

**Memorandum**

JUL - 5 2000

Date

From

*Michael Mangano*  
for June Gibbs Brown  
Inspector General

Subject

Review of Outpatient Psychiatric Services Provided by the Tomball Regional Hospital for Fiscal Year Ended June 30, 1998 (A-06-99-00014)

To

Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

This memorandum is to alert you to the issuance on July 7, 2000, of our final report "Review of Outpatient Psychiatric Services Provided by the Tomball Regional Hospital for Fiscal Year Ended June 30, 1998." A copy of the report is attached. The objectives of our review were to determine whether psychiatric services rendered by the Tomball Regional Hospital (Hospital) on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements, and whether outpatient psychiatric costs claimed on the Hospital's Medicare cost report were appropriate. To accomplish our objectives, we reviewed both partial hospitalization program (PHP) claims and cost report items.

Our audit at the Hospital determined that a significant amount of the outpatient psychiatric charges claimed by the Hospital did not meet the Medicare criteria for reimbursement. Specifically, we identified charges for PHP services which were not reasonable and necessary, or were provided to beneficiaries who were not eligible for such services. Based on a statistical sample of claims, we estimate that the Hospital overstated its Fiscal Year (FY) 1998 Medicare outpatient psychiatric charges by at least \$1,098,553. Not included in the estimate were claims for occupational therapy charges totaling \$219,114 which were also unallowable because they related to the questioned PHP services.

The second part of our review was outpatient psychiatric costs claimed on the Hospital's FY 1998 Medicare cost report. The results showed that of the \$1,411,645 of costs claimed, \$45,059 was for unallowable patient transportation costs. In addition, we were unable to determine the reasonableness of \$818,429 because neither the management company nor the Hospital could provide supporting documentation of the costs that made up the contract fee schedule used to charge the Hospital on a per unit of service basis. The remaining \$548,157 was reasonable and appropriate.

We recommended that the Hospital strengthen its procedures to ensure that charges for PHP services are covered and properly documented in accordance with Medicare requirements.

We also recommended that the Hospital identify all costs that are included in the management contract fee schedule to assure that only reasonable costs are included, and establish an effective procedure for excluding costs related to noncovered services from its Medicare cost reports.

We will provide the results of our individual claims review to the fiscal intermediary (FI) so that it can apply the total adjustment of \$1,317,667 (\$1,098,553 for the sample claims results and \$219,114 for occupational therapy related to the unallowable PHP services) to the appropriate portion of the Hospital's FY 1998 Medicare cost report. We will also provide the FI with the results of our cost report review so it can determine whether management contract fees totaling \$818,429 were reasonable, and apply the adjustment for the unallowable transportation costs totaling \$45,059.

The Hospital believed that our report findings were inaccurate and unfounded. The Hospital stated in its March 7, 2000 response to our draft report that it planned to contest each issue, except for the unallowable transportation cost, to the full extent allowed by law. The Hospital was confident that the appeals process would validate the integrity of its outpatient psychiatric program. Regarding the review of services, the Hospital believed that the PHP services reviewed were reasonable and necessary and provided to eligible beneficiaries, and that the related occupational therapy charges were allowable under Medicare. The Hospital plans to appeal every denial that will be referred to the FI. Regarding the cost report issues, the Hospital believed that it provided clear and convincing evidence that the management company cost was reasonable and in accordance with Medicare regulations. The Hospital agreed to remove the unallowable patient transportation cost from its final FY 1998 Medicare cost report.

We believe that our final audit determinations are correct and in accordance with Medicare rules and regulations. The basis for our position is discussed in detail beginning on page 9 of the attached report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Donald L. Dille, Regional Inspector General for Audit Services, Region VI, (214) 767-8414.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT  
PSYCHIATRIC SERVICES PROVIDED  
BY THE TOMBALL REGIONAL  
HOSPITAL FOR FISCAL YEAR  
ENDED JUNE 30, 1998**



**JUNE GIBBS BROWN  
Inspector General**

**JULY 2000  
A-06-99-00014**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services  
1100 Commerce, Room 6B6  
Dallas, TX 75242

Common Identification Number: A-06-99-00014

Mr. Robert Schaper  
President-Chief Executive Officer  
Tomball Regional Hospital  
605 Holderrieth  
Tomball, Texas 77375

Dear Mr. Schaper:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Outpatient Psychiatric Services Provided by the Tomball Regional Hospital for Fiscal Year Ended June 30, 1998." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

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

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

To facilitate identification, please refer to Common Identification Number A-06-99-00014 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink that reads "Donald L. Dille".

Donald L. Dille  
Regional Inspector General  
for Audit Services

Enclosures

Page 2 - Mr. Robert Schaper

**Direct Reply to HHS Action Official:**

James R. Farris, MD  
Regional Administrator  
Health Care Financing Administration  
1301 Young Street, Room 714  
Dallas, Texas 75202

## **EXECUTIVE SUMMARY**

### **Background**

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. These services must be reasonable and necessary for the diagnosis or treatment of a patient's condition, and supported by sufficient documentation to justify the treatment provided. Claims are submitted for services rendered and are reimbursed on an interim basis. At year end, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final settlement. Medicare requires costs claimed to the program to be reasonable, allowable, and related to patient care.

### **Objective**

The objectives of our review were to determine whether psychiatric services rendered by the Tomball Regional Hospital (Hospital) on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements, and whether outpatient psychiatric costs claimed on the Hospital's Medicare cost report were appropriate.

### **Summary of Findings**

For Fiscal Year (FY) 1998 (July 1, 1997 through June 30, 1998), the Hospital billed Medicare and was reimbursed for outpatient psychiatric services which were not allowable under Medicare requirements. These services were charged on behalf of patients in the Hospital's partial hospitalization program (PHP). In addition, the Hospital claimed unallowable patient transportation costs on its Medicare cost report. Further, we could not determine the reasonableness of the outpatient psychiatric costs associated with a management company that administered the PHP program for the Hospital. Neither the management company, nor the Hospital could provide supporting documentation for the contract fee schedule used to charge the Hospital on a per unit of service basis.

In FY 1998, the Hospital submitted for reimbursement about \$2.3 million in charges for PHP services. To determine whether these charges were in compliance with Medicare requirements, we reviewed the medical and billing records for 100 statistically selected claims totaling \$487,616. Our analysis showed that \$408,226 of these charges representing 1,593 services did not meet Medicare criteria for reimbursement. These services were not reasonable and necessary, or for beneficiaries who were not eligible for PHP services. The remaining \$79,390 of the charges were allowable under Medicare rules.

Based on a statistical sample, we estimate that the Hospital overstated its FY 1998 Medicare charges for PHP services by at least \$1,098,553. Not included in the estimate were occupational therapy charges totaling \$219,114 which were also unallowable because they related to the questioned PHP services.

Our review of outpatient psychiatric costs claimed on the Hospital's FY 1998 Medicare cost report showed that of the \$1,411,645 claimed, \$45,059 was for unallowable patient transportation costs. We were unable to determine the reasonableness of \$818,429 because neither the management company, nor the Hospital could provide supporting documentation of the costs that made up the contract fee schedule used to charge the Hospital on a per unit of service basis. The remaining \$548,157 was reasonable and appropriate.

### **Recommendations**

We recommend that the Hospital:

1. Strengthen its procedures to ensure that charges for PHP services are covered and properly documented in accordance with Medicare requirements. Accordingly, we will provide the results of our review to the FI so that it can make the adjustment of \$1,317,667 to the Hospital's FY 1998 Medicare cost report, \$1,098,553 for the estimated overpayment, and \$219,114 for occupational therapy related to the unallowable PHP services.
2. Identify all costs that are included in the management contract fee schedule to assure that only reasonable costs are included, and establish an effective procedure for excluding costs related to noncovered services from its Medicare cost reports. We will provide the FI with details of the identified \$45,059 in unallowable costs so that it can apply the adjustment to the Hospital's FY 1998 Medicare cost report. We will also request that the FI determine whether management contract fees totaling \$818,429 were reasonable.

The Hospital did not agree with our findings and plans to appeal each issue, except for the unallowable patient transportation costs, to the full extent allowed by law. However, the Hospital was unable to provide additional documentation which would require us to revise the final report. Therefore, we continue to believe that our findings and recommendations are valid. The Hospital's comments are included as Appendix B to this report.

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## INTRODUCTION

### BACKGROUND

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

- ◇ “A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.” [42 CFR 482.24]
- ◇ Psychiatric “...services must be...reasonable and necessary for the diagnosis or treatment of a patient’s condition...Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.” [Medicare Intermediary Manual section 3112.7]

In addition, the following requirements are prescribed by HCFA Program Memorandum Publication 60A for patients receiving PHP services:

- ◇ “It is reasonable to expect the plan of treatment to be established within the first 7 days of a patient’s participation in the program, and periodic reviews to be performed at least every 31 days thereafter.”
- ◇ In order for an individual’s PHP services to be covered, a physician must certify that “The individual would require inpatient psychiatric care in the absence of such services....” Further, “This certification may be made where the physician believes that the course of the patient’s current episode of illness would result in

psychiatric hospitalization if the partial hospitalization services are not substituted.”

- ◇ In order for a Medicare beneficiary to be eligible for PHP services, he or she must exhibit a severe or disabling condition related to an acute psychiatric or psychological disorder, or an exacerbation of a severe and persistent mental disorder. In addition, a beneficiary must: be able to benefit from a coordinated program of services; have an adequate support system outside the program; have a diagnosis of mental illness; not be dangerous to themselves or others; and not require 24-hour care.
- ◇ PHP services are not reasonable and necessary for beneficiaries who: require primarily social, custodial, recreational, or respite care; require a low frequency of participation which could be managed in an outpatient setting; and have achieved sufficient stabilization of the presenting symptoms and will not require the intense level of services under a PHP.

For costs claimed on a hospital’s Medicare cost report, Medicare regulations and guidelines define:

- ◇ reasonable costs as “...all necessary and proper expenses incurred in furnishing services...However, if the provider’s operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable....” [42 CFR 413.9(c)(3)]
- ◇ that “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.” [Provider Reimbursement Manual (PRM) section 2102.1]
- ◇ costs related to patient care as those which “...include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider’s activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others....” [PRM section 2102.2]

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

The Hospital contracted with a management company to furnish all administrative management services necessary to develop and operate the Hospital's inpatient and outpatient psychiatric programs. For our audit period, the Hospital's psychiatric services included inpatient services and services provided by the PHP. The PHP was located in a building separate from the Hospital. The management company provided the medical director and all other clinical staff for the outpatient psychiatric program, except for the nursing staff. The Hospital employed the nurses who allocated their time between the inpatient psychiatric department and the PHP.

For FY 1998 (July 1, 1997 through June 30, 1998), the Hospital submitted for reimbursement about \$2.3 million in charges for PHP services, and claimed costs totaling about \$1.4 million for these services.

### **OBJECTIVE, SCOPE, AND METHODOLOGY**

The objectives of our review were to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements, and whether outpatient psychiatric costs claimed on the Medicare cost report were appropriate. To accomplish our objectives, we reviewed both PHP claims and cost report items.

Our audit was performed in accordance with generally accepted government auditing standards. We limited consideration of the internal control structure to those controls concerning PHP claims because the objective of our review did not require an understanding or assessment of the complete internal control structure at the Hospital. Our site work was conducted at the Hospital in Tomball, Texas.

We selected a statistical sample of paid claims for outpatient psychiatric services provided by the Hospital during FY 1998, and projected the overpayments for services that did not meet Medicare eligibility and reimbursement requirements to the universe. Specifically, we:

- ◇ reviewed criteria related to outpatient psychiatric services;
- ◇ obtained an understanding of the Hospital's internal controls over Medicare claims for outpatient psychiatric services;
- ◇ selected a statistical sample of 100 outpatient psychiatric claims;
- ◇ performed detailed audit testing on the billing and medical records for the claims selected in the sample;

- ◇ reviewed the occupational therapy charges related to the sample of 100 claims;
- ◇ utilized medical staff from the FI and the peer review organization (PRO) for Texas, including board certified psychiatrists, to medically review each of the 100 outpatient psychiatric claims;
- ◇ used a variables appraisal program to estimate the dollar impact of improper payments in the total population; and
- ◇ reviewed Medicare physician claims which corresponded to our sampled claims.

We also reviewed outpatient psychiatric costs claimed on the Hospital's Medicare cost report filed for FY 1998. We reviewed direct cost detail reported on the Hospital's trial balance and indirect cost allocations made on the Medicare cost report. In addition, we:

- ◇ reviewed the contract with the management company responsible for administering the PHP program for the Hospital;
- ◇ reviewed the units of service and rate charged to the Hospital by the management company; and
- ◇ verified that professional staff held a current license during the audit period.

## **FINDINGS AND RECOMMENDATIONS**

During FY 1998, the Hospital billed Medicare and was reimbursed for outpatient psychiatric services which were not allowed under Medicare requirements. These services were charged on behalf of patient's in the Hospital's PHP. In addition, the Hospital claimed unallowable outpatient psychiatric costs for patient transportation on its FY 1998 Medicare cost report. Further, we could not determine the reasonableness of the outpatient psychiatric costs associated with a management company that administered the PHP program for the Hospital.

In FY 1998, the Hospital submitted for Medicare reimbursement \$2,258,592 in charges for PHP services. We reviewed the medical and billing records for 100 statistically selected claims comprised of 1,593 individual services totaling \$487,616 in charges. Our analysis showed 81 claims for 1,329 units of service totaling \$408,226 did not meet Medicare criteria for reimbursement. The remaining \$79,390 were allowable under Medicare rules. Of the accepted charges, \$76,955 were for 256 units of service in 19 completely allowable claims. The remaining \$2,435 related to eight units of service in one claim that was partially unallowable.

Based on the statistical sample of claims, we estimate that the Hospital overstated its FY 1998 Medicare charges for PHP services by at least \$1,098,553. Charges were for PHP services not reasonable and necessary, or provided to ineligible beneficiaries.

In the Other Matters section in this report, we questioned \$219,114 for occupational therapy services which were also unallowable because they related to the questioned sample claims for PHP services.

The Hospital also claimed \$1,411,645 in costs for providing outpatient psychiatric services on its FY 1998 Medicare cost report. Of this amount, \$863,488 related to a management contract of which \$45,059 was ineligible for Medicare payment because it related to patient transportation. We were unable to determine the reasonableness of the balance of \$818,429 because neither the management company, nor the Hospital could provide supporting documentation of the costs that made up the contract fee schedule used to charge the Hospital on a per unit of service basis. The remaining \$548,157 of the \$1,411,645 was reasonable and appropriate under Medicare rules.

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

## **MEDICAL RECORD REVIEW**

We statistically selected for review 100 claims containing 1,593 units of service totaling \$487,616. Of the 100 claims reviewed, 81 claims for 1,329 units of services totaling \$408,226, did not meet Medicare reimbursement requirements. The services did not meet Medicare requirements because they were not reasonable and necessary, or provided to ineligible beneficiaries. Our results are as follows:

### ***Services Not Reasonable And Necessary***

Our review showed that 41 claims, representing 670 services totaling \$206,672 in charges, were not reasonable and necessary for the patients' conditions. The Medicare Intermediary Manual, section 3112.7 requires outpatient psychiatric services to be provided for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The Manual identifies a wide range of services a hospital may provide to outpatients who need psychiatric care. For such services to be covered, they must be "...reasonable and necessary for the diagnosis or treatment of a patient's condition..." The unallowable claims involved beneficiaries who had achieved sufficient stabilization of the presenting symptoms that he/she no longer required the intense involvement of a PHP. In addition, many of these beneficiaries were from a nursing facility and experienced adjustment difficulties that were expected to be addressed by the nursing facility.

For example, one claim totaling \$4,331 was unallowable because the PHP services were not reasonable and necessary. The 87 year old patient was treated for major depression in the PHP

for 13 weeks prior to the PHP admission for our sampled claim period. The patient demonstrated good coping skills and dealt with the death of a son. The patient had achieved sufficient stabilization of the presenting symptoms to require limited intervention on an intermittent basis, which could have been performed in an outpatient or office setting.

In another example, a claim totaling \$3,843, was also unallowable because the PHP services were not medically reasonable and necessary. The patient was experiencing adjustment problems related to the relocation from home to a nursing home 4 months prior to the PHP admission. The patient responded to increased socialization and medication, all of which could have been accomplished at a less intensive level of care. Problems related to residence in a nursing home are expected to be addressed by the nursing home staff.

### ***Ineligible Beneficiaries***

Our review showed that 40 claims, representing 659 services totaling \$201,554 in charges, were made for beneficiaries who did not meet the Medicare eligibility requirements for PHP services. In order for a Medicare beneficiary to be eligible for these services, he or she must exhibit a severe or disabling condition related to an acute psychiatric or psychological disorder, or an exacerbation of a severe and persistent mental disorder. In addition, a beneficiary must: be able to benefit from a coordinated program of services; have an adequate support system outside the program; have a diagnosis of mental illness; not be dangerous to themselves or others; and not require 24-hour care.

The unallowable claims involved beneficiaries who: (1) refused or could not participate due to behavioral, cognitive, or emotional status with the active treatment process or could not tolerate the intensity of the program, (2) were moderately to severely demented with no evidence that active treatment would modify the clinical course, (3) had multiple unexcused absences from treatment sessions or attended the sessions but were non-compliant, or (4) required primarily social, custodial, recreational, or respite care.

For example, one claim totaling \$5,838 was unallowable because the patient was not eligible for PHP services. The 91 year old patient had Parkinson's Disease and impaired memory and hearing. The patient had poor attendance, preferred to be isolated, and had to be awakened during group sessions. Patients who refuse or cannot participate with the active treatment process; or cannot tolerate the intensity of the PHP due to their cognitive, behavioral, or emotional status are not eligible for the PHP.

In another example, a claim totaling \$3,465 was also unallowable because the patient was not eligible for PHP services. The 81 year old patient had a history of many years of excessive alcohol use. The patient continued to drink while in the PHP, participated poorly, was irritable, and had poor insight. The treatment plan did not address the patient's chemical dependency problem. A patient is ineligible for PHP if he or she refuses or cannot participate with the active

treatment process due to behavioral, cognitive, or emotional status; or cannot tolerate the intensity of the PHP.

## **REVIEW OF OUTPATIENT PSYCHIATRIC COSTS**

The Hospital claimed \$1,411,645 in costs for outpatient psychiatric services on its FY 1998 Medicare cost report (direct costs of \$1,031,106 and indirect costs of \$380,539). Of this amount, \$863,488 related to a management contract of which \$45,059 was ineligible for Medicare payment because it related to patient transportation. We were unable to determine the reasonableness of the balance of \$818,429 because neither the management company, nor the Hospital could provide supporting documentation of the costs that made up the contract fee schedule used to charge the Hospital on a per unit of service basis. The remaining \$548,157 of the \$1,411,645 was reasonable and appropriate under Medicare rules. Our results are as follows:

### ***Unable to Determine Reasonableness of Management Contract***

A management company was responsible for administering the inpatient and outpatient psychiatric programs for the Hospital. For our audit period, the Hospital's psychiatric services included only inpatient services and services provided in the PHP. The management company provided the medical director and all other clinical staff for the PHP program, except for the nursing staff. The Hospital employed the nurses who allocated their time between the inpatient psychiatric department and the PHP. The management company charged the Hospital \$863,488 based on a per unit of service fee schedule. These charges made up 84 percent of the total direct outpatient psychiatric costs. However, neither the management company, nor the Hospital could provide detailed supporting documentation for the costs included in the fee schedule. Further, the fee schedule has not changed since the contract's inception in August 1993. The remaining 16 percent appeared to be reasonable and appropriate and was composed of 14 percent for nursing salaries and 2 percent for other direct costs. Of the \$863,488, we are unable to express an opinion on \$818,429. The remaining \$45,059 is discussed below.

### ***Unallowable Transportation Costs***

The Hospital did not have adequate controls established for the preparation of its FY 1998 Medicare cost report to exclude all nonreimbursable costs and insure that costs claimed in the management contract fees were documented and allowable in accordance with Medicare regulations and guidelines.

The Hospital relied on the management company to report any unallowable costs that should be adjusted from the outpatient psychiatric cost category on the Medicare cost report. For our audit period, the management company reported unallowable transportation costs of \$45,059, but they were not properly adjusted on the cost report. For our audit period, the management company did not break out its cost between inpatient, PHP, and other. However, the transportation costs were identifiable because they were 100 percent allocable to PHP patients. The management

company provided transportation for the PHP patients and these costs were included on the Medicare cost report under purchased services (management company). The Medicare Intermediary Manual, section 3112.7 states that noncovered outpatient psychiatric services include transportation.

## **OTHER MATTERS**

To select a statistical sample of 100 claims, we used the Provider Statistical and Reimbursement Report for the Hospital's FY 1998 to identify psychiatric claims submitted by the Hospital. Such claims were identified by revenue center codes 900-904, 909-912, and 914-919 (psychiatric/psychological services). However, some of these psychiatric claims also included services for occupational therapy, revenue center codes 433 and 434. These occupational therapy services were provided to the beneficiaries in our sample as a component of the PHP. Accordingly, the occupational therapy services were reviewed in conjunction with the psychiatric/psychological services included on the claim. Our review showed that occupational therapy charges totaling \$219,114 were unallowable because they related to the questioned PHP services. This amount is not included in our estimate of overpayments for psychiatric/psychological services.

## **CONCLUSION**

For FY 1998, the Hospital submitted for reimbursement \$2,258,592 in charges for outpatient psychiatric services. Our audit of 100 statistically selected claims totaling \$487,616 showed that \$408,226 should not have been billed to the Medicare program, and \$79,390 was acceptable under the program.

Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that the Hospital billed at least \$1,098,553 in error for FY 1998. We attained our estimate by using a single stage appraisal program and applying a 90 percent confidence level. The precision of the point estimate at the 90 percent confidence level is plus or minus 10 percent (see Appendix A). Not included in the estimate are occupational therapy charges totaling \$219,114 which were also unallowable because they related to the questioned PHP services.

In support of the above claimed charges, the Hospital claimed \$1,411,645 in costs for these outpatient psychiatric services on its FY 1998 Medicare cost report. Of this amount, \$45,059 was ineligible for Medicare payment because it related to outpatient transportation; and \$818,429 was related to a management contract for which we could not determine reasonableness. The remaining \$548,157 was allowable under Medicare.

## **RECOMMENDATIONS**

We recommended that the Hospital:

1. Strengthen its procedures to ensure that charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements.

Accordingly, we will provide the results of our review to the FI, so that it can make the adjustment of \$1,317,667 to the Hospital's FY 1998 Medicare cost report, \$1,098,553 for the sample results and \$219,114 for occupational therapy related to the unallowable sample services.

2. Identify all costs that are included in the management contract fee schedule to assure that only reasonable costs are included, and establish an effective procedure for excluding costs related to noncovered services from its Medicare cost reports. We will provide the FI with details of the identified \$45,059 in unallowable costs so that it can apply the adjustment to the Hospital's FY 1998 Medicare cost report. We will also request that the FI determine whether the management contract fees totaling \$818,429 were reasonable.

## **HOSPITAL COMMENTS AND OIG RESPONSE**

### **The Hospital's Response**

The Hospital believed that OIG's report findings were inaccurate and unfounded. The Hospital questioned the motivation of any governmental entity that publishes an audit report as "final" when its findings cannot be "final" until the audited entity has completed the appeals process. The Hospital was confident that the appeals process will validate the integrity of its outpatient psychiatric program. The Hospital was concerned that the OIG would issue the final report without being able to assess the medical review issues, knowing that the Hospital would appeal each allegation.

It was the Hospital's contention that any proper review of a PHP program must look at the totality of the program including the program's historical performance and direction based on the focused review process, rather than looking at a single "snapshot." The Hospital stated that the OIG auditors refused to address the historical "rate of denials" for the time period immediately preceding and including the audit period and chose to disregard documentation sent to them regarding the results of the FI's focused medical review process. The Hospital also stated the OIG auditors assumed a "snapshot" approach, taking decisions out of the context of the patient's overall treatment plan and failing to consider the totality of the patient's needs.

The Hospital believed that the outpatient psychiatric services the OIG reviewed were reasonable and necessary and provided to eligible beneficiaries, and that the related occupational therapy charges were allowable under Medicare. The Hospital plans to appeal every denial that will be referred to the FI. The Hospital specifically questioned the: (1) medical reviewers' and OIG auditors' expertise, (2) amount of weight given to the medical decisions made by the treating physicians, (3) determinations regarding at least two claims which the Hospital believed contradict earlier decisions of Medicare Hearing Officers, and (4) determinations regarding two claims which the Hospital stated were reviewed and paid by the FI as a part of a focused medical review.

Regarding the cost report issues, the Hospital believed that it provided the OIG clear and convincing evidence that the management company cost was reasonable and in accordance with Medicare requirements. The Hospital agreed to remove the unallowable transportation cost from its final Medicare cost report.

### **The OIG's Response**

The OIG conducted its audit in accordance with generally accepted government auditing standards and its audit policies and procedures. As part of the audit process, we issued our draft report and provided Hospital officials the opportunity to respond to our audit findings. The OIG considers the auditee's comments to be an essential part of a report's development.

Accordingly, OIG auditors reviewed the additional documentation provided regarding the results of the FI's focused medical review process and found that the outcome of the review did not impact our specific sample items tested. Further, the OIG auditors did not assume a "snapshot" approach in making its medical review decisions. The medical reviewers, who have experience with the PHP Medicare requirements, reviewed the entire medical record for each beneficiary sampled and then specifically made a determination for the sampled claim.

This final report includes our findings and recommendations as well the Hospital's comments. In accordance with OIG policy, the final report is made available to the public through our internet site. The statutory or regulatory support for publishing a report on the internet is the Electronic Freedom of Information Act Amendments of 1996 [Public Law 104-231].

The OIG does not play a role in the adjudication or appeals process. The data supporting our recommendations will be provided to the FI which is responsible for adjudicating claims determined to be in error. The Hospital is entitled by law and regulations to specified appeals. The multi-level appeals process provides for a reconsideration by HCFA, a hearing before a Federal Administrative Law Judge (ALJ), a review of the ALJ decision by the Appeals Council, and a civil action in the U.S. District Court for a review of the final administrative decision if the amount in dispute is \$1,000 or more. All of these appeals remain available to the Hospital.

Regarding the cost report, we reviewed all of the information provided by the Hospital and the management company, but still were unable to render an opinion on the reasonableness of the contracted cost. The information provided was not sufficient to identify the costs and profit margin that made up the fee schedule used by the management company to charge the Hospital.

The following is a more detailed discussion of specific points made in the Hospital's comments to our findings.

#### **(1) Qualifications of Medical Reviewers**

##### **The Hospital's Comments**

The Hospital questioned whether OIG auditors had the training and expertise necessary to render decisions as to the reasonableness and medical necessity of services and the

eligibility of beneficiaries for such services. The Hospital stated that the OIG auditors referred medical review questions to the FI, which is the same entity that had previously reviewed and paid the claims that are now the subject of dispute in the eyes of the OIG. The Hospital stated that it also had concerns with the PRO reviewers because they were often registered nurses who lack the professional training to evaluate patient care and treatment decisions made by physicians.

### **OIG's Response**

The OIG auditors are not medical experts and all medical issues were referred to the medical experts to review the sampled claims. The OIG auditors relied on the medical expertise of registered nurses with the FI as well as board certified psychiatrists under contract with the PRO to determine the reasonableness and medical necessity of services and the eligibility of beneficiaries for such services. Both the FI and the PRO reviewed the medical records for the beneficiaries in our statistical sample of 100 claims. We will provide the results to the FI, so that it can adjudicate the questioned claims.

## **(2) "Treating Physician Rule"**

### **The Hospital's Comments**

The Hospital strongly believed that a determination of medical necessity by the physician who actually examined a patient was the best evidence of the need for and the reasonableness of the services that were subsequently provided to that patient. The Hospital stated that it appeared that the medical reviewer ignored the long-standing and judicially recognized "treating physician rule." The Hospital asserted that the rule assumes that the treating physician was in the best position to determine what care was appropriate for the patients and, in the absence of substantial evidence to the contrary, should not be second-guessed. The Hospital believed that the physicians who treated the patients in question made rational, medically justifiable decisions regarding the care that was ultimately provided.

### **The OIG's Comments**

Medicare claims have always been subject to review for reasonableness and necessity. These reviews are made by qualified staff and are comprehensive. For our review, the patient's complete medical record was evaluated to make a determination of medical need for the services rendered and eligibility of the beneficiaries for the PHP. For the 100 sampled claims, the reviewers' examination, included: (1) intake forms and admission information, including medical history; (2) psychiatric history/assessment; (3) psychological evaluation/assessment; (4) nursing assessments; (5) treatment plans; (6) certification and re-certification for the continued need for PHP services; (7) clinical/progress notes; (8) physician notes; and (9) group notes/treatment summaries. As we discussed in our report, the medical record of the services claimed did not support the Medicare claim.

**(3) Earlier Decision of Medicare Hearing Officers**

**The Hospital's Response**

The Hospital stated that two sample claims (#20 and #79) denied by OIG auditors were independently determined to be covered by Medicare Hearing Officers for July 1997 and June 1998, respectively. The Hospital stated that for these sample claims the patients were in the program for single episodes of illness that lasted several months. The Hospital stated that it billed on a monthly basis during both episodes of illness rather than billing for one "lump sum" at the end of each episode of illness. For sample claim number 20 it submitted 4 separate bills for treatment of the episode of illness that lasted from July 22, 1997 through October 14, 1997. For sample claim number 79, it submitted 3 separate bills for treatment of the episode of illness that lasted from April 1, 1998 through June 26, 1998. The Hospital stated that if the complete medical record had been evaluated, the medical necessity of services for this claim, as well as the services in the other sample claims, would not have been challenged.

**The OIG's Response**

The complete medical record was evaluated as a part of the OIG audit. The medical reviewers evaluated the entire medical record for each beneficiary in our sample and then specifically made a medical determination for the sampled period. Because the treatment plan is required to be reviewed at least every 31 days, it is quite possible that a claim could be covered 1 month and not the next. Specifically, the Medicare Hearing Officer decisions did not cover our particular sampled periods — September 1997 for sample number 20 and April 1998 for sample number 79 - and his decisions are binding only for the specific dates of service covered by his review.

**(4) Reliance on the FI Determinations During Focused Review**

**The Hospital's Response**

The Hospital stated that at least two patient claims had been reviewed and paid by the FI as part of a focused review, were subsequently denied by the OIG auditors.

**The OIG's Response**

The Hospital did not specify in its response whether it was referring to a pre-payment or post-payment focused review. The Hospital was not under a pre-payment review during our audit period, however, there was a post-payment review. The FI's post-payment review for 1997 showed that 25 Hospital claims were reviewed with 11 denials and 14 approvals. This focused medical review did not impact the particular samples that we tested.

The Hospital provided us with 23 requests from the FI for medical records for review. We reviewed this documentation and found that only two matched particular service dates and beneficiaries that we sampled. For one claim, the medical records had been requested but were never reviewed by the FI, and for the other claim, the request for records resulted in an overpayment determination.

**(5) Occupational Therapy Charges**

**The Hospital's Response**

The Hospital stated that the occupational therapy charges should be reinstated as allowable.

**The OIG's Response**

Occupational therapy charges totaling \$219,114 were unallowable because they related to questioned sample services. If the patient sampled was not eligible for PHP services or such services were not medically necessary and reasonable, then the occupational therapy services were also not allowable under Medicare requirements. The occupational therapy provided were for PHP services which were a component of the patients' treatment plan.

**(6) Reasonableness of Management Contract Fee**

**The Hospital's Response**

The Hospital stated that the management arrangement meets Medicare criteria, that competitive bids were properly requested, accepted and evaluated, and that the management fees charged are reasonable and appropriately calculated on a per unit of service basis. The Hospital stated that it provided the OIG with clear and convincing evidence that it obtained three competitive bids in its use of a competitive bidding process. The Hospital further stated that it previously provided the auditors with numerous documents and supporting financial information, showing that such management costs were reasonable and documented the per unit basis upon which the contract fee was calculated. The Hospital also stated that the management company assumed that the OIG auditors did not utilize these costs to calculate the per unit basis; therefore, the Hospital provided those calculations in its response. The Hospital believed that these calculations indicate that the contract management fees were necessary, proper, and appropriately documented.

**The OIG's Response**

We verified that the management company charged the Hospital on a per unit of service basis using the management contract fee schedule. However, the Hospital could not provide supporting documentation showing that it obtained three competitive bids, and the fee schedule itself was not supported. We requested the Hospital and the

management company to provide detailed documentation showing how the contract fee schedule was established. According to the management company, it was made up of 100 percent of its outpatient psychiatric costs plus a profit margin. We requested the management company's detail for these costs. However, the documentation provided by the Hospital and management company did not separate the inpatient and outpatient program costs for our audit period (FY 1998), and it did not explain the costs included in the "per unit" contract fee schedule. Without this information, we could not determine the reasonableness of these charges. The calculations presented in the Hospital's response to our draft report were based on an extrapolation based on the units of service and the charges billed to the Hospital, rather than detailed cost information.

The management company began breaking out its inpatient and outpatient program costs in FY 1999. The management company attempted to go back and breakout the FY 1998 outpatient costs and provide us with additional documentation showing the salaries allocated to the outpatient program. However, breaking out salaries covered only 42 percent of total costs for inpatient, outpatient, and other. The unallowable transportation costs made up about 3 percent, leaving about 55 percent of costs commingled. As a result, we could not identify the outpatient costs for the 55 percent balance.

**(7) Medicare Cost Report — Transportation Cost**

**The Hospital's Response**

The Hospital concurred with us regarding the unallowable transportation costs and agreed to make the necessary adjustment to the 1998 Medicare cost report.

**The OIG's Response**

None

**REVIEW OF  
OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY THE  
TOMBALL REGIONAL HOSPITAL**

**STATISTICAL SAMPLE INFORMATION**

POPULATION

Items: 299 Claims  
Dollars: \$1,423,558

SAMPLE

Items: 100 Claims  
Dollars: \$487,616

ERRORS

Items: 81 Claims  
Dollars: \$408,226

PROJECTION OF SAMPLE RESULTS

90 Percent Confidence Interval

Point Estimate: \$1,220,597  
Lower Limit: \$1,098,553  
Upper Limit: \$1,342,640

# TOMBALL REGIONAL HOSPITAL

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March 7, 2000

**VIA OVERNIGHT DELIVERY**

Mr. Donald L. Dille  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of the Inspector General  
Office of Audit Services  
1100 Commerce, Room 6B6  
Dallas, Texas 75242

RE: Tomball Regional Hospital's Response ("Response") to the OIG's Report  
Common Identification Number: A-06-99-00014

Dear Mr. Dille:

We at Tomball Regional Hospital ("TRH") feel compelled to respond to the Final Report ("Report") from the Office of Inspector General of the Department of Health and Human Services ("OIG") entitled "Review of Outpatient Psychiatric Services by Tomball Regional Hospital for Fiscal Year Ending June 30, 1998." Essentially, the Report alleges that (1) TRH billed the Medicare Program ("Medicare") and was reimbursed for outpatient psychiatric services that were not allowed under Medicare requirements; (2) TRH claimed unallowable outpatient transportation costs on its Medicare cost report; and (3) OIG auditors could not determine the reasonableness of the outpatient psychiatric costs associated with the management company that administers the TRH outpatient psychiatric program ("Program").

The OIG bases its allegations on a review of 100 sample claims that were submitted for Medicare reimbursement during the audited period. The medical decisions at issue in the Report pertain to elderly patients being treated by psychiatrists specializing in geriatric mental health care. As such, the cases are highly complex and personal in nature. Instead of looking at the entire medical record of a patient to understand the bases for the various treatment decisions, the OIG auditors assumed a "snapshot" approach, taking the decisions out of the context of the patient's overall treatment plan and failing to consider the totality of the patient's needs. The OIG auditors refused to address the historical "rate of denials" for the time period immediately preceding and including the audit period and chose to disregard documentation sent to them regarding the results of the Intermediary's focused medical review process. It is our contention that any proper review of a PHP program must look at the totality of the program, including the program's historical performance and direction based on the focused review process, rather than

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looking at a single "snapshot." As a result of the OIG's haphazard review methods, the Report is riddled with inaccuracies.

TRH went to considerable effort to explain to the OIG, both in writing and in verbal communications, that the Report is flawed. Each time that we attempted to address our concerns with the OIG, however, we were told that the auditors were not responsible for the medical necessity portions of the Report, and that their only obligations were to complete the audit process, put the Report in "final" form, and publish the Report. The auditors refused to inform TRH of the procedures that they followed in conducting the audit, and they would not explain how the medical reviews were performed. Despite knowing that they were incapable of assessing the medical review issues, despite knowing that TRH would appeal each allegation, despite knowing the Report would likely be amended following the appeals, and despite the absence of statutory or regulatory support for publishing the report on the Internet, the OIG nevertheless insisted on issuing the Report before TRH could pursue its administrative and judicial appeal rights. We question the motivation of any governmental entity that publishes an audit report as "final" when in fact its calculations are not and cannot be "final" until the audited entity has completed the appeals process. TRH is confident that the appeals process will validate the integrity of our Program.

It had been our hope that discussing our concerns during the exit conference with OIG representatives on February 16, 2000, would facilitate corrections to the Report and help to avoid the time and expense of an appeal. Unfortunately, the numerous inaccuracies of the Report and the unwillingness of OIG representatives to correct those inaccuracies leave us no option but to submit this rebuttal. Furthermore, because the allegations of the Report are potentially damaging and far-reaching, TRH will contest each issue to the full extent allowed by law.

TRH would also like to point out its concern that the efforts of the OIG are not in the best interest of Medicare beneficiaries. We all are aware that a crisis exists in mental health care, and the elderly are often ignored in the governmental bureaucracy of mental health care coverage. Credible sources repeatedly report that our elderly desperately need treatment for depression, medication dependency, and other mental health conditions. The United States Congress is aware of this need and has provided coverage for the outpatient psychiatric services that TRH has provided. Now the OIG is attempting to deny that coverage by recouping payment that TRH validly received from Medicare for the rendition of reasonable and necessary services. The OIG does not have the authority to legislate away what Congress has provided. Ironically, it appears that the OIG is more willing to provide payment for inpatient psychiatric treatment than outpatient psychiatric treatment, even though the costs to the U.S. taxpayers are much greater for inpatient services. TRH must object to this flagrant miscarriage of justice.

**1. Outpatient Psychiatric Services: Determination of Reasonableness and Necessity of Services and Eligibility of Beneficiaries.**

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The Report first alleges that TRH billed Medicare and was reimbursed for outpatient psychiatric services that were not allowed under Medicare requirements. In response to this allegation, the TRH board-certified psychiatrists who made the original initial eligibility and treatment decisions, as well as other TRH personnel, reviewed each of the sample claims in light of Partial Hospitalization Program ("PHP") requirements pertaining to outpatient psychiatric services as set forth in the Social Security Act and the federal regulations. PHP services are generally defined as mental health services that are reasonable and necessary for the diagnosis or active treatment of an individual's condition and are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization. Social Security Act § 1861(ff)(2). Physicians must certify that PHP patients would otherwise require inpatient psychiatric care. *Id.* at § 1835(2)(F). A physician must prescribe PHP services and generally supervise the services. 42 C.F.R. § 410.110(a).

In preparing this Response to the Report, representatives of TRH also examined the criteria that reviewers should use when making payment determinations. In its Transmittal No. A-99-39, dated September 1999, the Health Care Financing Administration ("HCFA") indicates that such criteria include initial psychiatric evaluation and physician certification, active treatment pursuant to an individualized treatment plan, and progress notes indicating that the services were actually provided. The criteria listed in Transmittal No. A-99-39 are essentially identical to those in related sections of the Medicare Intermediary Manual ("MIM"), as well as in the statutory and regulatory provisions pertaining to PHP claims. *See, e.g.*, Social Security Act § 1861(ff); 42 C.F.R. § 410.43; MIM § 3920.1.K3; and HCFA Program Memorandum No. A-95-8.

TRH reviewed each of the four cases cited in the Report in light of the criteria set forth in the statutes, regulations, and HCFA Manuals. Furthermore, the two board-certified psychiatrists who direct the Program reviewed the records and reconfirmed their initial diagnoses and treatment decisions. Our thorough review of the applicable law, regulations, and related HCFA guidelines indicates that TRH complied with all the requirements and that none of these four cases should have been the subject of coverage denials. These and other services questioned or disallowed by the OIG auditors were billed and reimbursed appropriately. We note some specific discrepancies in the first allegation:

*a. Challenge of the OIG Auditors and Medical Reviewers to the Decisions of Board-Certified Psychiatrists.*

TRH questions whether the OIG auditors have the training and expertise necessary to render decisions as to the reasonableness and medical necessity of services and the eligibility of beneficiaries for such services. Throughout the audit process, the OIG auditors and other representatives indicated to TRH that they were unable to address the medical or clinical issues and that those issues would need to be reviewed by the fiscal intermediary ("Intermediary"). Ironically, the Intermediary is the same entity that has previously reviewed and paid the claims that are now the subject of dispute in the eyes of the OIG. The Report explains that the OIG also

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referred its medical review of the claims (*i.e.*, as to whether they were reasonable and necessary) to the Texas Medical Foundation, the Texas peer review organization ("PRO"). We expressed our concern that PRO reviewers are often registered nurses who lack the professional training to evaluate patient care and treatment decisions made by physicians, while the physicians who are under contract with the Program and who made the medical treatment decisions for the patients in TRH's Program are board-certified psychiatrists with years of training and significant expertise in providing mental health care to geriatric patients.

During the Exit Conference, the OIG auditors repeatedly referred to "the nurse reviewers from the Intermediary." When representatives of TRH questioned the auditors about the appropriateness of nurses reviewing physicians' decisions, however, the auditors responded that each of the 81 claims in question had been reviewed by a board-certified psychiatrist on behalf of the PRO, and that each claim was reviewed again by a board-certified psychiatrist on behalf of the Intermediary. The OIG also indicated that the PRO and Intermediary psychiatrists concurred — on a claim-by-claim basis — with each finding of the initial review that the services in question were not reasonable or medically necessary. We are highly skeptical that two "independent" reviews of 81 professional psychiatric assessments by two "independent" psychiatrists would result in such uniform conclusions. Given the high degree of subjectivity in psychiatric diagnoses and the fact that neither the PRO's psychiatrist nor the Intermediary's psychiatrist had personally seen any of the 81 patients whose records were reviewed, it is inconceivable that there would be complete consensus, absent some type of discussion or corroboration between those two psychiatrists.

*b. OIG Auditors Failed to Give Appropriate Weight to the Medical Decisions Made by the Treating Physicians.*

The Report cites four sample claims in discussing its allegation of lack of medical necessity; TRH is limiting its Response to the specific cases cited in the Report. We will fully contest and appeal each of the medical decisions through the administrative and judicial processes. The sample claims cited in the Report were described as "not reasonable and necessary" or provided to beneficiaries "who did not meet the Medicare eligibility requirements for PHP services." Each case summary, when reviewed together with statements of the treating physician and the full medical record, reflects that the treatment decisions were appropriately documented and made in compliance with the statutory criteria for PHP services set forth in Section 1861(ff) of the Social Security Act.

TRH provided auditors with copies of the patients' medical records and related documents. Each of the four records identified in the Report contained a certificate signed by a board-certified psychiatrist, indicating that, in the psychiatrist's professional medical opinion, the patient's admission to the Program and the treatment provided were both reasonable and necessary. The certifications provide clear and convincing evidence that (1) partial hospitalization was the treatment of choice in lieu of admission to an inpatient unit; (2) each

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psychiatric diagnosis was adequately documented; (3) each patient received individualized active treatment appropriate for his or her treatment goals and level of functioning; and (4) all services were furnished in accordance with written individualized treatment plans supervised by a physician.

We strongly believe that a determination of medical necessity by the physician who actually examines a patient is the best evidence of the need for and the reasonableness of the services that are subsequently provided to that patient. It appears that the medical reviewers ignored the long-standing and judicially recognized *treating physician rule*. That rule assumes that the treating physician is in the best position to determine what care is appropriate for these patients and, in the absence of substantial evidence to the contrary, should not be second-guessed. The physicians who treated the patients in question made rational, medically justifiable decisions regarding the care that was ultimately provided.

Moreover, the OIG disregarded the fact that the TRH psychiatrists carefully consider whether each patient who is admitted to the Program meets "the Medicare eligibility requirements for PHP services." TRH, which is a governmental entity organized under Texas law as a municipal hospital authority, is extremely proud of the services that it provides to eligible beneficiaries. The OIG and HCFA failed to take into account, however, that many beneficiaries requesting services in the PHP are denied admission to the Program because, in the opinion of the psychiatrist, they do not meet the eligibility requirements. TRH's Program is not a psychiatric service mill for non-eligible geriatrics; rather, it is a worthwhile and legitimate program providing services to Medicare beneficiaries who meet stringently enforced eligibility criteria. TRH is *not* a for-profit entity or part of a for-profit chain; instead, as a governmental entity, it provides its services for the benefit of the public.

*c. At Least Two OIG Findings Contradict Decisions of Medicare Hearing Officers.*

In addition to the *four* cases discussed above, we call attention to two other cases cited in the Report, both of which were denied by the OIG auditors but were independently determined to be covered by Medicare Hearing Officers. In both Sample Claim No. 20 and Sample Claim No. 79, the patients were in the Program for single episodes of illness that lasted several months. As required by Medicare, TRH submitted bills on a monthly basis during both episodes of illness, rather than billing for one "lump sum" at the end of each episode of illness. Thus, for Sample Claim No. 20, TRH submitted four separate bills for treatment of the episode of illness that lasted from July 22, 1997, through October 14, 1997. For Sample Claim No. 79, TRH submitted three separate bills for treatment of the episode of illness that lasted from April 1, 1998, through June 26, 1998.

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Sample Claim No. 20 pertains to TRH's request for payment of PHP services in the amount of \$10,650.80 (80 percent of \$13,313.50). Coverage of these services, which were furnished between June 1, 1998, and June 30, 1998, was initially denied by the Intermediary as not medically reasonable and necessary for the beneficiary's diagnosis and condition. TRH appealed the denial, and a hearing was held on February 17, 2000. On February 21, 2000, the Intermediary's Fair Hearings Department notified TRH that the denial was overturned. The letter from the Medicare Hearing Officer, which TRH provided to the OIG on February 24, 2000, indicated that "Documentation provided for review does meet the Medicare documentation and coverage requirements. The services were ordered by a physician and the treatment plan was designed to address [the patient's] specific needs." The Hearing Officer concluded that coverage was warranted for the services provided.

TRH provided documentation to the OIG indicating a similar situation with Sample Claim No. 79. In a letter dated September 24, 1999, the Medicare Hearings Department notified TRH that the denial of a claim for \$6,690.60 (80 percent of \$8,363.25) had been overturned. The Intermediary had previously denied the claim, asserting that the documentation did not support the medical necessity of the services. TRH appealed the denial. After a hearing, and after reviewing the complete medical record and other supporting documentation provided by TRH, the Hearing Officer determined that the coverage criteria had indeed been met and instructed the Intermediary to adjust the claim. Less than two months later, however, the OIG auditors recommended that Sample Claim No. 79 should be denied.

In both Sample Claims, coverage criteria remained the same from month to month for each episode of illness. Both Sample Claims were subject to focused medical review for one month during the episodes of illness, and TRH successfully appealed both of those months' claims to the Intermediary following their initial denial. When the OIG audited the same cases, however, the OIG reviewed claims from different months of each episode of illness — claims that had not been under focused medical review by the Intermediary — and determined that the claims should be denied. The OIG auditors apparently failed to recognize that the claims they reviewed and denied and the claims the Hearing Officers reviewed and approved were for the same patients within the same episodes of illness.

We believe that, unlike the Medicare Hearing Officers who reviewed Sample Claims No. 20 and 79, the OIG auditors and/or PRO reviewers did not consider the full records concerning the claims. If the complete medical records had been evaluated by reviewers trained in medical record review, the medical reasonableness and necessity of services in Sample Claims No. 20 and No. 79, as well as the services in the other sample claims, would not have been challenged by the OIG. Both Hearing Officers concluded that, based on their decisions, no amounts remained in question, and "therefore, no higher levels of appeal are necessary." The Hearing Officers, unfortunately, did not anticipate that the OIG would second-guess them.

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TRH is in the untenable position of having to sort through conflicting determinations of two arms of the federal government. We therefore assert that any report on the TRH Program should, at the very least, address the inconsistency between the Intermediary's performance and direction to the Program, including the Hearing Officers' decisions regarding Sample Claims No. 20 and 79, vis-à-vis the contradictory OIG determinations. We believe that the Report should also address the incongruity of TRH's historical rate of reversals of previous denials vis-à-vis the rate of denials cited by the OIG.

During the exit conference, the OIG auditors told representatives of TRH that the Intermediary had denied, in writing, that TRH was ever under any focused review process. TRH subsequently provided the OIG with documentation showing that during the period from July 1, 1996, through June 30, 1998, the Intermediary requested 133 claims for focused medical review. Of those 133 claims subject to focused review, TRH had a total of only nineteen denials, constituting a denial rate of 14.28 percent, and the denial rate for *all* claims submitted by TRH was only 3.49 percent. The OIG, however, determined that 81 percent of the claims it audited should be denied. The OIG refused to explain how the Program could have previously received approval for 85.72 percent of all claims subject to the focused review from 1996-1998 and then have only a 19 percent approval rating under the OIG audit, which covers, in part, the same time period. Obviously, both rates cannot be correct. Clearly, the review criteria did not change for the audit period, and TRH has never received any documentation regarding any change in the admission, medical necessity, or eligibility criteria that have been used since the inception of our Program.

We contend that the historical rate of denials that TRH provided to the OIG is far more accurate than the rate cited in the OIG's Reports, if for no other reason than the fact that TRH completed the appeal process. Again, we question the motivation of the OIG auditors in publishing a report as "final" when their numbers are not and cannot be "final" until TRH has exercised its judicial rights through the appeals process. TRH believes in the integrity of its Program and will appeal every denial that the OIG refers to the Intermediary. TRH is confident that the appeals process will validate the integrity of its Program.

***d TRH Appropriately Relied on Intermediary Determinations during Focused Review.***

We noted above that as a result of its review of the first OIG allegation, TRH identified at least two patient claims that had been reviewed and paid by the Intermediary as part of the focused review, but that were subsequently denied by the OIG auditors. As described in MIM § 3939, focused review is a type of prospective review and approval process in which the Intermediary determines whether a provider is correctly documenting medical necessity and follows up with appropriate educational and/or corrective measures when necessary.

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The primary objective of a focused medical review is to maximize protection against inappropriate payments and abusive billing in the Medicare arena. In part, Intermediaries are required to achieve this objective by implementing activities that "educate providers to bill for only covered and necessary services" and that "educate providers about appropriate practices." MIM § 3939.B. Through the results of its focused review of TRH claims, the Intermediary indicated to TRH that TRH was billing correctly for covered and necessary services, and that TRH was using appropriate billing practices. The glaring inconsistency between the results of the Intermediary reviews and the OIG audit is one of the primary reasons that TRH believes the OIG audit is egregiously flawed.

TRH followed the Medicare criteria in effect at the time of the focused review, and the Intermediary's focused review confirmed the existence of medical necessity and other criteria, which were further validated by the Intermediary's reimbursement of the claims. The Intermediary was satisfied with TRH's documentation, and TRH relied upon the Intermediary's reimbursement decisions. MIM § 2221.1 advises Intermediaries that:

If the provider alleges that it was without fault with respect to the overpayment, e.g., where it claims that it billed for the services in reliance on misinformation from an official source, or if there is other evidence that the provider was without fault, consider relieving the provider of liability. . . . Explore this issue before pursuing recovery.

A review of all of the claims submitted during the audit period shows that TRH billed for the services in reliance on information from the official sources being HCFA, Medicare and the Fiscal Intermediary. During the appeals process, TRH will show that it has been wrongfully accused of inappropriate billing practices, and that its reliance on the Intermediary's decisions is evidence that TRH was not at fault with respect to the alleged overpayments.

*e. Occupational Therapy Charges.*

The OIG auditors also disallowed certain occupational therapy charges as a result of the sampling and statistical methodologies that were used. Again, TRH provided the OIG with evidence that these charges were inappropriately disallowed and therefore should be reinstated as allowable, but the OIG has refused to do so.

**2. Medicare Cost Report.**

Allegation number two of the Report states that TRH improperly included certain outpatient transportation costs in its 1998 Medicare Cost Report. Although TRH has accounting policies and procedural safeguards in place to monitor its accounting practices and retains a consultant to assist in the preparation of each year's cost report, we agree with the OIG that the outpatient transportation costs were erroneously included in the TRH 1998 cost report. We

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emphasize, however, that this entry was the only error mentioned by the OIG as a result of its review of all TRH financial activities. It is also true that the TRH 1998 Medicare cost report was not yet final at the time of the OIG audit because the cost report had not been audited by the Intermediary. Pursuant to PRM § 2931.2A, a provider may file an amended cost report to correct material errors detected subsequent to the filing of the original cost report. TRH will amend its 1998 cost report by deleting the entry for outpatient transportation costs.

### 3. Reasonableness of Management Contract Fee.

The Report alleges that the OIG auditors could not determine the reasonableness of the outpatient psychiatric costs associated with the fee of the management company that administered the psychiatric program for TRH, and that neither the management company nor TRH could identify or provide supporting documentation for the contract fee schedule used to charge the Hospital on a per unit of service basis. Such allegations are completely false. TRH provided the OIG with clear and convincing evidence that it obtained three competitive bids in its use of a competitive bidding process and selected the management company that submitted the lowest bid. We provided documentation that TRH and the management company are unrelated parties, and that our management agreement addresses the service needs of TRH and its patients and meets applicable Medicare criteria.

The management fees are based on reasonable costs incurred following the criteria set forth in HCFA Hospital Manual § 207, which acknowledges the appropriateness of noting such contractual arrangements as permissible costs on a cost report. Section 2135.2 of the HCFA Provider Reimbursement Manual ("PRM") states that the cost of comparable services among contractors is one consideration in evaluating the need for purchased management support services, and that "[g]enerally, a provider is prudent to solicit competitive bids." PRM § 2135.1. One OIG auditor faulted TRH because only two of the actual competitive bids — from more than seven years ago — could be found. It is significant to note that TRH had no obligation to maintain these records beyond the period of time required by Texas law. More importantly TRH subsequently located the final bid and submitted it to the OIG prior to the issuance of the Final Draft Report. Also submitted were minutes of the TRH governing board reflecting the terms of the third bid and revealed that TRH selected the lowest bid. Clearly the OIG is unwilling to consider clear and convincing credible evidence. By rejecting the information and denying the management fee the OIG has failed to follow HCFA's own criteria. Section 2135.1 goes on to provide as follows:

One method of purchasing the services is through a full service management contract in which the management contractor provides a complete package of services. . . . Another method is through a limited service management or administrative service contract in which a contractor provides certain specific services to a provider and is responsible for only those specific services. . . .

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Providers should always consider the most appropriate means for obtaining services needed for the ongoing rendition of patient care.

PRM § 2135.3 lists the factors that the Intermediary should consider in evaluating the reasonable cost of purchased management and administrative support services:

- (A) whether the contract results from competitive bids that are reasonable within industry norms for similar services;
- (B) whether the contract is between unrelated parties;
- (C) whether the contract provides for services that are designed to accomplish within a prescribed time frame clearly stated goals and objectives based on needs identified by the provider; and
- (D) whether the provider maintains adequate documentation of the services rendered and the status of the accomplishment of the stated goals and objectives.

In light of these PRM mandates and criteria, there is ample documentation that the arrangement between the Hospital and the management company was the most appropriate means for obtaining outpatient psychiatric services. Moreover, all identified costs were related to the operation of patient care facilities and activities and were properly reimbursable under applicable payment rules and regulations. See PRM § 2404.2F.

TRH and the management company provided the auditors with information appropriate to the determination of the management agreement fee. Furthermore, the management company provided a detailed account of its expenditures, identified costs associated with the counseling center, and removed those costs from the costs associated with inpatient psychiatric services. TRH also furnished the OIG with a breakdown of the costs for employees and other allocations of outpatient and inpatient costs. This detailed information demonstrates the management fee was used to purchase the professional services of clinical social workers and therapists who provided services in the Program, the expenses for the Medical Director and other direct patient care related expenses. Because the OIG auditors apparently did not utilize these costs to calculate the "per unit" basis, we provided the calculations to them. The calculations indicate that the contract management fees were necessary, proper, and appropriately documented. Furthermore, the fact that the management fee has not been adjusted for over six (6) years is indicative of the efficient manner in which the Program is operated.

#### 4. Additional Considerations.

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*a. TRH Is Not a Community Mental Health Center.*

In her report entitled "Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers (A-04-98-02145) dated October 5, 1998, Inspector General June Gibbs Brown indicates that numerous billing and compliance issues have surfaced at community mental health centers ("CMHCs") that are often indicative of Medicare fraud and abuse. Some of the most significant problems pertaining to CMHCs apparently relate to the qualifications of providers who deliver PHP services, the eligibility of the beneficiaries receiving the services, and the appropriateness of the services provided. The opening pages of the OIG's report contain the following statements:

In a program designed to pay for intensive outpatient psychiatric services provided to acutely ill individuals in order to prevent their hospitalization, Medicare was paying for PHP services to beneficiaries who had no history of mental illness or who suffered from mental conditions that would preclude them from benefiting from the program. In addition, Medicare was paying for therapy sessions that involved only recreational and diversionary activities such as drawing, arts and crafts, watching television, and playing bingo and other games.

We believe that Medicare made payments to CMHCs for unallowable and highly questionable services, in part, because individuals/companies are allowed to provide self-attestation statements to obtain Medicare CMHC provider numbers. Through this self-attestation process, HCFA relies exclusively on the integrity of the applicants to certify that they comply with requirements of the Social Security Act and are in compliance with State licensure laws. It is important to note that only about 40 percent of the States have licensure requirements for CMHCs. The lack of State oversight and the use of a self-attestation process permitted unscrupulous providers to participate in the Medicare program. Additionally, we believe that prior limited reviews performed by the [Intermediaries] have been inadequate to prevent CMHCs from enrolling ineligible beneficiaries and from billing for allowable PHP services.

We have not evaluated the delivery of PHP benefits in the hospital outpatient setting. However, the extensive nature of the problems found with CMHCs causes us to be concerned in general with this benefit. . . .

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Apparently the OIG auditors assumed that TRH conducts its Program in a manner similar to those CMHCs that are currently the subject of Ms. Brown's report. Nothing could be further from the truth. In order to assure that only eligible beneficiaries participate in the Program, TRH carefully screens each potential patient, and the board-certified psychiatrists overseeing the Program personally examine patients before recommending their participation in the Program. The OIG failed to consider that the Texas Department of Human Services provides oversight for PHP services provided in Texas, and that each patient admitted to the Program is scrupulously evaluated under State guidelines.

It is also important to note that TRH is not engaging in inappropriate marketing activities to obtain admissions to the Program. Rather, TRH has at least 25 different referral sources, and fewer than 30 percent of the persons who are referred to the Program or apply to the Program are actually admitted to the Program. TRH regards its Program as one operated for the benefit of patients and the entire Tomball community, not as a profit center. As previously indicated, TRH is a not-for-profit governmental entity, organized as a municipal hospital authority under the Hospital Authority Act. TEX. HEALTH & SAFETY CODE ANN. § 262.001 *et seq.* As such, TRH is accountable to the public. TRH complies with stringent government standards as well as licensure and certification requirements.

As additional evidence of our commitment to the Program, we provided the OIG with a copy of a recent letter that TRH received from the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), recognizing the Program as a model operation for behavioral health care services. The JCAHO is an organization authorized by HCFA to evaluate an array of healthcare facilities and programs. With JCAHO accreditation, a provider statutorily obtains "deemed" status as a provider of services under the Medicare program. In order to achieve its exemplary rating, the Program had to meet or exceed JCAHO quality standards. The JCAHO determined that TRH excelled in such important patient care standards as initial assessment procedures, patient care decisions, treatment planning, continuity of care, and organizational ethics. Again, these are exactly the types of performance issues that the OIG criticized in its Report. The inconsistencies between the findings of the JCAHO and the OIG are further indications that the Report is inaccurate.

***b. The GAO Report on HCFA's Implementation of the PHP Benefit Underscores the Misplaced Bias of the OIG.***

It is ironic that a little over a year after Inspector General Brown issued her report on her findings of improper and even abusive actions on the part of errant CMHCs, the General Accounting Office ("GAO") would issue a report on the "Lessons Learned from HCFA's Implementation of Changes to [Medicare] Benefits." GAO/HEHS-00-31, January, 2000 ("GAO Report"). At the request of Congressmen John Dingell, Ranking Member of the House Commerce Committee, and Ron Klink, Ranking Member of the House Subcommittee on Oversight and Investigations, the GAO compared HCFA's implementation of the expansion of

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the PHP benefit with its implementation of more recent changes under the Balanced Budget Act of 1997. To accomplish this task, the GAO reviewed the statutory requirements and HCFA documents and spoke with officials of the OIG, HCFA, and representatives of three Intermediaries that processed and paid almost two-thirds of all CMHC payments in 1997. GAO Report at p.1.

The GAO found that HCFA did not adequately evaluate the implications of the PHP benefit expansion, did not provide Intermediaries with timely and adequate guidance on the PHP benefit, did not monitor PHP claims until several years into the program, did not promptly investigate complaints or problems or share such information with other Intermediaries and contractors, and did not respond effectively when improper payments were discovered. *Id.* at pp. 2-4. HCFA failed to appropriately address concerns expressed by Intermediaries and HCFA Regional Offices such as (1) whether PHP would cover certain conditions, (2) whether the PHP benefit was available to certain patients, (3) which specific services could be billed under Medicare, (4) what frequency of services was required under PHP, and (5) what level of physician involvement was required under PHP. *Id.* at pp. 6-7. HCFA did not attempt to address these issues until several years after the PHP benefit was instituted, and did not address the problem as a whole until CMHCs were reviewed as part of Operation Restore Trust in 1997. *Id.* at p. 10. Even though it was keenly aware of the problem in 1997, HCFA did not undertake serious efforts to clarify the confusion among Intermediaries (and providers) until June and September of 1999, when it conducted training seminars for Intermediary claims review staff and issued a program memorandum setting forth the process by which Intermediaries were to conduct medical reviews of PHP claims. *Id.* at p.7.

The OIG reviewed TRH claims for the period of July 1, 1997, through June 30, 1998 — claims that were submitted well before Inspector General Brown issued her report, and well before HCFA attempted to get its own house in order. Since it first began its PHP program in 1993, TRH has consistently submitted claims based on its reasonable reliance of the Intermediary's focused review, unaware of the federal bureaucratic haze surrounding the criteria for and the process of PHP claims review. Then, in early 1999, influenced by Inspector General Brown's report but failing to distinguish TRH's good-faith billing practices and long-standing reputation for quality patient care from those of unscrupulous CMHCs, the OIG conducted its sample review of TRH claims with a predisposition toward finding fault. TRH is determined to correct the misconceptions and injustices that have plagued this audit process. We stand by our reputation, and we will make every effort to set the record straight.

*c. Positive Audit Results.*

We understand that one of the OIG's primary purposes in conducting any audit is to determine if a health care facility has participated in fraudulent billing activities with regard to the Medicare reimbursement program. Regrettably, the fact that the OIG found *no evidence of fraud* on the part of TRH is never mentioned in the Report.

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The OIG fails to point out other positive results of its audit. For example, the audit revealed a zero error rate pertaining to billing and documentation issues. It is reasonable to conclude that the low error rate is indicative of a high level of compliance in all other areas. The OIG's finding that TRH has a zero error rate of billing and documentation errors strongly mitigates against its finding that TRH billed Medicare for a significant number of patient services that were not reasonable and medically necessary. The fact that TRH had such a high level of compliance does not correlate with the OIG's allegation that 81 percent of the services provided under the Program fail to meet medical necessity criteria.

In the section of the Report entitled, "Objective Scope and Methodology," the OIG states the auditors reviewed the criteria related to outpatient psychiatric services and the credentials of the staff working in the Program. The Report also indicates that the auditors reviewed the operation and intensity of the services provided as well as hospital accounting systems relevant to the operation of a PHP. These areas were not discussed in the Report; therefore, it must be assumed that TRH met all PHP requirements in these areas.

#### **5. Formal Request for Information.**

In order to ensure due process, TRH will need to obtain copies of all documents relied upon by the OIG, its auditors, the Intermediary, the Texas PRO, and any other agencies involved in the OIG's adverse recommendation against TRH. Thus, pursuant to the Freedom of Information Act and the Texas Open Records Act, TRH formally requests copies of the following:

- a. Work papers and all documents created by the auditors and reviewers;
- b. The names and credentials of all of the auditors and/or medical record reviewers employed or retained by the OIG, the Texas PRO, the Intermediary, or HCFA, who made determinations relating to reasonableness, medical necessity, and eligibility of the beneficiaries who received PHP services at TRH for the 100 sample claims that were the subject of the audit.
- c. Copies of all instructions provided to the auditors and/or reviewers as criteria or guidelines for conducting reviews to determine reasonableness, medical necessity, and/or eligibility of the beneficiaries who received the PHP services at TRH.
- d. Copies of all manuals, criteria, and other documents used by the auditors and other reviewers in their determinations that relate to the Report.

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- e. Criteria used by HCFA to determine which patient files would be included in the review sample.
- f. Criteria, claims calculations and extrapolations, and sampling procedures used during the OIG audit to ensure compliance with the requirements of with MIM § 3939 (pertaining to focused review) and MIM §§ 3916.3, 3940, 3940.4 (pertaining to comprehensive medical review).
- g. All correspondence and contracts between the HCFA and the Intermediary for Texas during 1997, 1998, and 1999, including the reasons for any change in the Intermediary for Texas.

We are uncompromisingly resolved to prove that TRH's program is operated in compliance with HCFA and Medicare requirements. We will pursue our procedural rights, including our discovery, administrative and judicial rights, for as long and as far as necessary to show the inaccuracies of the OIG's Report and to show that the OIG's allegations are unfounded and untrue.

**6. Summary.**

In its review of TRH and the Program, the OIG found no fraudulent or abusive billing practices. Rather than focusing on the low rate of billing and documentation errors revealed during its audit, however, the OIG made serious and unfounded allegations in its Report concerning the reasonableness and medical necessity of certain Program services and the eligibility of certain beneficiaries for those services. The medical reviewers were inattentive to important entries in medical records and gave insufficient weight to the medical judgment of the Program's professionals. The auditors also failed to consider important information concerning the reasonableness of the fees provided under the Program's management services agreement. TRH and the management company provided the auditors with numerous documents and supporting financial information showing that the management agreement had been competitively bid and that the management fees are reasonable and appropriately calculated on a per unit of service basis.

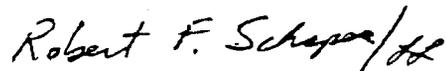
TRH strives to comply with all applicable statutory and regulatory requirements and is proud of its reputation for quality medical care. We also take considerable pride in our Program and make every effort to operate the Program in accordance with HCFA and Medicare guidelines. Because we recognize the need to monitor the administrative and financial practices of health care facilities, as well as the appropriateness of the OIG's audits of such practices, we cooperated fully with the OIG auditors during and after the onsite review. The OIG Report, however, indicates that our good faith was not reciprocated. Thus, we will use the information set forth in this Response, as well as the supplemental information previously provided to the auditors, to show that the allegations in OIG Report are inaccurate and unfounded.

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Thank you for the opportunity to express these concerns. If you have any questions about our Response, please feel free to contact me at 281/351-3601.

Respectfully submitted,



Robert F. Schaper  
President and Chief Executive Officer

cc: Kay Bailey Hutchison  
U.S. Senate

Phil Gramm  
U.S. Senate

Kevin Brady  
U.S. House of Representatives

Bill Archer  
U.S. House of Representatives

John Dingell  
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