MAR - 9 2006

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

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

SUBJECT: Medical Review of Synergy Behavioral Health's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2002 (A-06-04-00076)

Attached is a copy of our final report on the medical review of Synergy Behavioral Health's partial hospitalization services for the period August 1, 2000, through December 31, 2002. This is one of a series of reports on Medicare partial hospitalization program (PHP) services provided by community mental health centers. A PHP is an intensive outpatient program of psychiatric services provided to patients instead of inpatient psychiatric care.

Our objective was to determine whether the claims that Synergy Rehab Services, Inc., doing business as Synergy Behavioral Health (Synergy), submitted for PHP services met Medicare reimbursement requirements.

Overall, there was evidence that Synergy provided services that were active, intensive, and therapeutic, as required for a PHP level of care. However, Synergy submitted claims for PHP services that did not meet Medicare reimbursement requirements. Medical reviewers from a program safeguard contractor (PSC) determined that 51 of the 100 sampled claims did not meet Medicare reimbursement requirements. The reviewers questioned claims primarily for two reasons:

- The patient did not need, or was unable to benefit from, the services.
- The patient's medical records lacked the required documentation.

As a result, Synergy received $77,987 in unallowable Medicare payments for the 51 sampled claims.[1] Based on our sample results, we estimate that Synergy received at least $3,098,296 in payments for claims that should not have been billed to Medicare.

[1]The draft report stated that Synergy received $145,665 in unallowable Medicare payments and an estimated overpayment of $5,830,859. We adjusted these amounts in our final report because another review (A-06-04-00032) found unallowable payments to Synergy as a result of financial errors made by the fiscal intermediary for PHP services rendered between August 1, 2000, and June 30, 2003. Thus, the overpayments identified in this report do not duplicate those identified in the other report. As of the issuance of this report, we had not issued a final report on the other review.

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

We recommend that CMS determine the allowability of the claims that resulted in our $3,098,296 statistical estimate of unallowable payments.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at george.reeb@oig.hhs.gov. Please refer to report number A-06-04-00076 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Audit Services

Region VI
1100 Commerce, Room 632
Dallas, TX 75242

MAR - 9 2006

Report Number: A-06-04-00076

Mr. Scott Shaheen
Administrator
Synergy Behavioral Health
422 Colonial Drive
Baton Rouge, Louisiana 70806

Dear Mr. Shaheen:

This letter serves to notify you of our actions regarding the report entitled "Medical Review of Synergy Behavioral Health's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2002."

We reviewed the February 4, 2005, written comments on our draft report. The comments pertaining to the audit review process did not lead us to change our opinion that Synergy received some overpayments. However, because of the medical determination issues raised in the comments and the fact that the program safeguard contractor that conducted the review was no longer available for consultation because it no longer had a contract with the Centers for Medicare & Medicaid Services (CMS), we sent the records for the denied claims to the CMS Program Integrity Group. Based on the preliminary results of the group's review, we have decided to issue the final report directly to CMS for resolution. We will make Synergy's medical records concerning all claims reviewed available to CMS for appropriate consideration in the resolution process.

We are recommending that CMS determine the allowability of the claims that resulted in our $3,098,296 statistical estimate of unallowable payments.

Sincerely yours,

Gordon L. Sato
Regional Inspector General
for Audit Services

cc: Patrick Gilmore
Morgan, Lewis & Bockius LLP

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAL REVIEW OF SYNERGY BEHAVIORAL HEALTH'S PARTIAL HOSPITALIZATION SERVICES FOR THE PERIOD AUGUST 1, 2000, THROUGH DECEMBER 31, 2002

Daniel R. Levinson
Inspector General

MARCH 2006
A-06-04-00076

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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

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

OBJECTIVE

Our objective was to determine whether the claims that Synergy Rehab Services, Inc., doing business as Synergy Behavioral Health (Synergy), submitted for PHP services met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Overall, there was evidence that Synergy provided services that were active, intensive, and therapeutic, as required for a PHP level of care. However, Synergy submitted claims for PHP services that did not meet Medicare reimbursement requirements. Medical reviewers from a program safeguard contractor (PSC) determined that 51 of the 100 sampled claims did not meet Medicare reimbursement requirements. The reviewers questioned claims primarily for two reasons:

- The patient did not need, or was unable to benefit from, the services.

- The patient's medical records lacked the required documentation.

As a result, Synergy received $77,987 in unallowable Medicare payments for the 51 sampled claims.[1] Based on our sample results, we estimate that Synergy received at least $3,098,296 in payments for claims that should not have been billed to Medicare.

[1]The draft report stated that Synergy received $145,665 in unallowable Medicare payments and an estimated overpayment of $5,830,859. We adjusted these amounts in our final report because another review (A-06-04-00032) found unallowable payments to Synergy as a result of financial errors made by the fiscal intermediary for PHP services rendered between August 1, 2000, and June 30, 2003. Thus, the overpayments identified in this report do not duplicate those identified in the other report. As of the issuance of this report, we had not issued a final report on the other review.

RECOMMENDATION

We recommend that the Centers for Medicare & Medicaid Services (CMS) determine the allowability of the claims that resulted in our $3,098,296 statistical estimate of unallowable payments.

SYNERGY COMMENTS

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

OFFICE OF INSPECTOR GENERAL RESPONSE

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

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INTRODUCTION

BACKGROUND

Partial Hospitalization Program

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

Partial Hospitalization Payments

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

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

Intermediary Responsibilities

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

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

Synergy Behavioral Health

Synergy Rehab Services, Inc., doing business as Synergy Behavioral Health (Synergy), is a Medicare-certified CMHC in Baton Rouge, LA. Synergy received Medicare payments totaling $14.9 million from the inception of the OPPS in August 2000 through December 2002. More than 83 percent of these payments were outlier payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

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

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

We performed fieldwork at Synergy in Baton Rouge, LA, from January to February 2004.

Methodology

We reviewed relevant Federal laws, regulations, and other requirements. We also interviewed officials of CMS, TriSpan Health Services (Synergy's fiscal intermediary), and Synergy.

We selected a random sample of 100 claims from a universe of 5,127 claims for the period August 1, 2000, through December 31, 2002. Synergy received total Medicare payments of $14.9 million for the 5,127 claims.

Medical reviewers from TriCenturion, a Medicare program safeguard contractor (PSC), performed a clinical review of the 100 sampled claims on our behalf. The PSC reviewed the claims and applicable medical records to determine whether PHP services met Medicare coverage requirements and were medically necessary, reasonable, and billed in accordance with Medicare requirements. The codes billed on the sampled claims were Current Procedural Terminology codes 90801–Psychiatric Diagnostic Interview Examination, 90818–Individual Psychotherapy, and 90853–Group Psychotherapy, as well as Healthcare Common Procedure Coding System codes G0177–Training and Education Services and Q0082 and G0176–Activity Therapy.

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

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

FINDINGS AND RECOMMENDATIONS

Overall, there was evidence that Synergy provided services that were active, intensive, and therapeutic, as required for a PHP level of care. However, Synergy submitted claims for PHP services that did not meet Medicare reimbursement requirements. Medical reviewers from the PSC determined that 51 of the 100 sampled claims did not meet Medicare reimbursement requirements. The reviewers questioned claims primarily for two reasons:

- The patient did not need, or was unable to benefit from, the services.

- The patient's medical records lacked the required documentation.

As a result, we estimate that Synergy received at least $3,098,296 in payments for claims that should not have been billed to Medicare.

Appendix C details the errors for each sampled claim.

NONCOMPLIANCE WITH MEDICARE REIMBURSEMENT REQUIREMENTS

Medical review staff determined that 51 of the 100 sampled claims did not meet Medicare reimbursement requirements. PHP services must meet Medicare PHP coverage requirements and be medically necessary, reasonable, and billed in accordance with Medicare requirements. Many of the 51 claims were denied for more than 1 reason.

The Patient Did Not Need, or Was Unable To Benefit From, the Services

Pursuant to section 1862(a)(1)(A) of the Social Security Act and TriSpan Local Medical Review Policy PHP-2 (effective August 30, 1998, and as revised effective August 20, 2001), it is not reasonable and necessary to provide partial hospitalization services to patients who cannot, or refuse to, participate in the active treatment of their mental disorders. Furthermore, coverage is not permitted for patients who require inpatient treatment.

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

- For four claims, the patients were unable to participate because of psychiatric or medical instability or confusion.

  For example, documentation for one patient indicated that he appeared to have been incapable of effectively participating in, and benefiting from, the program because of the severity of his mental illness, which produced disruptive behavior. Furthermore, the patient attended the program irregularly, making the possibility of progress unlikely.

In another example, the medical records showed that the patient was suicidal. The patient had not signed a "no harm" agreement. This made the patient ineligible for partial hospitalization because the patient was a safety and security risk and required a more intensive level of service.

- For 17 claims, the documentation did not demonstrate the medical necessity of the patients' admissions, or the patients had excessive lengths of stay and should have been discharged to a less intensive level of care sooner.

  In one case, the records did not demonstrate an acute onset or exacerbation of psychiatric symptoms so severe that the patient would require partial hospitalization. The documentation noted that the patient was angry with family members and experiencing mood swings but did not indicate that the patient's symptoms were disabling or severely interfering with multiple areas of daily life.

  In another case, the documentation indicated that the patient's symptoms had stabilized and described the patient as "doing much better" and "significantly improved." Therefore, the medical reviewers concluded that the patient could have been safely transitioned to a less intensive outpatient level of care several weeks prior to the dates of service in this review.

The Patient's Medical Records Lacked Required Documentation

Section 1833(e) of the Social Security Act and TriSpan Local Medical Review Policy PHP-2 (effective August 30, 1998, and as revised effective August 20, 2001) require services to be documented. According to the Local Medical Review Policy, the initial psychiatric evaluation must be performed and placed in the chart within 24 hours after admission. The initial psychiatric evaluation includes the medical history, physical examination, and initial treatment plan. The medical history and physical examination must be performed between 30 days prior to admission and 24 hours after admission. The initial treatment plan must be completed and signed within 24 hours after admission. In addition, 42 CFR § 424.24(e)(2) requires the medical record to contain information to support the diagnosis and the type, amount, duration, and frequency of services, as well as the goals under the treatment plan.

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

- For 13 claims, the services billed lacked any documentation.

- For 38 claims, psychiatric evaluations were missing, incomplete, or not completed within the required timeframe. Therefore, the medical necessity of the services billed was not established. Most psychiatric evaluations had one or both of the following deficiencies:

  - The medical history and physical examination records were missing or not completed between 30 days prior to admission and 24 hours after admission. In some cases, the

documentation was from a prior admission; one record was dated 7 1/2 years prior to the patient's admission.

- The initial treatment plans were missing, incomplete, or not signed within 24 hours of admission. In some cases, the physicians had not signed the treatment plans, or the plans did not specify the goals or the types of services to be provided.

EFFECT OF IMPROPER BILLINGS

Synergy received $77,987 in unallowable Medicare payments for 51 of the 100 claims in the statistical sample.[1] Based on our sample results, we estimate that Synergy received at least $3,098,296 in payments for claims that should not have been billed to Medicare.

RECOMMENDATION

We recommend that CMS determine the allowability of the claims that resulted in our $3,098,296 statistical estimate of unallowable payments.

SYNERGY COMMENTS

In its February 4, 2005, written comments on our draft report, Synergy strongly disagreed with the findings and recommendations. Synergy took issue with many aspects of the review, including the audit review process and the medical determinations.

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

The full text of Synergy's comments is included as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

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

[1]The draft report stated that Synergy received $145,665 in unallowable Medicare payments and an estimated overpayment of $5,830,859. We adjusted these amounts in our final report because another review (A-06-04-00032) found unallowable payments to Synergy as a result of financial errors made by the fiscal intermediary for PHP services rendered between August 1, 2000, and June 30, 2003. Thus, the overpayments identified in this report do not duplicate those identified in the other report. As of the issuance of this report, we had not issued a final report on the other review.

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

APPENDIXES

SAMPLING METHODOLOGY

OBJECTIVE

Our objective was to determine whether the claims that Synergy Rehab Services, Inc., doing business as Synergy Behavioral Health (Synergy), submitted for partial hospitalization program (PHP) services met Medicare reimbursement requirements.

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

POPULATION

The population consisted of 5,127 paid claims for community mental health center (CMHC) Medicare PHP services for the period August 1, 2000, through December 31, 2002.

SAMPLING UNIT

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

SAMPLE SIZE

The sample size was 100 CMHC Medicare PHP paid claims.

ESTIMATION METHODOLOGY

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

APPENDIX B

STATISTICAL SAMPLE AND PROJECTION INFORMATION

Sample Characteristics

Population	Sample	Errors
5,127 claims	100 claims	51 claims
	$150,893.22	$77,986.51

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

Projection of Sample Results
(90-Percent Confidence Interval)

Point estimate	$3,998,368
Precision amount	$900,072
Lower limit	$3,098,296

MEDICAL REVIEW RESULTS BY CLAIM

Claim Sample #	Claim Allowed	Patient Did Not Need, or Was Unable To Benefit From, the Services	Patient's Medical Records Lacked Required Documentation
1	X		
2	X		
3	X		
4			X
5			X
6	X		
7		X	X
8	X		
9		X	X
10	X		
11	X		
12	X		
13	X		
14		X	
15	X		
16	X		
17	X		
18	X		
19	X		
20		X	X
21		X	X
22			X
23		X	X
24			X
25	X		
26	X		
27		X	
28			X
29	X		
30	X		
31	X		
32		X	X
33		X	X
34			X
35		X	
36	X		
37	X		
38	X		

Claim Sample #	Claim Allowed	Patient Did Not Need, or Was Unable To Benefit From, the Services	Patient's Medical Records Lacked Required Documentation
39	X		
40			X
41	X		
42			X
43	X		
44	X		
45	X		
46	X		
47		X	X
48		X	X
49	X		
50			X
51	X		
52	X		
53			X
54	X		
55	X		
56		X	X
57			X
58	X		
59	X		
60	X		
61		X	
62			X
63	X		
64		X	
65	X		
66			X
67			X
68			X
69		X	X
70	X		
71	X		
72		X	
73		X	X
74			X
75	X		
76		X	X
77			X

Claim Sample #	Claim Allowed	Patient Did Not Need, or Was Unable To Benefit From, the Services	Patient's Medical Records Lacked Required Documentation
78			X
79			X
80			X
81			X
82			X
83	X		
84			X
85			X
86			X
87			X
88		X	
89	X		
90	X		
91			X
92	X		
93			X
94			X
95		X	
96	X		
97	X		
98	X		
99	X		
100*			X
Total	**49**	**21**	**43**

*Medical record could not be located.

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VIA FEDERAL EXPRESS

February 4, 2005

Gordon L. Sato
Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region VI
1100 Commerce, Room 632
Dallas, Texas 75242

Re: Synergy Behavioral Health ("Synergy") Response to Draft Report entitled, "Medical Review of Synergy Behavioral Health's Partial Hospitalization Services for the Period of August 1, 2000 through December 31, 2002"
Report Number: A-06-04-00076

Dear Mr. Sato:

Thank you for the opportunity to submit written comments regarding the OIG's Draft Report entitled, "Medical Review of Synergy Behavioral Health's Partial Hospitalization Services for the Period of August 1, 2000 through December 31, 2002" ("Draft Report"). Synergy is a conscientious community based provider having a history of active participation in regulatory procedures and a proactive and positive relationship with its fiscal intermediary ("TriSpan"). For over 6 years, Synergy has worked closely with multiple TriSpan representatives to achieve and maintain compliance in a benefit area marked by a lack of clarity and difficulties in implementation.[1/]

Synergy takes issue with many aspects of this audit review and the Draft Report. Among other points addressed in greater detail below, Synergy maintains that the audit is inconsistent with generally accepted government auditing standards setout in Government Auditing Standards, 2003 Revision (the "Yellow Book"), that the review bypasses "Progressive Corrective Action" procedures, and that the findings of the contractor hired by the OIG to review the medical

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

records ("TriCenturion") are so inconsistent with Synergy's claims filing and review experiences with TriSpan that it raises substantial questions regarding the reliability and accuracy of TriCenturion's review. Synergy's concerns are arranged in five categories and addressed in detail below.

1. **General Observations.**

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

A. Faulty Review Process and Findings.

First, the provider maintains that the Draft Report is based solely on the results of the medical review conducted by TriCenturion. It is not apparent from the Draft Report whether the OIG conducted oversight activities to ensure that the field work was carried out in accord with Yellow Book standards or that competent evidential material was developed.

In addition, the conclusions reached in the Draft Report are questionable in the absence of any OIG testing or review of Synergy's internal controls. As stated in Mr. Sato's letter to Christopher White dated January 7, 2005, the OIG "... did not perform detailed test of Synergy's internal controls because we accomplished the objective of our review through substantive testing. The conclusion that the provider did not have adequate procedures in place is a deductive conclusion based on the results of the medical review." A deductive conclusion that the asserted error rate is attributable only to the provider, cannot stand where other possible, and so readily apparent, conclusions have not been evaluated and ruled out.[2/] TriCenturion's finding of a 51% error rate is at odds with TriSpan's six year claims review history of Synergy's partial hospitalization program. This discrepancy raises serious questions as to where the asserted lack of controls truly lies. TriCenturion may have misapplied the local medical review polices ("LMRPs") during the course of this review or it is possible that TriSpan's LMRPs interpretation with respect to Synergy differs from TriCenturion or government expectations. However, the OIG never investigated these or other potential possibilities and simply "deduced" that the problems must be attributable solely to Synergy. The fact that other potential causes are not

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

evaluated within this audit represents a particular weakness, where Congress and the Government Accountability Office have attributed partial hospitalization medical review variances to other non-provider causes[3/]. Deductive reasoning alone, without any testing of the provider's internal controls, particularly where it fails to evaluate and rule out other plausible causes, is not appropriate for or supportive of conclusions that a failure of provider's internal controls caused an overpayment of millions of dollars.

B. Inadequate Exit Interview.

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

It is our understanding that the OIG's Audit Process Manual sets out exit conference standards that call for the OIG to discuss the entire report -- background, scope methodology, results of audit, etc. -- before issuing a final report. These requirements are intended to enable the auditee to make meaningful contributions and to ensure that the final report is accurate. Neither the Draft Report nor the medical review work papers were available during the initial exit conference. Moreover, the OIG personnel attending the exit conference were unable to address fundamental questions regarding the medical review or to summarize the actual scope and basis for the medical review findings. Upon receiving these documents, approximately seven months after the post audit meeting, Synergy had serious questions concerning the accuracy of the findings and of the procedures used by TriCenturion and the OIG auditors. Because of its

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

concerns and because the Draft Report was not available for review during the initial exit conference, Synergy requested a more complete exit conference (see Attachment A). The provider's request was quickly rejected (see Attachment B). Synergy questions why the OIG would deny a request for a more complete exit interview that would enable the provider to contribute to the accuracy of the Draft Report and medical review findings. This denial is inconsistent with audit standards and puts the OIG at risk of issuing a flawed report without meaningful provider input.

In fact, it is questionable whether the OIG is taking steps necessary to ensure the accuracy of the medical records review, and hence the accuracy of the Draft Report. This is demonstrated in the January 19, 2005 letter attached hereto, where the OIG states that "...any disagreements with the medical review findings would need to be addressed with the fiscal intermediary once a demand letter is issued and Synergy exercises its appeal rights." Basically, the OIG is willing to rely on and use medical review findings to recommend the repayment of millions of dollars, but is unwilling to first verify the accuracy of those findings. In short, the audit process in this case and the failure to allow reasonable opportunity for the provider to comment on or be involved in the audit process, including the medical review, is inconsistent with the Yellow Book and serves to compromise the integrity of the overall findings.

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

In addition to the general concerns raised above, the audit and the Draft Report fail to comply with mandatory substantive and procedural Yellow Book requirements. Synergy requests that the OIG review and consider the concerns and issues outlined below. If you agree that there exist serious weaknesses or deficiencies in this audit's compliance with the Yellow Book standards, the final report should not be issued unless this matter can be satisfactorily remedied. If the OIG is determined to issue a final report despite the weaknesses noted below, at a minimum, the OIG should revise the Draft Report to describe why these weaknesses do not, in OIG's view, merit correction.

A. Substantive Non-Compliance with Yellow Book Standards.

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

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

3. The Draft Report is not consistent with the requirements of Reporting Standards 8.41 through 8.48 regarding completeness, accuracy and objectivity.

a). Reporting Standard 8.41 states that findings should include all necessary facts and explanations to promote an adequate understanding of the matters reported. The Draft Report only discusses matters that support the high error rate and does not report the fact that Synergy has never been flagged for scrutiny by TriSpan nor has Synergy had any prior issues with respect to lack of documentation or medical necessity. Finally, the Draft Report does not reflect the many significant positive findings of Synergy's operations (also reflective of the provider's internal controls) noted by TriCenturion in its final Executive Summary (see Attachment C).

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

c). Reporting Standards 8.46 through 8.48 require that the presentation of the results of the audit be balanced in content and tone, be presented impartially and fairly, and recognize the positive aspects of the reviewed program. It further requires that conclusions be supported with sound and logical evidence. Synergy contends that the Draft Report fails to meet any of these requirements. As mentioned previously the TriCenturion Executive Summary, in contradiction to its medical review findings, praises Synergy's partial hospitalization program. This fact was not disclosed in the Draft Report, nor was there any analysis of how these positive findings bear on the provider's internal controls.

B. Procedural Non-Compliance with Yellow Book Standards.

1. The OIG decision to select substantive testing over a review of internal controls suggests a bias contrary to General Standard 3.07(e) & (f) concerning personal impairment of auditors. Substantive testing is indicated when controls are known to be ineffective or unreliable. To Synergy's knowledge this is not the case. In fact, the opposite is true as Synergy has never been flagged for review or been subjected to scrutiny by TriSpan for medical documentation errors or for rendering services that lacked medical necessity. Additionally, the decision appears to be in conflict with the Field Work Standard 7.07(c), which requires the auditor to obtain an understanding of the internal controls as they relate to the specific objectives and scope of the audit and no review of internal controls was undertaken.

2. Field Work Standard 7.15 requires that when the internal controls are significant to the audit objectives, auditors should obtain evidence to support their judgements about the internal controls. Based on the Draft Report, the OIG apparently concluded the internal controls were inadequate without gathering or testing the internal controls; the OIG's failure to test internal controls is contrary to this standard.

3. Field Work Standard 7.39 states that auditors should communicate information about the planning, conducting and reporting of the audit to the audited entity. The communication should help the audited entity understand the objectives, time frames and data needs. Synergy believes this standard was only minimally met. During the course of this audit, Synergy was provided no information concerning the conduct of the medical review, was misinformed as to the scope and subject of the review and was not informed as to the type of report to be issued.

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

C. Specific Issues with Respect to Draft Report.

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

This section states that the OIG "did not perform detailed tests of Synergy's internal controls because the objective of our review was accomplished through substantive testing." However, as stated above, prior to attributing significant deficiencies to an alleged lack of internal controls, the OIG should have conducted testing of such internal controls. This is especially true in light of the fact that TriCenturion's findings differed significantly from Synergy's history with TriSpan. The Draft Report should be revised to explain how the OIG evaluated and ruled out other plausible reasons, including the possibility of TriCenturion error, and the possibility that TriSpan's interpretation of the LMRPs differs from CMS expectations. Only by ruling out these possibilities can the OIG state that Synergy's lack of internal controls are to blame for the error rate.

2. "Findings and Recommendations" Section (Draft Report, Pages 3 and 4).

This section of the Draft Report asserts that claims were denied because some patients did not need or were unable to benefit from services or that the patient's medical records lacked required documentation. As discussed below in the Medical Review section of this rebuttal, Synergy strongly disagrees with these findings. First, based solely on its interpretation of the record and without any contact with patients, TriCenturion simply substitutes its judgement over the judgement of the treating physician as to whether a patient meets the LMRP standards, could benefit from partial hospitalization treatment or should be transitioned to a less intensive outpatient setting. These claims should only be denied if no reasonable physician could come to the same conclusion reached by the treating physician. Second, Synergy's subsequent review of the records indicates that many documents purported to have been missing are actually in the records furnished. If Synergy had been provided the opportunity it requested to discuss the medical review findings with TriCenturion during the exit conference (or at any point during the review), Synergy could have indicated where the documents were in the file and point out other similar corrections.

3. "Cause" Section (Draft Report, Page 5).

There is no basis for the findings made in the "Cause" section of the report. This section states that the OIG "concluded that Synergy did not have adequate procedures in place to ensure claims submitted were in compliance with Medicare requirements." However, OIG never actually reviewed or tested Synergy's compliance processes or procedures.

4. "Recommendations" Section (Draft Report, Page 5).

The "Recommendations" portion of the Draft Report makes only general statements. For example, the Draft Report states that Synergy should "strengthen its procedures to ensure that claims for PHP services are in accordance with Medicare requirements and are properly documented." Because internal processes and procedures were never reviewed, the OIG is unable to identify which processes and procedures are found or asserted to be weak or which need to be strengthened.

The second recommendation is that Synergy work with TriSpan to reimburse the Medicare program $5,830,859 in unallowable payments. The Draft Report does not explain what is meant by "work with," ignores the fact that Synergy does not concur with the medical review findings and fails to reference other critical facts.

3. **Internal Inconsistency within TriCenturion's Executive Summary**.

TriCenturion provided an Executive Summary to explain its medical review findings. The summary discusses in very general terms how it determined that 51% of Synergy's claims should be denied. However, the summary also praises Synergy's partial hospitalization program. *The praise is substantial and provides specific instances and strengths of Synergy's programs and reflects favorably on Synergy's internal controls.* Examples of such positive statements include:

- "The partial hospitalization program provided active and intensive treatment. It was a multi-modal program including individual, group, family psychotherapies, activity and psycho-educational interventions. Beneficiaries had psychiatric impairments severe enough to warrant the services of a PHP and without such services would have required inpatient hospitalization.";
- "The documentation exceeded the Local Medical Review Policy requirements in most instances.";
- "The majority of beneficiaries in the sample appeared to have had acute exacerbations of psychiatric conditions.";
- "A total of seventy-four percent (74%) were admitted from an inpatient setting to the PHP. One beneficiary had a court mandated admission to the PHP. There was evidence that, when indicated, beneficiaries were stepped up to inpatient care when it was evident that PHP was no longer an appropriate setting.";

- "All beneficiaries were prescribed psychotropic medications and were appropriately monitored for effectiveness, side effects, signs and symptoms of decompensating behaviors."

- "The eligibility and medical necessity criteria for admitting the beneficiaries to the PHP were met as outlined by the TriSpan PHP-2 Local Medical Review Policies and CMS guidelines.";

- "The majority of the beneficiaries in the sample appeared to have a diagnosis of schizo-affective disorder or schizo-affective disorder rule out bipolar manic type, or schizo-affective disorder rule out schizophrenia.";

- "Groups were appropriately prescribed and utilized for all of the beneficiaries.";

- "The treatment plans, prescribed therapies and identified goals of treatment were individualized to the beneficiary's needs."; and,

- "Updates were usually completed on a weekly basis with an accompanying re-certification statement and an appropriate description of the need for continued partial hospitalization services."

The summary makes additional positive statements (see Attachment C). However, despite these positive findings, TriCenturion asserts a 51% error rate. It appears inconsistent that a partial hospitalization program that meets or exceeds LMRP documentation requirements and has active, intensive and therapeutic sessions could have a 51% error rate. This internal inconsistency within the Executive Summary must be critically reviewed by the OIG prior to accepting the medical review findings at face value. Moreover, these findings reflect favorably on internal controls and the OIG needs to explain its decision on internal controls notwithstanding TriCenturion's findings.

4. **Overpayment Calculation Issues**.

The overpayment calculation methodology substantially overstates the asserted overpayment arising from the asserted denials. Under the methodology used, it appears that if TriCenturion determined that an individual patient did not require a specific group therapy session for a particular day, the entire regimen of the patient's stay in the partial hospitalization program would be denied. In fact, the absence of a single group therapy session, if true, would only form a basis for denial of that day of service not for the entire length of stay. Similarly, in instances where it was obvious from the medical record that a service was rendered, such as activity therapy, yet the claim was submitted for another service such as education training, instead of investigating the claim to uncover the source of the discrepancy, which most likely uncover a

simple clerical error, TriCenturion denied the entire claim. The extrapolated overpayment should have included the denial for a specific claim as opposed to all claims arising from the entire stay, and the difference (if any) between the service that was provided and the service that was inadvertently billed, not the entire amount of the claim.

The application of both of the above has caused the error rate and the overpayment amount to become significantly inflated. The OIG should review the results of the claim denials and services provided and revise the overpayment and error rate accordingly.

5. **Medical Review Issues**.

Once the documentation was furnished on January 7, 2004, Synergy closely reviewed the relevant medical records, TriCenturion's work papers and the Executive Summary. Synergy's review uncovered gross inconsistencies between TriCenturion's reported findings and the content of the records. Synergy's review raises significant concerns because it demonstrates that TriCenturion's reviewers simply substituted their judgement for the judgement of the treating physician, in some cases appear contrary to the LMRPs in effect at the time that claims were submitted, overlooked documentation included in the medical records under review, and denied claims for the incorrect code being billed despite the fact that a billable service was in fact rendered.

The Draft Report summarizes TriCenturion's findings under two broad categories:

- The patient did not need or was unable to benefit from services; and,
- The patient's medical records lack required documentation.

Each of these categories contains several subcategories intended to support the conclusions. For ease of review, each of these subjects will be discussed using the same organizational structure as used in the Draft Report. In order to rebut TriCenturion's findings, Synergy located and reviewed the medical records for each partial hospitalization stay denied by TriCenturion. The examples provided below are the results of those reviews, although all case identification information has been removed. Please contact Synergy if you would like to obtain the case identifiers if you wish to review Synergy's results.

A. The Patient Did Not Need Or Was Unable To Benefit From Services.

1. Four Claims Showed the Patient Was Unable to Participate Due to Psychiatric or Medical Instability Or Confusion. As an initial matter, it should be noted that two of the four claims were for the same patient during the same stay in the partial hospitalization program and were for services rendered within one week of each another. Therefore, there are actually only three patients in the sample that the reviewers believed would be unable to benefit from the partial hospitalization program. The denial of these claims led to the denial of the entire patient stay. Because both claims are from the same stay, the stay is denied twice, included in the denial rate twice and added to the amount to be extrapolated twice.

a.) The Draft Report claims that "…documentation in the notes and updates for one patient indicated that the patient appeared to have been incapable of effectively participating in and benefiting from the program due to his behavior arising from the severity of his mental illness. The patient was reported to be disruptive. Furthermore, the patient's attendance in the program is documented to have been very irregular, making the possibility of progress unlikely."

- This patient has had schizophrenia since his adolescence, has a history of electro-convulsive therapy, has been tried on numerous psychotropic medications and has been hospitalized multiple times in the last 10 years. He was discharged from an inpatient hospital to the partial hospitalization program.

- Neither the physician's nor the clinicians' progress notes indicate that the possibility of progress is unlikely. This is solely the opinion of the TriCenturion reviewer who is unfamiliar and has no working history with the patient.

- In the summary of findings, the reviewer quotes a social worker that the patient's attendance was irregular. The actual quote is, "attendance irregular *but father states patient not feeling well."* The progress notes document a call to the father whereby the father states that the patient has flu-like symptoms. The patient's irregular attendance during the time period under review was due to physical illness and not to an inability to participate on a mental/behavioral level.

- While the patient may have been disruptive and had difficulty participating in group therapy *at times*, there were also group notes that indicate the patient participating and not being disruptive. In fact, this patient had been making progress. The social worker states that this patient "has made some progress, he is no longer hostile." In addition the records indicate that the violent content of the patient's thoughts and the behavioral symptoms had decreased.

- The instances where the patient was disruptive and had difficulty participating in a particular group therapy were selected, quoted and generalized to include the patient's entire group therapy experience and treatment in the program and ignored other aspects of the patients treatment in the program including medication management, individual and family work, etc.

- The LMRP description for medical necessity states the patient "must require comprehensive, structured, multi-modal treatment requiring medical supervision and coordination because of a mental disorder, which severely interferes with multiple areas of daily life, including *social*, vocational, and/or educational functioning." This patient's mental illness interfered with his *social* functioning as demonstrated by his periodic disruptive behavior in group settings.

- This patient could not only benefit from partial hospitalization treatment but was benefiting from the treatment.

- The TriCenturion reviewer suggests that the patient should have been stepped up to inpatient treatment. However, this patient had already been discharged from an inpatient program to the partial hospitalization program because the patient obviously no longer required inpatient treatment.

b). Two other patients were denied for being unable to participate in the partial hospitalization program because of instability or confusion.

- One of these patients has a history of schizophrenia and was discharged to the PHP from an inpatient hospital. The patient had been in the hospital for a total of 45 days prior to direct admission to the partial hospitalization program. The TriCenturion reviewer suggests that the patient should be discharged from the partial hospitalization program after reviewing the claim for the first week of partial hospitalization treatment after an inpatient stay of 45 days.

- The medical records indicate that because the patient had appeared with severe symptoms after an extended inpatient stay, the physician was trying to rule out any organic problem. However, the denial code used by the TriCenturion reviewer states that the claim is to be denied if, "patients cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment for their mental disorder *except for a brief admission necessary for diagnostic purposes*".

- This patient remained in the partial hospitalization program for only two weeks prior to discharge.

- The TriCenturion reviewer suggests that the patient is unable to benefit due to instability or *confusion.* However, the psychiatrist and team assessing the patient disagree. The psychiatrist writes in his initial psychiatric evaluation on admit that the patient is "cognitively alert and oriented to person and place." The patient is also noted to know where he was hospitalized and what medication he had been taking. The patient's memory was intact for remote and recent memory. This indicates the patient was not confused and unable to cognitively benefit.

- The TriCenturion reviewer noted that this patient tends to be disruptive in group and repeated efforts to set limits in group were largely unproductive. These symptoms of acute illness are not indicative of an inability to benefit from treatment in a partial hospitalization program and do not require discharge. Patients are often received from inpatient treatment still exhibiting severe symptoms which require continued medication and stabilization to avoid inpatient readmission.

- The TriCenturion reviewer notes that it was documented that the patient had garbled speech and was incontinent of urine *(noted one time in one group.)* The treatment and attempt to stabilize this patient was aggressive. The patient's anti-psychotic medication had been increased which most likely sedated the patient resulting in garbled speech, lethargy and the incontinence noted on the day reviewed.

- This patient was discharged from the partial hospitalization program after less than thirty days of treatment to a lesser level of care, indicating that the team was successful in helping this patient to not return to an inpatient hospital.

c). The Draft Report claims that "[i]n another example, the patient's medical records document the patient to be suicidal. The patient did not sign a "no-harm" agreement. This makes the patient ineligible for partial hospitalization, because the patient is a safety and security risk and requires more intensive level of service.

- Synergy is unable to determine to which patient this quote refers. The TriCenturion summary of findings indicate no claims denied for this reason.

- As a general observation, the absence of a signed "no-harm" agreement is not a reason for denial under the relevant LMRP.

- The LMRP indicates that "patients admitted for treatment to a partial hospitalization program will not be in immediate danger to self, others, property, but there may be a recent history of self-mutilation, serious risk-taking, or other self-endangering behavior." Patients who are assessed by the psychiatrist to be in immediate danger to self are immediately transferred to a hospital. In fact, if a patient is in immediate danger, it is incumbent upon the psychiatrist to legally commit the patient if the patient does not agree to voluntary admission. A "no-harm" agreement would never be prudent in such a case. A "no-harm" agreement is usually used when a patient is saying they are having suicidal thoughts. Patients may be admitted to a partial hospitalization program with suicidal ideation and a "no-harm" agreement may sometimes be used, however it is not a standard practice.

2. Seventeen Claims Did Not Demonstrate Medical Necessity for Admission or Had an Excessive Length of Stay and Should Have Been Discharged to a Less Intensive Level of Care Sooner. Synergy assumes that the number seventeen is based on the TriCenturion Executive Summary where it states that "[i]n nine (9) reviews, the beneficiaries met medical necessity criteria on admission, but had an excessive length of stay and should have been discharged to a less intensive level of care sooner, as their treatment goals were met and there were no medication adjustments made to indicate an unstable condition for an extended period of time[,]" "…in seven (7) reviews, there was no documentation of an attempt at a lesser level of care before being admitted to the PHP or medical necessity for admission to the PHP was not established[,]" and "[t]he provider failed to submit one (1) medical record[.]"

First, the term "excessive length of stay" is constantly used by the TriCenturion reviewers, however no such language exists in the LMRP. The LMRP does not define an appropriate length of stay but rather instructs that individualized treatment is to be provided. Claims must be reviewed to determine that the continued stay criteria is met but a statement like "excessive length of stay" is strictly one of opinion. It is also an example of negative terminology used by the reviewers.

Second, with respect to the seven records noted by TriCenturion, all have physician orders stating "reason for admission" which correspond to medical necessity criteria in the LMRP and all records have a statement of initial certification by the psychiatrist. All records have a multi-disciplinary psychiatric evaluation and document the reasons for admission which support medical necessity criteria under the LMRP.

Third, there is no requirement in the LMRP for "documentation of an attempt at a lesser level of care before being admitted to the PHP." What the LMRP requires is that "there must be evidence of failure at *or inability to benefit from a less intensive out patient program.*" (Italics added.) Nowhere does the LMRP require that prior to admission, a lesser level of care has to be attempted. In some cases the patient presents with signs and symptoms of illness too severe for a

lesser level of care than partial hospitalization and the physician makes the medically responsible and appropriate decision to use partial hospitalization as the least restrictive setting in lieu of inpatient hospitalization. It is unreasonable to think that *every* patient must be treated in outpatient first despite the severity of their symptoms. In the claims reviewed, patients were either seen in an outpatient setting and were not responding to treatment (in some cases the physician treating the patient in outpatient is the same physician who referred the patient to the partial hospitalization program) or the patient presented, in the physicians opinion, too sick for a lesser level of care than partial hospitalization and certified the patients as same.

a). The Draft Report states "…in one case the records do not demonstrate an acute onset or exacerbation of psychiatric symptoms so severe that partial hospitalization would be required. The documentation noted that the patient was angry with family and experiencing mood swings, but there is no indication that the patient's current symptoms were disabling or severely interfering with multiple areas of daily life."

- This patient has long been suffering from chronic paranoid schizophrenia, has had multiple inpatient hospitalizations, is unable to work due to disability from mental illness and has a history of suicide attempts by overdose.

- The patient is noted to have failed outpatient treatment and was referred to the partial hospitalization program because the patient's psychiatrist believed the patient needed more intensive treatment.

- The records indicate depression as the patient's problem. Therefore in considering signs of exacerbation of the patient's illness, depressive or mood symptoms and not psychotic symptoms need to be reviewed. The records indicate that the patient was experiencing sleep disturbance, weight gain, decreased motivation, anxiety, isolation, agitation, mood swings, distractibility and suspiciousness.

- The records indicate that the patient's symptoms interfered with the patient's social functioning. Specifically the patient's familial function was disrupted, the patient exhibited socially inappropriate behaviors due to suspiciousness and paranoia, and the patient had obsessive guilty thoughts. The patient's mental condition also affected the patient's physical well-being. Some improvement in the patient's condition had been noted before discharge but the patient was not indicated as being at baseline on admission as concluded by the TriCenturion reviewer.

- Because the claim reviewed was for the day of admission only, the TriCenturion reviewer does not have adequate information to make judgment on the entire stay in

the partial hospitalization program. Other material in the record clearly establishes that the patient meets the LMRP requirements for the partial hospitalization benefit.

- Because this patient was seen in an outpatient setting by a psychiatrist who referred the patient to partial hospitalization program for more intensive treatment, it is an obvious conclusion that the patient's symptoms had exacerbated and could no longer be treated effectively in an outpatient setting. As the patient continued treatment beyond the first day of treatment examined by the TriCenturion reviewer, signs and symptoms became more apparent to the team to validate the psychiatrist's decision to admit the patient to the partial hospitalization program.

b). The Draft Report states that "[i]n another case, the treatment plan updates and individual therapy notes evidenced that the patient's symptoms had stabilized. The documentation described the patient 'doing much better' and 'significantly improved.' Therefore, the medical reviewers concluded that the patient could have been safely transitioned to a less intensive outpatient level of care several weeks prior to the dates of service in this review."

- The TriCenturion reviewer states that "during the dates of service under review, the beneficiary's symptoms had stabilized, as evidenced by documentation in Treatment Plan Updates/Recertifications and Individual Therapy notes. Documentation on 10/18/2002 and 10/25/2001 described the beneficiary as 'doing much better' and 'significantly improved'. [The patient] was sleeping well, socializing, compliant with [their] medications, and demonstrating increased motivation and decreased paranoia and hallucinations. There were no medication adjustments made during the last 6 weeks of the program. Because of the chronic nature of [the patient's] condition, some delusional behavior and paranoid ideation continued as what was most likely [the patient's] baseline functional level. It appears that the beneficiary could have been safely transitioned to a less intensive level of care several weeks prior to the dates of service in this review. [The patient's] total length of stay in the program for this admission was 154 days. For the period of time reviewed, the beneficiary no longer met the criteria for PHP level of care."

  This statement is incorrect in several ways. First, medication adjustments were made up until 10/11/01 which was a little over a month before discharge from the partial hospitalization program. Second, while the patient was doing better by 10/18/01, a judgment as to whether a patient has "stabilized" requires more time for observation. Stabilization is individual to each patient and must be judged in the context of the patient's history.

- The reviewer states that "the patient has, most likely, reached baseline." A patient's baseline cannot be judged by review of the record only. The psychiatrist and treatment team (with collaboration from family and review of previous records) know the patient's history from previous admissions and know the patient's baseline. The statement by the reviewer appears biased and is based only on his/her opinion. Delusional behavior and paranoid ideation is not this patient's baseline. The treatment team knows from past experience treating this particular patient that the patient's wellness is fragile and not to discharge this patient as soon as the patient appears "better." The physician and the treatment team certified that the patient still required services and the LMRP does not specify a length of stay.

- The patient's treatment remained active and medications were changed a total of seven times in the course of the stay in partial hospitalization program. The last medication change was on 10/11/01 where the patient's anti-psychotic medication was significantly decreased. The patient was to be monitored to be sure that the decrease in medication would not cause a relapse.

- This patient did not have a perfectly smooth recovery. The patient's status changed during the stay from better to worse and therefore a statement by a clinician on a particular day of review would not indicate that the patient is necessarily ready for discharge. After going through a period of panic and having auditory hallucinations the patient's condition finally improved, but the MDE states, "[the patient] still seems fragile. Once [the patient] has consolidated these gains, and it appears that patient's improvement is consistent, we will discharge [the patient]." The physician continued to assess the patient's condition at least weekly for *consistent improvement.* On 10/25 the physician notes that the patient is continuing to improve but that "[the patient's] affect is still somewhat constricted and mood mildly depressed." On 11/08 the physician states that patient appears much better and "we have started working with the patient on termination issues." Patient was then discharged the following week when the physician and team felt the gains patient had could be maintained after partial hospitalization.

The following presents another example or error on the part of the TriCenturion reviewer.

- The TriCenturion reviewer denied partial hospitalization for this patient because the reviewer believed that the "patient should have been stepped down to a lesser level of care sooner because signs and symptoms of illness were no longer severe enough to warrant a partial hospitalization level of service."

- The reviewer states that the psychiatrist note on 6/6/02 reported that this patient's hallucinations and mood were improving and that the beneficiary denied depression. The reviewer therefore concludes that the patient was stable and should have been therefore discharged.

- On 7/25/02 a psychiatrist note stated: "The patient's depressive symptoms after showing some improvement, in fact, seem to have come to a plateau." The psychiatrist is saying that symptoms appears to have plateaued and are not worsening. This does not, in turn, mean that the symptoms are still not severe. This one statement cannot be misconstrued to mean that the patient is ready for discharge.

- More importantly, however, the psychiatrist note was only partially quoted by the reviewer, who used only the portion of the note that supported the reviewer's opinion. The note actually goes on to say "[The patient] continues to engage and responding to internal stimuli and stays focused in a very obsessive manner on his auditory and visual hallucinations." Obviously the entire statement leads to a different conclusion than simply, "the patient's depressive symptoms after showing some improvement, in fact, seems to have come to a plateau." The entirety of the note describes this patient's continued psychosis and need for stabilization.

B. The Patient's Medical Record Lack Required Documentation.

1. Thirteen Claims Had No Documentation for the Procedure Billed. This appears to be in contravention to the TriCenturion Executive Summary where it states under the "Notable Findings" section that "[a] small percentage of services billed were not documented in the records. However, there were also a small percentage of services documented but not billed. There were no trends or patterns of billing for services not rendered identified in this review." Each of the claims identified as having missing or incorrect documentation were located and reviewed. As the following summary shows, the great majority of these claims encompass services that were performed but were billed incorrectly. These types of errors are of the type that are best corrected through education and training and not through claim denials (since the services were performed although billed incorrectly).

- The TriCenturion reviewer determined that a diagnostic interview was not included in the record but had been billed. A review of the records indicates that the patient received a diagnostic interview by the licensed clinical social worker on admission who provided a preliminary diagnoses or diagnostic impression. A copy was provided to the reviewer. This claim should therefore be allowed.

- The TriCenturion reviewer states that "there is no documentation that the psychiatric diagnostic interview occurred." However, the multidisciplinary group notes show

that the patient missed Group III of the day because the patient was in a one-on-one or individual psychotherapy session with the social worker. The multidisciplinary notes section of the record includes a narrative note from the social worker documenting the individual psychotherapy session for the same time. Obviously the social worker billed a 90801 instead of the proper 90816. A revised claim indicating the proper codes should be allowed.

- The TriCenturion reviewer states that "one unit of Activity Therapy, HCPCS code G0176, was documented...and not billed. One unit of Education Training, HCPCS code G0177 was billed on each of those same days but not documented." Obviously the Activity Therapy was billed inadvertently as Education Training. However, the charge for the two sessions is the same. If it had been billed correctly the services rendered would constitute a partial hospitalization day. Also, there is no pattern of such error and it is obvious that it was an unintended by the clinician. The revised claim should therefore be allowed.

- The TriCenturion reviewer notes that an education group was billed but not documented. However a review of the group notes for the day indicates that during what would normally be the patient's first group of the day, the patient was in a one-on-one or individual psychotherapy session with the social worker. There was obviously a mistake where an education session was billed instead of an individual psychotherapy session. An individual therapy session has a greater charge than an education session and had the claim been billed correctly, the partial hospitalization day would be in full compliance with the LMRP. A revised claim indicating an individual psychotherapy session should be allowed.

- The TriCenturion reviewer states that "[a] Psychiatric Diagnostic interview cannot be found in the documentation although it was billed for..." A review of the record indicates that the psychiatric nursing assessment was billed as part of the diagnostic interview. The assessment is found in the record. Therefore this claim should be allowed.

- The TriCenturion reviewer states that "[p]rogress note not found. There was no progress note for the family psychotherapy session scheduled for 11/27/02." Unfortunately due to an error, the last page of the progress notes in the chart were not sent to the reviewer by the provider. This page is available upon request and shows that family psychotherapy services were provided as billed. This claim should therefore be allowed.

- The TriCenturion reviewer states that "[o]n 9/25 patient did not attend a min of three hours per day. There are two GT documented – the third is billed for but not

documented." This is a case of a billing error. A testing was completed but not billed. This is the admit day for the patient and the patient attended two therapy groups, an RN assessment, and a Social Worker Intake/Diagnostic Interview. The patient did attend partial hospitalization for a minimum of 4 hours. Therefore the diagnostic interview should be allowed and a revised claim indicating diagnostic testing rather than Group Therapy should be allowed.

- The TriCenturion reviewer found that a Group Therapy was billed but not documented. A review of the records indicates that a Group Therapy was preformed but billed under the incorrect code. Therefore a revised claim indicating Group Therapy should be allowed.

- The TriCenturion reviewer found that an Individual Therapy was billed but the service was not documented. A review of the records indicates that a G0177 was preformed and the clinician incorrectly billed for a 90518. The service was preformed but inadvertently billed under the wrong code. A revised claim indicating G0177 should be allowed.

- The TriCenturion reviewer found that an Education Group was billed but not documented. A review of the records indicates that an Activity Therapy Group was inadvertently billed as an Education Group. Therefore, a revised claim indicating Activity Therapy Group should be allowed.

- The TriCenturion reviewer found that an individual session was billed but not documented. A review of the records indicates that the counselor met with the patient one on one and incorrectly dated the note. Since this session is documented, it should be allowed.

- The final claim was denied because the records were missing.

2. Thirty-Eight Claims Had a Missing or Incomplete Psychiatric Evaluation/Initial Certification. It is unfair and prejudicial for the Draft Report to indicate that claims were missing or had incomplete psychiatric evaluations or initial certifications. This leads to a conclusion that the majority of denials for occurred because patients were being seen without a psychiatric evaluation, which is contrary to the LMRP. In reality, *no records were missing a psychiatric evaluation*. In addition all of the records indicated that the psychiatrist certified patients as being appropriate for partial hospitalization within 24 hours of admission. The only conclusion that can be made is that the reviewers did not see the information in the copied medical records.

In fact, the TriCenturion reviewers only denied one claim for missing a psychiatric evaluation but the denial was made in error. For this claim the TriCenturion reviewer states that "[t]here is no psychiatric evaluation in the medial record" and "since there is no psychiatric evaluation in medical record, the diagnosis is per the record as well". However, the copied record that was delivered to TriCenturion contained a full psychiatric evaluation dated on the day prior to admission to the partial hospitalization program by the referring physician. The psychiatric evaluation is handwritten by the physician on a page entitled "MD Progress Notes" but is clearly a full initial psychiatric examination and includes the presenting problem, past psychiatric history, past medical history, allergies, personal & family history, MSE, diagnoses, etc.

Synergy has also reviewed the medical records for claims denied by TriCenturion reviewers for asserted incomplete psychiatric evaluations. The results of Synergy's reviews include the following:

- For the first claim the TriCenturion reviewer stated that "[t]he Psychiatric Evaluation from the inpatient record is incomplete. There is no documentation found in the medical record that demonstrates updates were added.". The reviewer went on to state that "[t]he Psychiatric Evaluation is incomplete. The Psychiatric Evaluation was provided by the beneficiary stay at [the] Psychiatric Hospital and is therefore acceptable to use for [the patient's] PHP program. The beneficiary's chief complaint is not documented, the history of present illness is not documented, the education level, impact of symptoms on functioning, estimate of intellectual function, orientation, and memory is not documented. There is no other physician documentation during the PHP admission that provides the missing information and/or updates."

  The reviewer appears to have not seen or read the inpatient psychiatric evaluation from the psychiatric hospital. The note is typed off center so that the identifying information and chief complaint, and history of present illness are in the same paragraph but are obvious when read. The psychiatric evaluation provides the information that the reviewer deemed to be missing. This should therefore have been allowed.

- For the second claim, the records indicate that the patient was discharged from the inpatient hospital by the physician. The full psychiatric evaluation from the hospital and the history and physical exam is in the record. The physician had obviously seen the patient on day of admit since the physician had signed orders and had written in the progress notes, "admission note dictated." However, due to an oversight that admission note was not copied and sent with the record but is immediately available upon request.

- The third claim was denied because the TriCenturion reviewer stated that "[t]he Physician did not sign the certification on the Master Treatment Plan." However, the

initial certification of need is located in the chart on a separate page from the MTP and the physician's orders. The physician signed a certification of need on the day of admission, which states: "I certify that the patient would require inpatient psychiatric care if the Partial Hospitalization Services were not provided and services will be furnished under the care of a physician and written plan of treatment."

- The fourth claim was denied because the TriCenturion reviewer found that the initial psychiatric evaluation is dated three days after admit to the partial hospitalization program by the physician and that it did not include a physician supervised plan of care, and that the treatment plan not signed for one month after admit.

  This patient was discharged from an inpatient hospital to the partial hospitalization program. The psychiatric evaluation from the hospital was dated less than thirty days prior to admit to partial hospitalization program, therefore only an update to the inpatient evaluation was required. The partial hospitalization psychiatrist updated the evaluation – the certification was signed on day of admission, the physician saw the patient and updated the record.

a). The Draft Report states: "The medical history and physical examination was missing or not completed within the required timeframe. In many cases, the medical history and physical examination was not found in the medical records. In other cases the documentation was from a prior admission; one dating back to 7 ½ years prior to the patient's admission."

Nineteen claims were denied by the TriCenturion reviewers for missing the medical history and physical examination, for not performing the medical history and physical examination within 24 hours of admission or for not having an appropriate update after inpatient admission. However, all nineteen medical records reviewed by the TriCenturion reviewers contain a medical history and physical examination.

The medical history is part of a psychiatric evaluation conducted by the psychiatrist on admission, which is documented by a nurse through the initial admission nursing assessment. On admission, a nurse obtains completes an in-depth assessment of the patient under the supervision and direction of a physician. The nursing assessment includes a basic physical assessment, including temperature, pulse, respiration and vital signs, a nutritional assessment, and an assessment of systems of EENT, including cardiac, respiratory, gastrointestinal, bowel, genitourinary, musculo-skeletal, neuro, endocrine and infectious disease. It also includes assessments of pain, skin, sensor motor skills, ability to participate in ADLs, gait, ROM fine motor skills, etc. An AIM is performed and by the nurse and reviewed and signed by the physician within 24 hours of admission.

The one record that indicated that the medical history and physical examination were over seven years old was erroneous. This patient's record contained a large amount of history requested from previous physicians and clinics which was inadvertently copied instead of a more recent information. Given the emphasis placed on this one record in the Draft Report, Synergy would be happy to provide the OIG with the most recent medical history and physical examination available in the record.

Synergy also believes that the LMRP may have been misapplied by the TriCenturion reviewers. Specifically, LMRP- 2, pages 7 - 8 states: "The initial psychiatric evaluation with medical history and physical examination must be preformed and placed in the chart within **24** hours of admission in order to establish medical necessity for partial hospitalization services. If the patient is being discharged from an inpatient psychiatric admission to a partial hospitalization program, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate updates are acceptable". The LMRP also states on page 8 that "[a] team or multi-disciplinary approach may be used in developing the initial psychiatric evaluation, however there must be evidence in the patient's medical record that a physician provided direct patient care, provided supervision and direction…, reviewed the medical record, and determined the extent to which the therapeutic goal are being met."

Synergy is not confident that the TriCenturion reviewers properly applied this standard, may have only reviewed the psychiatrist's portion of the initial psychiatric evaluation and may have missed the nurses', social workers' and other team members' contribution to the initial psychiatric evaluation.

b). The Draft Report states: "The treatment plan was missing, incomplete, or not signed within the required timeframe. In a few cases, the master treatment plan was not found in the medical records. In other cases, the physician did not sign the treatment plan or the plan did not specify the goals or the types of therapy to be provided."

One reason that the reviewers believed that the psychiatric evaluations were incomplete was their determination that there was no plan of care on admission. However, while the plan of care is not always located in the psychiatric evaluation, it is always contained in the physician's orders section of the medical record under the label "Preliminary Treatment Plan." The preliminary treatment plan contains the types, duration, and frequency of therapies to be delivered and is in every medical record delivered to TriCenturion.

After reviewing the twelve records where TriCenturion determined that the treatment plans were not signed within the required timeframe, Synergy believes that TriCenturion is misapplying the LMRP. The treatment plan required to be included in the initial psychiatric evaluation and

completed within 24 hours is NOT the master treatment plan. The initial treatment plan is actually the plan that the multi-disciplinary team, under the direction of a psychiatrist, creates based on their initial evaluation and impression of the patient. This is the plan required to be submitted into the medical record within 24 hours. The master treatment plan, on the other hand, is submitted within seven days of admission and takes into account all clinical information collected by the multi-disciplinary team over the initial days of treatment. While the master treatment plan is also reviewed and signed by a physician, it is not required by the LMRP to be submitted into the record within 24 hours of treatment.

6. **Conclusion**.

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

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

- The OIG should reconsider its findings concerning a lack of internal controls because the OIG never tested Synergy's internal controls, never evaluated and ruled out the reasonable alternatives identified above and because significant errors in the medical review results were uncovered.

- The Draft Report should describe and reconcile Synergy's longstanding positive history with TriSpan with the fact that TriCenturion's asserted a 51% error rate. At minimum the disparate results should be referenced.

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

- The OIG should investigate TriCenturion's medical review findings to reconcile the internal inconsistency within TriCenturion's Executive Summary.

- The OIG should withdraw the overpayment recommendation in the Draft Report until Synergy can coordinate with the OIG and TriCenturion to ensure that claims denied by TriCenturion are claims that should truly be denied for lack of documentation, lack of medical necessity or for services billed but not rendered.

- The OIG should revise the "Recommendation" section of the Draft Report to reflect that TriSpan is to engage Synergy in a progressive action program as required by §3.11 of Medicare Manual 100-8.

If we can be of any further assistance, please contact Christopher White, Esq. at 202.739.5240 or myself.

Sincerely,

Christopher L. White

Attachments

cc: Sean Wendell
Valerie Dalton
Patrick Gilmore

ATTACHMENT A

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January 18, 2005

Gordon L. Sato
Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Re: Draft Report Number: A-06-04-00076 (Synergy Behavioral Health)

Dear Mr. Sato:

On behalf of Synergy Behavioral Health (the "Provider"), we recently received materials under cover of your letter dated January 7, 2005 concerning the medical review conducted by TriCenturion, LLC ("TriC") on behalf of the OIG. We understand from your letter that we have thirty (30) days to review the materials and provide a rebuttal response to the above-referenced Draft Report.

However, due to information contained in the materials and based on facts concerning the original exit conference provided by Synergy, we hereby request a second exit conference with the OIG and representatives from TriC in a position to discuss the medical review findings. The reasons for requesting a second exit conference are as follows:

- The Draft Report was issued on October 2004 while the exit conference was held on June 24, 2004. Synergy had no opportunity to discuss the contents of the Draft Report with the auditors or the TriC medical reviewers who conducted the audit;
- In the materials provided by the OIG, there is a document from TriC entitled "Executive Summary of the Review of Outpatient Mental Health Services Provided By Community Mental Health Centers A-07-04-04028" that lists the general findings and observations of the TriC medical reviewers. However, this

document was not provided to Synergy during the original exit conference; therefore, Synergy was not able to fully discuss TriC's findings;

- There was no representative of TriC at the original exit conference with whom Synergy could discuss the medical review findings. We request that a representative of TriC familiar with the medical review of Synergy be present at any second exit conference; and

- From the materials provided we have serious questions concerning TriC's findings. This includes conclusions that required documents were missing from medical records that, upon review, are clearly present and statements of violations of non-existent Local Medical Review Policy standards.

In light of the above facts, we request an extension of the time to file a rebuttal to the Draft Report until such time as a second exit conference has been concluded. In the meantime and until we receive a reply to this request, we will fully comply with your deadline and continue to draft our rebuttal response.

If you have any questions or comments, please do not hesitate to contact Christopher L. White at (202) 739-5240 or myself. I look forward to your response.

Sincerely,

Patrick L. Gilmore /vs

Patrick L. Gilmore

cc: Christopher L. White, Esq.
Sean Wendell
Valerie Dalton

ATTACHMENT B

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

January 19, 2005

Report Number: A-06-04-00076

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

Dear Mr. Gilmore:

This is in response to your January 18, 2005, letter requesting a second exit conference and an extension of time to file a response to our draft report entitled *Medical Review of Synergy Behavioral Health's Partial Hospitalization Services for the Period August 1, 2000 through December 31, 2002* (Report Number A-06-04-00076).

Specifically, you state that because (1) Synergy had no opportunity to discuss the medical review findings with a TriCenturion representative and (2) you have serious questions concerning the findings, Synergy should be granted a second exit conference with the OIG and representatives from TriCenturion before filing a response to the draft report.

We are unable to grant Synergy a second exit conference with the OIG and TriCenturion representatives. During the exit conference, and restated in the July 8, 2004, letter, we informed Synergy that due process would be afforded through the provider's right to appeal. We stated that any disagreements to the medical review findings would need to be addressed with the fiscal intermediary once a demand letter is issued and Synergy exercises its appeal rights.

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

Therefore, we request that you provide us with a response to Report Number A-06-04-00076 by February 7, 2005.

Page 2 – Patrick Gilmore

If you have any questions or need additional information, please contact Ms. Sylvie Witten, Audit Manager, at (512) 339-3071, extension 222, or Ms. Michelle Richards, Senior Auditor, at (214) 767-9202.

Sincerely yours,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
For Audit Services

cc: Sean Wendell
Valerie Dalton

ATTACHMENT C

TRICENTURION (TASK ORDER 0007 – FLORIDA)

Executive Summary of the Review of Outpatient Mental Health Services Provided By Community Mental Health Centers A-07-04-04028

SUBJECT:	**Partial Hospitalization Programs**
Provider Name:	**Synergy Behavioral Health Partial Hospitalization Program**
Provider Number:	**194665**
Review Period:	**Claim paid dates August 1, 2000 through August 31, 2003**

A medical review was conducted on a sample of one hundred (100) Medicare outlier claims with paid dates August 1, 2000 through August 31, 2003 for Partial Hospitalization Program (PHP) services provided by Synergy Behavioral Health Partial Hospitalization Program of Baton Rouge, Louisiana. The **total claim count was one hundred (100)**, the **total number of beneficiary records was ninety-nine (99)**, the **total number of claim lines was eight hundred and forty-three (843)**, and the **total number of services was one thousand six hundred and sixty-five (1,665)**. The provider failed to submit one (1) medical record, although a claim for services was submitted. This claim was denied for lack of documentation.

The purpose of the review was to determine if payments made for selected services provided to Medicare beneficiaries in Partial Hospitalization Programs met the Centers for Medicare & Medicaid Services (CMS) eligibility requirements, were medically necessary, reasonable and billed in accordance with CMS guidelines.

CODES REVIEWED:

CPT 90818 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately forty-five (45) to fifty (50) minutes face-to-face with the patient.

CPT 90847- Family psychotherapy, family counseling services for which the primary purpose is the treatment of th patient's condition.

CPT 90853 - Group psychotherapy (other than of a multiple-family group).

CPT 90801- Psychiatric diagnostic interview examination, psychiatric general services.

CPT 96100- Psychiatric testing: Folstein mini-mental status exam, Hamilton Anxiety Scale, Abnormal Involuntary Movement Scale (AIMS), Beck Depression Inventory, Geriatric Depression Inventory.

HCPCS G0176 & Q0082 - Individual activity therapies that are not primarily recreational or diversionary. These activities are individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals.

HCPCS G0172 & G0177 - Education training to the extent the training and educational activities are closely relatec the individual's care and treatment of their diagnosed psychiatric condition.

TRICENTURION (TASK ORDER 0007 – FLORIDA)

Executive Summary of the Review of Outpatient Mental Health Services Provided By Community Mental Health Centers
A-07-04-04028

SUMMARY OF FINDINGS:

The Partial Hospitalization Program (PHP) provided by Synergy Behavioral Health did appear to meet the basic criteria and requirements for partial hospitalization programs outlined in TriSpan Health Services Local Medical Review Policy (LMRP) PHP-2. Fifty-one percent (**51%) of the claims in the sample were denied** for one or more of the reasons detailed below.

Of the one hundred reviews performed, two (2) beneficiaries were found not to have attended the program for the required minimum of three (3) hours per day. Thirty-eight (38) beneficiaries had a missing or incomplete psychiatric evaluation or it was not updated within the required time frame. Nineteen (19) reviews had no medical history or physical examination or this document was not completed within the required time frame. Three (3) beneficiaries had no Master Treatment Plan. In twelve (12) of the reviews, the treatment plan was not signed in the time frame required, was not signed by the beneficiary, or was incomplete. In nine (9) reviews, the beneficiaries met medical necessity criteria on admission, but had an excessive length of stay and should have been discharged to a less intensive level of care sooner, as their treatment goals were met and there were no medication adjustments made to indicate an unstable condition for an extended period of time. In four (4) reviews, the beneficiaries were too disruptive and/or mentally unstable to participate in an intensive partial hospitalization program or benefit from partial hospitalization services. Finally, in seven (7) reviews, there was no documentation of an attempt at a lesser level of care before being admitted to the PHP or medical necessity for admission to the PHP was not established. The provider failed to submit one (1) medical record, although a claim was submitted. Therefore, all services billed on that claim were denied. The Summary of Findings is an explanation of the denial reasons; the Notable Findings are items of note or trends that were observed, but are not necessarily reasons for denial. The Notable Findings are useful in helping to identify areas for provider education.

Overall, there was evidence that the therapy sessions were active, intensive, and therapeutic in nature, as required for a PHP level of care. Progress notes from the therapy sessions did describe the nature of the treatment , the beneficiary's behavior, verbalizations, and mental status during the course of the service, the therapeutic interventions provided, and the beneficiary's response to interventions. The relationship of the interventions to the long and short-term goals in the treatment plan was not always clear. This was an area identified as an opportunity for improvement.

The scope of the program was broad and included multiple treatment modalities. They consisted of Individual Psychotherapy (CPT code 90818), Group Psychotherapy (CPT code 90853), Family Therapy (CPT code 90847), Activity Therapy (HCPCS codes G0176 and Q0082), and Education Training (HCPCS codes G0177 and G0172). Groups were appropriately prescribed and utilized for all of the beneficiaries. Dual diagnoses groups were provided for beneficiaries who required this service. Psychiatric testing was ongoing and usually performed as ordered by the physician. The treatment plans, prescribed therapies and identified goals of treatment were individualized to the beneficiaries' needs. Updates were usually completed on a weekly basis with an accompanying re-certification statement and an appropriate description of the need for continued partial hospitalization services. The documentation exceeded the Local Medical Review Policy requirements in most instances. Treatment plans and goals were updated according to the beneficiaries' progress or lack of progress. Dr. Imran, a psychiatrist for this PHP, provided medication management. All beneficiaries were prescribed psychotropic medications and were appropriately monitored for effectiveness, side effects, and signs and symptoms of decompensating behaviors. Registered nurses participated in the delivery of care and monitoring practices. Discharge plans were based on the individual needs of each beneficiary and were varied.

TRICENTURION (TASK ORDER 0007 – FLORIDA)

Executive Summary of the Review of Outpatient Mental Health Services Provided By Community Mental Health Centers A-07-04-04028

The majority of the beneficiaries in the sample appeared to have had acute exacerbations of psychiatric conditions. A total of seventy-four percent (74%) were admitted from an inpatient setting to the PHP. One beneficiary had a court mandated admission to the PHP. There was evidence that, when indicated, beneficiaries were stepped up to inpatient care when it was evident that PHP was no longer an appropriate setting. Most Global Assessment of Functioning (GAF) scores were documented on admission or on a psychiatric evaluation from the inpatient medical record, an acceptable practice according to the LMRP. However, some discrepancies in the scores were noted from document to document, and some beneficiaries had a higher score on discharge from the inpatient setting than on admission to the PHP. These discrepancies demonstrated a wide gap in scores for same day transitions or day after admissions which it made it appear as if the beneficiary had been discharged from the inpatient setting prematurely when this was not the case.

NOTABLE FINDINGS:

- This partial hospitalization program provided active and intensive treatment. It was a multi-modal program including individual, group, family psychotherapies, activity and psycho-educational interventions. Beneficiaries had psychiatric impairments severe enough to warrant the services of a PHP and without such services would have required inpatient hospitalization.
- The eligibility and medical necessity criteria for admitting the beneficiaries to the PHP were met as outlined by the TriSpan PHP-2 Local Medical Review Policies and CMS guidelines.
- Ninety-seven of the one hundred beneficiaries in the sample, ninety-seven percent (97%), did attend the PHP for the required minimum of three (3) hours per day four (4) days per week. Only two (2) beneficiaries did not meet that standard. One (1) beneficiary's attendance hours could not be determined, as no medical record was submitted.
- Thirty-eight (38) claims, thirty-eight percent (38%), had a missing or incomplete psychiatric evaluation.
- Nineteen (19) claims, nineteen percent (19%), had no medical history or physical examination or this document was not completed within the required time frame.
- Sixty-one (61) claims, sixty-one percent (61%), were billed incorrectly using HCPCS codes G0177 and G0172 under revenue code 915. They should have been billed under revenue code 942. This was not a reason for denial however this high percentage demonstrates a trend of incorrect billing practices according to TriSpan Local Medical Review Policies PHP-2.
- Fourteen (14) Global Assessment of Functioning (GAF) scores, fourteen percent (14%), were not recorded or there was a discrepancy from the discharge inpatient score (higher) than the PHP admission GAF score (lower).
- The majority of the beneficiaries in the sample appeared to have a diagnosis of schizo-affective disorder or schizo-affective disorder rule out bipolar manic type, or schizo-affective disorder rule out schizophrenia.
- Fifteen (15) treatment plans, fifteen percent (15%) , were signed but not dated by the psychiatrist.
- Twelve (12) treatment plans, twelve percent (12%), were not signed by the beneficiary or not signed within the time required.
- Three (3) beneficiaries, three percent (3%) had no treatment plans.
- It was not always clearly documented in the progress notes if the group provided was an activity group or an education group.

TRICENTURION (TASK ORDER 0007 – FLORIDA)

Executive Summary of the Review of Outpatient Mental Health Services Provided By Community Mental Health Centers A-07-04-04028

- Nine (9) beneficiaries, nine percent (9%), met medical necessity criteria on admission, but had an excessive length of stay and should have been discharged to a less intensive level of care sooner than they were as the treatment goals were met and there were no medication adjustments made to indicate unstable condition for an extended period of time.
- Seven (7) records, seven percent (7%), had no documentation of an attempt at a lesser level of care before being admitted to PHP, or medical necessity for admission to PHP was not established.
- Four (4) records, four percent (4%), had illegible physician notes.
- Four (4) beneficiaries, four percent (4%), were too disruptive and/or mentally unstable to participate in an intensive partial hospitalization program or benefit from partial hospitalization.
- The therapeutic interventions were not consistently documented in the progress notes. Thus, the relationship with treatment goals was not always clear.
- A small percentage of services billed were not documented in the records. However, there was also a small percentage of services documented but not billed. There were no trends or patterns of billing for services not rendered identified in this review.

RECOMMENDATIONS

1. Provider education related to appropriate matching of revenue codes with CPT and HCPCS codes.
2. Provider education on the timeframe and components that make up the psychiatric evaluation. The psychiatric evaluation establishes medical necessity for admission to the PHP and the timeframe for placing this information on the medical record is specific in the Local Medical Review Policies. If any component is missing such as appropriate updates, medical history and physical examination, or initial treatment plan, medical necessity cannot be established.
3. Provider education on utilization of the Global Assessment of Functioning (GAF) tool. When a beneficiary is discharged from an inpatient setting with a GAF score it would be expected that upon admission to the PHP the GAF score would be the same or higher than the inpatient discharge GAF score, not much lower as was documented in some of the records reviewed.
4. Provider education on how to write therapeutic interventions that bear a relationship to the treatment goals.
5. Provider education related to the appropriate time to discharge a beneficiary to a lesser level of care. When multidisciplinary documentation consistently demonstrates improvements and there are no medication adjustments being made, a lesser level of care is appropriate and consistent with the Local Medical Review Policies.