APR - 5 2006

TO: Tim Hill
Director, Office of Financial Management
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Medical Review of Green Cross's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2002 (A-04-04-02003)

Attached are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General final report entitled "Medical Review of Green Cross's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2002." This is one of a series of reports on Medicare partial hospitalization program (PHP) services provided by community mental health centers. A PHP is an intensive outpatient program of psychiatric services provided to patients instead of inpatient psychiatric care.

Our objective was to determine whether the claims that Green Cross submitted for PHP services met Medicare reimbursement requirements.

Green Cross submitted claims for PHP services that did not meet Medicare reimbursement requirements. Medical reviewers from a program safeguard contractor (PSC) determined that 95 of the 100 sampled PHP claims did not meet Medicare reimbursement requirements because:

- initial certification/evaluation did not meet requirements of 42 CFR § 424.24(e)(1),

- re-certifications did not meet requirements of 42 CFR §§ 424.24(e)(3) and 424.24(e)(3)(a), and

- beneficiaries did not meet eligibility criteria for PHP services in accordance with Florida Local Medical Review Policies.

As a result, Green Cross received $111,591 in unallowable Medicare payments for the 95 sampled claims. Based on our sample results, we estimate that Green Cross received at least $4,762,036 in payments for claims that should not have been billed to Medicare.

In its comments on our draft report, Green Cross strongly disagreed with the findings and took issue with many aspects of the review, including the audit review process and the

medical determinations. Green Cross's comments relating to the audit review process did not lead us to change our opinion that Green Cross received some overpayments. However, because of the medical determination issues that Green Cross raised in its response to the draft report and the fact that the PSC that conducted the review was no longer available for consultation because it no longer had a contract with the Centers for Medicare & Medicaid Services (CMS), we sent the records for the denied claims to the CMS Program Integrity Group. Based on the preliminary results of the group's review, we have decided to issue the final report directly to CMS for resolution. We will make Green Cross's medical records concerning all claims reviewed available to CMS for appropriate consideration in the audit resolution process.

We recommend that CMS determine the allowability of $4,762,036 based on our statistical estimate of unallowable payments.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please call me or George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at george.reeb@oig.hhs.gov. Please refer to report number A-04-04-02003 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAL REVIEW OF GREEN CROSS'S PARTIAL HOSPITALIZATION SERVICES FOR THE PERIOD AUGUST 1, 2000, THROUGH DECEMBER 31, 2002

Daniel R. Levinson
Inspector General

APRIL 2006
A-04-04-02003

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

A partial hospitalization program (PHP) is an intensive outpatient program of psychiatric services provided to patients instead of inpatient psychiatric care. A hospital or a community mental health center (CMHC) may provide a PHP. PHP services are included in the Medicare hospital outpatient prospective payment system, which was implemented in August 2000. Under that system, PHP providers receive a per diem payment. Providers may receive additional payments, called outlier payments, when the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses.

This review was part of a series of audits of payments to CMHCs.

OBJECTIVE

Our objective was to determine whether the claims that Green Cross, Inc. (Green Cross) submitted for PHP services met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Green Cross submitted claims for PHP services that did not meet Medicare reimbursement requirements. Medical reviewers from a program safeguard contractor (PSC) determined that 95 of the 100 sampled PHP claims did not meet Medicare reimbursement requirements because:

- initial certification/evaluation did not meet requirements of 42 CFR § 424.24(e)(1),

- re-certifications did not meet requirements of 42 CFR §§ 424.24(e)(3) and 424.24(e)(3)(a), and

- beneficiaries did not meet eligibility criteria for PHP services in accordance with Florida Local Medical Review Policies.

As a result, Green Cross received $111,591 in unallowable Medicare payments for the 95 sampled claims. Based on our sample results, we estimate that Green Cross received at least $4,762,036 in payments for claims that should not have been billed to Medicare.

RECOMMENDATION

We recommend that the Centers for Medicare & Medicaid Services (CMS) determine the allowability of the claims that resulted in our $4,762,036 statistical estimate of unallowable payments.

GREEN CROSS COMMENTS

In its comments on our draft report, Green Cross strongly disagreed with the findings and took issue with many aspects of the review, including the audit review process and the medical determinations. Green Cross's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

Green Cross's comments pertaining to the audit review process did not lead us to change our opinion that Green Cross received some overpayments. However, because of the medical determination issues that Green Cross raised in its comments and the fact that the PSC that conducted the review was no longer available for consultation because it no longer had a contract with CMS, we sent the records for the denied claims to CMS's Program Integrity Group. Based on the preliminary results of the group's review, we have decided to issue the final report directly to CMS for resolution. We will make Green Cross's medical records concerning all claims reviewed available to CMS for appropriate consideration in the resolution process.

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INTRODUCTION

BACKGROUND

Partial Hospitalization Program

A partial hospitalization program (PHP) is an intensive outpatient program of psychiatric services provided to patients instead of inpatient psychiatric care. It is designed to provide patients who have profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program. A hospital or a community mental health center (CMHC) may provide a PHP.

Partial Hospitalization Payments

The Balanced Budget Act of 1997 required the Centers for Medicare & Medicaid Services (CMS) to implement a Medicare prospective payment system for hospital outpatient services. Partial hospitalization services that CMHCs provide are included in the Medicare hospital outpatient prospective payment system (OPPS), which was implemented in August 2000. Under the OPPS, CMHCs receive per diem payments.

In addition, Medicare makes outlier payments for situations in which the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. Medicare makes these payments when the CMHC's charges for the services, adjusted to cost, exceed a given threshold established by the Secretary of Health and Human Services.

Intermediary Responsibilities

CMS contracts with the fiscal intermediaries for assistance in administering the PHP. Intermediaries are responsible for:

- processing and paying claims for CMHCs,
- conducting audits of CMHCs' cost reports, and
- performing medical review of claims for necessity and reasonableness of services.

Green Cross, Inc.

Green Cross, Inc. (Green Cross) is a Medicare-certified CMHC located in Coral Gables, Florida. Green Cross received Medicare payments totaling more than $6 million from the inception of OPPS in August 2000 through December 2002.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the claims that Green Cross submitted for PHP services met Medicare reimbursement requirements.

Scope

This review was part of a series of audits of CMHCs that received high levels of outlier payments. We selected the providers to audit based on a ranking of total outlier payments made to each provider from August 1, 2000, to June 30, 2003.

We did not perform detailed tests of Green Cross's internal controls because we accomplished our objective through substantive testing.

We performed fieldwork at Green Cross in Coral Gables, Florida, from January to May 2004.

Methodology

We reviewed relevant Federal laws, regulations, and other requirements. We also interviewed officials of CMS, First Coast Service Options, Inc. (Green Cross's fiscal intermediary), and Green Cross.

We selected a random sample of 100 claims from a universe of 4,626 claims for the period of August 1, 2000, through December 31, 2002. Green Cross received total Medicare payments of $6.4 million for the 4,626 claims.

Medical reviewers from TriCenturion, a Medicare program safeguard contractor (PSC), performed a clinical review of the 100 sampled claims on our behalf. The PSC reviewed the claims and applicable medical records to determine whether PHP services met Medicare coverage requirements and were medically necessary, reasonable, and billed in accordance with Medicare requirements. The codes billed on the sampled claims were Current Procedural Terminology codes 90853 – Group Psychotherapy, as well as Healthcare Common Procedure Coding System code G0172 and G0177[1] – Training and Educational Services.

We extracted individual detailed claim information from the Standard Analytic File using the Data Extract System for PHP claims for the period August 1, 2000, to December 31, 2002. We reconciled this data to the provider statistical and reimbursement reports from the fiscal intermediary.

We conducted our review in accordance with generally accepted government auditing standards.

[1] Code G0172 was deleted and replaced with G0177 in 2001.

FINDINGS AND RECOMMENDATION

Green Cross submitted claims for PHP services that did not meet Medicare reimbursement requirements. Medical reviewers from the PSC determined that 95 of the 100 sampled PHP claims did not meet Medicare reimbursement requirements because:

- initial certification/evaluation did not meet requirements of 42 CFR § 424.24(e)(1),
- re-certifications did not meet requirements of 42 CFR §§ 424.24(e)(3) and 424.24(e)(3)(a), and
- beneficiaries did not meet eligibility criteria for PHP services in accordance with Florida Local Medical Review Policies.

As a result, we estimate that Green Cross received at least $4,762,036 in payments for claims that should not have been billed to Medicare.

Appendix C details the errors for each sampled claim.

NONCOMPLIANCE WITH MEDICARE REIMBURSEMENT REQUIREMENTS

Medical review staff determined that 95 of the 100 sampled claims did not meet Medicare reimbursement requirements. PHP services must meet Medicare PHP coverage requirements and be medically necessary, reasonable, and billed in accordance with Medicare requirements. Many of the 95 claims were denied for more than 1 reason.

Initial Certification/Evaluation Did Not Meet Requirements

Regulations (42 CFR § 424.24(e)(1)) require a certification by the physician indicating that patients admitted to the PHP would require inpatient psychiatric hospitalization if partial hospitalization services were not provided. It further requires that services be furnished while under the care of a physician and under a written plan of treatment. In addition, Florida Local Medical Review Policy also contains requirements that a claim must meet to be in compliance with Medicare requirements.

The medical reviewers found the following instances of noncompliance with Medicare requirements:

For 12 claims, initial psychiatric evaluations/certifications did not meet Medicare requirements.

Medical reviewers denied 2 of the 12 claims because the medical necessity for the partial hospitalization services was not established. They concluded that there was no medical history or physical examination that was current or completed within the last 30 days (Florida Local Medical Review Policy APHPPROG, page 15).

For 10 claims, the initial psychiatric evaluation/certification did not contain the certification language required by the Florida Local Medical Review Policy (APHPPROG, page 13). Specifically, they did not include an attestation that the services would be furnished under the care of a physician and under a written plan of care.

Ten of the 12 claims contained at least 1 other condition that, in the opinion of the medical reviewers, rendered these claims deniable under other relevant sections of the Florida Local Medical Review Policy.

Re-Certifications Did Not Meet Requirements

Regulations (42 CFR § 424.24 (e)(3)) require that the physician who is treating the patient and has knowledge of the patient's response to treatment must sign a re-certification. The CFR further requires the first re-certification of treatment as of the 18th day of partial hospitalization services and subsequent re-certifications at intervals established by the provider, but no less frequently than every 30 days. Also, regulations (42 CFR § 424.24 (e)(3)(a)) require documentation of the patient's response to the therapeutic interventions provided by the PHP and the psychiatric symptoms, which continue to place the beneficiary at risk of hospitalization.

The medical reviewers found the following instances of noncompliance with Medicare requirements:

- For 19 claims, the required initial re-certification was not found in the medical records documentation (Florida Local Medical Review Policy APHPPROG, page 11).

- For 21 claims, the initial re-certification was not documented as being performed within the 18 calendar days following admission to the PHP (Florida Local Medical Review Policy APHPPROG, page 14). For 3 of these 21 claims, medical reviewers either did not find evidence of subsequent re-certifications that are required no less frequently than every 30 days or the re-certifications that they found were not prepared timely.

- For 27 claims, the re-certification did not contain documentation of the beneficiary's response to intensive therapeutic interventions, changes in functioning, or the status of serious psychiatric symptoms that continued to place the beneficiary at risk for hospitalization (Florida Local Medical Review Policy APHPPROG, page 14). For 10 of these 27 claims, medical reviewers also indicated that the re-certification consisted solely of physician orders and the physician's attestation that patients' continued attendance in the PHP was necessary to prevent inpatient hospitalization.

- For one claim, the re-certification language used was not in accordance with the required re-certification language (Florida Local Medical Review Policy APHPPROG, page 14).

Fifty-six of the 68 claims contained at least 1 other condition that, in the opinion of the medical reviewers, rendered these claims deniable under other relevant sections of the Florida Local Medical Review Policy.

Beneficiaries Did Not Meet Medicare Eligibility Requirements

Florida Local Medical Review Policy APHPPROG, page 4, requires patients to have the capacity for active participation in all phases of the multidisciplinary and multimodal program; i.e., the patient must be medically stable and not limited by another serious medical condition, and the patient must demonstrate an appropriate level of cognition. The Florida Local Medical Review Policy APHPPROG, page 4, further identifies medical stability as a requirement for participation in a PHP, and PHP participants must demonstrate an appropriate level of cognition. In addition: (1) it is generally expected that a less intensive treatment in an outpatient setting be attempted prior to admission to a PHP and (2) documentation for such patients should support these attempts as well as the patient's failure at or inability to be managed in a less intensive outpatient setting.

The medical reviewers found the following instances of noncompliance with Medicare requirements:

- For 13 claims, there was no documentation to identify that less intensive treatment options (e.g., intensive outpatient, psychosocial, day treatment, and/or other community support) were attempted and had failed prior to admission to the PHP program.

- For one claim, the beneficiary was unable to participate due to medical reasons as demonstrated by medical records documentation. Also, the psychiatric evaluation reported that the beneficiary's concentration and memory was somewhat impaired.

- For one claim, the documentation provided in the psychiatric evaluation presented the beneficiary as unable to tolerate the intensity of the PHP. According to the psychiatric evaluation, while an inpatient, the beneficiary underwent eight electroconvulsive therapy applications and upon admission to the PHP was still slightly confused from the electroconvulsive therapy treatment. The beneficiary was very depressed and reported feeling very weak with fear that she was going to fall. She was making irrelevant comments to her caretaker at home and not able to engage in her activities of daily living such as showering, dressing, and eating.

One of the 15 claims contained at least 1 other condition that, in the opinion of the medical reviewers, rendered these claims deniable under other relevant sections of the Florida Local Medical Review Policy.

EFFECT OF IMPROPER BILLINGS

Green Cross received $111,591 in unallowable Medicare payments for 95 of the 100 claims in the statistical sample. Based on our sample results, we estimate that Green Cross received at least $4,762,036 in payments for claims that should not have been billed to Medicare.

RECOMMENDATION

We recommend that CMS determine the allowability of the claims that resulted in our $4,762,036 statistical estimate of unallowable payments.

GREEN CROSS COMMENTS

In its May 25, 2005, written comments on our draft report, Green Cross strongly disagreed with the findings and recommendations. Green Cross took issue with many aspects of the review, including the audit review process and the medical determinations.

Green Cross said that we never explained the verification process that we followed to ensure that the PSC was qualified as an expert in Medicare coverage and reimbursement of PHP services or to ensure that the review was conducted according to Medicare rules and regulations.

The full text of Green Cross's comments is included in Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

Section 202 of the Health Insurance Portability and Accountability Act of 1996, as codified in section 1893 of the Social Security Act, established the Medicare Integrity Program and authorized CMS to contract with entities, such as PSCs, to perform certain program safeguard activities, including medical review, cost report audit, data analysis, provider education, and fraud detection and prevention. We relied on the medical review determinations of a PSC that was under contract with CMS to promote the integrity of the Medicare program. CMS verified the qualifications of the PSCs when it awarded the contracts and through performance evaluations.

Green Cross's comments pertaining to the audit review process did not lead us to change our opinion that Green Cross received some overpayments. However, because of the medical determination issues Green Cross raised in its comments and the fact that the PSC that conducted the review was no longer available for consultation because it no longer had a contract with CMS, we sent the records for the denied claims to CMS's Program Integrity Group. Based on the preliminary results of the group's review, we have decided to issue the final report directly to CMS for resolution. We will make Green Cross's medical records concerning all claims reviewed available to CMS for appropriate consideration in the resolution process.

APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY

OBJECTIVE

Our objective was to determine whether the claims that Green Cross, Inc. (Green Cross) submitted for partial hospitalization program (PHP) services met Medicare reimbursement requirements.

To achieve our objective, we selected an unrestricted random sample of claims for medical review.

POPULATION

The population consisted of 4,626 paid claims for community mental health center (CMHC) Medicare PHP services for the period August 1, 2000, through December 31, 2002.

SAMPLING UNIT

The sampling unit was a paid CMHC Medicare PHP claim to Green Cross with a patient service date during the period August 1, 2000, through December 31, 2002.

SAMPLE SIZE

The sample size was 100 CMHC Medicare PHP paid claims.

ESTIMATION METHODOLOGY

We used the Office of Audit Services Statistical Software Variable Appraisal program to project the amount of the unallowable claims.

APPENDIX B

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 4,626 Claims	Items: 100 Claims	Items: 95 Claims
Dollars: $6,417,223	Dollars: $ 114,350	Dollars: $111,591

We used the RAT-STATS Statistical Software Variable Appraisal program to obtain the sample projection. We reported the lower limit of the 90 percent confidence interval. Details of our projection appear below:

Projection of Sample Results
90 Percent Confidence Interval

Point Estimate:	$5,162,188
Precision Amount:	$400,152
Lower Limit:	$4,762,036
Upper Limit:	$5,562,340

MEDICAL REVIEW RESULTS BY CLAIM

Claim Sample No.	Claim Allowed	Initial certification/ evaluation did not meet requirements	Re-certifications did not meet requirements	Beneficiary did not meet eligibility requirements
1		X		
2		X		
3		X		
4		X		
5		X		
6		X		
7		X		
8		X		
9		X		
10		X		
11			X	
12			X	
13			X	
14			X	
15			X	
16			X	
17			X	
18			X	
19	X			
20				X
21			X	
22			X	
23			X	
24			X	
25				X
26			X	
27				X
28				X
29			X	
30				X
31				X
32				X
33				X
34			X	
35	X			
36		X		
37			X	
38			X	

MEDICAL REVIEW RESULTS BY CLAIM

Claim Sample No.	Claim Allowed	Initial certification/ evaluation did not meet requirements	Re-certifications did not meet requirements	Beneficiary did not meet eligibility requirements
39			X	
40			X	
41		X		
42			X	
43			X	
44			X	
45			X	
46				X
47			X	
48			X	
49	X			
50			X	
51			X	
52			X	
53			X	
54			X	
55			X	
56	X			
57			X	
58			X	
59			X	
60			X	
61			X	
62			X	
63			X	
64			X	
65			X	
66			X	
67			X	
68			X	
69			X	
70			X	
71			X	
72				X
73			X	
74			X	
75			X	
76				X
77	X			

MEDICAL REVIEW RESULTS BY CLAIM

Claim Sample No.	Claim Allowed	Initial certification/ evaluation did not meet requirements	Re-certifications did not meet requirements	Beneficiary did not meet eligibility requirements
78			X	
79			X	
80			X	
81			X	
82			X	
83				X
84			X	
85			X	
86			X	
87			X	
88			X	
89			X	
90			X	
91			X	
92			X	
93			X	
94				X
95			X	
96			X	
97				X
98				X
99			X	
100			X	
Totals	**5**	**12**	**68**	**15**

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May 25, 2005

Lori Pilcher
Regional Inspector General for Audit Services
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Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Re: Green Cross Inc. ("Green Cross") Response to Draft Report entitled, "Medical Review of Green Cross' Partial Hospitalization Services for the Period of August 1, 2000 through December 31, 2002"
Report Number: A-04-04-02003

Dear Ms. Pilcher:

We hereby submit written comments regarding the OIG's Draft Report entitled, "Medical Review of Green Cross' Partial Hospitalization Services for the Period of August 1, 2000 through December 31, 2002" ("Draft Report"). Green Cross disagrees with essentially every aspect of this audit review and the Draft Report. Among other points addressed in greater detail below, Green Cross maintains that the audit is inconsistent with generally accepted government auditing standards set out in Government Auditing Standards, 2003 Revision (the "Yellow Book"); that the review bypasses "Progressive Corrective Action" procedures mandated by the Centers for Medicare and Medicaid Services ("CMS"); and, that the findings of the contractor hired by the OIG to review the medical records ("TriCenturion") are so inconsistent with Green Cross' claims filing and review experiences with its assigned fiscal intermediary ("First Coast") that it raises substantial questions regarding the reliability and accuracy of TriCenturion's review.

Green Cross is a conscientious community based provider having a history of active participation in regulatory procedures. Green Cross is JCAHO accredited. As an accredited and reaccredited

provider, Green Cross has undergone an extensive, independent review to verify that Green Cross promotes and maintains the following behavioral health care provider requirements, controls and standards:

- Ethics, rights and responsibilities
- Provision of care, treatment and services
- Medication management
- Surveillance, prevention and control of infection
- Improving organization performance
- Leadership
- Management of the environment of care
- Management of human resources
- Management of information
- Behavioral health promotion

Since its inception, Green Cross has had a proactive relationship with First Coast. Green Cross has attended meetings and communicated directly with First Coast to achieve and maintain compliance in a benefit area marked by a lack of clarity and difficulties in implementation.[1] Despite Green Cross' positive relationship with First Coast, Green Cross is concerned that any final report issued by the OIG that fails to adhere to the Yellow Book standards will bias First Coast against Green Cross when First Coast is subsequently tasked with adjudicating the results of such final report.

Green Cross' concerns are arranged into three categories and addressed in detail below.

1. **General Observations.**

Before addressing specific concerns with respect to such issues as adherence to Yellow Book standards, content of the Draft Report and medical review findings, we identify certain overarching concerns regarding the audit in general.

A. Faulty Review Process and Findings.

First, the Draft Report is based solely on the results of the medical review conducted by TriCenturion. It is not apparent from the Draft Report whether the OIG conducted oversight

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[1]/ See GAO report entitled "Medicare – Lesson Learned from HCFA's Implementation of Changes to Benefits," January 2000.

activities to ensure that the field work was carried out in accord with Yellow Book standards or that competent evidentiary material was developed.

In addition, the conclusion reached in the Draft Report that Green Cross "did not have adequate procedures in place to ensure claims submitted were in compliance with Medicare requirements[]" is unsupported and unwarranted in the absence of any OIG testing or review of Green Cross' internal controls. As stated in the letter attached hereto as Attachment B from Lori Pilcher to Patrick Gilmore dated February 25, 2005:

> "...the conclusion that the provider did not have adequate procedures in place is a deductive conclusion based on the results of the medical review documentation provided by Green Cross. Our logic is that if the provider had adequate procedures in place, the medical reviewers would not have determined that 95 of the 100 claims did not meet Medicare reimbursement requirements."

A deductive conclusion that the asserted error rate is attributable only to the provider cannot stand where other possible, and readily apparent, conclusions have not been evaluated and ruled out.[2/] This is particularly true for an accredited provider, having extensive internal controls and policies necessary to maintain JCAHO accreditation status.

TriCenturion's finding of a 95% error rate is at odds with First Coast's claims review history of Green Cross' partial hospitalization program. This discrepancy raises serious questions as to where the asserted lack of adequate procedures truly lies. TriCenturion may have misapplied the local medical review polices ("LMRPs") during the course of this review or it is possible that First Coast's LMRP interpretation with respect to Green Cross differs from TriCenturion or government expectations. However, the OIG never investigated these or other potential possibilities and simply "deduced" that the problems must be attributable solely to Green Cross. The fact that other potential causes are not evaluated within this audit represents a particular weakness, especially when Congress and the Government Accountability Office have attributed partial hospitalization medical review variances to other non-provider causes[3/]. Deductive reasoning alone, without any testing of the provider's internal controls, particularly where it fails

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2/ Moreover, a "deductive conclusion" that fails to evaluate and eliminate other obvious potential causes is inconsistent with verbal representations made by OIG audit management at the outset of this review. Specifically, provider management was informed that the scope of the review *would encompass the entire partial hospitalization benefit, including CMS and fiscal intermediary performance in regulating, administering and monitoring the benefit.* The Draft Report makes no reference to the outcomes or findings of these reviews and how they may bear on the asserted error rate.

3/ See GAO report entitled "Medicare – Lesson Learned from HCFA's Implementation of Changes to Benefits," January 2000.

to evaluate and rule out other plausible causes, is not appropriate for or supportive of conclusions that the provider's lack of adequate procedures caused an overpayment of millions of dollars.

B. Lack of Provider Input in Audit Process.

The OIG acted solely as a conduit between Green Cross and TriCenturion, serving only to select a sample of records for review, obtain medical records, provide those records to TriCenturion, and extrapolate and report the results. In fact, the Draft Report relies exclusively on TriCenturion's medical review findings. However, despite TriCenturion's extensive role in this review, Green Cross was never provided an opportunity to meet with the reviewers from TriCenturion to discuss the results of the medical review, despite Green Cross' earnest requests to do so. Fundamental fairness dictates that Green Cross would, at minimum, be allowed to speak with the reviewers to gain an understanding of their findings, to discuss policy issues or to identify any factual errors. For example, had TriCenturion representatives been present during the exit interview, Green Cross could have easily directed their attention to documentation contained in the record relevant to the reviewers' analysis. Not only would a meeting with TriCenturion representatives have been more administratively efficient and less burdensome, but OIG audit standards, consistent with fundamental fairness, required greater exchange on the medical review process and standards than was allowed in this case. Because this opportunity was denied, the provider's only remaining means of participation in the review is to identify factual inaccuracies and to address many other specific medical review inadequacies under the Medical Review section of this rebuttal.

The OIG's Audit Process Manual sets out exit conference and advance discussion standards that call for the OIG to discuss the entire report -- background, scope methodology, results of audit, etc. -- before issuing a final report. These requirements are intended to enable the auditee to make meaningful contributions and to ensure that the final report is accurate.

The OIG did not follow its own procedures that ostensibly were developed to ensure adherence to audit standards and accuracy of reporting. In this regard, neither the Draft Report nor the medical review work papers were available during the initial exit conference. Moreover, the OIG personnel attending the exit conference were unable to address fundamental questions regarding the medical review or to summarize the actual scope and basis for the medical review findings. Upon receiving these documents, approximately seven months after the post audit meeting, Green Cross had serious questions concerning the accuracy of the findings and of the procedures used by TriCenturion and the OIG auditors. Because of its concerns and because the Draft Report was not available for review during the initial exit conference, Green Cross requested a more complete exit conference (see Attachment A).

Green Cross' request was rejected (see Attachment B). Green Cross questions why the OIG would deny a request for a more complete exit interview that would enable the provider to contribute to the accuracy of the Draft Report and medical review findings. This denial is inconsistent with audit standards and puts the OIG at risk of issuing a flawed report without meaningful provider input.

The OIG did not demonstrate to Green Cross that it took steps necessary to ensure the accuracy of the medical records review, and hence the accuracy of the Draft Report. This is demonstrated in the February 25, 2005 letter attached hereto as Attachment B, where the OIG states that:

> "...due process would be afforded through the provider's right to appeal. We stated that any disagreements to [sic] medical review findings would need to be addressed with the FI during the audit resolution process."

Basically, the OIG is willing to rely on medical review findings to recommend the repayment of millions of dollars, but is unwilling to first verify the accuracy of those findings. Further, the medical review appeals process should not be used as a substitute for ensuring the accuracy of the OIG audit report findings. In short, the audit process in this case and the failure to allow reasonable opportunity for the provider to be involved in the audit process, including the medical review, is inconsistent with the Yellow Book and OIG audit standards and serves to compromise the integrity of the overall findings.

In order to verify that the medical review was conducted by competent individuals knowledgeable of the Florida LMRPs for partial hospitalization services (in effect as of the dates of service), and that judgments with respect to medical necessity were rendered by licensed medical professionals, Green Cross requested but was denied access to information concerning the qualifications and credentials of the TriCenturion reviewers. In the February 25, 2005 letter the OIG states that it "rel[ies] on CMS to ensure that the PSC medical reviewers are qualified to perform Medicare medical reviews." However, this is inconsistent with CMS policy and practice.

First, CMS does not review or verify the qualifications of the PSC's non-Key Personnel employees. CMS leaves those hiring decisions to the discretion of the PSC. Hence, if the OIG relies on CMS to ensure qualified medical reviewers, and if CMS defers to the PSC, there can be no assurance that the reviewers in this case were experienced or qualified to interpret and apply First Coast's then-current LMRPs. Further, the implication of the statement in the letter is that the OIG took no affirmative steps to credential or otherwise confirm the qualification and competence of the medical revenues, *even though the OIG wholly defers to and specifically adopts the medical reviewers' findings as accurate in all respects*. Second, the OIG did not specify in its Task Order for this project the categories or qualifications of the personnel required

to conduct the medical review. If the purpose of this review is to determine medical necessity and whether medical records meet LMRP standards, then the reviewers should be licensed medical professionals, as is required by CMS for complex prepay medical reviews under Medicare (see Program Integrity Manual 100-8, §3.4.5). Despite this program requirement, Green Cross has been precluded from confirming, (and the OIG appears to be unaware of) whether licensed clinical professionals actually conducted the medical review in this case.

In February 25, 2005 letter the OIG stated that under "a task order awarded on June 3, 2002, TriCenturion performed fraud and abuse safeguard functions for the Medicare Part A workload in Florida, a function that used to be performed by First Coast Service Options, Inc." However, as mentioned below under Section 1.D, that contract was recently terminated by CMS, calling into question the quality and reliability of the program integrity work performed by TriCenturion in Florida.

The Task Order issued to TriCenturion by the OIG to conduct this review contains the implication that quality and performance criteria used to measure TriCenturion's successful completion of the Task Order would be based on negative outcomes. For example, Section III, Subsection A, which is entitled "Desired Outcomes," lists four (4) tasks. These include: 1) Medical review of services provided to Medicare beneficiaries to assess whether payments made to the CMHCs for PHP services were made in accordance with Medicare requirements for medical necessity, reasonableness, eligibility and reimbursement; 2) Identification of actual overpayments from the sampled claims; 3) Calculation of correct payment amounts using applicable Medicare reimbursement requirements for these types of services; and 4) Identification of potential billing problems by the provider. A simple reading of these "desired outcomes" strongly implies that in order for TriCenturion to successfully complete the Task Order, TriCenturion must uncover and identify overpayments. Moreover, the co-Government Task Leader responsible for evaluating TriCenturion's performance under the Task Order is the same OIG official responsible for overseeing the CMHC audits. This relationship constitutes a conflict of interest and provides an improper incentive for TriCenturion to produce medical review results that meet preconceived outcomes acceptable to the OIG.

C. The TriCenturion Medical Review Results Are Grossly Inconsistent with Past Reviews of Green Cross Claims.

Green Cross was under 100% medical review by First Coast from early 1998 through the beginning of 1999. Subsequent to that, Green Cross was subject to periodic reviews as well as a probe review of its clinical documentation. In contrast to TriCenturion, First Coast found that Green Cross' medical documentation met applicable LMRP requirements. This discrepancy demonstrates the possibility that there may be serious flaws with the review conducted by TriCenturion. The Draft Report provides no explanation for how Green Cross went from few, if

any, errors under First Coast's multiple reviews to a 95% error rate under the TriCenturion review.

Given that the reviews conducted by First Coast do not corroborate TriCenturion's findings highlights the lack of reproducibility of the OIG's findings and undermines the review process implemented by TriCenturion. It is quite possible that TriCenturion may have misapplied the LMRP criteria that resulted in adverse findings for the records selected for medical review.

On page 6 of the OIG Final Report entitled "Medical Review of Quitman Clinic's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2002," which involved the medical review of the Quitman Clinic's partial hospitalization claims by TriCenturion, this same issue was raised by the auditee. OIG responded "[a]ccording to TriCenturion review officials, there are significant differences between the scope of a prepayment review performed by a fiscal intermediary and the comprehensive medical review TriCenturion performed as part of this audit. A prepayment medical review often entails a review of only certain aspects of a claim. The comprehensive medical review entails a review of the entire claim as well as a more thorough review of a beneficiary's medical history." This position is not sustainable in this case. The Medicare Program Integrity Manual 100-8, §3.4.5 states that there are three types of prepayment review – automated, routine and complex. Complex reviews require the application of clinical judgment by a licensed medical professional in order to evaluate medical records. The manual indicates that complex medical review determinations require a licensed medical professional to make a clinical judgment about whether a service is covered, and is reasonable and necessary. The comprehensive medical review described by TriCenturion appears to be exactly the same as the complex medical review conducted by First Coast with respect to Green Cross. For this reason, First Coast and TriCenturion in fact provided the same level of review, and yet, TriCenturion's findings deviate materially from First Coast's. The Draft Report fails to reconcile this difference, or acknowledge that TriCenturion may have misapplied the LMRP standards.

Moreover, it appears that the results of previous reviews conducted by First Coast were not reviewed by the OIG as required by Yellow Book standards (See Field Work Standards 7.29 and 7.32). The current audit simply ignored and did not attempt to reconcile the substantial material differences between First Coast's medical review results (determined through multiple reviews over a sustained period) and the one time review by TriCenturion. The absence of such reconciliation demonstrates that the audit did not gather sufficient evidence regarding the internal controls to meet Field Work Standards 7.29 and 7.32 described in the Yellow Book. Also, the evidence gathered was not sufficient to conclude that TriCenturion's results were acceptable or accurate. *At a minimum*, the Draft Report should disclose that the results of the TriCenturion review differ drastically from prior reviews.

D. Reliability of TriCenturion's Findings.

TriCenturion had a contract with CMS to provide program safeguard activities (which includes medical review, data analysis and fraud investigations) for Medicare Parts A and B for Florida and Puerto Rico. However, TriCenturion's contract with CMS was abruptly terminated and TriCenturion was replaced by EDS, along with its subcontractor, IntegriGuard, as the PSC responsible for Florida and Puerto Rico. We submitted a Freedom of Information Act request to CMS for information concerning TriCenturion's performance as a PSC and for information pertaining to the termination of TriCenturion's PSC contract. As of this date we have not received any information from CMS. However, we believe that if TriCenturion's PSC contract was terminated due to quality or performance related issues, it may seriously undermine the validity and reliability of TriCenturion's medical review results. Because the Draft Report relies exclusively on TriCenturion's medical review findings, even if TriCenturion's contract was cancelled for non-medical review related issues, the OIG should acknowledge and declare what assurances it obtained to ensure that the medical review results are not be flawed.

2. **Failure to Comply with Yellow Book Standards.**

A. Substantive Non-Compliance with Yellow Book Standards.

1. Reporting Standard 8.17 provides that the audit report should state the scope of the auditor's work on internal controls and any significant deficiencies. The "Scope" section of the Draft Report states that no tests were performed on the provider's internal controls, yet these internal controls were reported as the cause of a very significant error rate. Field Work Standard 7.65 states that the auditors should clearly demonstrate and explain with evidence and reasoning the link between problems and factor(s) identified as the cause. As noted earlier, there exists other plausible and recognized reasons for the findings, and it is unclear why the OIG chose not to evaluate and rule out such equally plausible causes.

2. The Draft Report does not conform to Reporting Standard 8.30 which provides that: (1) the report should state that the audit was made in accordance with generally accepted government auditing standards; and (2) the report be qualified in situations where the auditors did not follow an applicable standard. Auditors are required to disclose any standards not followed, the reasons therefor, and how not following such standard affected or could have affected the results of the audit. The Draft Report stated that internal controls were not reviewed, but did not explain how the limitation impacted the results of the audit. Green Cross contends that explaining any such impact is important to fairly reporting the results of the audit.

3. The Draft Report does not measure up to the requirements of Reporting Standards 8.41 through 8.48 regarding completeness, accuracy and objectivity.

a). Reporting Standard 8.41 states that findings should include all necessary facts and explanations to promote an adequate understanding of the matters reported. The Draft Report appears to report only the matters that support the high error rate and it does not report the evidence that the provider has previously undergone reviews by First Coast with no or minimal consequence.

b). Reporting Standards 8.43 and 8.44 are pertinent to fair and balanced reporting. Section 8.43 states that the evidence must be true and the findings correctly portrayed. Section 8.44 states that the report should contain information that is supported by sufficient, competent, and relevant evidence. If data are significant to the audit findings and conclusions but are not audited, the report should clearly indicate the data's limitations and not make unwarranted conclusions or recommendations based on the data. These standards have not been met in this case because the conclusions in the Draft Report are based solely on TriCenturion's medical review findings, despite the fact that serious questions have been raised regarding the results of the review and documentation contained in the medical records. The OIG simply relies on TriCenturion's findings with no input from any other source including the provider and First Coast.

c). Reporting Standards 8.46 through 8.48 require that the presentation of the results of the audit be balanced in content and tone, be presented impartially and fairly, and recognize the positive aspects of the reviewed program. It further requires that conclusions be supported with sound and logical evidence. Green Cross insists that the OIG failed to meet this requirement because the OIG illogically determined the cause of the alleged error rate. The rules of logic allow for deductive conclusions only after other possible causes have been ruled out, which the OIG did not do.

B. Procedural Non-Compliance with Yellow Book Standards.

1. The OIG decision to select substantive testing over a review of internal controls suggests a bias contrary to General Standard 3.07(e)&(f) concerning personal impairment of auditors. Substantive testing is indicated when controls are known to be ineffective or unreliable. To Green Cross' knowledge this is not the case. In fact, the opposite is true as Green Cross experienced successful reviews in the past (see Section 1.C. above). Additionally, the decision appears to be in conflict with the Field Work Standard 7.07(c), which requires the auditor to obtain an understanding of the internal controls as they relate to the specific objectives and scopes of the audit and no review of the internal controls was undertaken.

2. Field Work Standard 7.15 requires that when the internal controls are significant to the audit objectives, auditors should obtain evidence to support their judgments about the internal controls. Based on the Draft Report, the OIG concluded the internal controls

were inadequate without gathering or testing the internal controls; the OIG's failure to test internal controls is contrary to this standard.

3. The decision to not review internal controls implies that the auditors were out of compliance with Field Work Standard 7.32 which requires the consideration of work performed by other auditors. Since this audit was essentially the same as a probe audit conducted by First Coast, Standard 7.32 compels the auditors to consider previous medical reviews performed by First Coast and to reconcile and develop explanations for any differences in results.

4. Field Work Standard 7.39 states that auditors should communicate information about the planning, conducting and reporting of the audit to the audited entity. The communication should help the audited entity understand the objectives, time frames and data needs. Green Cross believes this standard was only minimally met. Green Cross received incomplete answers about the reporting requirements during entire audit. Furthermore, Green Cross was advised by one audit official that the audit would take two weeks and by another that it would take three to six weeks. The audit ultimately took seven months. During the course of this audit, Green Cross was provided no information concerning the conduct of the medical review, was misinformed as to the scope and subject of the review and was not informed as to the type of report to be issued.

5. Field Work Standard 7.52(a) states: "Evidence should be sufficient to support the auditors' findings. In determining the sufficiency of evidence, auditors should ensure that enough evidence exists to persuade a knowledgeable person of the validity of the findings." We do not believe that the presentation of non-validated negative medical review findings would necessarily persuade a knowledgeable person that there is a lack of internal controls. In addition, the evidence collected was not sufficient to validate the medical review results. Green Cross was not afforded the opportunity to meet with the TriCenturion reviewers and the OIG did not gather any evidence to ensure that TriCenturion's review used the same standards advocated by First Coast.

6. In addition to aforementioned questions concerning the application of the Yellow Book standards, Green Cross questions whether the OIG complied with General Standards 3.06 and 3.41 concerning technical competence and independence, respectively. Green Cross attempted to confirm the qualifications, training and competence of the TriCenturion reviewers but was provided with no information. In addition, the OIG never explained the verification process that the OIG followed to ensure that the organization selected to conduct the reviews is qualified as an expert in Medicare coverage and reimbursement of partial hospitalization services or to ensure that the review was conducted according to Medicare rules and regulations.

C. Specific Issues with Respect to Draft Report.

1. "Scope" Section (Draft Report, Page 2).

This section states that the OIG "did not perform detailed tests of internal controls because the objectives of our review was accomplished through substantive testing." However, as stated above, prior to attributing significant deficiencies to an alleged lack of internal controls, the OIG should have conducted testing of such internal controls.

In addition, internal controls in place at Green Cross were imposed by First Coast. Green Cross was under review by First Coast during the period encompassed by this audit and willingly implemented all of First Coast's suggestions with respect to its internal controls. Moreover, First Coast's review of Green Cross' medical records resulted in no claim denials, in stark contrast to the results of the OIG audit, which raises serious doubts concerning OIG's claim of a lack of internal controls.

The Draft Report should be revised to explain how the OIG evaluated and ruled out other plausible reasons for the error rate, including the possibility that TriCenturion's medical review findings are in error, and the possibility that First Coast was responsible for the internal controls at Green Cross. Only by ruling out these possibilities can the OIG state that Green Cross' lack of internal controls are to blame for the error rate.

2. "Findings and Recommendations" Section (Draft Report, Page 3).

The "Findings and Recommendations" section of the Draft Report asserts that claims were denied because of improper certification, improper re-certification or because the beneficiaries did not meet Medicare eligibility requirements. At the end of each of these three sections, the Draft Report states that a particular number of "claims contained at least 1 other condition, that in the opinion of medical review experts, would render these claims deniable under other relevant sections of the Florida Local Medical Review Policy." However, the Draft Report does not state what those conditions are.

It is unfair and prejudicial to make general accusations of not meeting requirements without specifying the non-compliant condition. If there is truly a lack of internal controls as stated by the OIG then it would be beneficial for Green Cross to understand what these additional conditions are so that its processes can properly strengthened. Without knowing what the additional conditions are, it is impossible for Green Cross to properly evaluate and comment on the results so that a fair, objective and balanced final report is issued. In the absence of specifying what the additional conditions are along with an opportunity for Green Cross to

evaluate and address them, Green Cross requests that these statements be struck from the final report.

3. "Cause" Section (Draft Report, Page 6).

There is no basis for the findings made in the "Cause" section of the report. This section states that the OIG "concluded that the [sic] Green Cross did not have adequate procedures in place to ensure claims submitted were in compliance with Medicare requirements." However, OIG never actually reviewed or tested Green Cross' compliance procedures. In the absence of any review of Green Cross' compliance procedures, the OIG cannot logically reach any conclusion regarding the effect or impact of such procedures.

Essentially, the Draft Report asserts that the medical documentation did not meet First Coast's LMRPs for partial hospitalization services, therefore Green Cross must not have adequate procedures in place to ensure that its claims met Medicare requirements. However, this statement ignores the fact that Green Cross vigorously disputes the medical review findings. In a letter to Donald Czyzewski, Audit Manager, OIG Region IV, dated September 22, 2004 (see Attachment C), Dr. Miguel Nunez specifically, point by point, refutes the medical review findings, yet the OIG has neither acknowledged this correspondence nor addressed its substance in the Draft Report.

Although the OIG stated, "[o]ur logic is that if the provider had adequate procedures in place, the medical reviewers would not have determined that 95 of the 100 claims did not meet Medicare reimbursement requirements[]," the conclusion is not logical without first eliminating all other probable causes. For example, it is possible that TriCenturion found a 95% error rate because it misapplied the LMRPs or because First Coast provided incorrect education and guidance to Green Cross concerning its medical review policies and requirements. Because it is equally as logical that the error rate was caused by a faulty medical review by TriCenturion or by incorrect guidance from First Coast as it is that the error rate was caused by a lack of internal procedures, the OIG cannot make the conclusion that it has. Therefore, Green Cross requests that the cause be struck from the final report unless adequately developed.

4. "Recommendations" Section (Draft Report, Page 6).

The "Recommendations" portion of the Draft Report makes only general statements and is not developed. For example, the Draft Report states that Green Cross should "strengthen its procedures to ensure that claims for partial hospitalization services are in accordance with Medicare requirements and are properly documented." Because internal processes and procedures were never reviewed and the cause was not developed, the OIG is unable to identify

which processes and procedures are found or asserted to be weak or which need to be strengthened.

The second recommendation is that Green Cross work with First Coast to reimburse the Medicare program $4,762,036 in unallowable payments. The Draft Report does not explain what is meant by "work with," ignores the fact that Green Cross does not concur with the medical review findings and fails to reference other critical facts.

Ordinarily, if problems are uncovered by a fiscal intermediary with respect to a provider, CMS requires the fiscal intermediary to enroll the provider into a progressive corrective action program ("PCA"). Such programs consist of educating the provider with respect to correct billing practices and medical review policies, subjecting the provider to pre-pay review and maintaining open communication with the provider until the provider's problems have been resolved. However, in the Draft Report, the OIG did not recommend that First Coast utilize this procedure, but rather simply collect the overpayment. Green Cross believes that the OIG did not recommend PCA because the OIG did not properly develop the cause of the overpayment. Therefore, if the OIG truly believes that there is a lack of internal controls at Green Cross, the OIG should revise the Draft Report to eliminate the requirement that First Coast collect an overpayment and instead instruct First Coast to engage Green Cross in a PCA program so that Green Cross may improve its internal procedures.

3. **Medical Review Issues.**

Green Cross, assisted by outside clinical consultants, closely reviewed relevant medical records, TriCenturion's work papers and Executive Summary. Green Cross' review uncovered gross inconsistencies between TriCenturion's reported findings and the content of the records.

TriCenturion's findings raise significant concerns because: (1) they are inconsistent with the results of past partial hospitalization audits; (2) they appear contrary to the LMRPs in effect at the time claims were submitted; and (3) they overlook, or at worst ignore, documentation included in the medical records under review.

The Draft Report outlined TriCenturion's findings under three subsections:

- Initial Certification/Evaluation Did Not Meet Requirements
- Re-Certifications Did Not Meet Requirements, and
- Beneficiaries Did Not Meet Medicare Eligibility Requirements

Green Cross' response to TriCenturion's findings under each subsection is outlined below.

A. Initial Certification/Evaluation Did Not Meet Requirements.

1. TriCenturion asserts that for two claims the medical necessity for partial hospitalization services was not established. TriCenturion's medical reviewers concluded that there was no medical history or physical examination that was current or completed within the last 30 days as required by LMRP. However, Green Cross' Medical Director performs physical examinations for all patients admitted to the partial hospitalization program if one has not been performed within 30 days prior to admission, or if not available from another provider for inclusion in the medical record. When performed by the Medical Director, it is included in the Admission Note/Psychiatric Evaluation in the section titled "Physical Examination." This is easily found in the medical documentation.

For example, in the medical records for patient sample #41, on page 2 of the Admission Note/Psychiatric Evaluation performed on 9/19/2002, a Physical Examination is included. Green Cross requests that TriCenturion re-review these records where indicated above to locate the medical history and physical examination. Because this information is in the records, Green Cross requests that these claims not be denied.

2. TriCenturion asserts that for ten claims, the initial certification did not contain the required certification content as per the LMRP.

First Coast reviewed Green Cross' charts in 2002 and intermittently throughout recent years and has always found them to be favorable. Green Cross has established a cooperative working relationship with the First Coast reviewers, who often given verbal feedback on ways to improve documentation. Green Cross has always considered such feedback and implemented immediate changes. Some of these same charts that had been reviewed and approved by First Coast have now been denied by TriCenturion.

The language used in the LMRP is: "I certify that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization services, and services will be furnished under the care of a physician, and under a written plan of treatment." Green Cross reviewed the medical records implicated and each contained certification language as follows:

> "I, a physician licensed to practice medicine, certify that Partial Hospitalization services are medically necessary in lieu of hospitalization to improve the patient's condition and functional level. I further certify that the patient is capable of participating in all aspects of the Partial Hospitalization Program, has adequate support outside the PHP and is not currently a threat to him/herself or others. I will oversee care for this patient

> and help develop a written individualized treatment plan geared toward stabilization."

While not the exact same language as contained in the LMRP, the above clearly meets the substance and intent of the LMRP. In fact, CMS does not require specific language with respect to a physician's certification. Section 3194.2.A of the Medicare Intermediary Manual states: "[u]pon admission, a certification by the physician must be made that the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization." Nowhere does CMS indicate that specific certification language must be used for a certification to be acceptable. In addition, it is unclear how not using verbatim certification language contained in the LMRP makes an underlying PHP service medically unnecessary. Therefore, these claims should be allowed.

B. Re-Certifications Did Not Meet Requirements.

1. TriCenturion asserts that the required initial re-certification was not found in the medical record documentation for nineteen claims as required by LMRP. But, in fact, a certification statement is included at the end of each Admission Note/Psychiatric Evaluation. In addition, a certification statement is also included in the Physician Admission Order. Each of these documents is completed and placed in the chart within 24 hours of the patient's admission to the partial hospitalization program. The first recertification is completed on the 14th calendar day following admission to the PHP, with subsequent recertification completed no less frequently than every 30 days.

Green Cross' practice is that, when a chart is requested for review, Green Cross sends, in addition to other requested documents, the Admission Note/Psychiatric Evaluation, the Physician Admission Order and the Physician Re-Certification Order *that pertain to the dates of service under review.* For example, for patient sample #68, a certification statement was included at the end of the Admission Note/Psychiatric Evaluation completed on 5/08/02. In addition, a certification statement was included on the Physician Admission Order completed on 5/08/02. The first re-certification order for this patient was completed on 5/22/02, the second on 6/02/02, the third on 6/20/02, the fourth on 7/19/02 and the last one on 8/16/02. *However, only the Physician Admission Order and the Physician Re-Certification Order completed on 7/19/02 were sent to OIG because the dates of service requested were from 7/24/02 through 7/31/02.* That is, Green Cross complied with the OIG's document request relative to the specific dates of

service referenced - the provider did not submit the entire voluminous medical record for each patient. If the OIG wanted the complete record of each patient for review in this case, it should have so requested. In short, the re-certifications TriCenturion claims are missing for 19 records, in fact appear in the medical record. Green Cross is more than happy to submit the re-certifications for these denied claims to the OIG. TriCenturion's findings on all charts where the re-certifications exist and can be provided should be reversed.

2. TriCenturion asserts that for twenty-one claims the initial re-certification was not documented as being performed on the date required by LMRP (18 calendar days following admission to the program). In addition, for three of the twenty-one claims (samples 34, 37 and 47) subsequent re-certifications, required no less frequently than every 30 days, were not found or not timely executed.

As mentioned above, only re-certifications that pertain to the dates being reviewed were sent when a review is requested. For example, in the records for patient sample #88, the first recertification order was completed on 10/07/02, which was the 14th calendar day following the patient's admission to the PHP on 09/23/02. Subsequent recertification orders were completed on 10/23/02 and 11/20/02. Green Cross is more than happy to submit this information to the OIG. TriCenturion's findings on all charts where the re-certifications exist and can be provided should be reversed.

3. TriCenturion asserted that for twenty-seven claims, Green Cross' records did not include documentation of beneficiaries' response to intensive therapeutic interventions, changes in functioning and the status of serious psychiatric symptoms which continue to place the beneficiary at risk of hospitalization. According to the relevant LMRP "re-certification should be based on a thorough reevaluation of the treatment plan in relation to the reason for admission and the progress of the patient." Green Cross reviewed a sampling of the specific records in question and in each case the re-certification met the requirements of the LMRP. The Green Cross Medical Director holds weekly clinical team meetings to thoroughly discuss each patient. The Green Cross Medical Director is a "physician trained in the diagnosis and treatment of the patient" as required by the relevant LMRP. Issues discussed include the patient's treatment plan, progress toward identified and objective goals, response to treatment interventions and obstacles in treatment. A summary of the discussion for each patient, along with a mental status and review of each identified short-term treatment goal, is included in the Weekly Summary and Treatment Plan Review. Each member of the interdisciplinary team, including the Psychiatrist/Medical Director, signs each Summary and Treatment Plan Review. Re-certification by the Medical Director is based on these findings, along with his own weekly Individual Therapy session with each patient. This is clearly documented in Green Cross' charts.

For example, in the Weekly Summary and Treatment Plan Review for patient sample #26, on 08/03/01 states the patient's response to intensive therapeutic interventions ("cooperative," "passive" and "needs frequent redirection"). It also states that the patient "reports feeling comfortable in the groups" and that the patient is making progress towards "being less guarded and defensive." Changes in functioning and the status of serious psychiatric symptoms which continue to place him at risk of hospitalization are reflected through the Treatment Goals Update. Each short-term, measurable treatment goal is reviewed, along with the status of each goal. Each treatment goal reflects a serious psychiatric symptom which places the patient at risk for hospitalization.

In addition, the Weekly Summary and Treatment Plan Review completed on 07/05/02 for patient sample #66 indicates the patient's response to intensive therapeutic interventions ("cooperative," "inappropriate," and "needs frequent redirection"). It also indicates changes in functioning and the status of serious psychiatric symptoms which continue to place the patient at risk of hospitalization, as indicated by the Treatment Goal Updates. These problems and goals correspond to the problems and goals documented in the Interdisciplinary Master Treatment Plan. For example, on this particular date (07/05/02), the findings of the clinical team were that patient had made further progress on Problem #1, Short-Term Goals #2, 3, 4 and 5, and Problem #2, Short-Term Goal #1. Each of the goals mentioned in the Interdisciplinary Master Treatment Plan reflect an objective and medically necessary behavior needed to obtain stabilization and prevent hospitalization and thus reflect serious psychiatric symptoms which place the patient at risk of hospitalization.

As the above examples demonstrate, this information is indicated in the medical records and Green Cross would be more than happy to point them out to TriCenturion. Because this information is contained in the records, these claims should be allowed.

4. TriCenturion asserts that one claim was denied because the re-certification language utilized was not in compliance with the re-certification language required by the LMRP. As noted above, the language used by Green Cross is unquestionably in compliance with the substance of the language recommended by the LMRP and therefore these claims should be allowed.

C. Beneficiaries Did Not Meet Medicare Eligibility Requirements.

1. The Draft Report states that thirteen claims were denied because there was no documentation to identify that less intensive treatment were attempted and failed prior to admission to the partial hospitalization program. The relevant LMRP does NOT require that less intensive treatment options be tried and fail prior to admission to a partial hospitalization program. Specifically, the LMRP states "[i]t is generally expected that less intensive treatment

in an outpatient setting be attempted prior to admission to partial hospitalization." A general expectation is not a mandatory requirement and it is improper and inconsistent with First Coast practices and policy to deny a claim on this basis.

Even so, most of the patients referred to the PHP at Green Cross. are either transitioned from an inpatient hospital treatment program or are referred by their primary psychiatrists following failed attempts to stabilize them at a less intensive level of treatment (i.e., outpatient therapy with medication management). Oftentimes patients are admitted to a weekly outpatient program at Green Cross, which consists of weekly group therapy and/or individual therapy conducted by a Licensed Psychologist or Licensed Clinical Social Worker. This outpatient program is used either as a step-down from PHP treatment or as an attempt to manage patients in a less intensive outpatient setting.

For example, the Admission Note/Psychiatric Evaluation for patient sample #83 on 10/15/02 states: "patient had begun the weekly outpatient program once again on 09/09/02 after recognizing that [the patient] was getting worse." A treatment plan for outpatient therapy was formulated and/or reviewed by two Licensed Psychologists and a Licensed Clinical Social Worker at that time and attempts were made to stabilize the patient at this less intensive level of treatment. Specifically, the patient was being seen weekly for group and individual therapy by a Licensed Clinical Social Worker. In addition, the patient's primary psychiatrist, the Medical Director of Green Cross, was also making attempts "to stabilize patient through medication changes" but the patient "continued to deteriorate." Because of these failed attempts at a less intensive level of treatment and because of her severe presenting symptoms, the patient was admitted to the PHP.

2. TriCenturion concluded that one beneficiary was unable to participate due to medical reasons as demonstrated by medical record documentation and that another beneficiary could not tolerate the intensity of the partial hospitalization program as demonstrated in the psychiatric evaluation. However, Green Cross has strict procedures in place to ensure that all patients are both physically and mentally prepared to participate in the partial hospitalization program. The Green Cross Medical Director, a Board Certified Psychiatrist, performs an extensive initial evaluation for each patient referred. Included in the evaluation is a physical examination. If the patient is admitted to the partial hospitalization program, on the day of admission he/she is seen by the Clinical Director, a Licensed Psychologist, and an Initial Treatment Plan is formulated. This initial treatment plan, along with clinical findings regarding the patient, is discussed between the Medical Director and Clinical Director. At this time notes are compared and questions are raised regarding any discrepancy in information or opinions. Although the Medical Director makes the final decision, mutual respect and confidence allows for open communication regarding whether or not a patient meets admission criteria. One of the criteria addressed is whether a patient has the capacity for active participation in all phases of the

program. In addition, within 72 hours of admission to the partial hospitalization program, a patient is also evaluated by a Licensed Clinical Social Worker and a Psychosocial Assessment is completed. The weekly clinical team meetings are also utilized to address treatment issues and if/how the patient is benefiting from the program. If a patient decompensates in the course of treatment, this issue is addressed amongst the clinical team and the Medical Director makes a decision regarding continued treatment.

The first patient referred to by TriCenturion is patient sample #32. Upon admission, this patient presented with medical problems, as indicated by the Admission Note/Psychiatric Evaluation. In particular, the patient suffered from glaucoma and an ulcer on his right ankle. The Patient was receiving treatment for the latter problem twice a week at South Shore Wound Healing Center, as indicated in the evaluation. Although his medical problems exacerbated the patient's depression, the patient's depression had been deteriorating following the loss of the patient's sibling one year prior to admission. The patient had been living with this sibling and other family members for 10 years. Approximately one month following the loss of the patient's sibling, this patient found a family member unconscious at home. The patient tried to resuscitate the family member but the family member passed away. These losses, along with the patient's medical problems, contributed to severe impairment in daily functioning. However, the degree of impairment was not considered so severe that the patient was incapable of participating and benefiting from an active treatment program. On the contrary, the patient made significant progress while in the program. In particular, the Discharge Summary states, "[The patient] appears less depressed and more accepting of the losses [the patient] has experienced in [the] family during the last year. Patient is starting to show more motivation to engage in ADL's, including self-care, and [the patient's] energy level has increased considerably. In addition, [the patient] is less isolative and more able to interact with others and participate in pleasant activities. Regarding [the patient's] physical and medical problems patient started to learn better ways to compensate for [the patient's] limitations and to cope with [] illness. [The patient] was able to remain medically stable while in the program and demonstrated more appropriate sleeping and eating patterns."

Although TriCenturion believed that patient sample #32 was unable to participate due to medical reasons, the above clearly shows that this patient was able to participate and in fact benefited from the PHP. TriCenturion reviewers should not simply substitute their opinion for that of medical professionals who actually interact, treat and care for patients. This claim should be allowed.

The second patient referred to by TriCenturion is patient sample #76. As indicated in the Admission Note/Psychiatric Evaluation, this patient was referred to PHP treatment following discharge from Mercy Hospital, where the patient received 8 ECT applications. The patient was admitted "in lieu of continued hospitalization." During the initial evaluation the patient presented as "very depressed and still slightly confused from the ECT applications." The patient

was "oriented to person and place but had difficulty with the date." The patient needed "prompting to elaborate on some of [the patient's] responses, presenting as very quiet." *These symptoms are common in patients following ECT treatment and tend to subside shortly following such treatment.* The patient's primary psychiatrist, Dr. Hector Sanchez, had been treating this patient for three years and also felt the patient was appropriate for PHP treatment at that time.

On the patient's first date of treatment the patient responded adequately in the groups. In the Symptoms Management Group on 09/09/02, the patient was "able to identify specific symptoms that she is currently feeling. The patient was able to acknowledge how treatment is very important in the patient's life this time and is the patient's number one priority, even though the patient "appeared to be somewhat somatic and concerned with [the patient's] physical health..." On that same day in the Psychotherapy Process Group, the patient stated "at this time, the most important thing is [the patient's] health and what [the patient] needs to do to improve [the patient's] mental health." It later stated that "the patient became receptive towards the end of the session." On the following day the patient was "attentive and alert" and "oriented x3" in all three groups. The patient was able to verbally participate and demonstrated insight into the patient's problems. For example, in the Decision Making/Problem Solving Skills Group the patient stated that "lately, [the patient] has not been strong enough to make decisions by [the patient's self]." In the Grief/Loss Group that same day the patient discussed how the patient "is having difficulty dealing with the multiple changes [the patient] has undergone during the patient's later years." On 09/11/02 in the Insight/Self-Awareness Group it is stated that the patient "was attentive and willing to participate" and that the patient "was able to explore more effective ways of coping with family conflicts as well as with [] mental illness." In the Relapse Prevention Group on that same date the patient "identified the need to comply with [] medications daily as well as to engage in hygiene care and activities with others." It later stated that "Positive feedback was provided to reinforce [the patient's] insight and participation in this group session."

It was not until 09/13/02 that the patient began to demonstrate symptoms that were incompatible with benefiting from treatment. For example, in the Psychotherapy Process Group it is noted that "patient continues to be with a lack of concentration and communicating in a tangential manner." The therapist later stated that the patient "was not able to adequately discuss the concept of control of our lives. The clinical will continue to monitor this situation to discuss appropriate steps to take with this patient." The patient had been presenting as tangential with difficulty staying focused most of the day, which had been a setback for this patient. The issue was addressed with the Medical Director and Clinical Director on that same date, as is protocol, and the Medical Director made the decision to discharge patient that same day "due to medical instability."

Although TriCenturion believed that patient sample #76 could not tolerate the intensity of the partial hospitalization program, the medical records indicate that for a period of time, the patient in fact was able to tolerate the intensity of the program. When it was later determined that the patient was no longer able to tolerate the intensity of the program, the patient was discharged. It is entirely normal for a patient's mental status and ability to respond to treatment to change over time, which is what occurred in this case. Because Green Cross appropriately dealt with the subsequent changes in this patient's status and made the proper decision to discharge the patient, this claim should be allowed..

4. **Conclusion.**

We hope this letter clearly and unequivocally explains Green Cross' position with respect to this review. Because of its many weaknesses, we hope that the OIG reconsiders issuance of the Draft Report in its current form. At minimum, Green Cross requests that the OIG reissue the Draft Report after the following bulleted revisions and actions have been taken:

- Reconsider the denial of Green Cross' request for an exit interview to discuss the Draft Report and to have a full and meaningful dialogue concerning the conduct of the review and the medical review findings.

- The OIG should reconsider its findings concerning a lack of internal controls because the OIG never tested or reviewed Green Cross' internal controls.

- The Draft Report should be revised to explain how the evidence forms a rational basis for the reviewer's judgment that there is a lack of internal controls when other likely and reasonable alternative explanations for the evidence, such as faulty medical review, incorrect direction provided by First Coast and other reasons were not first reviewed and ruled out.

- The Draft Report should describe and reconcile Green Cross' longstanding positive history with First Coast with the fact that TriCenturion's asserted a 95% error rate. At minimum the disparate results should be referenced.

- The Draft Report should describe what procedures were undertaken by the OIG to ensure that TriCenturion's medical review was accurate, fair and unbiased and that TriCenturion reviewers were appropriately trained and appropriately applied the LMRPs.

- The Draft Report should explain any procedures undertaken by the OIG to validate the accuracy and reliability of TriCenturion's medical review findings.

- The Draft Report should disclose the fact that TriCenturion subsequently had its contract to perform as a PSC for Florida and Puerto Rico terminated, the reasons for such termination and whether the reasons behind the termination may affect the reliability of the medical review results referenced in this report.

- The OIG should strike the medical review findings until a subsequent review can be undertaken by properly licensed and qualified medical personnel to evaluate the information Green Cross has provided herein.

- The OIG should revise the "Recommendation" section of the Draft Report to eliminate the recoupment requirement and instead require First Coast to engage Green Cross in a progressive action program as required by §3.11 of Medicare Manual 100-8.

If we can be of any further assistance, please contact through the contact information set out above.

Very truly yours,

Christopher L. White

Patrick L. Gilmore

Attachments

cc: Miguel Nunez MD, MBA
Gerald Dunham

ATTACHMENT A

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Morgan Lewis
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Patrick L. Gilmore
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February 2, 2005

John T. Drake
Acting Regional Inspector General
for Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Re: Report Number: A-04-04-02003

Dear Mr. Drake:

Thank you for your response dated January 24, 2005 to our correspondence of October 11 and 18, 2004 to Charles Curtis. Although the information set out in your correspondence is helpful, it raises material questions. In addition, we hereby request a formal exit conference to discuss draft report number A-04-04-02003 entitled "Medical Review of Green Cross' Partial Hospitalization Services for the Period August 1, 2000, through December 31, 2002" (the "Draft Report"). As you know, in a meeting on July 20, 2004 between representatives of Green Cross (the "Provider") and OIG auditors, the OIG only presented the Program Safeguard Contractor's (the "PSC's") medical review results and were unable to discuss the PSC review results in any substantive or meaningful way.

The following are questions and concerns raised by your January 24, 2005 correspondence:

1. Your response stated that the OIG had no interviews with the FI and CMS concerning directions, policies or guidelines relative to the medical review and that the only documentation concerning the conduct of the medical review was the Florida Local Medical Review Policy ("FLMRP"). However, the Draft Report section entitled "Methodology" states that the auditors "...interviewed officials with the FI, CMS, and provider." We are requesting all documentation that was used by the independent reviewer to support the statement that these officials were interviewed and information concerning the substance of those interviews. We are basing this request on the OIG requirement found in The Audit Process Manual (the "TAP Manual") that all reports be independently reviewed.

2. Your response also stated that the OIG has no working papers regarding a review of the Provider's procedures because the OIG relied on substantive tests. The deductive conclusion that the excessive error rate was the fault of the provider does not appear valid because it does not rule out other possible conclusions. In a letter to Donald Czyzewski dated September 22, 2004, the Provider suggested at least three other possible conclusions. Briefly, these included: (1) The PSC review was based on different standards; (2) The findings were contrary to the operable FLMRP as it is construed by the cognizant FI; and (3) the findings may have overlooked documents included in records reviewed.

   In addition to the three possibilities mentioned above, there are other plausible conclusions as well. Processing Medicare claims includes an integrated network of control environments that cannot be unilaterally reviewed. When assessing the cause of claims not meeting reimbursement requirements, one is compelled to inspect a provider's claims submission procedures, the FI's progressive corrective action program, and the FI's medical review and provider education activities. Historically, the Provider fared well under claims reviews conducted by the FI. There was rarely ever a denial and the Provider adopted any improvements suggested by the FI.

   We therefore request the working papers that support the deductive conclusion that the Provider did not have adequate procedures in place to ensure claims met the Medicare reimbursement requirements. We are also requesting the authority or the guidance that the OIG follows in forming conclusions using deductive reasoning. Deductive reasoning does not appear to be appropriate for conclusions that result in the repayment of millions of dollars by a Medicare provider.

3. Your response implied that the reason that the information in the September 22, 2004 letter from the Provider was not mentioned in the Draft Report was because the letter stated that it was not to be considered a final rebuttal. While it is true that the Provider wanted to make certain that the letter was not considered a final rebuttal, the information in the letter was directly relevant to the conclusions reached by the OIG in the Draft Report and warranted serious consideration. The letter advised the OIG of specific medical review errors on the part of the PSC, and the Provider believed the OIG would want to investigate these disparate matters before issuing an erroneous report. The Provider still intends that the matters discussed in the letter be addressed in the Draft Report. In fact, the TAP Manual indicates that the comments of the Provider should be sought throughout the audit; not just as a rebuttal to the draft report (see SWP-4).

Morgan Lewis
COUNSELORS AT LAW

4. The OIG has placed the totality of its audit results on the expertise of an external organization: the PSC. We are requesting that we be provided with the verification process that the OIG followed to select an organization that qualifies as an expert in Medicare coverage and reimbursement and to verify that the review was conducted according to Medicare rules and regulations. We do not believe that a PSC is qualified by definition to apply coverage and reimbursement rules developed by another entity.

Finally, we are requesting that we be given the opportunity to have a formal exit conference with the auditors to discuss the draft report. At the time of the earlier meeting held on July 20, 2004, we were provided with only a copy of the PSC results and an extrapolation. The substantive PSC results could not be addressed at that time despite the Provider's request because the auditors said they could not discuss them. Again the TAP manual provides for an exit conference to discuss the draft report and we are therefore requesting that one be scheduled as soon as practicable.

Thank you for your usual prompt attention to this request.

Sincerely,

Patrick L. Gilmore

cc: Miguel A. Nuñez, Jr., M.D.
Gerald R. Dunham
Christopher L. White, Esq.

ATTACHMENT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

February 25, 2005

Report Number: A-04-04-02003

Mr. Patrick Gilmore, Esq.
Morgan, Lewis & Bockius LLP
1111 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Dear Mr. Gilmore:

This is in response to your February 2, 2005 letter requesting a second exit conference and additional information to respond to our draft report entitled *Medical Review of Green Cross' Partial Hospitalization Services for the Period of August 1, 2000, through December 31, 2002* (report number A-04-04-02003). Specifically, in your February 2nd letter you requested:

(1) a second exit conference with the auditors to discuss the draft report;

(2) all documentation that was used by the independent reviewer to support the statement that officials with the fiscal intermediary (FI), the Centers for Medicare & Medicaid Services (CMS), and the provider were interviewed and information concerning the substance of those interviews;

(3) the working papers that support the deductive conclusion that the provider did not have adequate procedures in place to ensure claims met Medicare reimbursement requirements;

(4) that the matters discussed in the September 22, 2004 letter from the provider be addressed in the draft report; and

(5) the verification process that the Office of Inspector General (OIG) followed to select an organization that qualifies as an expert in Medicare coverage rules and regulations.

In response to requested item (1), we have provided all available information relative to medical review findings and during the initial exit conference on July 20, 2004, we informed Green Cross that due process would be afforded through the provider's right to appeal. We stated that any disagreements to medical review findings would need to be addressed with the FI during the audit resolution process. We do not believe another conference would be beneficial.

We also explained to Green Cross that it would have the opportunity to provide management comments to express concerns relating to the findings. Green Cross' management comments will be incorporated as submitted into the final report. The only exception is if the response specifically identifies a patient, that part would have to be redacted.

Relating to requested item (2), we have no documentation other than the Florida Local Medical Review Policies (FLMRP) as the interviews we had with the FI and CMS did not involve directions, policies or guidelines relative to the medical review. Rather, our discussions related primarily to identifying providers for review.

Relating to requested item (3), as stated in our draft report, the conclusion that the provider did not have adequate procedures in place is a deductive conclusion based on the results of the medical review documentation provided by Green Cross. Our logic is that if the provider had adequate procedures in place, the medical reviewers would not have determined that 95 of the 100 claims did not meet Medicare reimbursement requirements. Generally accepted government auditing standards permit the use of analytical evidence based on rational arguments. Our conclusion is a logical sequence and to the reported findings. Therefore, we continue to believe our conclusion is appropriate.

Relating to requested item (4), we again assert that Green Cross would have an opportunity to provide management comments to express concerns relating to the findings, and that these comments will be incorporated into the final report.

Regarding requested item (5), OIG uses an existing CMS contract with the program safeguard contractor (PSC) to perform claims reviews on behalf of the OIG. We rely on CMS to ensure that the PSC medical reviewers are qualified to perform Medicare medical reviews.

Your letter also stated that, "*We do not believe that a PSC is qualified by definition to apply coverage and reimbursement rules developed by another entity.*" The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program, in part, to strengthen CMS's ability to deter fraud and abuse in the Medicare program. CMS created PSCs to perform program safeguard functions such as medical review, cost report audit, data analysis, provider education, and fraud detection and prevention. Under a task order awarded on June 3, 2002, TriCenturion performed fraud and abuse safeguard functions for the Medicare Part A workload in Florida, a function that used to be performed by First Coast Service Options, Inc.

We have provided you with all requested information, except for information applicable to your firm's Freedom of Information Act (FOIA) request. Once your firm has been notified of the departmental decision regarding your FOIA request, please provide us with a response to report number A-04-04-02003 no later than 30 days from that date. If you do not provide comments by close of business on that date, we reserve the right to issue the report as final without comments.

If you have any questions or need additional information, please contact Mr. Donald Czyzewski, Audit Manager, at (305) 536-5309, extension 10, or Mr. Mario Pelaez, Senior Auditor, at (305) 536-5309, extension 15.

Sincerely,

for Lori S. Pilcher
Regional Inspector General
for Audit Services, Region IV

ATTACHMENT C

September 22, 2004

Donald G. Czyzewski, Audit Manager
Office of Inspector General
Office of Audit Services, Region IV
51 SW 1st Ave., Rm 504
Federal Building, Box 20
Miami, FL 33130-1631

RE: "Summary of Findings" and exit conference for Green Cross, Inc. 10-4666. CIN: A-07-04-04028 (This should not be construed as a response to a "draft report" of the OIG).

Dear Mr. Don Czyzewski:

I am writing in follow up to the exit conference of July 20, 2004, where the OIG shared, but were unable to substantively address, the PSC's findings based upon review of 100 patient charts. The Green Cross clinical team, assisted by outside clinical consultants, closely reviewed each medical record at issue in response to the PSC's findings. The review demonstrated gross error and inconsistencies with prior audit results. Based on these errors, we feel compelled to write at this time, even before having received a draft audit report, to bring these errors and inconsistencies to the OIG's attention. Notwithstanding the detail and analysis presented in this letter, this letter should not be construed as Green Cross's rebuttal statement in response to the audit. Green Cross expressly reserves its rights to comment upon the draft audit report, within a reasonable period after Green Cross's receipt of the report.

The "Summary of Findings" provided in a spreadsheet format during our exit conference provides reasons for denial that on our careful review are not substantiated by the facts. Our confidence in our medical records is not solely based on our review but also of being under periodic review by the fiscal intermediary and by undergoing a full probe review of forty medical records covering this same time period conducted by the medical review department of our fiscal intermediary.

Green Cross, Inc. was under 100% medical review by the fiscal intermediary from early 1998 through the beginning of 1999. Subsequent to that we came steadily off review and have had periodic reviews of samples of our charts as well as the probe review at the end of 2001. The probe review during this period showed our medical records to be in compliance with the standards of documentation and found the claims to be acceptable. The other periodic reviews conducted around this same time period by the fiscal intermediary of a sampling of our records also resulted in favorable findings. We have had a good working relationship with the fiscal intermediary and any feedback the FI has provided we have been quick to adopt. Our center has also undergone Joint Commission (JCAHO) accreditation and reaccredidation reviews. We have been JCAHO accredited since 1996. We believe from our detailed review of the records in question that all of the claims will ultimately be acceptable to the fiscal intermediary.

It is quite possible that in reviewing these claims, if we are to assume a non-prejudiced review, the PSC may have applied different criteria that have resulted in adverse findings for the providers selected for medical review. Given that other reviews by independent outside agencies do not corroborate the findings presented at the exit conference but instead clearly contradict them highlights the lack of reproducibility of the OIG findings and undermines the review process implemented by the PSC of the medical records. In the scientific community such contradictory and non-reproducible findings would not be worthy of publication in any peer-reviewed journal with the conclusions that have been suggested. If any conclusions could be drawn they would be to highlight a possible disparity in the review process and criteria used by the fiscal intermediary (whose reviews have been corroborated by JCAHO reviews and our own internal reviews) and the current review produced by the PSC that has a radically different outcome.

Upon close scrutiny, the PSC's findings raise significant concerns because: (1) they are inconsistent with the provider's long-standing experience with multiple other audits, and appear to be based on different standards than those applied in other Medicare audits; (2) the findings are contrary to the operable LMRP as it is construed and applied by Green Cross's fiscal intermediary; (3) the findings overlook documents included within the records under review. We would welcome the opportunity to discuss the PSC findings with their reviewer.

I will highlight some of our findings in reviewing the summary provided by the OIG in the Exit Conference. On the first page of the summary, 17 claims were denied stating "...the required certification language did not

contain the required certification content as per LMRP...." The language suggested by the LMRP is: "I certify that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization services, and services will be furnished under the care of a physician, and under a written plan of treatment." We looked at all 17 medical records and each had the certification language. An example of the certification language we use contained at the end of the Psychiatric Admission Note and signed by a licensed Psychiatrist is a follows:

> "I, a physician licensed to practice medicine, certify that Partial Hospitalization services are medically necessary in lieu of hospitalization to improve the patient's condition and functional level. I further certify that the patient is capable of participating in all aspects of the Partial Hospitalization Program, has adequate support outside the PHP and is not currently a threat to him/herself or others. I will oversee care for this patient and help develop a written individualized treatment plan geared toward stabilization."

This same language, minus the last sentence, is again contained and reaffirmed on our physician's admission order sheet.

The next reason given for denial states, "...Specifically, it did not include documentation of beneficiaries response to intensive therapeutic interventions, changes in functioning and the status of serious psychiatric symptoms which continue to place the beneficiary at risk of hospitalization." According to the relevant LMRP "recertification should be based on a thorough reevaluation of the treatment plan in relation to the reason for admission and the progress of the patient." We looked at the specific records in question (or a sampling of them) and in each case the recertification met the requirements of the LMRP. At Green Cross, Inc., weekly clinical team meetings are held by the Medical Director to thoroughly discuss each patient. Issues discussed during these meetings include, but are not limited to, the patient's treatment plan, progress toward identified and objective goals, response to treatment interventions and obstacles in treatment. A summary of the discussion for each patient, along with a mental status and review of each identified short-term treatment goal, is included in the Weekly Summary and Treatment Plan Review. Each member of the interdisciplinary team, including the Psychiatrist/Medical Director, signs each Summary and Treatment Plan Review. Recertification by the Medical Director is based on these findings, along with his own weekly Individual Therapy session with each patient.

This is all clearly documented in our charts as can be seen from a sample of a reviewed chart. In the Weekly Summary and Treatment Plan Review

for this patient, it states his response to intensive therapeutic interventions ("cooperative," "passive" and "needs frequent redirection"). It also states that he "reports feeling comfortable in the groups" and that he is making progress towards "being less guarded and defensive." Changes in functioning and the status of serious psychiatric symptoms which continue to place him at risk of hospitalization are reflected through the Treatment Goals Update. Each short-term, measurable treatment goal (found in the Interdisciplinary Master Treatment Plan) is reviewed, along with the status of each goal. Each treatment goal reflects a serious psychiatric symptom which places the patient at risk for hospitalization.

The next reason for denial given was "Recertification did not meet requirements" and "For these 19 claims, the required initial recertification was not found in the medical records documentation as required by LMRP." As noted above, a certification statement is included at the end of each Admission Note/Psychiatric Evaluation. In addition, a certification statement is also included in the Physician Admission Order. Each of these documents is completed and placed in the chart within 24 hours of the patient's admission to the partial hospitalization program. The first recertification is completed on the 14th calendar day following admission to the PHP (this is more stringent than the published guideline in the LMRP to recertify on the 18th calendar day), with subsequent recertification completed no less frequently than every 30 days. This also addresses the following reason given for denial of 21 other claims, "the initial recertification was not documented as being performed on the date required by LMRP (18 calendar days following admission to the program) ... subsequent recertification required no less frequently than every 30 days were not found or not timely executed."

When a chart is requested for review, Green Cross, Inc. sends, in addition to other requested documents, the Admission Note/Psychiatric Evaluation, the Physician Admission Order and the Physician Recertification Order that pertains to the dates of service being reviewed. As an example one of the patients listed had an admission on May 8, 2002. For this patient, a certification statement is included at the end of the Admission Note/Psychiatric Evaluation completed on 5/08/02. In addition, a certification statement is included on the Physician Admission Order completed on 5/08/02. The first recertification order for this patient was completed on 5/22/02, the second on 6/02/02, the third on 6/20/02, the fourth on 7/19/02 and the last one on 8/16/02. Only the Physician Admission Order and the Physician Recertification order completed on 7/19/02 were sent because the dates of service requested were from 7/24/02 through 7/31/02.

Another reason given for denial of 10 claims was "...the initial psychiatric evaluation/certification did not contain certification language required by LMRP. Specifically, they did not include an attestation that the services will be furnished under the care of a physician and under a written plan of care". We have already noted above the language in our certification which contains in substance everything required by the LMRP. Furthermore, a review of charts was conducted by the Fiscal Intermediary in 2002. In addition, charts have also been reviewed intermittently throughout the recent years by the FI and have always been found favorable. A cooperative working relationship has been maintained with the reviewers and verbal feedback was often given by them on ways the chart documentation can be improved. Such feedback has always been considered and immediate changes implemented. Throughout these reviews comments were never made regarding certification documents and the charts have been found favorable. Some of these same charts that have been reviewed and found favorable have been denied at this time by the OIG Inspection. As noted our charts include a comprehensive treatment plan signed by the psychiatrist as well as at least weekly progress notes by the psychiatrist, there is no question treatment in our facility is under the care of a physician.

The next denial reason for 2 claims is "...the medical necessity for partial hospitalization services was not established. Medical reviewers concluded that there was no medical history of physical examination that was current or completed within the last 30,days as required by LMRP." The Medical Director of Green Cross, Inc. performs physical examinations for all patients admitted to the partial hospitalization program if one has not been performed within 30 days prior to admission or if not available from another provider for inclusion in the medical record. When performed by the Medical Director, it is included in the Admission Note/Psychiatric Evaluation in the section titled "Physical Examination." In our review and the multiple reviews conducted by the fiscal intermediary this has always been easily found in our documentation.

Another reason for denial of 13 claims was "...there was no documentation to identify that less intensive treatment options (i.e., intensive outpatient, psychological, day treatment) were attempted and had failed prior to admission to the PHP program." Most of the patients referred to the PHP at Green Cross, Inc. are either transitioned from an inpatient hospital treatment program or are referred by their primary psychiatrists following failed attempts to stabilize them at a less intensive level of treatment (i.e., outpatient therapy with medication management). Oftentimes patients are admitted to a weekly outpatient program at Green Cross, Inc., which consists of weekly group therapy and/or individual

therapy conducted by a Licensed Psychologist or Licensed Clinical Social Worker. This outpatient program is used either as a stepdown from PHP treatment or as an attempt to manage patients in a less intensive outpatient setting.

All of this is clearly documented in the charts in question. As an example from one of the charts, in the Admission Note/Psychiatric Evaluation it was noted that the patient "had begun the weekly outpatient program once again on 09/09/02 after recognizing that she was getting worse." A treatment plan for outpatient therapy was formulated and/or reviewed by two Licensed Psychologists and a Licensed Clinical Social Worker at that time and attempts were made to stabilize patient at this less intensive level of treatment. Specifically, she was being seen weekly for group and individual therapy by a Licensed Clinical Social Worker. In addition, her primary psychiatrist, the Medical Director of Green Cross, Inc., was also making attempts "to stabilize patient through medication changes" but she "continued to deteriorate." Because of these failed attempts at a less intensive level of treatment and because of her severe presenting symptoms, she was admitted to the PHP.

Again, another reason given for denial of 10 claims was "...the re-certification did not contain the required certification content as per the LMRP. Specifically, it did not include documentation of beneficiaries response to intensive therapeutic interventions, changes in functioning and the status of serious psychiatric symptoms which continue to place the beneficiary at risk of hospitalization. In addition, the re-certification document consisted solely of physician orders and the physician attestation that continued attendance to the PHP was necessary to prevent inpatient hospitalization. " As mentioned above, the Weekly Summary and Treatment Plan Review contains documentation of the patient's response to intensive therapeutic interventions, changes in functioning and the status of serious psychiatric symptoms which continue to place the patient at risk of hospitalization. These Weekly Summary and Treatment Plan Reviews, along with the Medical Director's weekly Individual Therapy sessions with each patient, help him determine whether recertification/continued PHP treatment would benefit patient to prevent relapse or hospitalization.

Also, as indicated above, are the reviews of charts which have been conducted intermittently in recent years by the Fiscal Intermediary. Throughout these reviews comments were never made regarding recertification documents and the charts have been found favorable. As an example taken from one of the charts in question, the Weekly Summary and Treatment Plan Review completed on indicates her

response to intensive therapeutic interventions ("cooperative," "inappropriate," and "needs frequent redirection"). It also indicates changes in functioning and the status of serious psychiatric symptoms which continue to place her at risk of hospitalization, as indicated by the Treatment Goal Updates. These problems and goals correspond to the problems and goals documented in the Interdisciplinary Master Treatment Plan. Each of the goals mentioned in the Interdisciplinary Master Treatment Plan reflect an objective and medically necessary behavior needed to obtain stabilization and prevent hospitalization and thus reflect serious psychiatric symptoms which place the patient at risk of hospitalization.

The next reason for denial of 1 claim was "...the recertification language utilized was not in compliance ith the recertification language required by the LMRP". I have previously noted the language we use and noted how it is unquestionably in compliace with the substance of the language in the LMRP. Furthermore, several charts from the same period of time reviewed by the OIG have been reviewed and approved by the Fiscal Intermediary. Feedback regarding the re-certification language used by Green Cross, Inc. has never been provided. In incidences when feedback has been provided, changes have been made immediately. For example, Green Cross, Inc. was asked in December, 2000, to include the length in time of each group provided on page 1 of the Interdisciplinary Master Treatment Plan form. This form was modified immediately.

For 2 claims, "...it was concluded that 1 beneficiary was unable to participate due to medical reasons as demonstrated by medical records documentation and the other beneficiary could not tolerate the intensity of the PHP as demonstrated in the psychiatric evaluation." At Green Cross, Inc., an extensive initial evaluation is performed by the Medical Director, a Board Certified Psychiatrist, for each patient referred. Included in the evaluation is a physical examination. If the patient is admitted to the PHP, on the day of admission he/she is seen by the Clinical Director, a Licensed Psychologist, and an Initial Treatment Plan is formulated (see Attachment N). This initial treatment plan, along with clinical findings regarding the patient, is discussed between the Medical Director and Clinical Director. At this time notes are compared and questions are raised regarding any discrepancy in information or opinions. Although the Medical Director makes the final decision, mutual respect and confidence allows for open communication regarding whether or not a patient meets admission criteria. One of the criteria addressed is whether a patient has the capacity for active participation in all phases of the program. In addition, within 72 hours of admission to the PHP, a patient is also evaluated by a Licensed Clinical Social Worker and a Psychosocial Assessment is completed. The

weekly clinical team meetings are also utilized to address treatment issues and if/how the patient is benefiting from the program. If a patient decompensates in the course of treatment, this issue is addressed amongst the clinical team and the Medical Director makes a decision regarding continued treatment.

In conclusion, based on our review of the records and the documentation we provided as well as based on the previous multiple intensive reviews of our medical records by the fiscal intermediary these denials could not hold up when reviewed in a non-prejudicial manner. We would welcome the opportunity to meet in person with the PSC reviewers for a direct explanation of the basis for each denial. If this audit were to be held up to the government's due diligence standards the only reasonable conclusion from the data presented at the exit conference is to highlight a possible disparity in review processes and not an internal deficiency of a provider.

I hope these comments have been helpful. At Green Cross, Inc. we have a long history of working together with government, it's agencies, and contractors to provide quality mental health services to our community. Should you have any questions or wish to dialog further please feel free to contact me.

Cordially,

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Chief Executive Officer

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