MAR - 1 2005

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 Quitman Clinic's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2002 (A-07-04-04034)

Attached is an advance copy of our final report on partial hospitalization program (PHP) services claimed by Clinic Resources Management, Inc. (Quitman Clinic) for the period August 1, 2000, through December 31, 2002. We will issue this report to Quitman Clinic within 5 business days. This is one of a series of reports on Medicare PHP services provided by community mental health centers. Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients instead of inpatient psychiatric care.

The audit objective was to determine if Medicare claims submitted by Quitman Clinic for PHP services met Medicare reimbursement requirements.

Quitman Clinic submitted claims for PHP services that did not meet Medicare reimbursement requirements. Medical reviewers from a program safeguard contractor determined that none of the services on 100 sampled claims met Medicare reimbursement requirements. The medical reviewers questioned every claim primarily for one or more reasons:

- Services did not meet the requirements of section 1861(ff)(2)(E) of the Social Security Act (the Act) because there was no evidence that the therapy sessions were active, intensive, and therapeutic in nature.

- The beneficiaries did not attend the PHP for the minimum hours per week required by the Texas Local Medical Review Policy.

- Medical records contained copied documents from previous admissions and, accordingly, did not meet the requirements of section 1833(e) of the Act.

- The PHP recertifications did not include all of the information required by 42 CFR § 424.24(e)(3).

- Medical records did not contain documentation that the beneficiaries had approved of and participated in their plans of care as required by Texas Local Medical Review Policy.

Based on the results of the medical review, we concluded that Quitman Clinic did not have adequate procedures to ensure that claims were submitted in compliance with Medicare requirements. As a result, for the 100 claims in the statistical sample, Quitman Clinic received $717,147 in unallowable Medicare payments. Because none of the sampled items were eligible for Medicare reimbursement, the entire universe of 1,714 claims for the period August 1, 2000, through December 31, 2002, totaling $12,491,797 in payments, should not have been billed to Medicare.

We recommend that Quitman Clinic refund to the Medicare program $12,491,797 in unallowable payments and strengthen its procedures to ensure that PHP claims meet Medicare reimbursement requirements.

While Quitman Clinic disagreed with the recommendation to repay the $12,491,797, it agreed to strengthen its procedures. Because the program safeguard contractor found that none of the sampled claims met Medicare reimbursement requirements, we continue to believe that Quitman Clinic should refund the money.

If you have any questions or comments about this report, please do not hesitate to 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 Mr. James P. Aasmundstad, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591. Please refer to report number A-07-04-04034 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

Report Number: A-07-04-04034

MAR - 4 2005

Mr. Nathan Ingram
Manager
Clinic Resources Management, Inc.
1320 Quitman Street
Houston, Texas 77009

Dear Mr. Ingram:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Medical Review of Quitman Clinic's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2002." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

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

We will provide the results of this audit to the Medicare fiscal intermediary for appropriate adjustments.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Pease refer to report number A-07-04-04034 in all correspondence.

Sincerely,

James P. Aasmundstad
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

James R. Farris, Jr., M.D.
Regional Administrator, Region VI
Centers for Medicare & Medicaid Services
Department of Health and Human Services
1301 Young Street, Suite 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICAL REVIEW OF QUITMAN CLINIC'S PARTIAL HOSPITALIZATION SERVICES FOR THE PERIOD AUGUST 1, 2000, THROUGH DECEMBER 31, 2002

MARCH 2005
A-07-04-04034

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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The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

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The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. The OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

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The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

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

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients instead of inpatient psychiatric care. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a community mental health center (CMHC). Partial hospitalization services are included in the Medicare hospital outpatient prospective payment system (OPPS) that was implemented in August 2000. Under the OPPS, partial hospitalization providers receive a per diem payment. In extraordinary cases, additional Medicare payments, called outlier payments, may be made in situations where the cost of care is high in relation to the average cost of treating comparable conditions or illnesses.

This review is part of a nationwide audit of payments to CMHCs.

OBJECTIVE

The audit objective was to determine if Medicare claims submitted by Clinic Resources Management, Inc. (Quitman Clinic) for PHP services met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Quitman Clinic submitted claims for PHP services that did not meet Medicare reimbursement requirements. Medical reviewers from a program safeguard contractor (PSC) determined that none of the services on 100 sampled claims met Medicare reimbursement requirements. The medical reviewers questioned every claim primarily for one or more reasons:

- Services did not meet the requirements of section 1861(ff)(2)(E) of the Social Security Act (the Act) because there was no evidence that the therapy sessions were active, intensive, and therapeutic in nature.

- The beneficiaries did not attend the PHP for the minimum hours per week required by the Texas Local Medical Review Policy.

- Medical records contained copied documents from previous admissions and, accordingly, did not meet the requirements of section 1833(e) of the Act.

- The PHP recertifications did not include all of the information required by 42 CFR § 424.24(e)(3).

- Medical records did not contain documentation that the beneficiaries had approved of and participated in their plans of care as required by Texas Local Medical Review Policy.

Based on the results of the medical review, we concluded that Quitman Clinic did not have adequate procedures to ensure that claims were submitted in compliance with Medicare requirements. As a result, for the 100 claims in the statistical sample, Quitman Clinic received $717,147 in unallowable Medicare payments. Because none of the sampled items were eligible for Medicare reimbursement, the entire universe of 1,714 claims for the period August 1, 2000, through December 31, 2002, totaling $12,491,797 in payments, should not have been billed to Medicare.

In another audit of Quitman Clinic's PHP services, we are recommending that the fiscal intermediary work with the Centers for Medicare & Medicaid Services (CMS) to recover improper outlier payments for PHP services rendered between August 1, 2000, and December 31, 2003.[1] Of the $12,491,797 in unallowable payments identified in this medical review audit:

- $7,164,566 were associated with the same unallowable outlier payments in the other audit of Quitman Clinic's PHP services and

- $5,327,231 were not outlier payments and were not included in the other audit.

RECOMMENDATIONS

We recommend that Quitman Clinic:

- refund to the Medicare program $12,491,797 in unallowable payments and

- strengthen its procedures to ensure that PHP claims meet Medicare requirements.

AUDITEE COMMENTS

In response to our draft report, Quitman Clinic said it did not agree to reimburse the Medicare program $12,491,797. Quitman Clinic said that it would strengthen internal quality controls and seek training to adhere to Medicare requirements. Quitman Clinic's response is summarized in our report and included as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

As reported, the medical reviewers found that none of the services on 100 sampled claims met Medicare reimbursement requirements. Therefore, we continue to believe that Quitman Clinic should refund the Medicare program $12,491,797.

[1]In another audit of Quitman Clinic's PHP services (A-07-04-04045), we found unallowable payments totaling $8,802,649 because the fiscal intermediary used an outdated cost-to-charge ratio to compute the outlier payment contrary to Medicare reimbursement requirements. Of the $8,802,649, $7,164,566 were associated with the same unallowable payments in this report. We therefore recommend in the other report that recovery action be coordinated with resolution of this audit. As of the issuance of this medical review audit report, we had not issued a report on our other audit of Quitman Clinic's PHP services.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Partial Hospitalization Program

A 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 PHP may be provided by a hospital to its outpatients or by a CMHC.

Partial Hospitalization Payments

The Balanced Budget Act of 1997 required CMS to implement a Medicare prospective payment system for hospital outpatient services. Partial hospitalization services provided by CMHCs are included in the Medicare hospital OPPS that was implemented in August 2000. Under the OPPS, CMHCs receive a per diem payment.

Outlier Payments

Congress authorized Medicare outlier payments for situations where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. In addition to providing per diem payments for PHP services, Medicare makes additional payments for outlier cases when the provider's charges for the services, adjusted to cost, exceed a given threshold established by the Secretary of the Department of Health and Human Services.

Intermediary Responsibilities

CMS contracts with fiscal intermediaries to assist it in administering the PHP. Intermediaries are responsible for:

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

Quitman Clinic

Quitman Clinic, a Medicare-certified CMHC located in Houston, TX, received Medicare payments totaling more than $12 million from the inception of the OPPS in August 2000 through December 2002. Of these payments, more than half were outlier payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The audit objective was to determine if Medicare claims submitted by Quitman Clinic for PHP services met Medicare reimbursement requirements.

Scope

To accomplish our objective, we selected a random sample of 100 claims from a universe of 1,714 claims for the period August 1, 2000, to December 31, 2002. Quitman Clinic received total Medicare payments of $12,491,797 for the 1,714 claims.

We did not perform detailed tests of internal controls because we accomplished the objective of our review through substantive testing.

This review is a part of a series of CMHC audits of providers receiving high levels of outlier payments. We selected the providers to audit in these reviews based on a ranking of total outlier payments made to each provider between August 1, 2000, and June 30, 2003.

Methodology

We reviewed the Balanced Budget Act of 1997, the Balanced Budget Refinement Act of 1999, the Federal Register, program memorandums, and the Provider Reimbursement Manual as they pertain to payments for PHP services. We also interviewed officials of the fiscal intermediary, CMS, and Quitman Clinic.

Medical reviewers from TriCenturion, a Medicare PSC, performed a clinical review of a statistical random sample of 100 claims on behalf of the Office of Inspector General (OIG). The PSC reviewed the claims and applicable medical records to determine if payments were made for PHP services that met Medicare eligibility requirements and were medically necessary, reasonable, and billed in accordance with Medicare guidelines. The codes billed on the sampled claims were Current Procedure Terminology codes 90818–Individual Psychotherapy and 90853–Group Psychotherapy, as well as Modifier 76–Repeat Procedure by Same Provider.

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 performed fieldwork at Quitman Clinic in Houston, TX, from November 2003 to May 2004.

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

FINDINGS AND RECOMMENDATIONS

Quitman Clinic submitted claims for PHP services that did not meet Medicare reimbursement requirements. The medical reviewers from a Medicare PSC determined that none of the services on the 100 claims in our sample, totaling $717,147 in payments, met Medicare reimbursement requirements. Medical reviewers questioned every claim primarily for one or more reasons:

- Services did not meet the requirements of section 1861(ff)(2)(E) of the Act because there was no evidence that the therapy sessions were active, intensive, and therapeutic in nature.

- The beneficiaries did not attend the PHP for the minimum hours per week required by the Texas Local Medical Review Policy.

- Medical records contained copied documents from previous admissions and, accordingly, did not meet the requirements of section 1833(e) of the Act.

- The PHP recertifications did not include all of the information required by 42 CFR § 424.24(e)(3).

- Medical records did not contain documentation that the beneficiaries had approved of and participated in their plans of care as required by Texas Local Medical Review Policy.

Based on the results of the medical review, we concluded that Quitman Clinic did not have adequate procedures to ensure that claims were in compliance with Medicare requirements. As a result, Quitman Clinic received $717,147 in unallowable Medicare payments for the 100 claims in the statistical sample. Because none of the sampled items were eligible for Medicare reimbursement, the entire universe of 1,714 claims for the period August 1, 2000, through December 31, 2002, totaling $12,491,797 should not have been billed to Medicare.

Appendix A details the errors for each sampled claim.

NONCOMPLIANCE WITH MEDICARE REIMBURSEMENT REQUIREMENTS

The Medicare PSC's medical reviewers determined that none of the services on 100 statistically sampled claims met Medicare requirements. The PHP services must meet Medicare eligibility requirements and be medically necessary, reasonable, and billed in accordance with Medicare guidelines.

Services Not Covered

The PSC's medical reviewers determined that the PHP services on 99 of the 100 claims sampled were primarily social, recreational, or diversionary or provided only a level of functional support that did not treat the psychiatric symptoms presented by the beneficiaries. For example, the medical reviewers found that documentation for one claim consisted primarily of brief quotes of what the beneficiary said during the session. This documentation was insufficient to establish that group therapy sessions were active, intensive, and therapeutic in nature as required for a PHP. Specifically, section 1861(ff)(2)(E) of the Act states that individualized activity therapy services that are recreational and diversionary are not allowable.

Minimum Hours Per Week Not Met

Ninety of the 100 claims sampled did not meet the minimum intensity standard for the program because the beneficiaries failed to attend the PHP for the required minimum of 20 hours per week for 1 or more of the weeks reviewed. Section 1861(ff)(3)(A) of the Act states that partial hospitalization services are a distinct and organized intensive ambulatory treatment service. According to the Texas Local Medical Review Policy V-2A-R4, page 4, beneficiaries must receive a minimum of 20 hours of service a week to be eligible for Medicare reimbursement.

Copied Medical Records

For 25 of the 100 claims, medical records contained copied documents from previous admissions of the same patient. The copied documents included Master Treatment Plans, Intake Assessments/Psycho-Social Histories, Consents for Services, and Patient Registration/Assignment of Benefits forms. It appeared that these documents were copied and used repeatedly from admission to admission. Dates were altered for each admission, but there was no evidence that the documents were updated to reflect the beneficiary's current status as required. Section 1833(e) of the Act requires services to be documented in order for payment to be made. In addition, 42 CFR § 424.24(e)(2) requires medical records to contain information to support the diagnosis, type, amount, duration, and frequency of services, as well as the treatment goals under the plan.

Recertification Requirements Not Met

None of the recertifications (of 69 claims that required recertifications) met Medicare requirements. A recertification of treatment as of the 18th day of PHP services is required by 42 CFR § 424.24(e)(3). Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days. The recertifications are required to include the patient's response to the therapeutic interventions provided by the PHP, the patient's psychiatric symptoms that continue to place the patient at risk of hospitalization, and treatment goals for coordination of services to facilitate discharge from the PHP. However, the PSC's medical reviewers determined that none of the 69 PHP claims that required a recertification plan met these requirements.

Beneficiaries' Approval or Participation Not Documented

For all 100 claims reviewed, Quitman Clinic did not document evidence in the medical record that the beneficiaries approved of and participated in their plans of care, such as a signature on the treatment plan, as required by Texas Local Medical Review Policy V-2A-R4, page 13.

CAUSE OF UNALLOWABLE CLAIMS

Based on the results of the medical review, we concluded that Quitman Clinic did not have adequate procedures to ensure that claims were submitted in compliance with Medicare requirements.

EFFECT OF IMPROPER BILLINGS

For the 100 claims in the statistical sample, Quitman Clinic received $717,147 in Medicare payments for services that did not meet the Medicare reimbursement requirements. Because none of the sampled items were eligible for Medicare reimbursement, the entire universe of $12,491,797 was unallowable.

In another audit of Quitman Clinic's outlier payments, we are recommending that the fiscal intermediary work with CMS to recover improper outlier payments for PHP services rendered between August 1, 2000, and December 31, 2003. Of the $12,491,797 in unallowable payments identified in this medical review audit:

- $7,164,566 were associated with the same unallowable outlier payments in the other audit of Quitman Clinic's PHP services and

- $5,327,231 were not outlier payments and were not included in the other audit.

RECOMMENDATIONS

We recommend that the Quitman Clinic:

- refund to the Medicare program $12,491,797 in unallowable payments and

- strengthen its procedures to ensure that PHP claims meet Medicare reimbursement requirements.

AUDITEE COMMENTS AND OIG RESPONSE

Quitman Clinic's written response to our draft report is included as Appendix B. We redacted personal information from the response and omitted less pertinent attachments.

In summary, Quitman Clinic did not agree to reimburse the Medicare program $12,491,797. However, Quitman Clinic said that it would strengthen internal quality controls and had arranged for training to adhere to Medicare requirements.

Quitman Clinic's response included the following main issues:

Medical Review Differences

Quitman Clinic Comment

Quitman Clinic said that TrailBlazer's prepayment medical reviews indicated that more than 90 percent of Quitman Clinic's charts were compliant with Medicare regulations. In performing a medical review as part of this audit, TriCenturion found a 100-percent error rate. Quitman Clinic asserted that if TrailBlazer was accurate in its assessment of Medicare compliance, TriCenturion either changed the focus of the review or its assessment was simply inaccurate.

OIG Response

According to TriCenturion review officials, there are significant differences between the scope of a prepayment medical review performed by a fiscal intermediary and the comprehensive medical review TriCenturion performed as part of this audit. A prepayment medical review often entails a review of only certain aspects of a claim. The comprehensive medical review entails a review of the entire claim as well as a more thorough review of a beneficiary's medical history. Furthermore, the TrailBlazer medical reviews ended in August 2000. TriCenturion's medical review covered August 2000 through December 2002. Since the scope and time period of the TriCenturion and TrailBlazer medical reviews were not the same, the results should not be compared.

Fiscal Intermediary's Role

Quitman Clinic Comment

Quitman Clinic said if TrailBlazer was inaccurate in its assessment of Quitman Clinic's Medicare compliance, TrailBlazer had a role in the deficits that led to the questioned costs. Quitman Clinic said that because TrailBlazer did not provide training on what constitutes an acceptable claim, Quitman Clinic should not be responsible for overpayments. In summary, Quitman Clinic has indicated that TrailBlazer is at least equally responsible for the deficiencies, but only Quitman Clinic is penalized.

OIG Response

The provider is required to comply with Medicare laws and regulations. CMS Form 855A, the Medicare provider application for enrollment, requires the provider to sign a certification statement agreeing to abide by the Medicare laws, regulations, and program instructions that apply to the provider type.

The Texas Local Medical Review Policy includes a detailed explanation of Medicare requirements related to PHP services. TrailBlazer made the Texas Local Medical Review Policy available to all Medicare providers via the Internet.

According to TrailBlazer, it provided multiple educational opportunities by working with Quitman Clinic over a period of years in different settings and using various educational tools. It provided Quitman Clinic with the necessary information required to appropriately document in a patient's chart the applicable information that would be expected to meet Medicare requirements for rendering PHP services. During these sessions, TrailBlazer educated Quitman Clinic staff in workshops and one-on-one at its facility.

TriCenturion's Independence

Quitman Clinic Comment

Quitman Clinic said there is overwhelming evidence that TriCenturion, the Medicare PSC that performed the medical review on behalf of OIG, is not an independent audit firm. TriCenturion is a related party of TrailBlazer, and TrailBlazer is a subject of OIG's CMHC audit.

OIG Response

As part of this audit, OIG contracted with TriCenturion to perform the medical review of 100 claims. TriCenturion is a PSC under contract with CMS to perform selected program integrity functions.

The Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program, in part, to strengthen CMS's ability to deter fraud and abuse in the Medicare program. CMS created PSCs to perform program safeguard functions such as medical review, cost report audit, data analysis, provider education, and fraud detection and prevention. Under a task order awarded on June 3, 2002, TriCenturion performs fraud and abuse safeguard functions for the Medicare Part A workload in Texas, a function that used to be performed by TrailBlazer. While TrailBlazer and TriCenturion are affiliated, CMS transferred program integrity workload to the PSCs to enhance independence.

Per the PSC Statement of Work, if the PSC or contractor performs a program integrity function, it is imperative that both entities work together to achieve the common goal of ensuring the integrity of the Medicare program. According to TrailBlazer, the reviews

performed by each individual contractor are unique, and in order to enhance independence, TrailBlazer does not communicate with the PSC regarding individual review decisions.

Selection Criteria

Quitman Clinic Comment

Quitman Clinic said that it was the only CMHC in Texas that warranted a chart audit as part of the OIG audit. Quitman Clinic stated that it seemed irregular, given the description of the purpose of the audit, not to review the charts of each CMHC that was audited.

OIG Response

This review is part of a series of medical review audits of CMHC providers receiving high levels of outlier payments. We selected the providers to audit based on a ranking of total outlier payments made to each provider between August 1, 2000, and June 30, 2003.

Qualifications of the Medical Reviewers

Quitman Clinic Comment

Quitman Clinic respectfully requested the names and credentials of the reviewers who performed the medical reviews of the claims.

OIG Response

We did not independently select the medical reviewers. Through CMS, we contracted with the PSC to perform medical reviews. As with all our medical review contracts, we relied on CMS to ensure that the PSC medical reviewers were qualified to perform Medicare medical reviews.

Application of the Audit

Quitman Clinic Comment

Quitman Clinic said (1) OIG misrepresented the application of the audit and (2) indicated that the recommendation would not include a projection of the sample error to the universe.

OIG Response

The audit results and recommendations were based on a statistically valid sample of claims. The audit sample was specifically designed to allow for a statistical projection to the universe of claims in accordance with our sampling methodology. During the audit, we communicated this audit approach with Quitman Clinic and did not misrepresent the audit.

APPENDIXES

MEDICAL REVIEW RESULTS BY CLAIM

Claim Sample #	Service Not Covered	Minimum Hours Per Week Not Met	Copied Medical Records	Recertification Requirements Not Met	Beneficiaries' Approval or Participation Not Documented
1	X	X			X
2	X	X		X	X
3	X	X		X	X
4	X	X	X	X	X
5	X	X		X	X
6	X	X		X	X
7	X		X	X	X
8	X	X			X
9	X	X	X	X	X
1O			X		X
11	X	X		X	X
12	X	X		X	X
13	X	X		X	X
14	X	X		X	X
15	X	X		X	X
16	X	X		X	X
17	X	X		X	X
18	X	X		X	X
19	X	X		X	X
20	X	X		X	X
21	X	X			X
22	X	X		X	X
23	X	X		X	X
24	X	X		X	X
25	X	X		X	X

Claim Sample #	Service Not Covered	Minimum Hours Per Week Not Met	Copied Medical Records	Recertification Requirements Not Met	Beneficiaries' Approval or Participation Not Documented
26	X	X			X
27	X	X		X	X
28	X	X		X	X
29	X	X	X		X
30	X	X		X	X
31	X	X		X	X
32	X	X		X	X
33	X	X		X	X
34	X				X
35	X			X	X
36	X	X		X	X
37	X	X		X	X
38	X	X		X	X
39	X	X			X
40	X	X			X
41	X	X		X	X
42	X	X	X	X	X
43	X	X	X	X	X
44	X	X		X	X
45	X		X		X
46	X	X	X	X	X
47	X	X			X
48	X	X	X	X	X
49	X	X		X	X
50	X	X			X

Claim Sample #	Service Not Covered	Minimum Hours Per Week Not Met	Copied Medical Records	Recertification Requirements Not Met	Beneficiaries' Approval or Participation Not Documented
51	X	X		X	X
52	X	X			X
53	X	X		X	X
54	X	X	X	X	X
55	X	X			X
56	X	X	X		X
57	X	X	X	X	X
58	X	X		X	X
59	X	X		X	X
60	X	X		X	X
61	X				X
62	X	X		X	X
63	X	X	X	X	X
64	X	X			X
65	X	X			X
66	X			X	X
67	X	X	X	X	X
68	X	X			X
69	X	X		X	X
70	X			X	X
71	X	X			X
72	X	X		X	X
73	X	X			X
74	X	X	X	X	X
75	X	X		X	X

Claim Sample #	Service Not Covered	Minimum Hours Per Week Not Met	Copied Medical Records	Recertification Requirements Not Met	Beneficiaries' Approval or Participation Not Documented
76	X	X	X	X	X
77	X	X		X	X
78	X	X	X	X	X
79	X	X		X	X
80	X	X		X	X
81	X	X		X	X
82	X	X	X		X
83	X	X		X	X
84	X	X			X
85	X	X			X
86	X				X
87	X		X		X
88	X	X	X	X	X
89	X	X	X	X	X
90	X	X	X		X
91	X	X			X
92	X	X		X	X
93	X	X	X	X	X
94	X	X			X
95	X	X			X
96	X	X		X	X
97	X	X		X	X
98	X	X		X	X
99	X	X	X	X	X
100	X	X			X
Total	**99**	**90**	**25**	**69**	**100**

CLINIC RESOURCES MANAGEMENT, INC.
1320 QUITMAN HOUSTON, TX 77009
713-227-8246

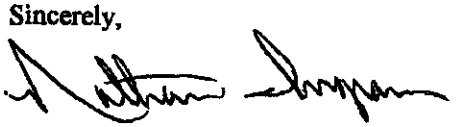
October 15, 2004

U.S. Department of Health and Human Services
Attention James P. Aasmundstad
Regional Inspector General
601 East 12th St. Room 284A
Kansas City, Missouri 64106

Dear Mr. Aasmundstad:

Please find attached my formal response to your recommendations. Although I vehemently disagree with your perplexingly passive stance regarding TrailBlazer's role in our deficits and sincerely appeal to you to initiate remedial action with them, I am nevertheless glad that your department serves as it does, and am grateful for the forty-five minutes' conversation with you on October 12.

Sincerely,



Nathan Ingram
Manager

FORMAL RESPONSE TO REPORT NUMBER A-07-04-04034, "MEDICAL REVIEW OF QUITMAN CLINIC'S PARTIAL HOSPITALIZATION SERVICES FOR THE PERIOD OF AUGUST 1, 2000 THROUGH DECEMBER 31, 2002".

I. DEMOGRAPHIC SUMMARY

We have partnered with Medicare within our community since 1993, being the first freestanding community mental health center in Harris County to provide partial hospitalization services to Medicare patients under Section 1866 (e) (2) of the Social Security Act. Incidentally, we are also one of the last, having survived - through much effort - the Center for Medicare and Medicaid Services' severe corrective initiative among CMHCs of 1998-2000.

Our health center is near downtown Houston, within Houston's north-side district. According to a 1992 University of Houston census, there are approximately 80,000 persons living within a three-mile radius, earning a per capita annual income of $9,000. Sixty per cent are African-American, 40% are Hispanic and eleven persons are Caucasian. Medicare has designated this area as a Health-Care Professional Shortage Area (HPSA). Services available within our community include a Salvation Army, a Harris County Hospital District clinic, an inner-city church, a few small medical clinics, and us.

We employ sixty-seven persons: thirty-six males and thirty-one females. Nineteen are Hispanic, twenty-three are Caucasian, twenty-four are African-American, and one is Asian. We employ twenty-nine admitted Catholic Christians, twenty-nine Protestant Christians, one of the Jewish faith, one Buddhist, one Agnostic and six who are Other. One is an MD General Practitioner, one an MD Psychiatrist, two are Doctors of Public Health, and one has a PhD in Counseling. Two are Certified Physician's Assistants, one is an Advanced Nurse Practitioner, eighteen are Master's level licensed therapists, and numerous are support personnel. We employ two self-professed homosexuals, and one transsexual. Our oldest employee is seventy-eight years old and our youngest is nineteen, the average being forty-three years old. The oldest living Licensed Chemical Dependency Counselor in Texas (licensed longer than anyone) works here. Our professionals boast a cumulative three hundred forty seven years' experience in their field, with seventeen years' average per person.

Our clinic serves a population of approximately forty walk-in medical patients per day and approximately one hundred sixty mental health patients per day. Roughly 50% have Medicare benefits, 29% are indigent with no benefits, 15% have Medicaid and 6% are cash patients. We serve the indigent patients for free.

Of the Mental health patients, 45% carry a diagnosis of Schizophrenia, 28% have Bi-Polar Disorder, and 27% are diagnosed with Depression or other mental illnesses. Most live in assisted living centers and many suffer from chronic physical health problems. During CMS's severe corrective action of 1998-2000, most of the community mental health centers in Harris County closed, and since that time our patient census has increased three-fold. We expect an additional demand on our services due to the Mental Health and Mental Retardation Authority of Harris County (MHMRA) cutting their case-load by 5% because of budget constraints (Attachment 1). We receive referrals from MHMRA, the Harris County Guardianship Program, local hospitals, assisted living centers and private persons.

II. REASONABLENESS OF THE RECOMMENDATIONS

I have written three times to [redacted] regarding this subject (Attachment 2). In short, from a provider's point of view these recommendations are unreasonable in the extreme. The OIG is commissioned to protect the integrity of HHS programs, and I strongly submit that its mission includes the responsibility to provide tools for success to providers. This recommendation is devastating with no right to appeal, and certainly does not promote a spirit aimed at preserving the integrity of HHS programs. To the contrary, it threatens the very existence of this longstanding provider of Medicare services, based upon one sample of one hundred charts reviewed by an audit firm that the OIG was auditing the same time they were auditing us. Furthermore, the OIG found the firm to be lacking in its provider education responsibility. If I said no more, that is enough to justify a softer approach. However, other salient points bear upon my stance.

1. Charts are subjective, and TrailBlazer has the responsibility to train providers on what they want to see in a chart. Most of the sampled one hundred were denied because, in the auditor's view, they failed to demonstrate active and intense treatment. TrailBlazer should tell us what they expect to see on a chart note that does demonstrate active and intense treatment. Since they haven't told us, we have no way to tell. In light of this fact, the OIG recommendation is far too punitive.

2. In the OIG's audit of CMHCs in the United States, apparently we were the only CMHC in Texas who warranted a chart audit. It seems irregular, given [redacted] description of the purpose of the audit, not to audit the charts of each CMHC that was audited. The present recommendation would be much easier for me to accept gracefully had there been a comparative standard among all the targeted CMHCs in Texas.

4. In my verbal efforts to prevail upon the OIG, the auditors have told me that my only source of appeal is to appeal the charts with TrailBlazer after the OIG issues its final report. Since Tri-Centurian – who reviewed our charts – is the same as TrailBlazer, I will almost certainly lose the appeal. OIG is commissioned to conduct independent audits (Attachment 3). It seems unusual, and from a provider's point of view, beyond belief that the OIG would hire someone they are auditing to audit us.

Accountability is imperative within HHS programs, and I have never fled accountability. However, unrestrained punitive action should be avoided, allowing recourse for survival of a much-needed service.

III. ACTIONS TAKEN OR CONTEMPLATED

I have taken a great deal of action in trying to collaborate with OIG auditors concerning the fairness of their proposed recommendation. In short, I have written [redacted] three times, and after three letters to Mr. Aasmundstad, have flown to Kansas City to meet for forty-five minutes with him and [redacted] I have appealed to the lack of rationale involved in penalizing a provider out of existence as long as there is a possibility that the fiscal intermediary is culpable for lack of adequate training. Thus far, I have been wholly unsuccessful.

It is clear to me that we must have training, not on how to conduct therapy or how to identify patients who need therapy, but on how to chart in a manner satisfactory to the auditors. To that end, I contacted Tri-Centurian twice asking for training, but was told both times that they were chart reviewers, not trainers. They referred me to TrailBlazer. I submitted two written requests to TrailBlazer for training (Attachment 4), and have now made contact with them for them to come here and train us. In twelve years I have never been able to get a TrailBlazer employee to tell me what they expect a good chart to look like. Perhaps they will now, and I would ask the OIG, again, to encourage them to.

We have determined to get JCAHO accreditation as a result of this audit, and have ordered their manual.

We are strengthening our internal quality control to make sure that all chart notes are in charts, all signatures are on forms, etc.

We likely treat one of the largest populations of mentally ill persons in Southeast Texas. My research during the past two years has led me to persons who claim to have been cured of mental illness. There are enough of them to make me believe that it is possible, at least for some individuals. We need research funds to help us find cures and we ask the OIG to assist us. An effort like this would certainly go a long way in preserving the integrity of this HHS program.

IV. PROVIDER OBSERVATIONS

I applaud OIG's mission to preserve the integrity of HHS programs, and to that end I believe that we should be accountable. However, equally important is the need for the Office of the Inspector General to be both accountable and upright in their dealings with American small businesses, especially since they wield the greater power. We have been reviewed thoroughly, and the OIG recommendation is extended. I offer a few examples that, from a provider's point of view, indicate an unsound approach to fairness.

1. [redacted] misrepresented the application of this audit. At the entrance interview, I asked him directly if there were individual repercussions to an audit like this, since his opening statements led me to believe that the purpose of the audit was to see how much it actually costs community mental health centers to operate. He answered in the negative. Perhaps, he said, instead of utilizing outlier payments, the per diem rates should be raised. Per my direct questioning, he de-emphasized the importance of the chart audits and emphasized the desire of the federal government to preserve the partial hospitalization benefit. He said that he was also auditing TrailBlazer at the same time he was auditing us. I was most pleased that we would get a fair assessment and perhaps get clear directives going forward, and that someone would hold TrailBlazer accountable also.

2. Later in the auditing process, [redacted] directly told me twice that his recommendation would not include a projection of penalty to the universe of charges, but that he would probably recommend that we pay back the amount of the actual charts that were denied. My letter to him dated June 17, 2004 reflects my impression of what he said. [redacted] says that he does not remember saying that. I'm sure we set an industry record copying our charts and getting them to [redacted] (one hundred charts within 24 hours of his request) because we were under the impression that, if there were errors, we would have to pay for the errors in the charts, but most importantly we would move forward with a collaborative spirit of training and improvement. Had [redacted] been clear of the implications, we would have at least reviewed the charts ahead of time to make sure that all the signatures, etc. were in them, which would be a perfectly legitimate thing to do. The truth is important, particularly when one is in a position that carries so much public authority. I stoutly maintain that this audit was misrepresented.

3. Per my conversations with [redacted] Mr. Aasmundstad, I get the clear impression that no matter what I say or what arguments I present in this response, the recommendation of the OIG will not change. Indeed, per Mr. Aasmundstad, he is not authorized to change it. That leads me to believe that the OIG is soliciting a response – not from a genuine desire to hear what I have to say or that my input would have any impact – but because of a directive from somewhere that they solicit a response from the provider. I am at a loss to understand the purpose of my response. I fear that the OIG's final report will confirm this belief, although I maintain high hopes for fair treatment.

4. The OIG's stock response to my arguments has been that I have a right to appeal: I can appeal to TrailBlazer on the merit of the charts. I am concerned that a chart appeal

will be hampered if more basic foundations are not in place. For instance, if the audit was not truly independent but was indeed performed by a related party with a conflict of interest, to whom do I appeal? Or, if it actually is true, as the OIG has discovered, that TrialBlazer was remiss in training and that a certain percentage – no matter how small – of the chart denials can be traced to that cause, to whom do we appeal? A chart appeal will not address that issue because TrailBlazer has no interest or jurisdiction, and an appeal of that nature would be asking them to incriminate themselves. The OIG is the only agency that can intervene there, and I must say that its silence on this subject is deafening. Thus far, the OIG is not responsive to the possibility that there are mitigating factors to their review.

V. PROVIDER APPEAL TO THE OIG

Since the recommendation is extended with apparently no amendment possible, I ask for the OIG's intervention with TrailBlazer in the area of training and payback terms. The last training we received was in 1999. In late 2001, I attended a training for Skilled Nursing Facilities and met, for the first time, the TrailBlazer employee in charge of provider education for CMHCs. She said that she had been in that position for one year and that I was the first representative of a CMHC that she had met. She promised to find a training for me, but apparently was unable to, because I never heard from her again. Later, I called [redacted] at TrailBlazer asking where I could get some training. She said she would look, but she was apparently unable to find anything because I never heard from her again. We have been audited seven times on our cost reports and numerous times I have asked for direction and guidance on the auditor's expectations. In spite of clear directives to the contrary in Chapters 8 and 9 of the Fiscal Intermediary's manual of audit guidelines, each time I have been met with some rendition of "We are your auditors, not your consultants." If I encounter this attitude with TrailBlazer again, I am going to insist that we call the Office of the Inspector General together and discuss the appropriate roles.

In the payback situations we have endured with TrailBlazer, their policy with us has been to deny a payback of more than thirty-six months' duration, not because they can't allow a longer time-frame, but because they must get special permission from Baltimore and they don't want to do that. If the current situation threatens the existence of our service, I will ask the Office of the Inspector General to intervene on our behalf to obtain a workable payback schedule.

ATTACHMENT II

CLINIC REOURCES MANAGEMENT, INC.
1320 QUITMAN HOUSTON, TX 77009
713-227-8246

June 17, 2004

Office of the Inspector General
Office of Audit Services
Attention [redacted] Senior Auditor
1961 Stout Street
Room 346 Federal Building
Denver, CO 80294

Re: COMMENTS PURSUANT TO 06/15/04 EXIT CONFERENCE WITH [redacted] REGARDING PROVIDER NUMBER 45-4620 OIG AUDIT RESULTS

Dear [redacted]

I wanted to thank you for coming in person for our exit conference on 6/15/04. Although you brought distressing news to us, your presentation was both professional and courteous.

We have a few comments relative to your report, in hopes that some of them will be included in your final draft.

Our most glaring reported deficit was the medical necessity of our services as reported in the one hundred charts that Tri-Centurian reviewed. Of the one hundred, all one hundred of them were recommended for denial. I am anxious to see the reasons and will be urgent in changing what we need to change going forward.

There are some pertinent points regarding the chart review that I think would greatly help us in the future.

1. Of the total CMHCs audited in three states (Texas, Florida, Louisiana), all of them experienced a greater than 90% denial rate on their charts. This is a very troubling and informative statistic. Unless we can accurately assume that all the CMHCs in these three states are run by incompetent and/or dishonest people, then we must take a close look at this problem. Generally speaking, if the exception to the rule becomes the rule, then there is something wrong with the original rule that generated the exceptions. In other words, it should be an exception for a chart to be denied, but it has actually become the rule for three entire states, so I think there is something wrong with the original rule. I would respectfully and urgently ask that close attention be paid to this

statistic. My understanding is that we might be billed for the overpayment generated by this report, which in our case is four hundred forty thousand dollars. I would ask your recommendation be to postpone the overpayment request until you resolve the following issues:

a. Three entire states had the same problem we had. A prudent person would intuitively think that the results are somewhat skewed.

b. Perhaps the requirements for this service are too restrictive. There is no realistic way that one hundred percent of our patients were not appropriate for this service.

c. In spite of our requests, we have been unable to get adequate training from TrailBlazer. I have attended every training seminar that I was aware of. In each one, the trainers could or would not show me an example of an acceptable chart. Two years ago I went to a training that was primarily for Skilled Nursing Facilities. The education provider for CMHCs was there, so I asked her for some training. She said that she had been in that position for nearly a year and I was the first CMHC she had heard from. She was to find or create some training, but I haven't heard from her. Finally, I have included with this report a transcribed telephone conversation with [redacted] after his audit of our 1999 cost report. It reflects the overall attitude I have encountered the past few years relative to training providers.

2. In 2000, TrailBlazer determined that we had achieved more than 90% compliance on our charts. Now, Tri-Centurian finds a zero percent compliance.

I have enclosed a letter we received from TrailBlazer that was written August 4, 2000 stating that we had achieved a denial rate of less than ten percent on our charts. Our staff has not changed during this time, and our charting has actually improved. Every one of our patients is seen by a medical doctor experienced in mental health with a treatment team of mature professional therapists. We maintain serious concerns regarding a reviewer who is not a doctor overriding a doctor's assessment and orders, thereby jeopardizing an entire industry. (In an unrelated case, I took a Medicare Part B appeal to an Administrative Law Judge Hearing. The case pertained to Outpatient Psychiatric Services. At the Hearing, the Law judge asked me if I was aware that the TrailBlazer employee who had denied my psychiatric charts was an End Stage Renal Disease nurse. Of course, I wasn't). This is a problem.

[redacted] basically what I think is, if you go forward with this collection effort it will severely penalize us while rewarding TrailBlazer, yet TrailBlazer is at least equally responsible for the problem in the first place. Additionally, while TrailBlazer generally allows for an appeal process, the appeal is time consuming and costly. It would be more beneficial to utilize the historical data by pointing out deficits on each side and hold both providers and FI accountable going forward. Right now I am troubled and embittered by TrailBlazer's unfriendly handling of us in recent years, and would urgently appeal to you to utilize whatever persuasion you have to promote a more collaborative spirit.

Again, I am thankful to you for meeting with us, and I wish you the best. For my part, I am willing and eager to do whatever is necessary to comply with both the letter and the spirit of the regulations. Have a great day.

Sincerely,

Nathan Ingram
Manager

CLINIC RESOURCES MANAGEMENT, INC.

1320 QUITMAN HOUSTON, TX 77009
713-227-8246

September 3, 2004

U.S. Department of Health and Human Services
Attention [redacted]
Senior Auditor
1961 Stout St.
Room 346 Federal Bldg.
Denver, CO 80294

Dear [redacted]

I am in receipt of draft report number A-07-04-04034, referencing the audit of our partial hospitalization services. I am intent upon developing and maintaining a collaborative relationship with Medicare, so with that in mind I offer the following comments. Please note that this is not our formal response but a preliminary statement with a more detailed formal response to follow. Also, the severity of the sanctions proposed against us requires a longer preparation period than thirty days, so we would respectfully ask for an extension of an additional thirty days. I offer this brief letter in hopes that the final outcome will be fair and equitable to all concerned.

In Mr. Aasmundstad's cover letter dated August 27, 2004, he asked us to present our views relative to the **validity of the facts** and the **reasonableness of the recommendations**. I think that when we consider the facts we must realize the subjective nature of chart audits and admit room for error, and given that room, I strongly believe that your recommendation is extraordinarily punitive. I submit, instead, a more reasoned approach that allows us to survive as a business and continue to do the work we were commissioned to do.

Your report states that one hundred of our charts did not meet Medicare guidelines, therefore all our charts did not meet guidelines, and we are liable for the universe of charges for a full two years and one quarter of revenues (over twelve million dollars). The following considerations allow room for doubts of the validity of your report.

1. Trailblazer sent us a letter on August 4, 2000, stating that we were more than 90% compliant, and now Tri-Centurian finds us 100% **non**-compliant for dates of service beginning August 1, 2000. The guidelines didn't change and neither did our charting. If TrailBlazer's letter is accurate, I strongly contend that Tri-Centurian either changed the focus of review or their assessment was simply inaccurate. However, if Tri-Centurian

was right, as you believe, then TrailBlazer was wrong and they inaccurately told us that we were compliant.

2. If TrailBlazer **inaccurately** told us that we were compliant, we are not liable. The real truth is that care was ordered by a physician and performed by licensed therapists. The problem is not with the actual care given, but with interpretation of charts -or, if Tri-Centurian wants us to write it down differently - with proper training and communication.

3. There is overwhelming evidence that Tri-Centurian is not an independent audit firm. In my efforts to contact them to ask for training, I discovered that, in order to get them on the phone, I had to call TrailBlazer's number. In fact, they are housed in TrailBlazer's offices in Dallas and have a contract with TrailBlazer to audit charts for them. Furthermore, per your statement to me, they are actually an offshoot of TrailBlazer. This discovery was very discouraging to me. First, Tri-Centurian is a related party to TrailBlazer, the very firm I was depending upon you to hold accountable and not unfairly penalize providers. Second, TrailBlazer will conduct the collection effort, and they have a vested interest in collecting all they can. Third, I am chagrined that you would hire someone you are auditing to audit us. It appears that this is a clear conflict of interest.

4. One hundred per cent of charts reviewed in Texas CMHCs were deemed unacceptable, not just ours. Furthermore, 95% of all charts reviewed in Florida got the same rating. I respectfully remind you that during the severe corrective action by CMS in 1999 and 2000, over 90% of CMHCs in the country went out of business. Thankfully, we survived and are now in our twelfth year of business. The reason we survived was because we put an intense effort into training and quality control. I assume that the others left standing did the same. In light of what we went through, it is preposterous to conclude that all of us have degenerated to zero compliance.

5. In a previous audit we underwent with TrailBlazer, I discovered that the person auditing our **mental health** charts was an **end stage renal disease** nurse. In light of the related party issue with Tri-Centurian, I respectfully request the names and credentials of the persons conducting the present audit, along with all the charts they audited and the auditors' notes, before your final draft. Were they experts in mental health who could defend their comments to our full-time medical doctor and over eighteen master's prepared licensed therapists who signed their names to the charts? Are they really qualified to say that there is **no evidence** that the therapy was not active, intensive and therapeutic in nature? There is no doubt in my mind that our clinicians performed needed therapy. The problem is in communicating the therapy that was done. This has been a problem and continues to be a problem today in the mental health industry. Our clinicians continue to get training to maintain their licenses, so the problem is not in the therapists' credentials or therapy; it is in communicating the therapy such that the auditors grasp it. This is a situation that requires collaborative effort, not punitive sanctions.

6. Given the above salient points, I respectfully submit that extrapolating to over seventeen hundred charts from a sample of one hundred is unfairly punitive. Before submitting to it, I would respectfully request the methodology used to derive the random sample, the statistical rationale allowing the extrapolation and the origin of the mandate to do so.

Our company has contracted with Medicare to perform PHP services since 1993. Our professionals each have many years' experience. Our doctor is full-time. Your suggestion that everything we have done since August 1, 2000 is wrong, is simply untenable and I cannot accept it. Your recommendation will almost certainly kill our business, and there is no need for it. This method of allowing a provider to pay all expenses to perform services for years, and then charge them back the whole amount without proper consideration is devastating, discouraging and simply wrong. I urge you to change your recommendation.

A better and more equitable answer is to not charge any payback at all. I propose that we assess this situation as it really is. The fact is that TrailBlazer trained us to chart a certain way, and we did. The evidence is in the letter. Then, without further training or warning of any kind, Tri-Centurian reviewed our charts with a different idea and found us lacking. Let me say again, the problem is not in the work, but in the charting. No one has audited the work, only the charting. I propose that Tri-Centurian come train us to chart the same way TrailBlazer did. I don't mind being held accountable if I am prepared ahead of time, but it is not fair to be blind-sided like this without recourse except for a lengthy, costly appeal that will not allow us to survive. We will be glad to pay for the training and to pay whatever penalties we must face **after** being properly trained.

Regarding the status of actions or contemplated actions concerning these recommendations, I have already called Tri-Centurian twice for training, but have been referred both times to TrailBlazer. I called TrailBlazer and sent a written request for training, from which I have not heard. I am also appointing a Quality Control therapist with many years' experience to monitor charts following our training. Additionally, regarding the points in the audit where our operation is obviously lacking (missing signatures, inadequate number of therapy hours per week, etc.) we are mounting an aggressive campaign to improve compliance.

Obviously, our first choice is to maintain a collaborative relationship with you and the fiscal intermediary, moving forward with clear expectations on both sides. We are being assessed an unfair penalty upon sparse and questionable evidence-not on our work but on our charts-and I am unable to accept it without a passionate response. Please know that this feels to me like you are misunderstanding my business as an enterprise and my integrity as a person, and it is very discomfiting. I earnestly appeal to you to resolve this matter fairly.

I am in the process of preparing a more thorough and detailed response. Please allow an additional thirty days for its completion.

Sincerely,

Nathan Ingram
Manager
cc James P. Aasmundstad

CLINIC RESOURCES MANAGEMENT, INC.
1320 QUITMAN HOUSTON, TX 77009
713-227-8246

September 20, 2004

U.S. Department of Health and Human Services
Attention [redacted]
Senior Auditor
1961 Stout St.
Room 346 Federal Bldg.
Denver, CO 80294

Dear [redacted]

Thank you for the information regarding congressmen who have an interest in healthcare. I am integrating my correspondence with them into my general effort to respond effectively.

I wanted to write you informally, however, before my formal response, in an effort to persuade you to change your recommendation before your final report. If I can do that, I believe that fairness will prevail and I will be spared an extended, intense and focused campaign arguing with you. I have written Mr. Aasmundstad twice asking for a personal appointment with him, but have not received a response. I would certainly appreciate a thirty-minute conversation with him in light of the severity of sanctions recommended against me.

I have two points to address. First, regarding my request for copies of the Tri-Centurian auditors' credentials, charts, and chart notes who reviewed our documentation, your response to me was that you did not know their credentials, and that I could ask for that information when TrialBlazer sent me a bill. I respectfully disagree with the wisdom of that approach.

Any appeal rights I exercise with TrailBlazer will cover chart content only, and TrailBlazer will not be authorized to address the process that was used to arrive at the payback amount. I must appeal to you for that. The best time to do that is now, so I must respectfully ask, before I submit my formal response, for the names and credentials of the persons performing the audit, along with all the charts they audited and the auditor's notes.

Second, I must assert this: If you fully believe - as your recommendation clearly implies - that we are an illegitimate provider conducting one hundred per cent medically unnecessary services from August 1, 2000 through today, then you must necessarily adopt the belief that we are defrauding the federal government. The rationale follows.

A definition of fraud includes deceiving while knowing that the deception could result in unauthorized benefit (please see attached correspondence from TrailBlazer). Willful intent is a key concept. Your recommendation implies that we deceived with intent. Here's how.

You are holding us responsible for the entire amount, implying that everything we did was wrong and that no one besides us was culpable. If no one else is culpable, then all other parties (TrialBlazer, Tri-Centurian and you) operated flawlessly in training and reviewing us. Therefore, since everything we did was wrong, it must have been on purpose. That's fraud. If it isn't, then we could not possibly be responsible for the entire amount.

If your recommendation stands in your final report, I will seriously consider presenting myself to your office the Monday following, insisting that I be arrested and indicted on one thousand seven hundred fourteen counts of fraud.

[redacted] the reason I am willing – and intend – to take this stance is that I have no further appeal option beyond you, and I believe my position to be in the right. I want you to know that there are two principles driving this decision. The first comes from President Andrew Jackson, who was from my home state of Tennessee. He said, "It is hard to stop a man who knows he is right and keeps coming". The second comes from a scripture that says, "Having done all ... stand". I haven't done all until I have done this, and when I do, I will stand.

In twelve years I have not had a moment's assurance that my business will last more than the next thirty days. TrailBlazer has imposed sanctions at will, citing technicalities of reporting, collecting all or nearly all they paid us, years after the actual expenses of running the business were incurred and settled. And now, you are doing the same.

I must say, with all due respect, that I am weary to my bones of trying to defend my viability over and over again, losing every time, and having TrailBlazer – and now you – say, "I know you provide a valuable service, but you haven't done your documentation right, so pay us back everything we paid you". I must tell you that I am unwilling to continue in that vein until you and TrailBlazer exert some effort in a collaborative relationship that will allow us to document the way you want it. I have asked TrialBlazer repeatedly what documents are acceptable for cost reports. Their stock answer is, "We are your auditors, not your consultants", which of course allows them to disallow whatever they want. TrailBlazer told us in 2000 that our charts were over 90% compliant, but now they have apparently changed their minds, and so far not one individual in the organization has been willing to tell us what a good chart is supposed to look like, in spite of two requests to Tri-Centurian and two requests to TrailBlazer since

your initial report. Consequently, our charts haven't changed and we have no defense against you auditing us again and disallowing everything from December 31, 2002 until now.

I am sending this letter only to you, but of course you are free to show it to whomever you wish. I am sincerely appealing to you for a chance to survive. If your report remains unchanged, it threatens to fully undo us. My entire agenda is to convince you to change your recommendation to a more equitable settlement, preserving the integrity of both the government's money and the providers' services. Thank you very much for your consideration.

I will present my formal response by October 10, as you have requested.

Sincerely,

Nathan Ingram
Manager