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★ ★ ★ **OPERATION RESTORE TRUST** ★ ★ ★

December 8, 1997

Mr. Curtis Lord, VP Program Safeguards
Blue Cross/Blue Shield of Florida
532 Riverside Avenue
PO Box 2078
Jacksonville, FL 32231-0048

Dear Mr. Lord:

The enclosed report provides the results of the Operation Restore Trust (Wedge Project) review of the Victoria Behavioral Health Services, Community Mental Health Center (Provider #10-4724) located in Miami, Florida. The objectives of this review were two-fold. First, to evaluate whether the provider met the certification requirements for a CMHC to provide Partial Hospitalization services in accordance with § 1861 ff of the Social Security Act and § 1916 (c)(4) of the Public Health Service Act. Secondly, to evaluate the payments made to the provider to ensure they were appropriate.

A sample of 20 beneficiaries was reviewed for the period January 1996 through December 1996. Our findings will require corrective actions by the Fiscal Intermediary, HCFA, and the OIG.

Please prepare and submit to the HCFA Miami ORT office, an action plan to implement recommendations made in this report that pertain to your organization.

If there are any questions regarding this report, please call Dewey Price at 305-536-6772 or Sheila Kanaly at 305-536-6588.

Sincerely,

Rose Crum-Johnson
Rose Crum-Johnson
HCFA Region IV Administrator

Charles J Curtis
Charles Curtis
Region Inspector General-Audit

cc: Angela Bryce-Smith, HCFA CO
Mario Pelaez, OIG-OA
Dale Kendrick, HCFA Region IV
Eugene Grasser, HCFA Region IV
Barbara Bisno, AUSA

VICTORIA BEHAVIORAL HEALTH SERVICES
Provider No. 10-4724

I. INTRODUCTION

The Secretary of the Department of Health and Human Services and the President initiated Project Operation Restore Trust (ORT), an innovative, collaborative project designed to address growing concerns over rising health care costs. A review of departmental records indicated that over the last 10 years, many segments of the health care industry have experienced a surge in health care fraud and that the States of Texas, California, Illinois, New York and Florida receive annually over 40 percent of all Medicare and Medicaid funds. As a result, these States were selected to participate in the ORT 23-month pilot project.

Within the Department of Health and Human Services, ORT has been a joint effort by Health Care Financing Administration (HCFA), the Office of the Inspector General (OIG), and the Administration on Aging. These components are focusing attention on program vulnerabilities identified through investigations and audits. In 1997, HCFA, its State agencies and contractors, and the OIG carried out various projects (commonly referred to as wedge projects). In the State of Florida, one of these projects involved onsite reviews of community mental health centers (CMHCs). Through analysis of HCFA Customer Information System (HCIS) billing data and review of complaints, ten CMHCs were selected for onsite review.

These onsite reviews were conducted by an ORT team consisting of representatives from HCFA, the Medicare contractor, the Florida Agency for Health Care Administration (Survey and Certification Staff), and the OIG- Office of Audit.

This report provides the results of the combined review of the Victoria Behavioral Health Center (Victoria) Partial Hospitalization Program (PHP) conducted on July 7, 1997 through July 9, 1997.

II. EXECUTIVE SUMMARY

The objectives of the review were to:

1) determine whether the provider met the certification criteria for a Community Mental Health Center;

2) determine whether the 20 sample Medicare beneficiaries met the eligibility requirements for the Partial Hospitalization Program (PHP) benefit;

3) determine whether the Medicare coverage and reimbursement criteria were met for PHP services claimed by Victoria from 1/1/96 through 12/31/96 on behalf of 20 sample Medicare beneficiaries; and

4) determine whether the costs claimed on Victoria's fiscal year 1995 (04/01/95 - 3/31/96) cost report were allowable, reasonable, and necessary.

The significant findings of our review were as follows.

1) The team determined that the facility did not meet certification requirements to operate as a CMHC under sections 1916(c)(4) of the Public Health Service Act and section 1861 of the Social Security Act. Specifically, the provider was unable to substantiate provision of any of the five required core services. Therefore, it is recommended that this provider's number be voided and that all payments made to the provider since its effective date of participation in the Medicare program be recouped (this amount approximates $ 4,510,161 as per the Medicare Part A Provider Summary Report).

2) The team's medical review of the 20 sampled beneficiaries found that none were eligible for PHP benefits.

3) The services provided to the sample 20 Medicare beneficiaries for whom Victoria submitted claims for PHP services for the period of January 1, 1996 through December 31, 1996 represented a net reimbursement in the amount of $1,959,296 (as per HCFA Customer Information System (HCIS) data reported on November 5, 1997). The medical review conducted by the Fiscal Intermediary (FI) staff and HCFA concluded that all of the services claimed during the reviewed period did not meet the Medicare coverage and reimbursement criteria and that the content of the group sessions was social, recreational, and diversionary, rather than of a psychotherapeutic nature. Furthermore, the review team determined that the group sessions were conducted by nonlicensed staff.

4) The review concluded that Victoria had claimed costs in its Fiscal Year (FY) 1995 Cost Report totaling $1, 196,664 that were unnecessary and unreasonable charges, and therefore unallowable. The "de facto" owner of Victoria was the Executive Medical Director (EMD) of Victoria. The audit found that Victoria's EMD and family members received approximately $1.2 million in 1995 from various management and consulting contracts including: a medical management service; a staffing company; an information systems service; a billing service company; a realty company, and a transportation/food service company. The contractual relationships between these related parties were not disclosed in either the Medicare application or cost report. We are thus recommending these costs be disallowed and that this information be referred to OIG-Office of Investigations.

On July 29, 1997, the Miami Satellite Office directed the fiscal intermediary to suspend without notice all Medicare payments to Victoria. This action was taken under the provision of 42 CFR 405.372(a)(4), as a result of the determinations by the team: that the provider did not meet the certification requirements for a CMHC; that the 20 beneficiaries did not meet the eligibility criteria for the PHP benefit; that the services were non-therapeutic in nature; and that there was more than $1,196,000 in disallowed costs. Additionally, the Miami Satellite Office recommended to HCFA Region IV on August 8, 1997, that the

provider agreement with Victoria be terminated.

III. BACKGROUND

Title XVIII of the Social Security Act (the Act) authorizes the Medicare program to provide medical benefits to individuals who are age 65 or over, and certain individuals under age 65 who are disabled or suffering from end-stage renal disease. Section 1835 of the Act established coverage of partial hospitalization services for Medicare beneficiaries. Section 1861(ff)(2) of the Act generally defines partial hospitalization services as those [mental health] services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary will by regulation establish. This benefit was designed to be a last step treatment for patients who had been diagnosed with mental illness and their condition was in an acute state. These services were supposed to be of limited duration and would be the last steps before inpatient hospitalization. Thus, it was perceived by Congress that this benefit would result in cost savings for treating the mentally ill and because it is limited to those beneficiaries whose mental illness is in an acute state, the expenditures for these services would be minimal.

Section 4162 of Public Law 101-508 (OBRA 1990) amended Section 1861 of the Act to include CMHCs as entities that are authorized to provide partial hospitalization services under Medicare. Section 1916(C)(4) of the PHS Act lists the services that must be provided by a CMHC. A Medicare-certified CMHC can either provide PHP services directly or under arrangement with other providers, in order to render CMHC services as required by the Public Health Service Act.

HCFA's definition of a CMHC is based on §1916(c)(4) of the Public Health Service (PHS) Act. The PHS definition of a CMHC is cross-referenced in section 1861(ff) of the Social Security Act. HCFA defines a CMHC as an entity that provides:

- outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health services area who have been discharged from inpatient treatment at a mental health facility;
- 24-hour a day emergency care services;
- day treatment or other partial hospitalization services or psychosocial rehabilitation services;
- screening for patients being considered for admission to State mental health facilities to determine the appropriateness for such admission; and
- consultation and education services.

In order for a Medicare patient to be eligible for a partial hospitalization program, a physician must

certify (and recertify where such services are furnished over a period of time):

1) that the individual would require inpatient psychiatric care in the absence of such services, [This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted];

2) an individualized plan for furnishing such services has been established by a physician and is reviewed periodically by a physician; and

3) such services are or were furnished while the individual is or was under the care of a physician. [Physician certification is required under the procedures for payment of claims to providers of partial hospitalization services under §1835 (a)(2)(F) of the Act.]

A Medicare partial hospitalization program is an appropriate level of active treatment intervention for individuals who:

❑ are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment. Partial hospitalization is the level of intervention that falls between inpatient hospitalization and episodic treatment on the continuum of care for the mentally ill;

❑ do not require 24-hour care and have an adequate support system outside the hospital setting while not actively engaged in the program;

❑ have a diagnosis that falls within the range of ICD-9 codes for mental illness (i.e., 290 through 319). However, the diagnosis in itself is not the sole determining factor for coverage; and

❑ are not judged to be dangerous to self or others.

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

Victoria Behavioral Health Center is a for-profit corporation with its principal place of business at 2225 SW 18th Avenue in Miami, Florida. Its effective date of participation in the Medicare program was January 24, 1995. The provider number was issued based on a self-attestation statement certifying the facility's compliance with the Federal requirements in Sec. 1861 (ff)(3)(B) of the Public Health Service Act, Sec. 1866 of the Social Security Act, and its conformance with the provisions concerning Medicare provider agreements. The fiscal intermediary for Victoria was identified as Florida Blue Cross/Blue Shield.

IV. SCOPE AND METHODOLOGY

In order to determine if the provider met the certification requirements for a CMHC, Victoria staff were interviewed and requested to provide documentation (including medical records) demonstrating their provision of the five required core services.

During the review, applicable laws, regulations, and Medicare guidelines were used to determine whether the sample beneficiaries and the services claimed met the Medicare eligibility and reimbursement guidelines. The medical review was performed using the criteria set forth in Title 42 CFR 424.24 which provides that Medicare pays for partial hospitalization services only if a physician certifies the content of the plan of care. The plan must include the physician's diagnosis, the type, frequency, and duration of services to be administered, and the goals of the treatment plan. In addition, the patient must meet eligibility criteria to receive PHP services.

The medical review was conducted by staff from HCFA and the fiscal intermediary. The review process consisted of a review of all claims submitted by Victoria for the 20 sample beneficiaries between January 1st and December 31st, 1996. The sample used for this review was not based upon a statistically valid random sample, and therefore, the results would not be extrapolated to the entire universe of the provider's claims.

The financial data, reports, and supporting documentation for fiscal year 1995 were requested to determine if costs claimed on the FY 1995 cost report were allowable, reasonable, and necessary. The cost report review was performed in accordance with generally accepted governmental auditing standards.

The field work was conducted at Victoria Behavioral Health Center in Miami, Florida and at the administrative offices in Coral Gables, Florida. In addition, beneficiary interviews were conducted at the residences of several beneficiaries. The site visit began July 7, 1997 and concluded on July 11, 1997.

V. FINDINGS

1. Certification

The provider was unable to provide any satisfactory records/supporting documentation to substantiate its provision of any of the five core services as delineated in the Public Health Services Act. The provider had submitted a self-attestation statement dated 1/24/95 certifying that it provided these services which resulted in its certification by HCFA. As a result of the misrepresentations made on this document and the overpayments found in the medical review, on August 6, 1997, the FI suspended, without notice, all payments to the provider as directed by HCFA. On August 19, 1997, HCFA Region IV was advised of the findings of this review and a recommendation was made to terminate the provider agreement.

2. *Patient Eligibility and Physician Certification*

The medical review determined that payment for all of the services claimed by Victoria for the 20 beneficiaries should be denied because the beneficiaries did not meet the Medicare eligibility criteria for PHP services (see attached chart delineating the medical review results for the 20 beneficiaries in the sample). Specifically, the review determined that none of the beneficiaries required the intensive services of a partial hospitalization program, although the provider had physician certifications for PHP services in 19 of the 20 sample patient medical records (no 1996 medical records were available for one beneficiary in the sample). The documentation in the medical records did not show symptoms of severe psychiatric disorders which would have required inpatient hospitalization in the absence of PHP services. On the physicians' certifications, it appeared that the physician's signature had been "copied and pasted" onto the forms. Furthermore, there was no indication that a physician provided any monitoring of the patients' progress or supervision to the treatment staff.

3. *Medical Necessity*

The medical review found the services to the 19 of the 20 sample beneficiaries (since the records were missing for one beneficiary) were not reasonable and necessary and that the content of the groups presented was social, recreational and diversionary, rather than of a psycho-therapeutic nature. The documentation in the medical records for 19 of the 20 beneficiaries were not individualized according to each patient's treatment, progress, and diagnosis. Progress notes did not indicate on the initial evaluations that improvement or benefit could be attained by the patient (e.g. patients with cognitive conditions which would render them unable to actively participate in psychotherapy groups). The same group sessions were recommended for all patients. Furthermore, none of the therapy groups were led by licensed individuals, as required. [Only physicians, Licensed Clinical Social Workers (LCSWs), Licensed Mental Health Counselors (LMHCs), and Clinical Psychologists are authorized to provide such services in accordance with State law]. As a result of the medical review, $810,370 which is the amount of the net reimbursement to Victoria on the 20 sampled beneficiaries, is considered an overpayment.

4. Cost Report Issues

Medicare cost principles limit reimbursement to the costs that would be incurred by a reasonable, prudent and cost-conscious management. 42 CFR 413.9 provides that all payments to providers must be based on the "reasonable cost" of services covered under Tittle XVIII of the Act and related to the care of the Medicare beneficiaries. The regulations at 42 CFR 413.9 state in part that costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

The following costs are unallowable based on the above stated criteria:

- Medical management services totaling $659,164
- Clinical staffing services totaling $380,700
- Management and information services totaling $80,500
- Excessive rent expenses totaling $76,300

The total cost report disallowances were $1,196,664

Ownership/Related Parties

Before providing a description of the disallowed costs within each of the categories described above, it is important to discuss the ownership of Victoria. Although, the CEO/Administrator of Victoria is shown on documents as the owner of the facility, he is not the individual responsible for financial and operational matters. It is the "Executive Medical Director" (EMD) of Victoria who controls most of the provider's business decisions. The CEO/Administrator described the start-up of Victoria as a joint endeavor, with he being responsible for administrative matters and the EMD being responsible for the clinical areas. The EMD has created subsidiary companies owned by himself, his wife, and his son which contract with the provider. The review concluded that this family received approximately $1.2 million from these related party contracts in 1995. As a result of the above findings, it was concluded that the "de facto" owner of Victoria is the EMD. The contractual relationships between the EMD's subsidiary companies and the provider violates Medicare guidelines. Thus, it is recommended that all contract costs listed below be disallowed. (Records pertaining to these subsidiary companies were requested but have not been received to date.)

Columbia Medical Management (CMC)

CMC was contracted to provide medical management services to the provider. The company is owned by Victoria's EMD, who also owns at least five local PHPs and a clinic. The EMD maintains his corporate office within the administrative offices of Victoria. He described his duties as the supervision and oversight of all clinical matters, yet admitted to spending very little time at the facility. The contract with Victoria entitled the management company to $32 per patient per visit/session at the facility. During FY 1995, CMC received $659,164 from the provider. This amount was claimed in the direct patient service cost centers on the cost report. The full amount of this contract should be disallowed because the provider employs a full-time physician who was on-site regularly. There was

no need for these additional duplicative medical services.

Consolidated Management and Staffing (Consolidated)
Consolidated) was contracted to provide clinical staffing to the provider. The company is owned by Victoria's EMD or his wife. The wife signed as "Supervisor" of Consolidated on its contract with the provider. She denies any knowledge of this company and claims her signature on the contract is a forgery. The EMD also denies any knowledge of this company. Consolidated received $380,700 from the provider in FY 1995. This amount was claimed on the cost report as psychiatric services. Medical Review confirmed that none of the clinical staff was properly licensed to provide PHP services. It is recommended that the entire value of these services be disallowed upon verification that these unlicensed individuals were employed by Consolidated.

Integrated Delivery Systems (Integrated)
Integrated was contracted to provide management and information system services to the provider. The audit determined that this company is affiliated with Victoria's EMD or CEO/Administrator. Integrated received $80,500 from the provider in FY 1995. This amount was claimed on the cost report as a non-salary administrative and general expense. These services are unnecessary for a PHP and duplicate the other accounting and administrative positions.

Gables Professional Billing Services (Gables)
Gables was contracted to provide billing services. The company is owned by the wife of Victoria's EMD, and operates out of their home. Gables received approximately $312,800 for services rendered in FY 1995.

SIL Enterprises (SIL)
SIL is the lessor of the facility property. The lease was signed by the wife of Victoria's CEO/Administrator, who represented SIL. The audit team believed that this company is related to the provider, but the provider denies any relationship to SIL. The property was leased at $30.00 per square foot, and the provider claimed $152,600 in rent expense on the FY 1995 cost report. Real estate data indicated that similar office properties in the same geographical area are leased at $12 to $18 per square foot. It is recommended that 50 percent of the rent be disallowed based on this cost disparity. Furthermore, Medicare requires disclosure of all related party transactions and requires that such dealings be valued at cost. The audit concluded that there is a relationship between the two parties and that the value of the contract is not in accordance with Medicare contract requirements.

J.B. Transportation (J.B.)
J.B. provided patient transportation and meals for the provider. Victoria EMD's son was the president of J.B. during the period of this review. J.B. was paid $43,600 for transportation and $27,000 for meals. Although this amount ($70,600) was not claimed on the cost report, it represents a significant amount of money paid to the EMD's family.

Recommendations

It is recommended that:

- the CMHC's physician be referred to the Florida State licensing board (MQA) for investigation and corrective action;
- the FI institute administrative procedures to recover all payments made to the provider since the provider's effective date of participation in the Medicare program, 1/24/95, to present (this amount approximates $4,510,160.86 as per Medicare Part A Provider Summary Report);
- the FI should deny all pending and future claims received from this non-compliant provider;
- HCFA should take action to terminate the provider agreement; and
- the OIG-Office of Investigations consider further investigative actions against this provider, including evaluation for civil/criminal action.

VICTORIA BEHAVIORAL HEALTH CENTER (PROVIDER NO. 10-4724)

Medical Records for 1996 Reviewed.

Record No.	Bene. HIC No.	Results of Medical Review	Review Results	Amount Paid	Amount Denied
1	144-54-2429M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$62,645.90	$62,645.90
2	261-06-2457A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$52,606.85	$52,606.85
3	267-68-6915D	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$48,016.80	$48,016.80
4	552-48-5312B	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$46,591.25	$46,591.25
5	267-29-2983D	1. No medical records available for 1996.	Deny all services.	$44,008.00	$44,008.00
6	117-30-0528A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$42,951.70	$42,951.70
7	522-76-3826M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$42,767.75	$42,767.75
8	117-30-0529A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$41,866.60	$41,866.60

Record No.	Bene. Hic No.	Results of Medical Review	Review Results	Amount Paid	Amount Denied
9	262-92-0466M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$40,315.60	$40,315.60
10	261-72-8960A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$39,212.00	$39,212.00
11	262-74-7659C2	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$38,588.85	$38,588.85
12	264-59-1897A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$35,902.40	$35,902.40
13	265-72-6057A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$35,345.00	$35,345.00
14	498-07-6051A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$34,850.00	$34,850.00
15	116-34-4999A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$34,843.75	$34,843.75
16	265-84-4173D	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$34,539.00	$34,539.00

Record No.	Bene. Hic No.	Results of Medical Review	Review Results	Amount Paid	Amount. Denied
17	259-12-9144A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$34,513.00	$34,513.00
18	266-14-5455	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$34,084.00	$34,084.00
19	264-93-5230M	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$33,537.40	$33,537.40
20	577-56-1627A	1. Partial Hospitalization services and program do not qualify for the PHP benefit under § 1861 ff. 2. Patient did not meet eligibility criteria although physician certification is in file. 3. Partial Hospitalization services were not reasonable and necessary under § 1862 (a)(1)(A).	Deny all services.	$33,184.70	$33,184.70
Total Amount Paid/Denied				$810,370.55	$810,370.55