under New York State regulations and the policies of Saint Vincents applicable to adult clinic patients such as sample patient #70, the treatment plan must be reviewed and updated every 90 days. Accordingly, in the absence of a stated time period, it is presumed that the "Time Course," or duration, for the treatment plan is at least 90 days.

Sample Patient #76:

The OIG disallowed a $95 claim for 1 unit of service rendered on 1/9/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 13, the Treatment Reviews dated 12/29/96 and 3/29/97, which show the patient's diagnoses, the goals and objectives of treatment, response to treatment and anticipated discharge date. Please also see the Treatment Planning Flow Sheet for modality and frequency.

Sample Patient #77

The OIG disallowed a $1235 claim for 13 units of service rendered 10/2/97 - 10/27/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 14, the original Comprehensive Treatment Plan dated 7/8/97, the Treatment Plan dated 8/14/97, the Treatment Reviews dated 9/8/97 and 12/8/97 and Treatment Planning Flow Sheet. The Comprehensive Treatment Plan shows duration under "Discharge Planning," and modality and frequency under "Plan/Interventions." The 8/14/97 Treatment Plan shows modality under "Interventions". The Treatment Reviews show modality and frequency under "Response to treatment" and "Changes in treatment" and duration under "Date of Next Review" and "Discharge plan: Anticipated date." The Treatment Planning Flow Sheet shows the modality and frequency of each of the services ordered during the time frame under review.

Sample Patient #99:

The OIG disallowed a $50 claim for 1 unit of service rendered on 3/27/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 15, the Periodic Treatment Summaries dated 1/30/97 and 5/9/97, which show duration under "Time Course" and modality and frequency under "Psychosocial Therapies." The original Treatment plan dated 1/26/96 also shows modality and frequency under "Interventions."

As previously discussed, the reference to an "indeterminate" time course implies that treatment in accordance with the plan established should continue until the next assessment. As a patient in an adult clinic program, the treatment plan for sample patient #99 must be reviewed and updated every 90 days under State regulations and the policies of Saint Vincents. Accordingly, unless otherwise specified, it is presumed that the time course for the treatment plan is at least 90 days.

Missing Progress Notes (Exhibits 16-17)

Sample Patient #38:

The OIG disallowed a $190 claim for 2 units of service rendered 10/8/97 - 10/22/97 for the reason that progress notes were missing for the dates of service. Please see Exhibit 16, the Progress Notes for 10/8/97 and 10/22/97, reflecting the services rendered to the patient on these dates.

Sample Patient #62:

The OIG disallowed a $50 claim for 1 unit of service rendered on 6/10/97 for the reason that the progress note was missing for the 6/10/97 date of service. Please see Exhibit 17, the Progress Note entered 6/17/97 reflecting the services rendered to the patient on 6/10/97.

In the original worksheet, this claim also was denied for the reason that the treatment plan was incomplete and signed by the physician more than one month after the date of service. Please see the Treatment Plan annexed as part of Exhibit 17 signed by the physician on February 13, 1997.

Medical Necessity (Exhibit 18)

Sample Patient #46:

The OIG disallowed a $95 claim for 1 unit of service rendered on 1/29/97. Please see Exhibit 18, the Periodic Treatment Summaries dated 1/13/97 and 4/28/97, which reflect the patient's diagnoses of major depression and dysthymia. Both treatment plans also reflect that the patient

continues to require this level of treatment for a duration of at least six months in order to continue functioning in the community.

Non Partial Hospitalization Programs
Westchester Campus

Treatment Plan Errors (Exhibits 19-32)

The Saint Vincents Continuing Day Treatment Program at the Westchester campus has adopted an elaborate list of abbreviations that refer to particular treatment modalities and frequencies. A list of some of the abbreviations are as follows:

1:1	Individual Session
1o:1	Individual Session with Primary Care Clinician
1'or 1o	Group Therapy with Primary Care Clinician
Sym Med Ed	Symptom Management Education
ED	Eating Disorder Group
DBT	Dylectical Behavioral Therapy
PPS	Personal Problem Solving
MICA Support or MICA	Group Therapy for individuals with Mental Illness and Chemical Abuse Treatment Issues

The frequencies of all group therapies listed in the treatment plan follow a weekly group schedule given to the patient. Occasionally, frequency is also noted by a suffix next to the abbreviation as "x#", referring to the number of times per week, the therapy is scheduled. For example, "1ox1" means group therapy with Primary Clinician (or Primary Group Therapy) once a week; "PPSx2" means Personal Problem Solving Therapy twice a week.

It is the policy and practice of Saint Vincents at the Westchester Campus that Continuing Day Treatment Program patients requiring individual therapy are assessed every day for the need for such treatment. As most of the patients participating in the Continuing Day Treatment Program require treatment services multiple hours per day, multiple times per week, such assessments may be performed daily as needed. Because of this daily review of patient needs, no frequency for individual therapy is specified on a treatment plan.

Sample Patient #8:

The OIG disallowed a $1350 claim for 18 units of service rendered 9/2/97 - 9/29/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 19, the Comprehensive Treatment Plan Review dated 7/15/97, which shows duration under "Time Frame" and modality and frequency under "Method & Clinician".

Sample Patient #18 and #27:

The OIG disallowed a $225 claim for 3 units of service rendered to sample patient #18 on 9/30/97. The OIG disallowed a $2550 claim for 34 units of service rendered to sample patient #27 on 10/2/97 - 10/31/97. Sample patient #18 and sample patient #27 are the same patient. Please see Exhibit 20, the Comprehensive Treatment Plan Reviews dated 7/25/97 and 10/23/97, which show duration under "Time Frame" and modality and frequency under "Method & Clinician."

In the original worksheet, the claim relating to sample patient #18 also was denied for the reason that the sessions were not documented in the record. Please see the Progress Notes for services rendered 9/18/97 - 11/26/97, annexed as part of Exhibit 20, which reflect the treatment sessions the patient attended during the month of October 1997 and an evaluation of his progress.

Sample Patient #19:

The OIG disallowed a $3500 claim for 20 units of service rendered 1/2/97 - 1/31/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 21, the Comprehensive Treatment Plan Review dated 12/20/96, which shows duration under "Time Frame" and modality and frequency under "Method & Clinician". Please also see the CRP/CDTP Group Schedule and CRP-MAP/CDTP Group Schedules, respectively dated 9/20/96 and 1/20/97, for the frequency of the group therapies ordered in the treatment plan.

In the original worksheet, this claim also was denied for the reasons that the attendance sheets do not match the treatment plan and the summary notes do not list all groups. Please see the attendance sheet for the period from 1/2/97 - 1/31/97, annexed as part of Exhibit 21, which reflects all treatment received by the patient during the month of January, 1997. Please also see the Progress Notes for the period from 12/13/96 through 2/19/97, annexed as part of Exhibit 21, which show the treatment services rendered.

Sample Patient #22:

The OIG disallowed a $1275 claim for 17 units of service rendered 10/1/97 - 10/31/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 22, the Comprehensive Treatment Plan Reviews dated 7/18/97 and 10/20/97, which reflect duration under "Time Frame" and modality and frequency under "Method & Clinician."

Sample Patient #50:

The OIG disallowed a $225 claim for 3 units of service rendered 5/2/97 - 5/30/97 for the reason that the treatment plan does not indicate frequency, duration or modality. The OIG also disallowed a $1950 claim for 26 units of service rendered during the same time frame, for the same reason, and a $1165 claim for 11 units of service during the same time frame, for the same reason. Please see Exhibit 23, the Comprehensive Treatment Plan/Annual Review dated 2/19/97 and the Comprehensive Treatment Plan Review dated 5/19/97, which reflect duration under "Time Frame" and modality and frequency under "Method & Clinician." Both treatment plans are signed by the patient's psychiatrist. Please also see Progress Notes for services rendered 3/3/97 - 6/24/97, which show modality and frequency.

Sample Patient #53:

The OIG disallowed a $3150 claim for 18 units of service rendered 3/3/97 - 3/31/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 24, the Comprehensive Treatment Plan/Annual Review dated 3/7/97, which reflects duration under "Time Frame" and modality and frequency under "Method & Clinician."

Sample Patient #65:

The OIG disallowed a $1425 claim for 19 units of service rendered 6/2/97 - 6/30/97 for the reason that the treatment plan does not indicate frequency, duration or modality. The OIG also disallowed an $800 claim for 5 units of service rendered during the same time period, for the same reason and another claim for $300 for 4 units of service, also rendered during the same time period. Please see Exhibit 25, the Comprehensive Treatment Plan Review dated 4/3/97, which reflects duration under "Time Frame" and modality and frequency under "Method & Clinician." All groups listed in the treatment plan meet in accordance with Continuing Day Treatment Program Group Schedule dated 4/21/97, annexed as part of Exhibit 25. Please also see Progress Notes for the period from 4/25/97 through 7/28/97 reflecting treatment services rendered to the patient, frequency of participation and assessment.

Sample Patient #66:

The OIG disallowed a $300 claim for 4 units of service rendered 8/1/97 - 8/28/97 for the reason that the treatment plan does not indicate frequency, duration or modality. The OIG also disallowed a $1200 claim for 16 units of service rendered during the same time period, for the same reason, and another claim for $320 for 2 units of service also rendered during the same time period. Please see Exhibit 26, the Comprehensive Treatment Plan Review dated 6/12/97, which reflects duration under "Time Frame" and modality and frequency under "Method & Clinician." Please see Continuing Treatment Day Program Group Schedule dated 6/16/97, annexed as part of Exhibit 26, for frequency of group therapies specified in treatment plan. As previously stated, individual therapy sessions are scheduled based upon a daily assessment of the patient's needs.

Sample Patient #69:

The OIG disallowed a $145 claim for 1 unit of service rendered 4/1/97 - 4/28/97 for the reason that the services were not ordered on treatment plan. Please see Exhibit 27, the Comprehensive Treatment Plan Review dated 3/9/97 and Comprehensive Plan dated 6/21/93, which show modality and frequency under "Method & Clinician." Please also see the 4/1/97 progress note of psychiatrist, annexed as part of Exhibit 27, which shows the order for group therapy once per month.

Sample Patient #72:

The OIG disallowed a $2625 claim for 15 units of service rendered 1/2/97 - 1/30/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 28, the Comprehensive Treatment Plan Review dated 11/22/96 which reflects duration under "Time Frame" and modality and frequency under "Method & Clinician."

Sample Patient #80:

The OIG disallowed a $580 claim for 4 units of service rendered 1/7/97 - 1/28/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 29, the Comprehensive Treatment Plan and Comprehensive Treatment Plan Review, respectively dated 8/20/96 and 11/7/97, reflecting duration under "Time Frame" and modality and frequency under "Method & Clinician."

Sample Patient #84:

The OIG disallowed a $2250 claim for 30 units of service rendered 10/9/97 - 10/31/97 for the reason that the treatment plan does not indicate frequency, duration or modality. The OIG also disallowed a claim for $555 for 4 units of service rendered during the same time period for the same reason. Please see Exhibit 30, the Comprehensive Treatment Plan Review dated 10/20/97, which shows duration under "Time Frame" and modality and frequency under "Method & Clinician." The Continuing Day Treatment Program Group Schedule dated 9/10/97, annexed as part of Exhibit 30, showed the frequency of therapies listed on the treatment plan. Please also see Progress Notes for the period from 10/9/97 through 11/6/97 reflecting all treatment services rendered to sample patient #84 annexed as part of Exhibit 30.

In the original worksheet, this claim was disallowed, in part, for the reason that there was no progress note for the 10/20/97 visit. Please see Progress Notes dated 10/22/97, which are preceded by a list of all therapies attended by the patient since the prior note, including the 10/20/97 visit. Such intervals between recorded notes is proper for Continuing Day Treatment Program patients, such as sample patient #87. Under New York State regulations and the policies of Saint Vincents, progress notes for C.D.T.P. patients must be documented at least every 2 weeks.

Sample Patient #87:

The OIG disallowed a $600 claim for 8 units of service rendered 6/2/97 - 6/18/97 for the reason that the treatment plan does not indicate frequency, duration or modality. The OIG also disallowed a $255 claim for 3 units of service rendered to the same patient during the same time period. Please see Exhibit 31, the Comprehensive Treatment Plan/Annual Review dated 5/15/97, which shows duration under "Time Frame" and modality and frequency under "Method & Clinician."

Sample Patient #88:

The OIG disallowed a $75 claim for 1 unit of service rendered on 5/1/97 for the reason that the treatment plan does not indicate frequency, duration or modality. The OIG also disallowed a claim for $750 for 10 units of service rendered 5/1/97 - 5/30/97 for the same reason. Please see Exhibit 32, the Comprehensive Treatment Plan Reviews dated 2/28/97 and 5/28/97, which show duration under "Time Frame" and modality and frequency under "Method & Clinician."

Medical Record Errors (Exhibits 33-35)

Sample Patient #15:

The OIG disallowed a $150 claim for 2 units of service rendered 5/1/97 - 5/28/97 for the reason that the progress notes were missing for the dates of service. The OIG also disallowed a $1575 claim for 21 units of services rendered during the same period, for the same reason, and a $480 claim for 3 units of service rendered during the same period for the same reason. Please see Exhibit 33, the Comprehensive Treatment Plan/Annual Review dated 12/10/96 and the Comprehensive Treatment Plan Reviews dated 3/28/97 and 6/24/97, which show the duration, modality and frequency of the treatment plan. Progress Notes for the period from 4/15/97 - 6/24/97, show the services rendered to the patient since the prior note, frequency of participation and evaluation of same.

The original worksheet showed a disallowance of the $150 claim for the reason that the 5/27/97 Progress Note does not provide any date of group attendance. The Note clearly lists in narrative form all groups attended by the patient since the prior note.

In the original worksheet, the $1575 claim was disallowed for the reason that "no separate group notes indicating the patient's response/participation; groups are listed within individual therapy progress notes." We are aware of no regulations or Medicare guideline that prohibits a physician from recording a patient's attendance and progress in group therapies in a note also addressing individual therapy. Moreover, under New York State regulation and the policies of Saint Vincents, progress notes for patients participating in Continuing Day Treatment Programs are summarized and documented at least every two weeks. The Progress Notes for sample patient #15 discuss her participation in groups and responses.

Finally, all Progress Notes are deemed signed due to electronic signatures on file ("ESOF") for each of the clinicians involved.

Sample Patient #57:

The OIG disallowed a $1120 claim for 7 units of service rendered 7/1/97 - 7/31/97 for the reason that the progress notes were insufficient. The OIG also disallowed a $3750 claim for 50 units of service rendered during the same time frame for the same reason. See Exhibit 34, Comprehensive Treatment Plan Review dated 5/30/97, which shows the duration, modality and frequency of the treatment plan. Please also see the Progress Notes for the period 5/5/97 - 9/19/97, which show the group therapy, individual sessions and other treatment services the patient participated in during this time, together with an evaluation of her responses and progress.

Sample Patient #69:

The OIG disallowed a $160 claim for 1 unit of service rendered 4/1/97 - 4/28/97 for the reason that the progress note is missing for the date of service. Please see Exhibit 35, the Progress Notes dated 4/1/97 and 4/11/97 which show the treatment the patient received in April 1997, and assessments of the patient's progress.

In the original worksheet, the OIG also disallowed this claim for the reason that there was no documentation of psychological testing. The OIG's comment, is perplexing as the Treatment Plans for sample patient #69, annexed as part of Exhibit 27, show that no psychological testing was ordered.

Medical Necessity (Exhibits 36-37)

Sample Patient #40:

The OIG disallowed a $145 claim for 1 unit of service rendered on 8/14/97 for the reason that the services were deemed not reasonable and necessary. Please see Exhibit 36, the Progress Notes for services dated 8/1/97 - 9/29/97 and the 11/1/99 letter of Andrew P. Levin, M.D., Clinical Director of Outpatient Mental Health Services for Saint Vincents, Westchester Facility, which show that the patient was decompensating during the time frame under review despite attempts to manage her illness with higher doses of medication.

Sample Patient #63:

The OIG disallowed a $1050 claim for 14 units of service rendered 8/15/97 - 8/29/97 for the reason that the services were deemed not medically necessary. The OIG also disallowed a $160 claim for 1 unit of service rendered during the same time frame, for the same reason. Please see Exhibit 37, the Progress Notes for services rendered 7/28/97 - 12/9/97, and the November 3, 1999 letter of Richard Gersh, M.D., Chief, Geriatric Service Line, Saint Vincents, Westchester Facility, which show the medical necessity for the services rendered during the time frame under review. Dr. Gersh's letter further demonstrates that without the treatment provided by the Continuing Day Treatment Program, it is likely that this patient would have decompensated resulting in exacerbation of his symptoms, a suicidal overdose and/or rehospitalization.

Non-Partial Hospitalization Programs
Manhattan and Westchester Campuses:

Diagnosis Errors on Claims

The OIG disallowed several of the foregoing claims, including sample patients #24, #38, #43, #45, #48, #59, #61, #96 and #99, for the additional reason that the diagnosis on the claim does not match the documentation. Where the diagnosis is properly documented in the medical record, a diagnosis error on the claim is not material and may be corrected by the submission of a corrected bill. Moreover, as all services are billed at either a flat rate for adult clinic services or a group rate for Continuing Day Treatment Program services, a correction of the claim will have no financial impact on the amount of the claim. Thus, even if such diagnosis error occurred, it is not an appropriate basis for disallowance of a claim.

Partial Hospitalization Program
Westchester Campus:

Treatment Plan Errors (Exhibit 38)

Sample Patient #60:

The OIG disallowed a $3000 claim for 10 units of service rendered 9/2/97 - 9/15/97 for the reason that the treatment plan does not indicate frequency, duration or modality. Please see Exhibit 38, the Treatment Plan dated 8/27/97, which shows a one week duration under "Date of First Review" and modality and frequency under "Objectives." The treatment plan calls for the patient to attend all groups. A copy of the partial hospitalization program schedule for the time frame in question is annexed as part of Exhibit 38, showing all groups referred to in the treatment plan. Attendance sheets dated 8/31/97, 9/6/97 and 9/20/97 reflect all treatment services and modalities in which the patient participated.

The Purportedly Valid Statistical Methodology

We continue to voice concerns regarding the validity of the statistical sampling methodology used by the OIG to estimate a disallowance of at least $2,298,601, as a lower limit, and $4,041,258, as an upper limit when the total charges billed did not exceed $3.1M. Your office has failed to adequately explain this discrepancy. One must conclude that the methodology is inherently suspect. We request a full statement of the methodology so that it can be reviewed by our own expert.

* * *

We appreciate the opportunity to provide our response to the Draft Audit Report. If you would like to discuss it in person, please call me at your convenience.

Sincerely,

Fred Miller

Fredrick I. Miller

c (w/enclosure):
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