DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date OCT 31 2000

From for June Gibbs Brown
Inspector General

Subject Review of Outpatient Psychiatric Services Provided by Provena St. Joseph Hospital for the Period September 1, 1996 Through November 30, 1997 (A-05-00-00034)

To Michael Hash
Acting Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on Thursday, November 2, 2000, of our final report entitled, "Review of Outpatient Psychiatric Services Provided by Provena St. Joseph Hospital for the Period September 1, 1996 Through November 30, 1997." A copy of the report is attached. The objectives of the audit were to determine whether: 1) outpatient psychiatric services were billed for and reimbursed in accordance with Medicare requirements and 2) outpatient psychiatric costs reported on the cost reports were reasonable, allowable, allocable, and related to patient care. We found that Provena St. Joseph Hospital (Hospital), located in Elgin, Illinois, did not have procedures in place to ensure that beneficiaries admitted to the facility met the Medicare eligibility criteria for the partial hospitalization program (PHP) or other outpatient psychiatric services, that services were billed in accordance with Medicare reimbursement requirements, or that Medicare cost reporting principles were correctly applied.

Our audit at the Hospital determined a significant amount of the outpatient psychiatric charges claimed by the Hospital did not meet the Medicare criteria for reimbursement. Specifically, we identified charges for outpatient psychiatric services that were not medically necessary, not supported by medical records, or without any medical record. Based on a statistical projection, we estimate that at least $1,881,089 in outpatient psychiatric charges submitted by the Hospital did not meet Medicare criteria for reimbursement. We also identified $97,494 in unallowable costs claimed by the Hospital in its Medicare cost report covering a 15-month audit period for PHP outpatient psychiatric services. The unallowable costs pertain to meals, patient transportation, and other costs which were not supported.

Due to the significance of the error rates and the general lack of medically necessary services among claims reviewed, we were concerned with the Hospital's ability to participate as a Medicare PHP provider. In recognition of the significant percentages of unallowable services and costs being charged for the Hospital's outpatient psychiatric programs, the Hospital decided to cease providing PHP psychiatric services to Medicare beneficiaries. We agree with this decision, but also believe that improved controls for other psychiatric services should be implemented to meet Medicare requirements.

We recommended that the Hospital work with its fiscal intermediary (FI) to refund to the Medicare program, reimbursements received for PHP psychiatric services and to identify and refund unallowable Medicare reimbursements for the other outpatient psychiatric services and related costs. We will provide the results of our audit to the FI so that it can apply the appropriate adjustments of $1,881,089 in outpatient psychiatric charges and $97,494 in unallowable costs to the Hospital's Fiscal Year 1997 Medicare cost report. In relation to the Hospital continuing outpatient psychiatric programs, we recommended that the Hospital strengthen its controls and procedures to ensure that charges for other outpatient psychiatric services were covered and properly documented in accordance with Medicare requirements. We also recommended that the Hospital develop procedures to exclude unallowable costs from its Medicare cost reports.

The Hospital, in its June 23, 2000 response to our draft report, agreed with and already implemented the Office of Inspector General's (OIG) recommendation that procedures and controls be put in place to assure future outpatient billing and cost report compliance. We commend the Hospital for these actions. However, in regard to our finding of $1,881,089 in charges for outpatient psychiatric services, the Hospital expressed general concerns and took the "...position that the proposed recoupment is unfair and unwarranted in that the OIG applied different standards of claims review in the Audit than were in effect during the Audit Period. Further, the Hospital relied to its detriment on the advice and guidance of its former Fiscal Intermediary with respect to a variety of matters including medical necessity."

We believe that our final audit determinations are correct and in accordance with Medicare requirements. The basis for our position is discussed starting on page 8 of the attached report.

Any questions or comments on any aspect of the memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Paul Swanson, Regional Inspector General for Audit Services, Region V, (312) 353-2621.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY PROVENA ST. JOSEPH HOSPITAL FOR THE PERIOD SEPTEMBER 1, 1996 THROUGH NOVEMBER 30, 1997

JUNE GIBBS BROWN
Inspector General

OCTOBER 2000
A-05-00-00034

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region V
233 North Michigan Avenue
Chicago, Illinois 60601

CIN: A-05-00-00034

Mr. Larry Narum
President
Provena St. Joseph Hospital
77 N. Airlite Street
Elgin, Illinois 60123-4912

Dear Mr. Narum:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Outpatient Psychiatric Services Provided by Provena St. Joseph Hospital for the Period September 1, 1996 Through November 30, 1997." A copy of this report will be forwarded to the action official noted below for her review and any action necessary.

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

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-00-00034 in all correspondence relating to this report.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mrs. Dorothy Burk Collins
Regional Administrator
Health Care Financing Administration
233 N. Michigan Ave.
Suite 600
Chicago, Illinois 60601

EXECUTIVE SUMMARY

Background

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. In general, Medicare requirements define outpatient services as each examination, consultation, or treatment received by an outpatient in any service department of a hospital. Medicare regulations require that charges for those services reflect reasonable costs and be supported by medical records. These records must contain sufficient documentation to justify the treatment provided. Hospital costs for such services are generally the facility costs of providing services 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 fiscal intermediary (FI) for final reimbursement.

Objective

The objectives of the audit were to determine whether: 1) outpatient psychiatric services were billed and reimbursed in accordance with Medicare requirements and 2) outpatient psychiatric costs reported on the cost reports were reasonable, allowable, allocable, and related to patient care.

Summary of Findings

During the 15-month audit period, September 1, 1996 through November 30, 1997, Provena St. Joseph Hospital (Hospital) inappropriately charged Medicare for unallowable outpatient psychiatric services and related outpatient psychiatric service costs. The Hospital submitted $1,986,108 in charges for outpatient psychiatric services on behalf of patients in the Hospital's partial hospitalization program (PHP) and other psychiatric outpatient programs. Our analysis determined that all of the PHP and 11 of 13 claims for other outpatient psychiatric services in the sample were not in compliance with applicable Medicare requirements. Due to the significance of the error rates and the general lack of medically necessary services among claims reviewed, we are concerned with the Hospital's ability to participate as a Medicare PHP provider. Furthermore, the error rate applicable to the other outpatient psychiatric services indicated the need for increased controls at the Hospital. Specifically, we found:

- $226,356 in charges for PHP services that were medically unnecessary, not supported by the medical record, or were without a medical record; and

- $5,265 in other outpatient psychiatric services that were not reasonable, necessary, and/or not supported by medical records.

Based on a statistical sample of 100 selected claims, totaling $232,819, we estimate that the Hospital overstated its Medicare outpatient psychiatric charges by $1,881,089.

We also reviewed $260,710 of the $1,041,581 in costs claimed by the Hospital for PHP outpatient psychiatric services during the 15-month audit period. We determined that $97,494 of the PHP costs were unallowable. These unallowable costs included patient transportation, patient meals, and other unsupported amounts.

We attribute the overpayment for unallowable services and costs to inadequate controls and procedures over outpatient psychiatric services. The Hospital did not have procedures in place to ensure that beneficiaries admitted to the facility met the Medicare eligibility criteria for PHP or other outpatient psychiatric services, that services were billed in accordance with Medicare reimbursement requirements, or that Medicare cost reporting principles were correctly applied. We will provide the results of our audit to the FI for its recovery of PHP reimbursements and for its calculation of the appropriate adjustment for the other unallowable psychiatric services and costs included in the Fiscal Year (FY) 1997 Medicare cost report.

In recognition of the significant percentages of unallowable services and costs being charged for the Hospital's outpatient psychiatric programs, the Hospital decided to cease providing PHP psychiatric services to Medicare beneficiaries. We agree with this decision, but also believe that improved controls for other psychiatric services should be implemented to meet Medicare requirements.

Recommendations

We recommend that the Hospital:

- work with its FI to refund to the Medicare program reimbursements received for PHP psychiatric services;
- work with the FI to identify and refund unallowable Medicare reimbursements for the other outpatient psychiatric services and related costs;
- strengthen its controls and procedures to ensure that charges for other outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements; and
- develop procedures to exclude unallowable costs from its Medicare cost reports.

The Hospital, in its June 23, 2000 response to our draft report (see APPENDIX B), agreed with and already implemented the Office of Inspector General's (OIG) recommendation that procedures and controls be put in place to assure future outpatient billing and cost report compliance. We commend the Hospital for these actions. However, in regard to our finding of $1,881,089 in charges for outpatient psychiatric services, the Hospital expressed general concerns and took the "...position that the proposed recoupment is unfair and unwarranted in that the OIG applied different standards of claims review in the Audit than were in effect during the Audit Period. Further, the Hospital relied to its detriment on the advice and guidance of its former Fiscal Intermediary with respect to a variety of matters including medical necessity."

We believe that our final audit determinations are correct and no further adjustments to our report are necessary. The basis for our position is discussed starting on page 8 of this report.

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INTRODUCTION

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act (Act), provides Health insurance coverage to people aged 65 and over, the disabled, those with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Health Care Financing Administration (HCFA). The Act, section 1862 (a)(1)(A), excludes coverage for services, including outpatient psychiatric services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury. Outpatient psychiatric services are generally provided by staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. The Hospital submits claims for services rendered and receives reimbursement from the FI on an interim basis. At year end, the hospital submits a cost report to the FI for final reimbursement.

The Hospital provides outpatient psychiatric services through its PHP and other outpatient psychiatric programs. The PHP for both adults and adolescents is available through the Hospital's Psychiatric Center. Medicare defines a PHP as, a distinct and organized intensive psychiatric outpatient treatment, of less than 24 hours of daily care, for patients with acute mental illness. The PHP services are provided in lieu of inpatient hospitalization. A PHP is designed to provide an individualized, coordinated, intensive, comprehensive, and multi-disciplinary treatment program, not provided in a regular outpatient setting to patients with profound or disabling mental health conditions. Partial hospitalization requires admission and certification of need by a physician proficient in the diagnosis and treatment of psychiatric illness.

The PHP differs from inpatient hospitalization and other outpatient psychiatric services by: 1) the intensity of the treatment programs and frequency of participation by the patient and 2) the comprehensive nature of the structured program of services provided in accordance with a specified, individualized treatment plan, formulated by a physician and the multi-disciplinary team, with the patient's involvement.

The Medicare Intermediary Manual, section 3112.7 identifies a wide range of services that 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...."*
>
> *"...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...."*

"...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...."

OBJECTIVES, SCOPE, AND METHODOLOGY

The audit was performed in accordance with generally accepted government auditing standards. The objectives of the audit were to determine whether: 1) outpatient psychiatric services were billed and reimbursed in accordance with Medicare requirements, and 2) outpatient psychiatric costs reported on the cost reports were reasonable, allowable, allocable, and related to patient care.

The 15-month audit period, September 1, 1996 through November 30, 1997, covered two cost reporting periods. The Hospital submitted one cost report for FY September 1, 1996 through August 31, 1997, and a second interim report for the 3 months, September 1, 1997 through November 30, 1997. The Hospital changed to a new reporting period to align with the new parent group Provena Health Systems.

To accomplish our objectives, we:

- reviewed Medicare criteria related to outpatient psychiatric services and PHP services;
- interviewed appropriate Hospital personnel concerning internal controls over Medicare claims submission;
- selected a statistically valid sample of 100 outpatient psychiatric claims submitted by the Hospital;
- performed detailed audit testing of the billing and medical records for the services contained in the claims selected in the sample;
- utilized medical professionals to complete a medical review of the services contained in the sample claims; and
- reviewed the cost reports submitted by the Hospital for the audit period.

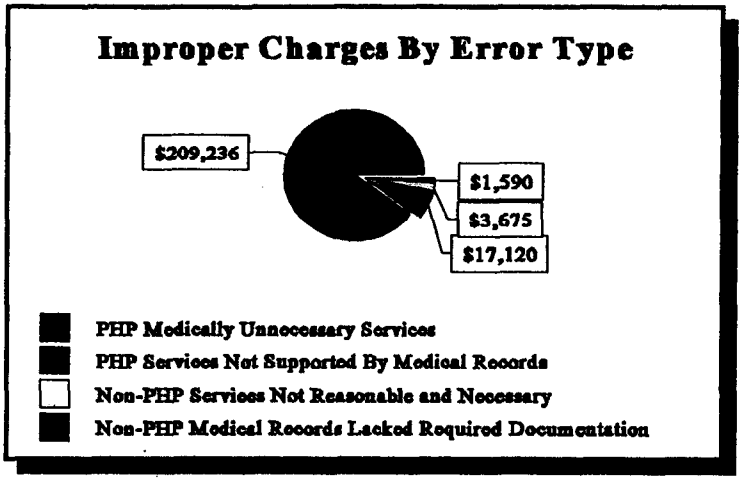
During the audit period, we identified a universe of 923 outpatient psychiatric claims, valued at approximately $2 million. Using the simple random sample approach, we selected a statistically valid sample of 100 claims. We obtained copies of the beneficiaries' medical records covering the dates of service for each sample claim. The medical records were reviewed by professionals at the Illinois Foundation for Quality Healthcare, a Medicare peer review organization (PRO), and AdminaStar Federal (AdminaStar), a Medicare FI.

Review of the internal control structure was limited to those controls relating to the submission of claims to Medicare. The objectives of the audit did not require an understanding or assessment of the entire internal control structure at the Hospital.

Field work was performed at the Hospital facilities located in Elgin, Illinois.

RESULTS OF AUDIT

We found that the Hospital overstated Medicare outpatient psychiatric charges by at least $1,881,089 and claimed $97,494 in unallowable costs in the cost reports. During the audit period, the Hospital submitted claims for Medicare reimbursement of outpatient psychiatric services in the amount of $1,986,107. Based on a statistical projection, we estimate that the Hospital overstated its Medicare outpatient psychiatric charges by $1,881,089 (See APPENDIX A). This projection reflects the medical review, of the services in our sample of claims, which indicated that 98 of 100 statistically selected claims, or $231,621 of $232,819 in charges, did not meet Medicare criteria for reimbursement. The unallowable charges were a result of medically unnecessary services, services not supported by medical records, or no medical record provided.



Based on a judgmental sample of $260,710 of $1,041,581 in PHP outpatient psychiatric costs claimed on related costs reports, we found $97,494 to be unallowable for Medicare reimbursement. The unallowable costs pertain to meals, patient transportation, and other costs which were not supported.

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

MEDICAL RECORDS REVIEW

The 100 outpatient psychiatric service claims selected for review included 87 billed for PHP services and 13 for other outpatient psychiatric services. The total psychiatric service charges of $232,819 included PHP claims of $226,356 and other psychiatric services of $6,463.

The PRO and FI reviewed the medical records for 85 PHP and 13 other psychiatric service claims and determined that $231,621 in charges did not meet Medicare criteria for reimbursement. Medical records for two sampled PHP claims could not be provided by the Hospital.

Partial Hospitalization Claims

All 87 of the sample claims billed by the Hospital for PHP services were denied by the medical reviewers. Seventy-seven of the claims were not allowable because the services were deemed to be medically unnecessary. The allowability of services for eight claims were not supported by the medical record documentation and no medical records were provided for two claims.

Information for the Hospital PHP provides that Medicare beneficiaries can attend psychiatric care programs in the morning, afternoon, or both and can receive a full range of treatment services. The Hospital offers group therapy on a wide range of topics, including general mental health issues and long-term specialized groups. The medical review determined that the Hospital was not meeting the guidelines specified in the Medicare requirements and that most of the services were medically unnecessary. Patients did not appear to be acutely ill. The medical reviewers cited problems with beneficiary eligibility, intensity of services, physician review, treatment plans, and other medical documentation.

The HCFA Program Memorandum, Publication 60A, states that:

> *"...In order for a Medicare patient to be eligible for a PHP, a physician must certify 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...."*

Based on the medical records review, Medicare beneficiaries in our sample did not appear to need PHP services in lieu of inpatient hospitalization. Therefore, we believe that the Hospital was not providing services to the Medicare beneficiaries that would qualify as PHP services. Details are, as follows:

Services Not Medically Necessary

For 77 claims, valued at $209,236, the Medicare beneficiary's psychiatric condition did not demonstrate the need for the acute, intense, structured combination of services provided by the PHP and services were not supervised or evaluated by a physician. This occurred because the Hospital did not have an adequate understanding of the qualifications and procedures needed to fulfill the Medicare program requirements of a PHP. These claims were not considered reasonable and necessary for the treatment of a beneficiary's condition and were not supervised or evaluated by a physician.

In one instance, a female beneficiary, age 85, was reported to be depressed following a stroke. The beneficiary was not assessed to be acutely ill, where PHP services would be rendered in lieu of inpatient admission, and the medical record did not have any evidence that a lesser level of

care was attempted before PHP services. This medical record did not have an initial certification and recertifications did not meet Medicare criteria. The beneficiary never attended more than 3 days per week and appeared to attend only one group session most days. The medical reviewer cited eligibility, physician supervision, and documentation concerns in relation to this claim.

Another female beneficiary, age 79, was reported to be depressed following her husband's death. The medical record contained no documentation of prior psychological problems or that a lesser level of care was attempted before PHP services. The beneficiary was not assessed to be acutely ill, where PHP services would be rendered in lieu of inpatient admission.

In another claim, the 78 year-old female beneficiary's medical record indicated that the physician ordered the patient to attend only 1 to 2 days of treatment per week. This does not meet the level of service requirements to qualify for PHP coverage under Medicare. The patient was not assessed to be acutely ill, where PHP services would be rendered in lieu of inpatient admission.

Services Not Supported by Medical Records

We identified eight claims representing $9,875 in charges for services with patient treatment plans which were not completed in an accurate or timely manner. The Hospital had not implemented adequate procedures to require accurate treatment plans for each patient receiving PHP services. The Medicare Intermediary Manual, section 3112.7(B), states in part, that for outpatient hospital psychiatric services to be covered:

> *"Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals."*

No Medical Record

We also identified two claims representing $7,245 which were denied because the Hospital could not locate the medical records. 42 CFR 482.24 states that:

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

Other Psychiatric Services

The Psychiatric Center also provided other outpatient psychiatric services for Medicare beneficiaries that are less intensive than a PHP. These services include periodic psychotherapy, medication monitoring, and other psychiatric care. The medical reviewers identified the same concerns with the other psychiatric service claims as they did for the PHP claims. Our sample of 100 claims contained 13 claims for other psychiatric services, valued at $6,463. We determined that one claim, with $3,675 in charges, was not reasonable and necessary and an additional 10 claims, billed for $1,590, lacked the required documentation. The FI could not determine

whether those claims for services were reasonable or necessary. The final two claims, amounting to $1,198, were for electro-convulsive therapy and were considered an allowable charge by the FI.

COST REPORT REVIEW

After Medicare cost report reclassifications and adjustments, the Hospital claimed $1,041,581 in costs for PHP outpatient psychiatric services. From this amount, we judgementally selected PHP costs of $260,710 for review. We determined that $97,494 of the costs reviewed were unallowable and that the Medicare cost reports were overstated. Descriptions of these unallowable costs are shown below.

Costs Related to Non-covered Services

We found that $61,739 in outpatient PHP costs in the FY 1997 cost report included primarily unallowable meals and transportation costs. Medicare Intermediary Manual, section 3112.7, states that:

> *"...non-covered outpatient psychiatric services include meals and transportation...."*

As part of the Hospital's outpatient psychiatry programs, the Hospital provided meals to the patients participating in these outpatient services. The Hospital claimed these unallowable meal costs in the amount of $48,685. The Hospital also provided patients with transportation to the Hospital from other care facilities via vehicles provided under contract with an ambulance company. These costs of $12,051 are also unallowable. An additional $1,003 was identified as unallowable office lease and utility expenses.

Costs With No Supporting Documentation

Additional outpatient costs of $23,203 were transferred from other cost centers and $12,552 in purchased services costs were considered unallowable because they were not supported by Hospital accounting records. 42 CFR 413.20(c)(1) requires that:

> *"...The provider has an adequate ongoing system for furnishing the records needed to provide accurate costs data and other information capable of verification by qualified auditors and adequate for cost reporting purposes...."*

CONCLUSION

We determined that the Hospital overstated Medicare outpatient psychiatric charges by at least $1,881,089 and claimed $97,494 in unallowable costs in the cost report. The medical review found that all of the PHP and 11 of 13 other psychiatric service claims in the sample were not in compliance with applicable Medicare requirements. We attribute the significant Medicare

overpayment for unallowable services and costs to inadequate Hospital controls. The Hospital did not have adequate procedures in place to ensure that beneficiaries admitted to the facility met the Medicare criteria for PHP outpatient psychiatric services, that the services were billed in accordance with Medicare reimbursement requirements, and that the Medicare cost reporting principles were applied correctly.

A PHP provider is required to establish that a Medicare beneficiary should be in the program in lieu of inpatient hospitalization. The Hospital PHP was not in compliance with applicable Medicare requirements for significant levels of intensive therapy and the maintenance of mandatory documentation. The medical review showed that most claims billed by the Hospital were for beneficiaries who did not appear to be acutely ill, showed little or no improvement after months in the program, and attended sessions 3 or fewer days per week. In addition, the majority of medical records did not contain documents required by Medicare to support the need for outpatient psychiatric services. The required documents include initial physician certifications and adequate recertifications that demonstrate beneficiary improvements.

Due to the significance of the error rates and the general lack of medically necessary services among the PHP claims reviewed, we are concerned with the Hospital's ability to participate as a Medicare PHP provider. Furthermore, if the Hospital continues to provide other outpatient psychiatric services, it needs to implement additional controls to assure that services are medically necessary and that costs are allowable.

The Hospital, in a letter to the FI dated February 29, 2000, announced the closure of its PHP program. The hospital cited meetings held with the FI, after the start of and during our audit, which clarified its understanding of the FI medical reviewer's application of the Medicare medical necessity requirements. The FI had withheld Medicare payment for PHP services since November 1998 through prepayment edit checks. Our audit concluded that all of the PHP services and most of the other outpatient psychiatric services submitted between September 1996 and November 1997 are unallowable.

RECOMMENDATIONS

We recommended that the Hospital:

- work with its FI to refund to the Medicare program reimbursement received for PHP psychiatric services;

- work with the FI to identify and refund unallowable Medicare reimbursements for the other outpatient psychiatric services and related costs;

- strengthen its controls and procedures to ensure that charges for other outpatient psychiatric services are covered and properly documented in accordance with Medicare regulations; and
- develop procedures to exclude unallowable costs from its Medicare cost reports.

AUDITEE RESPONSE AND OIG COMMENTS

The Hospital, in its June 23, 2000 response to our draft report (see APPENDIX B), agreed with and already implemented the OIG's recommendation that procedures and controls be put in place to assure future outpatient billing and cost report compliance. We commend the Hospital for these actions. However, in regard to our finding of $1,881,089 in charges for outpatient psychiatric services, the Hospital expressed general concerns and took the "...position that the proposed recoupment is unfair and unwarranted in that the OIG applied different standards of claims review in the Audit than were in effect during the Audit Period. Further, the Hospital relied to its detriment on the advice and guidance of its former Fiscal Intermediary with respect to a variety of matters including medical necessity."

We believe that our final audit determinations are correct and no further adjustments to our report are necessary. The basis for our position is discussed below.

OIG Retroactively Applied Different Standards

The Hospital believed that the OIG was unfair in applying the policies and interpretations of the present FI, AdminaStar Federal, to our audit. During the audit period, Health Care Services Corporation (HCSC) was the Hospital's FI. The Hospital stated that "On numerous occasions, the Hospital conferred with HCSC regarding payment matters related to PHP claims. During these meetings and conversations with HCSC, the hospital was led to believe that its PHP was in compliance with Medicare guidance." The hospital also stated that, "...correspondence between the Hospital and HCSC in late 1995 specifically addressed minimum participation requirements for PHPs." In this letter, the HCSC Provider Affairs Representative advised the Hospital that "...Medicare does not place a minimum or maximum number of visits a patient may attend a program provided the services are medically necessary." The Hospital further stated that, "...the requirement that a PHP patient must participate in active treatment for a minimum of three (3) hours per day and four (4) days per week was not in effect until 6/1/98 and it was not in effect during the audit period."

OIG Comments

We are aware that there was a change in the FIs as described by the Hospital. However, AdminaStar medical reviewers were instructed to evaluate the sampled claims in accordance with criteria applicable during the audit period. We also agree with the hospital that the first Local Medical Review Policy providing guidance on PHPs did not go into effect until 6/1/98 and it was in this policy that the minimum participation requirement for PHP patients went into effect. However, the medical reviewers did not use this criteria to evaluate the sampled claims.

They used the HCFA Program Memorandum, Publication 60A, issued June 1995, which clearly states: "Partial Hospitalization may occur in lieu of: 1) Admission to an inpatient hospital; or 2) A continued inpatient hospitalization." According to the medical reviewers, a patient that only attends treatment sessions one to two times per week is not acutely ill where PHP services would be rendered in lieu of inpatient hospitalization. It is our contention that the Hospital was not meeting the intent of the PHP program which is defined as a distinct and organized intensive psychiatric outpatient treatment, of less than 24 hours of daily care, for patients with acute mental illness in lieu of inpatient hospitalization.

Auditee Response to Review of Outpatient Psychiatric Costs

In regard to our identification of $97,494 in unallowable PHP costs claimed on the cost report, the Hospital did not take exception to our finding. The Hospital stated that "...they retained the professional services of outside auditors to develop specific protocols to identify unallowable costs. The hospital has implemented a protocol to search for all non-reimbursable costs in order that they be excluded from the cost report. The protocol includes periodic testing to assure compliance. This process was fully implemented prior to filing the 1999 cost report."

OIG Comments

Our determination that the identified costs $97,494 are unallowable remains unchanged. We commend the Hospital for the actions taken to exclude non-reimbursable costs.

APPENDICES

APPENDIX A

REVIEW OF OUTPATIENT PSYCHIATRIC SERVICES

PROVIDED BY PROVENA ST. JOSEPH HOSPITAL
FOR THE PERIOD SEPTEMBER 1, 1996 THROUGH NOVEMBER 30, 1997

STATISTICAL SAMPLE INFORMATION

POPULATION	SAMPLE	ERRORS
Items: 923 Claims	Items: 100 Claims	Items: 98 Claims
Dollars: $1,986,107	Dollars: $232,819	Dollars: $231,621

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: $2,137,862

Lower Limit: $1,881,089

Upper Limit: $2,394,635

Kankakee, IL 60901
815 928-6900 **Tel**
815 928-6156 **Fax**

PROVENA
Health

June 23, 2000

Mr. Paul Swanson
Regional Inspector General Audit Services
Department of Health and Hunan Services
Region V. Office of Inspector General
Two Illinois Center
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: CIN A-05-00-00034
Draft Audit Report: Review of Outpatient Psychiatric Services
Provena St. Joseph Hospital, Elgin, Illinois

Dear Mr. Swanson:

This letter is submitted in response to the draft audit report dated May 5, 2000 (the "Audit") issued by the Office of the Inspector General ("OIG") with respect to Medicare outpatient psychiatric services ("OP") and partial hospitalization program services ("PHP") provided by Provena St. Joseph Hospital (the "Hospital") for the fifteen month audit period from September 1, 1996 through November 30, 1997 (the "Audit Period"). This letter also responds to the matter of allowable costs for PHP and OP during the Audit Period.

At the outset, the Hospital wishes to express its continued willingness to cooperate with the OIG and HCFA with respect to a refund of agreed upon overpayments for past OP and PHP claims and related cost report disallowances. Moreover, the Hospital agrees with and has already implemented the OIG's recommendation that procedures and controls be put in place to assure future OP billing and cost report compliance. Please note however, that PHP billing and related cost report compliance is no longer an issue due to the fact that the Hospital closed its PHP in February of 2000.

Notwithstanding this spirit of cooperation, the Hospital's position is that the proposed recoupment is unfair and unwarranted in that the OIG applied different standards of claims review in the Audit than were in effect during the Audit Period. Further, the Hospital relied to its detriment on the advice and guidance of its former Fiscal Intermediary with respect to a variety of matters including medical necessity.

I. Hospital Compliance Program and Specific Initiatives Regarding Psychiatric Outpatient Services and Related Cost Report Procedures.

The Hospital implemented a Compliance Program (the "Program") in January, 1998. A summary of the Program is attached as Exhibit A. The Program is modeled after the OIG *Compliance Program Guidance for Hospitals*. The Program is directed by a Compliance Officer who reports to the Chief Executive Officer and the Board of Trustees of the health system. Each hospital within the health system has a designated compliance liaison who reports to the system compliance officer regarding compliance.

The Program includes all seven elements of the OIG guidance including a code of conduct, ongoing education and training sessions, a hot line and other methods of communication, continual monitoring and auditing, disciplinary guidelines, and the ability to respond to detected problems and take corrective action when necessary. The Program has proved to be an effective tool for problem identification and remediation.

Since the inception of the program, the health system developed protocols and procedures that address billing, as well as numerous other areas of compliance. With respect to the OIG's recommendation regarding OP billing compliance, we believe that this recommendation has already been fulfilled through the Program's comprehensive approach to compliance that includes extensive education and training for appropriate clinical and billing personnel.

With respect to cost report compliance, the Hospital retained the professional services of outside auditors to develop specific protocols to identify unallowable costs. The Hospital has implemented a protocol to search for **all** non-reimbursable costs in order that they be excluded from the cost report. The protocol includes periodic testing to assure compliance. This process was fully implemented prior to filing the 1999 cost report.

Suffice it to say, the Hospital is committed to compliance. As such, it takes the OIG recommendations seriously and is confident that the controls and procedures that are now in place will continue to assure ongoing billing and cost report compliance.

II. OIG Retroactively Applied Different Standards

The Hospital opened its PHP in February of 1995. At the time the Hospital opened its PHP and through September of 1998, the Hospital's Fiscal Intermediary was Health Care Services Corporation ("HCSC"). For over three and a half years, the Hospital dealt with HCSC regarding all matters related to Medicare coverage and billing. During HCSC's tenure as Fiscal Intermediary, the Hospital had numerous conversations with HCSC about PHP as well as other matters. HCSC regularly made its personnel available to the Hospital to assist with interpreting the various Medicare rules and regulations.

On numerous occasions the Hospital conferred with HCSC regarding payment matters related to PHP claims. During these meetings and conversations with HCSC, the Hospital was led to believe that its PHP was in compliance with Medicare guidance. The Hospital was never alerted

by HCSC that there were any problems with its PHP. Claims were processed in the normal course and denials were non-existent.

Although the vast majority of communications between the Hospital and HCSC was oral, the correspondence attached as Exhibit B provides written evidence of ongoing communication with the HCSC with regard to PHP coverage. This correspondence between the Hospital and HCSC in late 1995 specifically addressed minimum participation requirements for PHPs. In this letter dated November 7, 1995, the HCSC Provider Affairs Representative advised the Hospital as follows: *"with respect to the number of days per week of participation, Medicare does not place a minimum or a maximum on the number of visits a patient may attend a program provided the services are medically reasonable and necessary."*

The advice from HCSC regarding participation requirements is an example of the Hospital's reliance on HCSC for compliance issues for claims processed during the Audit Period. This advice regarding participation is in stark contrast to HCSC's first Local Medical Review Policy providing guidance on PHPs which did not go into effect until 6/1/98 (Exhibit C). The advice that Medicare did not have minimum participation requirements is also in stark contrast to subsequent guidance from Administar, the current Fiscal Intermediary.

Contrary to the HCSC's representation that Medicare did not have minimum participation requirements, the OIG, in its Audit report, states: *"In another claim, the 78 year old female beneficiary's medical record indicated that the physician ordered the patient to attend only one to two days of treatment per week. **This does not meet the level of** **service requirements** to qualify for PHP coverage under Medicare."* (emphasis added) The OIG is holding the Hospital responsible for a higher standard than was in effect at the time, and for a requirement that was expressly refuted by the Hospital's Fiscal Intermediary. The requirement that a PHP patient must participate in active treatment for a minimum of three (3) hours per day and four (4) days per week was **not** in effect until 6/1/98 and it was **not** in effect during the Audit Period.

Clearly, the "rules" for PHP had changed. The new Fiscal Intermediary took over on October 1, 1998 and soon thereafter the Hospital's experience changed dramatically. For example, in January of 1999, the Hospital began receiving a significant number of denials for PHP services. However, prior to 1999 there were no denials for PHP services. Then in March of 1999, the new Fiscal Intermediary advised the Hospital that it was under focused review for PHP documentation.

For the first time, the Hospital became aware that there was a problem. Clearly, the new Fiscal Intermediary had a stricter interpretation of PHP Medicare compliance. However, as soon as the Hospital understood that the new Fiscal Intermediary was providing new guidance, the Hospital sought to understand the new standard. Hospital personnel requested and received specific PHP compliance training from Administar.

It was at this time that the OIG selected the Hospital as part of its national initiative involving a ten-state PHP audit. Through the process of the Audit as well as its dealings with the new Fiscal Intermediary, it became clear to the Hospital that transitioning out of PHP was in the Hospital's best interest. The Hospital determined that it could no longer justify continuing a program that

had the potential of draining valuable Hospital resources from its other charitable purposes. Although the Hospital has discontinued PHP services, it continues to provide OP services.

III. Conclusion

The Hospital maintains that it is inappropriate and unfair for the OIG to conduct the Audit based on Local Medical Review Policies that were not in effect at the time services were rendered. HCSC, rather than Administar, was the Fiscal Intermediary during the Audit Period. HCSC had different standards pre and post 6/98. Indeed, HCSC provided no written guidance on PHPs until as late as June 1, 1998. Further, HCSC's standards were different from those of the subsequent Fiscal Intermediary. Prior to the 6/98 Local Medical Review Policy, the Hospital was forced to rely on oral guidance from HCSC as well as its actual claims payment experience.

In conclusion, the Audit Period was from 9/1/96 through 11/30/97. During this period there was no written guidance from the Fiscal Intermediary. Rather, there was a series of oral communications, none of which alerted the Hospital to any potential problem with respect to PHP or OP claims. Not only was the Hospital provided no notice of a problem, it was orally advised that all was well, and it regularly received reimbursement for claims as submitted. For the OIG to now direct HCFA to recoup payments based on a different standard of review with no notice to the Hospital and at a time when the Hospital is practically foreclosed from pursuing alternative collection on these accounts is unfair and improper.

We respectfully request that you consider the foregoing in issuing the final Audit Report for Provena St. Joseph Hospital.

Sincerely,

M. Meghan Kieffer

M. Meghan Kieffer, JD
System Vice President, Legal Affairs

cc: Joe Feth Larry Narum Vince Pryor Ungaretti & Harris