DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

September 29, 2006

Report Number: A-05-05-00055

Barry S. Maram
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Dear Mr. Maram:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicaid Community Mental Health Provider Services in Illinois." 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 will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days. 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, 5 U.S.C. § 552, as amended by Public law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-05-05-00055 in all correspondence.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
For Audit Services

Enclosures

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF MEDICAID COMMUNITY MENTAL HEALTH PROVIDER SERVICES IN ILLINOIS

Daniel R. Levinson
Inspector General

September 2006
A-05-05-00055

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Medicaid Clinic and Rehabilitative Services

Clinic and rehabilitative services furnished by Community Mental Health Providers (CMHPs) may qualify for Medicaid coverage under Title XIX of the Social Security Act (the Act). Section 1905(a)(9) of the Act authorizes "clinic services" that are provided or directed by a physician. Regulations (42 CFR § 440.90) define clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Section 1905(a)(13) of the Act allows optional Medicaid coverage for medical or remedial "rehabilitative services" that are recommended by physicians or other licensed practitioners and are provided "for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level."

In Illinois, Medicaid CMHP clinic and rehabilitative services are provided to adults and children who are diagnosed, based on a mental health assessment, with a mental illness or emotional disturbance and an impaired level of role functioning. Based on the goals and objectives established in a client's treatment plan, the authorized services are intended to generally restore, manage, or maintain the client's condition. For Federal fiscal year (FY) 2003, Medicaid paid about $170.5 million ($89 million Federal share) for CMHP services in Illinois.

OBJECTIVE

The audit objective was to determine whether the CMHP services were provided by qualified staff, were adequately documented, and were accurately paid on behalf of eligible beneficiaries.

SUMMARY OF FINDINGS

Based on a statistical projection of the sample results, we estimate that Illinois overpaid providers at least $11,477,280 ($5,971,577 Federal share) in Medicaid CMHP reimbursement for services provided during FY 2003. We found that 33 of 200 randomly selected CMHP service items included one or more payment errors because the services did not meet the Federal and State reimbursement requirements

The overpayments resulted from the providers' non-compliance with either the Federal requirements of the State Medicaid Manual or the State requirements of the approved State plan, the Illinois Administrative Code (the Illinois Code), and/or payment rate schedules.

The non-compliance generally occurred through oversight, billing errors, or failure to prepare or retain adequate documentation. The 33 service items included 36 errors, as follows:

- The provision of services was not documented. (11 errors)
- The furnished services did not involve direct patient care, or were not for the purpose of diagnosing, treating, or preventing impairment to an individual's physical or mental health. (10 errors)
- Treatment plans were not signed or reviewed by the appropriate staff. (4 errors)
- Incorrect service payment rates were used. (6 errors)
- Treatment plans did not support furnished services. (2 errors)
- The number of service units was not supported. (2 errors)
- Staff was not appropriately designated as required. (1 error)

We also found that detailed State level claiming requirements for CMHPs, established by Section 132 of the Illinois Code, were not followed within the sampled items. In part, these rules required treatment plans to be developed and approved by the appropriate staff on a continuing basis; be signed by clients, parents, or guardians, as appropriate; and include an accepted diagnosis. This section also required supporting service documentation to be retained for five years. The 73 identified deficiencies occurred because providers failed to prepare or retain complete records. These procedural deficiencies were not considered payment errors in our projection.

RECOMMENDATIONS

We recommend that Illinois:

- refund $5,971,577 to the Federal Government; and

- furnish written notification to CMHPs reminding them to prepare and retain complete documentation to fully support all applicable Federal and State claiming provisions.

STATE'S COMMENTS

In written comments dated September 27, 2006, Illinois did not address the findings and recommendations. Instead, it stated that it would use the results of the audit to reiterate required policies and improve its administration of the program.

The State's comments are presented in their entirety as an appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the Act) established Medicaid as a joint Federal and State program. Medicaid provides medical assistance to low-income persons who are age 65 and over, blind, or disabled, to members of families with dependent children; and to qualified children and pregnant women. Each State administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS), which is responsible for the program at the Federal level. Within broad Federal rules, each State determines eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. In Illinois, the Department of Healthcare and Family Services (HFS) is responsible for administering the Medicaid program.

Medicaid Clinic and Rehabilitative Services

Clinic and rehabilitative services furnished by Community Mental Health Providers (CMHPs) may qualify for Medicaid coverage. Section 1905(a)(9) of the Act authorizes "clinic services" that are provided or directed by a physician. Regulations (42 CFR § 440.90) define clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Section 1905(a)(13) of the Act authorizes medical or remedial "rehabilitative services" that are recommended by physicians or other licensed practitioners of the healing arts (LPHA) and are provided "for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level".

Illinois Medicaid Clinic and Rehabilitative Services

In Illinois, Medicaid CMHP clinic and rehabilitative services are provided to adults and children who are diagnosed, based on a mental health assessment, with a mental illness or emotional disturbance and an impaired level of role functioning. Based on the goals and objectives established in the client's treatment plan, the authorized services are intended to generally restore, manage, or maintain the client's condition. Mental health services must be provided by State certified CMHPs.

The Illinois Department of Children and Family Services (DCFS) and the Illinois Department of Human Services (DHS) each received provider claims for CMHP services that are furnished on behalf of the respective agencies. These agencies paid the CMHPs for claimed services and, subsequently, submitted claims for Medicaid reimbursement to HFS. The Federal Government reimbursed its share for these claims through the CMS-64 reporting process. About 200 certified CMHPs received Medicaid reimbursement totaling about $170.5 million ($89 million Federal share) for clinic and rehabilitative CMHP services provided during Federal fiscal year (FY) 2003.

The State's requirements addressing the provision and claiming of CMHP services were included in the approved State plan and the Illinois Administrative Code (the Illinois Code), Title 59, Chapter IV, Part 132.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The audit objective was to determine whether the CMHP services were provided by qualified staff, were adequately documented, and were accurately paid on behalf of eligible beneficiaries.

Scope

Our review covered CMHP clinic and rehabilitative services furnished during the period from October 1, 2002 through September 30, 2003 (FY 2003). The scope of our audit did not include a medical review or an evaluation of the medical necessity for the services. We excluded case management services from our review because they will be covered by separate reviews in selected States.

We performed fieldwork through a combination of site visits to CMHPs and a review of provider documentation submitted by mail.

Methodology

We obtained a general understanding of the CMHP claim filing and payment process through discussions with State and provider officials. We reconciled payments for CMHP services furnished during FY 2003 to the CMS-64 for a selected quarter and found them to be accurate. We selected an unrestricted random sample of 200 service items for review from a population of 2,965,413 items.

We reviewed the sampled service items to determine whether applicable Federal and State claiming requirements were met. For each sampled service, we:

- reviewed the supporting documentation including assessments, treatment plans, medication authorizations, and admission and service notes to assess overall compliance with regulatory requirements;

- confirmed that services were paid accurately based on correct payment rates and service locations;

- verified client eligibility for services;

- confirmed that services were furnished by qualified staff at appropriately certified CMHPs; and

- determined whether provider documentation supported the provision of services for purposes of direct client care and for diagnosing, treating, preventing, or minimizing client physical or mental health impairments.

The audit objective did not require a review of internal controls. We held discussions with State officials to obtain general knowledge of procedures used by DCFS, DHS, and HFS to monitor the CMHP claiming and payment process.

We performed the audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Based on a statistical projection, we estimate Illinois overpaid providers at least $11,477,280 ($5,971,577 Federal share) for Medicaid CMHP services furnished during Federal fiscal year (FY) 2003. The overpayments resulted from the providers' non-compliance with either the Federal requirements of the State Medicaid Manual or the State requirements of the approved State plan, the Illinois Code, and payment rate schedules. The providers' non-compliance generally occurred through oversight, billing errors, or failure to prepare or retain adequate documentation.

We found that 33 of the 200 randomly sampled service items included a total of 36 payment errors. We also found 73 procedural deficiencies within the sampled items that were not considered payment errors in our projection.[1]

PAYMENT ERRORS

The 36 payment errors are categorized, as follows:

Provision of Services Not Documented

Eleven of the payment errors (totaling $561) were attributable to a lack of documentation for the services. The providers were unable to support the services with notes, treatment plans, or other documentation needed to confirm that selected services were appropriately furnished or authorized.[2]

Section 132.85(a)(1)(G) of the Illinois Code specified that providers shall maintain "Hardcopy and source documents relating to the creation of the service billing files", while section 132.85(b) further stated that records must be retained for not less than five years from the date of service. Through provider error or oversight, the necessary supporting documentation was either missing or substantially incomplete.

[1]Each sampled item was reviewed in its entirety and could have included multiple services that were paid as a single item. In addition, each item could have contained multiple errors.

[2]An altered document was submitted by one CMHP as part of its service support documentation. This matter was referred to State officials for further action.

Specific Medicaid Requirements Not Met

Ten of the payment errors (totaling $285) pertained to a lack of documentation showing that the furnished services involved direct patient care and were for diagnosing, treating, or preventing impairment to the individual's physical or mental health. Examples included:

- attempted phone contacts, or other brief contacts where the billable nature of the service was not supported;
- client vocational training, including staff discussion of client employment options, or assistance provided to clients to locate employment;
- client transportation in circumstances where the transportation was the primary service;
- observation of client living quarters without further documented staff interaction; and
- client watching a movie without documented rehabilitative interaction between the client and staff.

The State Medicaid Manual, Section 4385(B), stipulates that services must involve direct patient care and must be for the express purpose of diagnosing, treating or preventing illness, injury, or other impairments to an individual's physical or mental health. In the identified instances, the supporting documentation did not verify that the reviewed services met these requirements.

Treatment Plans Not Signed or Reviewed

For services involving four payment errors (totaling $262), the physicians or LPHAs did not sign the client treatment plans or did not review the plans on a timely, continuing basis. In those instances where timely reviews of treatment plans could not be established, we considered payment errors to exist only when a selected date of service was not covered by a treatment plan.

Section 132.150(d)(2) of the Illinois Code required that treatment plans be signed by the physician or LPHA who is responsible for the plan review. Section 132.150(d)(7) further required that physicians or LPHAs review the plan every six months and modify the plan as needed. These critical signatures verified physician or LPHA involvement in reviewing and updating specific treatment approaches for individual clients on a continuing basis. In the absence of these signatures, we could not determine whether the furnished services were appropriate.

Incorrect Service Payment Rates

Six payment errors (totaling $51) occurred when CMHPs were paid for the services at incorrect payment rates. The CMHPs were either paid at higher "off-site" payment rates for services that were provided "on-site" or were paid rates for services that differed from those provided. We calculated the payment errors based on the difference between the rates that were paid and the rates that should have been used.

The State's fee-for-service payment rate schedules authorized different payment rates based on the types of services and the location of the services' delivery (site of service). The overpayments resulted from computerized billing software problems or other billing errors.

Treatment Plans Did Not Support Furnished Services

For services involving two payment errors (totaling $45), the beneficiaries' treatment plans did not include the selected service or failed to address the treatment goals or objectives relative to that service.

Section 132.150(d)(5) of the Illinois Code required treatment plans to "…indicate the specific mental health services to be provided and describe the mental health services needs of the client in relationship to mental health services to be provided including goals, objectives, expected outcome, frequency and responsible staff." Through provider oversight, the client treatment plans did not include the selected services or did not address the necessary client goals or objectives. As a result, providers received payment for services that were not appropriately authorized in the treatment plan.

Service Units Not Supported

Two payment errors (totaling $45) were made when providers received payments for service units in excess of the documented units.

The State's fee-for-service payment rate schedules authorize per unit payment rates. Pursuant to State Plan Attachment 4.19-B, page 36, service units are generally billed and paid based on 15-minute increments for delivered services. For the two payment errors, the providers erroneously billed for service units in excess of what was supported.

Staff Not Appropriately Designated

A payment error of $20 was made for one service that the provider could not furnish written medication authorization by staff providing and monitoring the service.

Section 132.150(e)(1)(G) of the Illinois Code required physicians to designate in writing those staff who were authorized to provide medication monitoring services.

PROCEDURAL DEFICIENCIES

We identified 73 less critical procedural deficiencies that were not considered payment errors in our projection. Section 132 of the Illinois Code presented detailed State claim filing requirements for CMHPs. In part, these rules required treatment plans to be developed and approved on a continuing basis by appropriately qualified staff; be signed by clients, parents, or guardians, as appropriate; and include accepted diagnosis codes. This section also required supporting service documentation to be retained for five years.

Full compliance with these requirements was not always achieved because providers failed to prepare or retain complete records, as noted in the following examples:

- Documentation did not clearly establish treatment plan development by appropriately qualified staff. In these cases, participating staff qualified as both an LPHA and as a qualified mental health professional (QMHP). However, these individuals often designated their treatment plan involvement in their LPHA capacities only and did not document their additional involvement as a QMHP. As a result, the extent of a staff member's involvement in the overall treatment plan development process was often unclear.

- Treatment plans were not reviewed and approved, on an ongoing basis, within the allowable six month time period.

- Clients, parents, or guardians did not sign treatment plans as required. Although some providers stated that appropriate signatures were sought, the reason why the signatures were not obtained was not documented.

- Treatment plans did not include diagnosis information. Although acceptable diagnosis information was generally available elsewhere in the files, the information did not provide reasonable assurance that the diagnosis was still current.

- Providers did not reliably document that professional credentialing requirements had been met by former employees or generally failed to prepare or retain other required supporting service documentation.

RECOMMENDATIONS

We recommend that Illinois:

- refund $5,971,577 to the Federal Government and

- furnish written notification to CMHPs reminding them to prepare and retain complete documentation to fully support all applicable Federal and State claiming provisions.

STATE'S COMMENTS

In written comments dated September 27, 2006, Illinois did not address the findings and recommendations. Instead, it stated that it would use the results of the audit to reiterate required policies and improve its administration of the program.

The State's comments are presented in their entirety as an appendix.

APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY AND RESULTS

POPULATION

The population consisted of 2,987,588 Medicaid Community Mental Health Provider (CMHP) service items furnished during Federal fiscal year (FY) 2003. The following service categories were included in the population:

- Category 09 – Department of Children and Family Services Rehab Option;
- Category 33 – Mental Health Clinic;
- Category 34 – Mental Health Rehab Option;
- Category 36 – Juvenile Rehab Option.

We excluded from the sampling frame 22,175 services, each with net payment values less than $5.00. The sampling frame, therefore, included 2,965,413 items. A sample unit was defined as a Medicaid CMHP service item with a net payment value greater than, or equal to, $5.00.

SAMPLE DESIGN

We selected an unrestricted random sample of 200 CMHP service items from the sampling frame.

RESULTS OF SAMPLE

The results of the sample review are presented below:

Sampling Frame	Sample Size	Number of Overpayments	Total Value of Overpayments	Federal Share of Overpayments
2,965,413	200	33	$1,269	$663

We used the HHS Office of Audit Services RAT-STATS variable appraisal program for unrestricted random samples to project the sample results.

The point estimate of the projection of the Federal share of overpayments was $9,828,565, with a precision of plus-or-minus $3,856,988 at the 90 percent confidence level.

ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

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September 27, 2006

Department of Health and Human Services
Office of Audit Services
Attn: Paul Swanson, Regional Inspector General for Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601-5502

Re: Draft Audit Report No. A-05-05-00055

Dear Mr. Swanson:

Thank you for providing an opportunity to comment on your audit report entitled, "Review of Medicaid Community Mental Health Provider Services in Illinois". We appreciate the work performed by the Office of Inspector General auditors. The Department will use your results to reiterate required policies and improve our administration of this program.

Sincerely,

Barry S. Maram
Director

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