DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

CIN: A-04-99-01199

APR 24 2001

Martha Garcia, Chief Executive Officer
Coral Gables Hospital
Tenet South Florida Health Systems
3100 Douglas Road
Coral Gables, Florida 33134

Dear Ms. Garcia:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, ***Review of Outpatient Psychiatric Services Provided by Coral Gables Hospital for Calendar Year Ending December 31, 1997***. A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The HHS action official named below will make final determinations as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 Code of Federal Regulations Part 5.) As such, within 10 business days after the final report is issued, it will be posted on the world web at http://hhs.gov/proorg/org.

To facilitate identification, please refer to Common Identification Number (CIN) A-04-99-01199 in all correspondence relating to this report.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Action Official
Dale Kendrick, Associate Regional Administrator
Division of Financial Management and Program Initiatives
Health Care Financing Administration

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY CORAL GABLES HOSPITAL FOR CALENDAR YEAR ENDING DECEMBER 31, 1997

APRIL 2001
A-04-99-01199

EXECUTIVE SUMMARY

BACKGROUND

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. Medicare regulations define outpatient services as "Each examination, consultation or treatment received by an outpatient in any service department of a hospital . . . " Medicare regulations further require that charges reflect reasonable costs and such services be supported by medical records. These records must contain sufficient documentation to justify the treatment provided. Hospital costs for such services are generally facility costs for providing the services of staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis based on submitted charges. At year end, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final reimbursement.

OBJECTIVE

The objectives of our review were to determine whether: (1) outpatient psychiatric services were billed and reimbursed in accordance with Medicare requirements, and (2) outpatient psychiatric cost claimed in the cost report were appropriate.

SUMMARY OF FINDINGS

Medical Review of Outpatient Psychiatric Services:

In Fiscal Year (FY) 1997, the Coral Gables Hospital (Hospital) submitted for reimbursement $1,441,015 in charges for outpatient psychiatric services. To determine whether controls were in place to ensure compliance with Medicare regulations, we reviewed the medical and billing records for 100 randomly selected claims totaling $694,880 of the total charges for outpatient psychiatric services. These services were charged on behalf of patients in the Hospital's partial hospitalization program (PHP). Our analysis showed that $563,394 of these charges did not meet Medicare criteria for reimbursement. Specifically, we found:

- $365,960 in charges were for PHP services provided to Medicare beneficiaries who did not meet the Medicare eligibility criteria for coverage of PHP services. According to medical experts, some of the patients' medical needs should have been addressed in an inpatient facility rather than in a PHP setting. In another instance, the reviewers found that the patients' needs for PHP services were not justified and their medical condition should have been addressed by another physician.

- $180,114 in charges for PHP services which were not reasonable and necessary. The treatment plans were not individualized to the beneficiary's specific needs. One treatment plan required a beneficiary to attend group therapy sessions in a

language that the beneficiary could not understand. In another claim, the treatment plan required that the beneficiary attend group sessions even though the patient was not making progress and required inpatient care rather than services rendered at a PHP level.

- $560 in charges for services that were not provided. In one instance, a brief encounter in the hallway was billed as "individual psychotherapy." In another instance, the provider billed two units on behalf of the same patient on the same day at the same time.

- $16,760 in charges for services billed on behalf of beneficiaries for whom the provider could not produce medical record documentation to support that the beneficiary received the services or that the services were provided.

Based on a statistical projection at the 90 percent confidence level, we estimate that the hospital overstated its FY 1997 Medicare outpatient psychiatric charges by $1,031,497. Based on the results of the review, we believe that the hospital did not have adequate controls in place to ensure that the beneficiaries enrolled in PHP met Medicare eligibility criteria and that the services billed met the reimbursement requirements.

Review of Costs Claimed for the Outpatient Psychiatric Department:

In its FY 1997 cost report, the Hospital included $4,284,976 in direct and allocated costs for the outpatient psychiatric department. Medicare regulations require costs claimed for the program to be reasonable, allowable, allocable, and related to patient care. We reviewed the provider's costs charged to the PHP operation. Our review showed that the PHP costs were overstated because the provider inappropriately included $1,648,063 in costs that were not related to the PHP operation.

RECOMMENDATIONS

We recommend the Hospital:

1. Strengthen its procedures to ensure that charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements. Accordingly, we will provide the results of our review to the FI, so that it can apply the appropriate adjustment of $1,031,497 to the Hospital's FY 1997 Medicare cost report.

2. Develop procedures to properly exclude costs related to noncovered services from its Medicare cost reports and to properly allocate costs. We will provide the FI with detail of the identified unallowable and/or inappropriate costs so that it can apply the appropriate adjustment to the Hospital's FY 1997 Medicare cost report.

We issued a draft report to the Hospital on August 15, 2000. On September 15, 2000, the Hospital verbally requested an extension to our standard 30 day response deadline and requested additional documentation regarding our findings. We provided that documentation to the Hospital on October 31, 2000. At that time, we granted a 30 day extension (until December 1, 2000). The hospital responded to our findings on December 13, 2000.

The Hospital responded that they disagree with certain findings, but their response was not clear as to which findings they disagreed. They indicated, however, that they would resolve their disagreements in the appeals process. The auditee's response, in it's entirety, is included in Appendix B of this report.

The Office of Audit Services considers the audited entity's comments to be an essential part of the report's development. However, after the audited entity's comments have been incorporated into the report, it is issued in final. We agree that the auditee maintains their rights to appeal our recommendations with U.S. Department of Health and Human Services (HHS) Action Officials and Medicare FIs.

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INTRODUCTION

BACKGROUND

The Health Insurance for the Aged and Disabled Act (Medicare), Title XVIII of the Social Security Act, as amended, is a program of health insurance that is administered by the Health Care Financing Administration (HCFA). The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. Such services are generally provided by staff psychiatrists, psychologists, clinical nurse specialists and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis based on submitted charges. At year end, the hospital submits a cost report to the Medicare FI for final reimbursement. Medicare regulations state that for benefits to be paid:

- "A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services." [Title 42 Code of Federal Regulations (CFR) §482.24]

- Psychiatric "services must be ...reasonable and necessary for the diagnosis or treatment of a patient's condition...Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed." [HCFA Fiscal Intermediary Manual, §3112.7]

In addition, for patients receiving partial hospitalization program service,

- "It is reasonable to expect the plan of treatment to be established within the first 7 days of a patient's participation in the program, and periodic reviews to be performed at least every 31 days thereafter." [HCFA Program Memorandum, Publication 60A]

- in order for an individual's PHP program to be covered, a physician must certify that "...The individual would require inpatient psychiatric care in the absence of such services...." Further, "This certification may be made where the physician believes the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted." [HCFA Program Memorandum, Publication 60A]

For costs claimed on a hospital's Medicare cost report, Medicare requirements define:

- reasonable costs as "...all necessary and proper expenses incurred in furnishing services...However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable." [Title 42 CFR, §413.9(c)(3)]

- that "Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation the provider seeks to minimize its costs and its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. If costs are determined to exceed the level such buyers incur, in the absence of clear evidence the higher costs were unavoidable, the excess costs are not reimbursable under the program." [Provider Reimbursement Manual, §2102.1]

- costs related to patient care are those which "...include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others." [Provider Reimbursement Manual, §2102.2]

- non-covered outpatient psychiatric services to include patient meals and patient transportation. It also limits drug coverage only to those which cannot be self-administered. [Medicare Fiscal Intermediary Manual, §3112.7]

The Coral Gables Hospital, a 273 bed acute care facility in Coral Gables, Florida, provides outpatient psychiatric services to patients in the greater Miami area. The Hospital provides these services through its PHP program. For FY 1997, the Hospital submitted for Medicare reimbursement 201 claims for partial hospitalization services valued at $1,441,015.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were to determine whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicare requirements and (2) the appropriateness of the outpatient psychiatric cost claimed on the cost report. Our review included services provided and costs incurred during FY 1997.

We conducted our audit during the period of February 1999 through April 2000 at the Hospital in Coral Gables, Florida in accordance with generally accepted government auditing standards.

We limited consideration of the internal control structure to those controls concerning claims submission because the objective of our review did not require an understanding or assessment of the complete internal control structure at the Hospital.

To accomplish our objective, we:

- reviewed criteria related to outpatient psychiatric services;
- obtained an understanding of the Hospital's internal controls over Medicare claims submission;
- used the Provider Statistical and Reimbursement Report provided by the FI for the Hospital's FY 1997 to identify 201 outpatient psychiatric claims from the Hospital with charges of $1,441,015;
- employed a simple random sample approach to select 100 outpatient psychiatric claims;
- performed detailed audit testing on the billing and medical records for the claims selected in the sample;
- utilized medical review staff from Mutual of Omaha Insurance Company of Nebraska, the Medicare FI, and psychiatrists contracted by the Florida Peer Review Organization (PRO), to review each of the 100 outpatient psychiatric claims;
- used a variable appraisal program to estimate the dollar impact of improper payments in the total population, and
- judgmentally selected and reviewed direct costs, administrative and general costs, and cost report statistics allocated to the PHP from the Hospital's 1997 Medicare cost report.

FINDINGS AND RECOMMENDATIONS

The Hospital provides outpatient psychiatric services to Medicare beneficiaries in the greater Miami area through its Partial Hospitalization Program. In FY 1997, the Hospital submitted for Medicare reimbursement $1,441,015 in charges for PHP services. We reviewed the medical and billing records for 100 randomly selected claims comprising 2,425 units of service totaling $694,880 in charges. Our analysis disclosed that $563,394 of the sampled charges did not meet Medicare criteria for reimbursement. Based on a statistical sample, we estimate that the Hospital overstated its FY 1997 PHP charges by at least $1,031,497. Charges found unallowable were for services provided to beneficiaries who did not meet the Medicare eligibility criteria for coverage of PHP, services which were not reasonable and necessary, services that were not provided, and services that lacked medical documentation.

The Hospital claimed $4,284,976 in costs for providing these outpatient psychiatric services, after reclassifications and adjustments, on its FY 1997 Medicare cost report. We reviewed the Hospital's direct and allocated costs charged to the PHP operation. Our review showed that the PHP costs were overstated because the Hospital inappropriately included $1,648,063 in costs that were not related to the PHP operation.

Findings from our review of medical records and outpatient psychiatric costs are described in detail below.

RESULTS OF MEDICAL RECORDS REVIEW

According to the Hospital, patients in the PHP program attended morning and afternoon sessions, 3 to 5 days per week. The Hospital offered group therapy on a wide range of topics including stress management, self esteem, coping skills, depression management, and relapse prevention. Our sample of 100 outpatient psychiatric claims, representing 2,425 units of service totaling $694,880 in charges were for services provided to PHP patients. Our review showed that $563,394 for 1,979 units of service did not meet Medicare criteria for reimbursement. Our results are as follows:

PHP Services Provided to Beneficiaries Who Were Not Eligible for the Program

Under HCFA Program Memorandum, Publication 60A, in order for an individual's PHP to be covered, a physician must certify that "...the individual would require inpatient psychiatric care in the absence of such services..." Further, "This certification may be made where the physician believes the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted."

From our review of the billing and medical records of the PHP claims, we identified $365,960 in charges for 1,279 units of PHP services billed to the Medicare program for beneficiaries who were not eligible for the PHP.

Specifically, we found that some of the patients' medical needs should have been addressed in an inpatient facility rather than in a PHP setting. In another instance, the reviewers found that the patients' needs were not justified and their medical condition should have been addressed by another physician.

Services Not Reasonable and Necessary

The Medicare Intermediary Manual, Section 3112.7 identifies a wide range of services a hospital may provide to outpatients who need psychiatric care. For such services to be covered, they must be "...reasonable and necessary for the diagnosis or treatment of a patient's condition...."

Our review showed that $180,114 in charges for 639 units were for PHP services that in the opinion of medical experts, were not reasonable and necessary for the patient's condition. The supporting medical records documentation for the 639 units of service did not demonstrate the level of treatment as being reasonable and necessary.

Specifically, we found that the treatment plans were not individualized to the beneficiary's specific needs. One treatment plan required a beneficiary to attend group therapy sessions in a language that the beneficiary could not understand. In another claim, the treatment plan required that the beneficiary attend group sessions even though the patient was not making progress and required inpatient care rather than services rendered at a PHP level.

Services Billed for and Not Rendered

Title 42 CFR, Section 482.24 states that, "A medical record must be maintained for every individual evaluated or treated in the hospital....The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services."

Our review showed $560 in charges for three units were for PHP services that were not provided but billed to Medicare. In one instance, a brief encounter in the hallway was billed as "individual psychotherapy." In another instance, the provider billed two units of service on behalf of the same patient on the same day at the same time.

Our review showed $16,760 in charges for 58 units were for PHP services that did not have any medical record documentation to support the services rendered.

As a result, we concluded that $16,760 in outpatient psychiatric charges did not have adequate documentation required for Medicare billing and did not meet Medicare's criteria for reimbursement.

RESULTS OF REVIEW OF OUTPATIENT PSYCHIATRIC COSTS

The Hospital claimed $4,284,976 in costs for its PHP, after reclassifications and adjustments, on its FY 1997 Medicare cost report. We reviewed the Hospital's direct and allocated costs charged to the PHP operation. Our review showed that the PHP costs were overstated because the Hospital inappropriately included $1,648,063 in direct costs that were not related to the PHP operation.

Title 42 CFR, §413.9(c)(3) defines reasonable costs as "...all necessary and proper expenses incurred in furnishing services...However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable...."

The Provider Reimbursement Manual Section 2102.2 defines costs related to patient care as those which "...include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities...."

Based on our analysis, we found that $1,648,063 in direct costs reviewed were not directly related to PHP patient care. This resulted in an overstatement, as related to PHP, of the Hospital's FY 1997 Medicare cost report. Specifically, we found that the Hospital claimed costs associated with offsite clinics operated for the benefit of the hospital not the benefit of the PHP program.

CONCLUSION

For FY 1997, the Hospital submitted for reimbursement $1,441,015 in charges for outpatient psychiatric services. Our audit of 100 randomly selected claims totaling $694,880 disclosed that $563,394 should not have been billed to the Medicare program. Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95% confident that the Hospital billed at least $1,031,497 in error for FY 1997. We attained our estimate by using a single stage appraisal program and applying a 90 percent confidence level. The precision of the point estimate at the 90 percent confidence level is plus or minus 8.91 percent. (See APPENDIX A)

In support of the above claimed charges, the Hospital claimed $4,284,976 in costs for these outpatient psychiatric services, after reclassification and adjustment, on its FY 1997 Medicare

that the Hospital billed at least $1,031,497 in error for FY 1997. We attained our estimate by using a single stage appraisal program and applying a 90 percent confidence level. The precision of the point estimate at the 90 percent confidence level is plus or minus 8.91 percent. (See APPENDIX A)

In support of the above claimed charges, the Hospital claimed $4,284,976 in costs for these outpatient psychiatric services, after reclassification and adjustment, on its FY 1997 Medicare cost report. Our review showed that the PHP costs were overstated because the provider inappropriately included $1,648,063 in direct costs that were not related to the PHP operation.

RECOMMENDATIONS

We recommend that the Hospital:

1. Strengthen its procedures to ensure that charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements. Accordingly, we will provide the results of our review to the FI, so that it can apply the appropriate adjustment of $1,031,497 to the Hospital's FY 1997 Medicare cost report.

2. Develop procedures to properly exclude costs related to noncovered services from its Medicare cost reports and to properly allocate costs. We will provide the FI with detail of the identified unallowable and/or inappropriate costs so that it can apply the appropriate adjustment to the Hospital's FY 1997 Medicare cost report.

Auditee Response

We issued a draft report to the Hospital on August 15, 2000. On September 15, 2000, the Hospital verbally requested an extension to our standard 30 day response deadline and requested additional documentation regarding our findings. We provided that documentation to the hospital on October 31, 2000. At that time, we granted a 30 day extension (until December 1, 2000). The Hospital responded to our findings on December 13, 2000.

The Hospital responded that they disagree with certain findings, but their response was not clear as to which findings they disagreed. They indicated, however, that they would resolve their disagreements in the appeals process. The auditee's response, in it's entirety, is included in Appendix B of this report.

OIG Comments

The Office of Audit Services considers the audited entity's comments to be an essential part of the report's development. However, after the audited entity's comments have been incorporated into the report, it is issued in final. We agree that the auditee maintains their rights to appeal our recommendations with U.S. HHS Action Officials and Medicare FIs.

In accordance with our policies and procedures, final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that the Hospital respond to the HHS action official within 30 days from the date of this letter. The Hospital's response should present any comments or additional information that may have a bearing on the final determination.

Dale Kendrick, Associate Regional Administrator
Division of Financial Management and Program Initiatives
Health Care Financing Administration
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

APPENDICES

APPENDIX A

REVIEW OF
OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY
CORAL GABLES HOSPITAL

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 201 Claims	Items: 100 Claims	Items: 85
Dollars: $1,441,015	Dollars: $694,880 Charges	Dollars: $563,394

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: $1,132,422
Lower Limit: $1,031,497
Upper Limit: $1,233,347