Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF THE MEDICARE PARTIAL HOSPITALIZATION PROGRAM AT THE PROGRAM, INCORPORATED

JUNE GIBBS BROWN
Inspector General

November 2000
A-03-98-00048

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
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Our Reference: Common Identification Number A-03-98-00048

Mr. Richard Reeves
Director and Vice President of Medicare
Mutual of Omaha
P.O. Box 1602
Omaha, Nebraska 68101

Dear Mr. Reeves:

This final audit report provides you with the results of our "Audit of the Medicare Partial Hospitalization Program at The Program, Incorporated." The Medicare partial hospitalization program (PHP) covers partial hospitalization services that are reasonable and necessary for the diagnosis and treatment of a Medicare beneficiary's condition. The objective of our audit was to determine whether charges by The Program, Incorporated (The Program) for PHP services during the period January 1, 1996 through September 30, 1998[1] met Medicare requirements.

EXECUTIVE SUMMARY

The entire sampled amount of $1,683,560 charged for PHP services (for which The Program received interim payment of $1,009,493) did not meet Medicare requirements. We found, through medical review, that 100 percent of charges for the services included on 20 judgementally selected beneficiaries claims did not meet Medicare requirements for one or more reasons. The Program received interim payments of $2,688,297 on the submitted charges of $4,482,935 for all services claimed during the period of our audit. We did not project the results of our audit to the entire universe because our sample was judgementally selected.

We recommend that the fiscal intermediary, Mutual of Omaha (Mutual):

1. Ensure that any future charges submitted by The Program for Medicare reimbursements are appropriate and properly documented in accordance with Medicare requirements.

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[1] The Program started its billing to Medicare for PHP services in January 1996. Mutual of Omaha was able to provide paid claims information for the January 1, 1996 through September 30, 1998 time period.

2. Recover the $1,009,493 paid to The Program during the period January 1, 1996 through September 30, 1998 for the 20 beneficiaries in our sample.

3. Perform a medical review of the 110 beneficiaries who were not included in our sample to determine whether the claims during the period January 1, 1996 through September 30, 1998 for these beneficiaries were allowable, and collect additional overpayments as appropriate.

BACKGROUND

Laws and Regulations

Title XVIII of the Social Security Act (Act) authorizes the Medicare program to provide medical benefits to individuals 65 years of age and older, and certain individuals under age 65 who are disabled or suffer from chronic kidney disease. Section 1832 of the Act established coverage of PHP services provided by community mental health centers (CMHC) for Medicare beneficiaries. Section 1861(ff)(2) of the Act generally defines PHP services as those (mental health) services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level, and to prevent relapse or hospitalization. Section 1835 of the Act requires physicians to certify that PHP patients would otherwise require inpatient psychiatric care.

Section 4162 of Public Law 101-508 (OBRA 1990) amended Section 1861(ff) of the Act to extend Medicare coverage of PHP services to CMHCs. Section 1916(c)(4) of the Public Health Services (PHS) Act listed the services that must be provided by a CMHC. Section 1861(ff) defines a CMHC for Medicare as an entity that furnishes the services in Section 1916(c)(4) of the PHS Act and meets applicable State licensure requirements. In 1992, the PHS Act was amended to require only four core services. The four core services are currently listed at Section 1913(c)(1)(B) of the PHS Act which superceded Section 1916(c)(4). The legislation states that any entity that provides these services would be considered a CMHC for purposes of the Act.

Section 1833 (a)(2)(b) of the Act provides that CMHCs will be paid for PHP services on the basis of reasonable cost. During the year, a CMHC receives interim payments based on a percentage of its billed charges. These payments are intended to approximate the CMHC's reasonable costs. Upon receipt of the Medicare cost report for the year, the fiscal intermediary (FI) makes a settlement payment based on the reasonable costs incurred.

The Program, Incorporated

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

The Program became operational September 18, 1995 and is a subsidiary of the Cornerstone Healthcare Systems, LLC (CHS). The CHS owns and controls another CMHC, The Corner Clinic Incorporated (Corner Clinic), which has its own Medicare provider number. The effective date of participation in the Medicare program was October 25, 1995. The Program's office is in Annapolis, Maryland which is also the office location for its corporate headquarters. For the period January 1, 1996 through September 30, 1998, The Program received interim payments of $2,688,297 on the submitted charges of $4,482,935.

Fiscal Intermediary Responsibilities

The Health Care Financing Administration (HCFA) contracts with intermediaries, usually large insurance companies, to assist them in administering the Medicare program. The intermediary for The Program during our period was Mutual of Omaha (Mutual). With respect to CMHCs, the intermediaries are responsible for:

- reviewing and processing claims for PHP services;
- performing liaison activities between HCFA and CMHCs,
- dissemination of information and educational material,
- making interim payments; and
- conducting audits of cost reports.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to determine whether charges by, and payments to, The Program for PHP services for the period January 1, 1996 through September 30, 1998 met the Medicare requirements.

Scope and Methodology

To accomplish our objective, a sample of paid claims for 20 beneficiaries (245 claims) was judgementally selected from The Program's universe of paid claims for 130 beneficiaries for the period January 1, 1996 through September 30, 1998. During this period The Program received interim payments of $2,688,297 on the submitted charges of $4,482,935. For the 20 beneficiaries in our sample, The Program received interim payments of $1,009,493 on the submitted charges of $1,683,560. The Program's first submission of claims for PHP services was January 1, 1996.

We performed our work in a cooperative effort with the HCFA Philadelphia Regional Office and Mutual. The Mutual medical review personnel reviewed supporting medical records maintained by the provider for each of the services included on 245 paid PHP claims for the 20 beneficiaries in our sample, to determine whether the claimed services met the Medicare eligibility and reimbursement requirements.

Our field work was performed at The Program in Annapolis, Maryland, between September 1998 and December 1998. We also met with and attempted to interview the 20 beneficiaries in our sample or a close relative at the time of our review. The interviews were conducted in the beneficiaries place of residence which included adult home facilities and private residence.

Our claims review was performed in accordance with generally accepted governmental auditing standards. We did not test the provider's internal control structure. Based on the objectives of this review, we judged that a review of internal controls was not necessary.

We did not project the results of our audit to the entire beneficiary population at The Program because our sample was judgementally selected.

This report is being issued in final. We did not issue a draft of this report to The Program because they are no longer a participating Medicare provider. However, the results of the review were discussed with representatives of The Program.

DETAILED RESULTS OF REVIEW

Our audit showed that none of the services on 20 judgementally sampled beneficiaries PHP claims met Medicare requirements. The 20 beneficiaries in our sample contained 245 paid PHP claims, which consisted of 13,240 units of PHP services. For the services on the 245 claims, The Program submitted charges of $1,683,560 and received $1,009,493 in interim payments. During the period of our review The Program received interim payments of $2,688,297 on the submitted charges of $4,482,935 for all of the services claimed by The Program. Since none of the sampled items were eligible for Medicare reimbursement for one or more reasons, the entire sampled amount of $1,683,650 in charges for the 20 beneficiaries is unallowable. We did not project the results of our audit to the entire universe because our sample was judgementally selected. We recommend that Mutual ensure that any future charges submitted by The Program for Medicare reimbursements are appropriate and properly documented in accordance with Medicare requirements; and recover the $1,009,493 paid to The Program during the period January 1, 1996 through September 30, 1998 for the 20 beneficiaries in our sample. We also recommend that the Mutual perform a medical review of the 110 beneficiaries who were not included in our sample to determine whether the claims for these beneficiaries were allowable, and collect additional overpayments as appropriate.

CRITERIA

According to Section 1861(ff)(2) of the Act, beneficiaries are eligible for PHP services if the services are reasonable and necessary for the diagnosis or active treatment of the beneficiaries' condition and functional level and to prevent relapse or hospitalization. It is also noted in Section 1861(ff)(2)(E) that individualized activity therapies services that are recreational and diversionary in nature are not allowable.

Ineligible Services

Beneficiaries Did Not Receive Appropriate Treatment

Review of the medical records performed by the Mutual medical review staff, found that none of the 13,240 units of service contained in the 245 claims of the 20 beneficiaries sampled met Medicare requirements. The Mutual medial review staff concluded that all 20 sampled beneficiaries received treatment that was inappropriate, not reasonable and necessary, recreational and diversionary and, thus not in compliance with Section 1861(ff) of the Act. It was also noted by the Mutual medical review staff that physician referrals appeared to be used as physician orders, some claims did not contain any physician's orders, patients were in therapy many months/years with minimal to no change noted and treatment plans were repetitive from month to month with minimal to no changes noted. There were also other reasons for which units of services contained in the sampled claims should have been denied. For example:

- ✓ one beneficiary was noted as having a long standing history of mental illness, substance abuse and mild mental retardation. The patient was either sleeping in group therapy or not attending group therapy. The documentation did not support the medical necessity of an intense program to prevent psychiatric admission. The patient appeared to need structure, support and socialization, which could have been provided at a lesser level of care.

- ✓ one beneficiary had a diagnosis of autistic disorder. Types of group therapy for this beneficiary consisted of Christmas shopping and dinner at McDonald's along with an onsite Bingo blowout. The patient was excused from a group to attend a photography class and was late for a group therapy because he was napping in another room. Services were not reasonable and necessary and appropriate for the patient's mental condition. Services were recreational and diversionary in nature and were not coverable.

- ✓ one beneficiary had a history of mental retardation and was referred from an adult day program to the PHP. Types of group therapy for this beneficiary consisted of a music therapy, closure group and a socialization skill group, in which the group played "hangman". The patient did not attend group therapy at times. The patient appeared to need socialization, structure and support, which could have been provided at a lesser level of care. The services appeared recreational and diversionary in nature and were not coverable.

- ✓ one beneficiary showed evidence of senility or Alzheimer's disease. The patient had impaired attention, concentration and memory. It was noted that the patient was refusing medication, asleep at times during group therapy and at other times refused to go to some group therapy. The patient appeared to be in need of structure and support and appeared unable to benefit from these services.

RECOMMENDATIONS

Based on the results of our audit, we recommend that Mutual:

1. Ensure that any future charges submitted by The Program for Medicare reimbursements are appropriate and properly documented in accordance with Medicare requirements.

2. Recover the $1,009,493 paid to The Program during the period January 1, 1996 through September 30, 1998 for the 20 beneficiaries in our sample.

3. Perform a medical review of the 110 beneficiaries who were not included in our sample to determine whether the claims during the period January 1, 1996 through September 30, 1998 for these beneficiaries were allowable, and collect additional overpayments as appropriate.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OIG, OAS reports are made available to members of the public to the extent the information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.) As such, within ten business days after the final report is issued, it will be posted on the world wide web at http://www.hhs.gov/proorg/oig.

To facilitate identification, please refer to the referenced Common Identification Number A-03-98-00048 in all correspondence relating to this report.

Sincerely yours,

David M. Long

David M. Long
Regional Inspector General
for Audit Services

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