STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Provider Reimbursements Made to Netcare Corporation

A Compliance Review by the:

Fraud, Waste and Abuse
Prevention Division

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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As part of a joint effort with the Ohio Department of Mental Health (ODMH), we reviewed payments for services rendered to Medicaid recipients by Netcare Corporation (the Provider) for the period January 1, 1999 through June 30, 2001. We identified findings in the amount of $255,051.80 that resulted from erroneous billings submitted by the Provider to the Franklin County Alcohol Drug Addiction and Mental Health (ADAMH) Board.

The findings are repayable to the Ohio Department of Mental Health and the Franklin County ADAMH Board. The Federal Financial Participation portion of the overpayment, amounting to $150,212.04 should be repaid to ODMH. The remaining balance, representing local matching funds and amounting to $104,839.76, should be repaid to the Franklin County ADAMH Board. Table 2 in Appendix I explains the basis for these amounts.

Please use the remittance sheets in the back of this report when remitting payment. Furthermore, please be advised that in accordance with Ohio Revised Code Section 131.02, if repayment is not made within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection.

We also identified $624,515.16 in questioned costs because the Provider billed and was reimbursed for "crisis intervention" services that could have been more appropriately billed as "residential services" and up to $1,194,202.83 in questioned costs because the Provider failed to bill third party insurers before billing Medicaid. We are recommending that the Department of Mental Health determine whether the questioned costs should be recovered. We are also recommending that the Department of Mental Health review rules regarding crisis intervention services to determine whether they appropriately define reimbursement requirements.

Copies of this report are also being sent to the Franklin County Alcohol, Drug Addiction and Mental Health Board, the Ohio Department of Job and Family Services, and the Ohio Attorney General. If you have any questions, please contact Johnnie L. Butts, Jr., Chief of the Fraud, Waste and Abuse Prevention Division at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

November 7, 2002

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ABBREVIATIONS

ADAMH	Alcohol, Drug Addiction and Mental Health, Board of
CMS	Center for Medicare and Medicaid Services (formerly known as HCFA)
FWAP	Fraud, Waste and Abuse Prevention, Division of
HCFA	Health Care Financing Administration (now known as CMS)
HCPCS	HCFA Common Procedure Coding System
MACSIS	Multi-Agency Community Services Information System
MMIS	Medicaid Management Information System
OAC	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
ODMH	Ohio Department of Mental Health
ORC	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State and the Ohio Department of Mental Health jointly reviewed Medicaid payments made to Netcare Corporation, doing business at 199 South Central Avenue, Columbus, Ohio. As a result of the review, we identified $255,051.80 in payments for which the Provider was not eligible for reimbursement under the Ohio Administrative Code (OAC). These resulted from duplicate Medicaid claims, missing and unsigned documentation in support of claims, incorrect billing for mental health services claimed by Netcare Corporation.

We also identified questioned costs of $624,515.16 because the Provider billed and was reimbursed for "crisis intervention" services that could have been more appropriately billed as "residential services" and questioned costs up to $1,194,202.83 because the Provider failed to bill third party insurers before billing Medicaid. We are recommending that the Department of Mental Health determine whether the questioned costs should be recovered. We are also recommending that the Department of Mental Health review the rules regarding crisis intervention services to determine whether they appropriately define reimbursement requirements.

BACKGROUND

In accordance with Section 117.10 of the Ohio Revised Code, the Auditor of State performs reviews to assess Medicaid providers' compliance with federal and state claims reimbursement rules. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients. The Auditor's office performs these reviews in cooperation with state agencies, such as the Ohio Department of Mental Health, that has responsibility for administering a specific aspect of the Medicaid program.

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federal/state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. The Ohio Department of Job and Family Services (ODJFS) administers the Medicaid program in Ohio.

ODJFS' Medicaid Provider Handbook, General Information, Section II, Subsection (B), Chapter 3334, states in part, "Medical necessity" is the fundamental concept underlying the Medicaid program. A physician or medical facility must render or authorize medical services within the scope of their licensure and based on their professional judgment of those services needed by an individual. "Medically necessary services" are services which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice.

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection (B), and OAC Section 5101:3-1-172 (E), providers are required to "Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years form the date of receipt of payment or until any initiated audit is completed, whichever is longer."

Pursuant to Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B (6), (OAC Section 5101-3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

In addition, rule 5101:3-1-29 (C) of the OAC states: "In all instances of fraud or abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

"Abuse" is defined in rule 5101:3-1-29 (B) as ". . . those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the medicaid program . . . "

The Ohio Department of Mental Health

The Ohio Department of Mental Health (ODMH) oversees the operation of more than 500 not-for-profit community mental health agencies through 50 county-level boards. About 265 community mental health agencies are Medicaid providers. The boards, established by legislation in 1967, function as the "Local Mental Health Authorities" and provide the funding, planning and monitoring for all services provided through the community agencies. Most boards oversee both mental health and addiction services as Alcohol, Drug Addiction and Mental Health (ADAMH) Service Boards. ODMH currently provides services to 250,000 people, including more than 75,000 adults who are severely disabled by mental illness and 70,000 children.

Providers of mental health and addiction services submit claims for reimbursement to the local ADAMH board. The claims are then entered into the Multi-Agency Community Services Information System (MACSIS), which tracks all mental health and addiction services provided to clients. After the claims are entered by the local board, the Ohio Department of Mental Health extracts those claims which contain services provided to Medicaid recipients and submits them to ODJFS for payment. ODJFS utilizes the Medicaid Management Information System (MMIS) to pay each claim. Payments to the providers flow back to ODMH and then to the local boards, who pay the individual providers for services rendered.

Netcare Corporation

Netcare Corporation is the largest provider of mental health services in Franklin County. Formed in 1996, it serves as the "front door" for mental health services in the county by providing a single point of access to mental health services and linking clients in need to other mental health and alcohol/drug addiction agencies around the county. Netcare Corporation provides a multitude of mental health services, such as a 24-hour crisis hotline, an on-site crisis intervention service program, a crisis stabilization unit, a community crisis response program, behavioral assessments, older adult services, and other mental health programs. Netcare also maintains an eight bed off-site facility called the Miles House.

PURPOSE, SCOPE AND METHODOLOGY

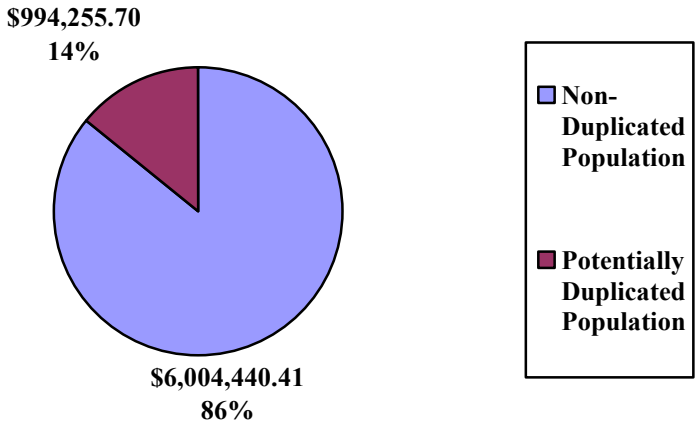
Our review was performed in cooperation with the Ohio Department of Mental Health, as part of a statewide project to detect potential duplicate

payments (two or more reimbursements for the same service to the same recipient on the same date) by utilizing a computer program to review each provider's claims.

We identified potential duplicate payments through an analysis of all mental health providers' claims history from ODMH's Multiple Agency Community Services Information System (MACSIS), which lists services billed to and paid by Medicaid. This computerized claims data includes patient name, date of service, type of service performed and length of service.

The scope of our review included claims that were identified as potential duplicate payments for which the Provider was paid by Medicaid during the period from January 1, 1999 to June 30, 2001. Our initial computer analysis of the Provider's claims history for the audit period identified $994,255.70 in potential duplicate payments (or 14 percent) out of the $6,998,696.11 in reimbursements the Provider received during the audit period. About 98 percent ($979,005.15) of the $994,255.70 in potential duplicate payments involved claims for "crisis intervention" services, which during our audit period were defined by Section 5101:3-27-02 (C) (6) of the OAC as "… a face-to-face response to a crisis or emergency situation experienced by an individual, significant others, or community system."[1]. The balance of the potential duplicate payments were "pre-hospitalization screenings" billed as procedure code M112, and "diagnostic assessments" billed as procedure code M121.

Chart 1: Population of Netcare Paid Claims and Amount of Potential Duplicates Found



Source: AOS analysis of ODMH MACSIS claims paid by Medicaid for Netcare Corporation, January 1, 1999 through June 30, 2001

We informed the Provider by letter they had been selected for this review, and an Entrance Conference was held on February 6, 2002 with Bobbe Fulton, President. Initially, we explained the purpose of the review was to determine whether the Provider filed claims for and was reimbursed two or more times for the same Medicaid service. Subsequently, after discussing the Provider's billing practices and reviewing the Provider's records, we raised additional questions about the appropriateness of the Provider's claims for crisis intervention services, and whether

[1] This rule was amended as of July 15, 2001.

the Provider met requirements for billing third party insurers before receiving Medicaid reimbursements.

To facilitate an accurate and timely review of paid claims, we selected a statistically random sample of 133 potentially duplicated service dates. The 133 service dates represented 882 crisis intervention services. We also performed a census (a full review) of all potentially duplicated pre-hospitalization screenings (18 service dates totaling $3,650.24) and diagnostic assessments (63 service dates totaling $11,600.31).

While analyzing the Provider's paid claims data, we noted instances where the Provider billed for providing more than 12 hours of service to a recipient in one day. Because we questioned the circumstances under which a Provider might provide such extensive services, we also reviewed documentation supporting these claims. During our review period, we identified 84 instances, involving 323 services and $81,268.88 in reimbursements, where the Provider billed for providing more than 12 hours of service to a recipient in one day.

The records review involved comparison of mental health records maintained by the Provider with the claims payment history from MACSIS. We requested from the Provider all documentation which fully disclosed all services rendered. During the on-site examination, we reviewed, among other documents, the Provider's contact logs and medication reports in the patient record, which show the nature of service provided and how it relates to the patient's Plan of Care.

During the course of our field work, we also learned that the Provider does not submit claims for mental health services to third-party insurers. Because by law, Medicaid is a "payer of last resort", we also analyzed the Provider's paid claims history for the review period to identify Medicaid reimbursements for services to recipients who also had some form of third party insurance coverage. The bulk of this coverage was to recipients who were also eligible for Medicare.

This audit was performed between February 2002 and November 2002 in accordance with government auditing standards.

FINDINGS

In all, we identified $255,051.80 in findings from our review. We identified findings in four areas: (1) Invalid Crisis Intervention Claims for Miles House services, (2) Undocumented Services and Duplicate Payments in the Crisis Intervention Sample**,** (3) Undocumented Services and Duplicate Payments for Pre-Hospitalization Screenings and Diagnostic Assessments, and (4) various issues associated with claims for service claimed for more than a 12-hour period. We are also questioning (1) claims paid to Netcare Corporation for crisis intervention services where it is questionable that crisis interventions were performed and (2) claims where the Provider did not bill third-party insurances. A discussion of each area follows.

Billing for Uncertified Crisis Intervention Services at Miles House

ODMH, in accordance with Sections 5119.01(H) of the Ohio Revised Code, certifies providers who meet minimal standards for providing mental health services. The types of certified services include Forensic Evaluation, Crisis Intervention, Community Support, Pre-Hospitalization, Diagnostic Assessment, Medication Somatic, Mental Health Education, and Other Mental Health Services. Each Netcare facility has a separate certification that specifies the scope of allowable services. Services provided at the Netcare facility known as Miles House are limited to "Residential Services", which are not reimbursable by Medicaid. Residential services include housing in a controlled environment, but do not include crisis intervention services. Therefore, the Miles House facility is not certified to provide and be reimbursed by Medicaid for crisis intervention.

We reviewed the Provider's records to determine if the Provider billed for crisis intervention services at the Miles House facility. We found 254 of the 882 services billed as crisis intervention services were for clients located at the Miles House facility. The Provider can not bill for crisis intervention services at Miles House.

We projected the error rate for the 254 services billed at Miles House as crisis intervention across the total population of potentially duplicated crisis intervention services and identified findings of $219,734.56, which represents the amount reimbursed by Medicaid.

Undocumented Services and Duplicate Payments in the Crisis Intervention Sample

According to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B (6) (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

In our sample of crisis intervention services, we found 2 services where the Provider did not supply any documentation to support the services rendered. Therefore, we could not determine if the services were performed or medically necessary. In addition, we found that 13 services were duplicated.

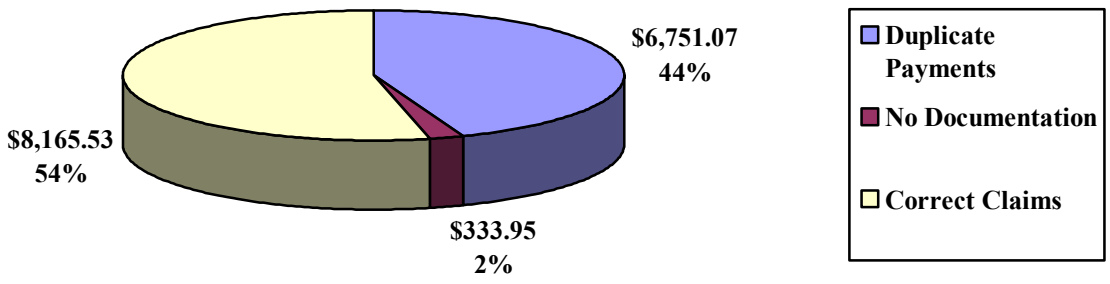
We projected the error rate for the 15 services that were undocumented or duplicated across the total population of potentially duplicated crisis intervention services by calculating the correct amount reimbursed to the Provider and thereby determining the amount overpaid. This resulted in projected findings of $4,875.25.

Undocumented and Duplicate Pre-Hospitalization Screenings and Diagnostic Assessments

As noted in the methodology section, we reviewed supporting documentation associated with $15,250.55 in potential duplicate payments for pre-hospitalization screening and diagnostic assessments claims. Our review identified $333.95 in findings because the documentation did

not exist to support that services were provided, and $6,751.07 in findings because a portion of the reimbursement was a duplicate payment. Chart 2 shows the breakout of findings in this category.

Chart 2: Findings in the Pre-Hospitalization Screening and Diagnostic Assessment Census

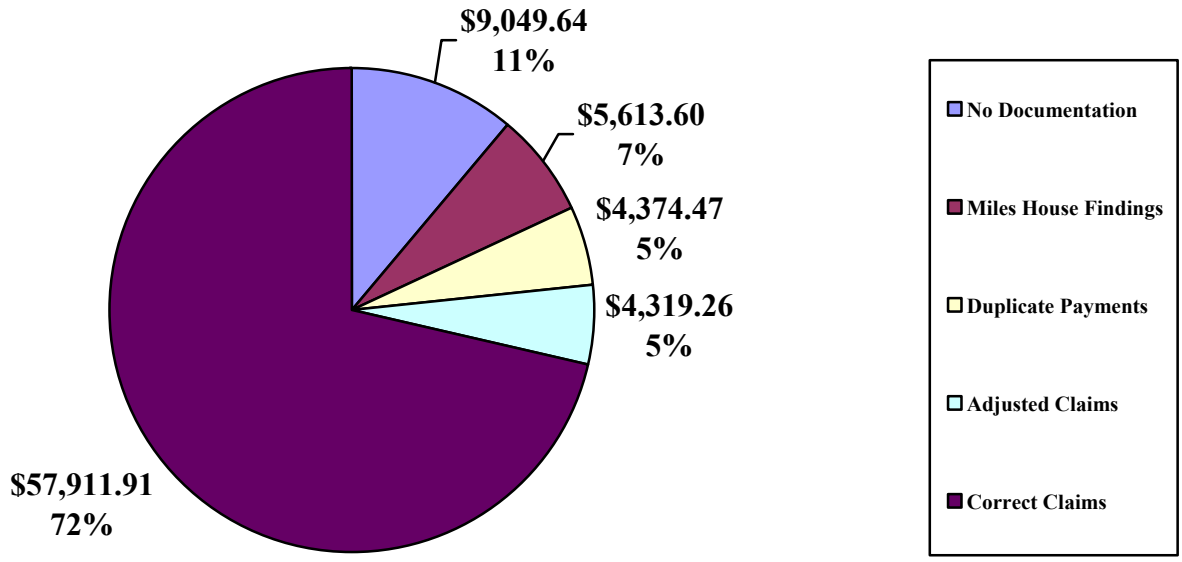


Source: Potentially Duplicated Pre-Hospitalization Screening and Diagnostic Assessment Claims paid by Medicaid for Netcare Corporation, January 1, 1999 through June 30, 2001

Unsupported and Incorrectly Billed Claims for Over 12 Hours of Service

Our review of 84 instances in which the Provider was reimbursed $81,268.88 for over 12 hours of service to the same recipient on the same day identified findings in four areas: $9,049.64 for services that were missing supporting documentation, $4,374.47 for duplicate payments, $4,319.26 for incorrectly billed services, and $5,613.60 for crises intervention services performed at the Mile House facility (see above discussion). The incorrectly billed services included instances where the Provider incorrectly billed the time spent on telephone calls. For example, in one instance, the Provider billed for 15 hours of telephone consultation when 15 minutes should have been billed. Findings for these four deficiencies totaled $23,356.97. Chart 3 breaks out the findings for this category.

Chart 3: Findings in the Hours Over Twelve Census



Source: Recipient dates of service with more than 12 hours of service charged paid by Medicaid for Netcare Corporation, January 1, 1999 through June 30, 2001

QUESTIONED COSTS

Nature of Services Billed as Crisis Intervention Services

Our review of the Provider's documentation to support billings for crisis intervention services led us to question whether the services represented "crises intervention", or should have more appropriately been billed as another type of mental health service. In particular, we noted instances where the Provider billed for crisis intervention when **(1)** clients were asleep, **(2)** clients were interacting with other clients, **(3)** clients were outside the facility smoking, and **(4)** clients were alone in their rooms resting.

Section 5111.022 of the Ohio Revised Code, defines crisis mental health services to be included in the state plan as "Unscheduled, emergency mental health services of a kind ordinarily provided to persons in crisis when rendered by persons supervised by a mental health professional."

The Department of Job and Family Services (ODJFS) pays for mental health services which are passed to it from the Department of Mental Health, and in that capacity also made rules concerning crisis intervention services. According to the Ohio Administrative Code, Section 5101:3-27-02 (C)(6) in effect during our review period (rules effective 9/28/95), "A 'crisis

intervention service' is a face-to-face response to a crisis or emergency situation experienced by an individual, significant others, or community system."

The Department of Mental Health and the OAC 5122-29-10; also defines crisis intervention services as those services which are:

> Provided face-to-face or by telephone and shall be available at an agency or in the person's natural environment, as appropriate to need. When the person served is a child or adolescent, the face-to-face interaction may also be with family members and/or parent, guardian and significant others when the intended outcome is improved functioning of the child or adolescent and when such interventions are part of the "ISP" [individualized service plan].

These definitions of crisis intervention led us to question some of services billed as crisis intervention by the Provider. For example, we noted the following services documented in patient charts:

Example 1:
Staff observed the client sleeping from 2:00 until 6:40 AM. The client took medication and ate breakfast from 6:40 AM to 7:45 AM. When asked if the client wished to return to the group home where the client resided, the client informed staff of being beaten while at the group home. The client was observed to have bruising. This conversation took place from 8:15 to 8:45 AM. From 9:30 to 9:45 AM the client was observed sleeping. At 10:30 to 12:05 PM, the client saw the doctor for evaluation and an inpatient stay was recommended. A staff member then called to find an inpatient facility to place the client in. No inpatient facility could take the client, so the client was held over again until Riverside Hospital could take the client the next day. From 12:05 to 10:00 PM, the client had lunch, remained in the holdover room, drew, and was pleasant with the staff. The client then fell asleep. At 10:45 PM and 11:45 PM the client was monitored sleeping in the room. The Provider billed for 16.5 hours of crisis intervention service.

Example 2:
The client arrived at Miles House at 1:10 PM from the Provider's crisis stabilization unit. The client denied the use of any illegal drugs or alcohol, and had not had hallucinations of any kind. The client had been in Miles House before according to staff notes. Agency staff monitored the client at 2:45 PM, at which time the client was outside of the facility smoking. The client was also monitored at 3:30 PM, 4:30, 5:40, and 6:30 PM (for fifteen minutes each time); the staff made note that the client was not in distress at the time. The client completed paperwork from 6:25 to 6:45 PM. A worker tried to get the client to talk at group meeting at 7:15 PM, but the client was tired. The client received medication at 8:10 PM. The client fell asleep sometime after this, and was monitored at 9:15, 10:20 and 11:15 for safety. Each service lasted 15 minutes. The Provider billed for 6.3 hours of crisis intervention service on this date.

Example 3:
The client, who was bipolar, came in with ex-spouse to discuss their pregnant daughter. The client stated that they do not know what to do about the situation. Both the client and the spouse completed a nursing assessment and denied any psychotic behavior. A treatment plan was

completed. The worker gave them information for their daughter and the client and spouse stated they felt better about talking. The Provider billed for 1.7 hours of crisis intervention.

Example 4:
The client came into the Provider at approximately 3:10 AM with auditory hallucinations. The Provider had the client complete paperwork and rest in an interview room until 8:00 AM. From 8:00 to 11:00 AM, the client was monitored for safety by agency staff. The client was described during this time as "resting with eyes closed." The client was also fed during this time and the doctor was told of the client's presence. From 11:50 AM to 1:30 PM, the client waited for the doctor in the interview room. From 1:30 to 2:20 the doctor evaluated the client and advised hospitalization. From 2:20 to 3:00 PM, a staff member called to find a hospital for the client, and the client was allowed to smoke outside the building. At 3:00, the client ate more food and waited for an ambulance to transport the client to the hospital. Sometime shortly after 3:00 PM, the client threatened to commit suicide unless the staff allowed the client to smoke, and the doctor advised staff to give the client a cigarette. Staff called for the ambulance a second time. From 4:30 to 6:00 PM, the client ate and waited for the ambulance. The client was picked up at 6:00 PM. The Provider billed 13.4 hours of crisis services for this client.

Of the 882 services we reviewed in our crisis intervention sample, 406 services were rendered while the clients were asleep, 261 services were rendered to recipients that were described as safety monitoring, and another 12 services were case management activities, such as referral phone calls and completing various paperwork. While we are not questioning whether the Provider in fact rendered services to their clients, we question the billing for crisis intervention services for activities similar to the ones described above. To qualify as crisis intervention, we had expected to see a face-to-face interaction mitigating a crisis situation. Some of these services may have been more appropriately billed as Residential Services, which are not paid by Medicaid. Others may not have been reimbursable at all.

As a result, we are questioning the $624,515.16 in reimbursements made to the Provider, which represents our projection of the amount reimbursed for crisis intervention services (See Appendix I.)

Non-Compliance with Third-Party Liability Regulations

According to the U.S. Code, Title 42, Chapter 7, Subchapter 19, Section 1396a, (a) (25), the state plan for medical assistance must provide

> (A) that the State or local agency administering such plan [the state plan] will take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan . . .

Furthermore, the U.S. Code, Title 42, Chapter 7, Subchapter 19, Section 1396b, (d)(2)(A and B), states

> (A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any

> overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.
>
> (B) Expenditures for which payments were made to the State under subsection (A) of this section shall be treated as an overpayment to the extent that the State of local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396(a) (25) of this title.

The Ohio Revised Code, Section 5111.02 (A) (3) states

> The department may deduct from payments for services rendered by a medicaid provider under the medical assistance program any amounts the provider owes the state as the result of incorrect medical assistance payments the department has made to the provider.

The Ohio Administrative Code, Section 5101:3-1-08 (B) indicates that

> Providers are expected to take reasonable measures to ascertain any third-party resource available to the recipient and to file a claim with that third party. In such instances, the department will not reimburse for the cost of services which are or would be covered by a third-party payer if billed to that third party payer. If the provider receives a third-party payment after having received a medicaid payment for the same items and services, the department must be reimbursed the overpayment. Under no circumstances may the provider refund any money received from a third party to a recipient.

Furthermore, Ohio Administrative Code, Section 5101:3-1-172 (C) states that the Provider should:

> Ascertain and recoup any third party resources available to the recipient prior to billing the Ohio Department of Job and Family Services. The Ohio Department of Job and Family Services will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set four in the 5101:3 of the Administrative Code.

This language is also included in the Ohio Medical Assistance Provider Agreement, which all providers sign to enroll in the Medicaid program. In signing, providers agree to abide by the rules set forth in the Medicaid Provider Handbook.

During our Entrance Conference on February 6, 2002, we were informed by the Franklin County ADAMH board that the Provider did not bill third-party insurances for any mental health services. Therefore, costs which could potentially be paid by another source were passed through the Board to the Medicaid program for reimbursement.

We subsequently spoke to the Provider, who confirmed that they do not bill third-party insurances. The Provider added that it is difficult to get insurance information from clients, because the clients that come in are in crisis and may not be in a state where they can give such information. In those cases, the clinical staff tries to obtain insurance information from the Medifax system. (However, at our exit conference, senior management told us Medifax information is usually invalid and they are reluctant to rely on it.) The Provider further stated that even if insurance information is obtained, most insurance carriers, including Medicare, do not cover crisis intervention services, or cover it only under restricted circumstances. Given, however, that the Provider should have billed other types of mental health services instead of crisis intervention, this argument may be moot.

We then reviewed the Provider's paid claims to determine if the Provider had billed claims to Medicaid which could have been paid by another source. We found that 19,853 claims for 988 recipients were eligible to be considered for payment by a third party; including 19,788 services that were eligible for payment under Medicare Part B. According to the Medicare Carriers Manual, Medicare pays for mental health services under certain circumstances. As the Provider does not determine third-party liability, we believe that up to $1,194,202.83 in Medicaid reimbursement can be questioned because the Provider failed to take reasonable measures to determine third-party liability before billing those services to Medicaid. This questioned cost would be reduced by the payment amount for any services ultimately determined not to be covered by third party payors.

STAKEHOLDER COMMENTS

To afford all affected parties an opportunity to review and comment on the results of our review, we provided a draft of this report to the Provider, the Franklin County ADAMH Board, and the Ohio Department of Mental Health. We then met with each party to discuss the contents of the report.

Comments from Netcare Corporation. The Provider believes it was certified to provide crisis intervention services at all of its locations, so it disagreed with our findings for these services provided at Miles House. We subsequently confirmed with the Department of Mental Health that certifications are intended to be "site specific", although the Department plans to further clarify this position by amending rules found in the Ohio Administrative Code.

The Provider also believes it had tacit approval to bill for crisis intervention services at Miles House because the Franklin County ADAMH Board approved this practice as part of the cost reporting mechanism in the Provider's budget. According to Netcare officials, these billings were part of an "unbundled" rate under which personnel costs were to be billed to Medicaid as crisis intervention services and other costs were to be billed to other funding sources.

Based on information supplied by the Provider, we were able to determine that the Provider had initiated correcting transactions for some of the duplicate payments we identified, so we adjusted our findings accordingly. The Provider stated that claims confirmed to be unallowable would be promptly reimbursed.

In response to our questioned costs for crisis intervention services, the Provider is seeking clarification of proper billing procedures from the Ohio Department of Mental Health and the Franklin County ADAMH Board. In the meantime, the Provider has revised its billing protocol for that portion of the services it calls "Crisis Holdover" activity. It said these services, which cover services provided to a patient after an initial crisis has passed, will be billed to non-Medicaid funding sources.

The Provider acknowledged that it does not routinely bill third party insurers, including Medicare, before billing Medicaid, in part because it believes that Medicare does not pay for the services except under restricted circumstances. According to Netcare's Vice President of Finance, the Franklin County ADAMH Board supported this practice until a January 2002 audit report called it into question. The Provider has agreed to begin billing third-party insurers in the future before billing Medicaid.

Comments from the Franklin County ADAMH Board. Board representatives are also seeking clarification from the Department of Mental Health on rules for billing crisis intervention services. They are concerned about the loss of federal matching funds if sources other than Medicaid are required to pay for these services.

The Board also assisted in verifying that adjusting entries for certain duplicate payments had been submitted to the MACSIS system.

Comments from the Department of Mental Health. The Department plans several actions in response to our recommendations. It plans to (1) perform additional review to make a determination on the recovery of questioned costs, (2) clarify billing requirements for crisis intervention services and third party insurer liability and (3) seek new rules relating to certification standards for crisis intervention services. The Department's full written comments, dated September 12, 2002, follow on the next page.

Ohio Department of Mental Health

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www.mh.state.oh.us

September 12, 2002

Mr. Johnnie L. Butts, Jr., Chief
Fraud, Waste and Abuse Prevention Division
State of Ohio, Office of the Auditor
35 North Fourth Street
Columbus, Ohio 43215

Dear Mr. Butts:

Thank you for meeting with me and members of my staff on August 28, 2002, to discuss your review of provider reimbursements made to Netcare Corporation. At the time of the meeting you requested an outline of future steps the Ohio Department of Mental Health will be taking as a result of the review. As you know, several of the findings are considered questioned costs that will require additional review and subsequent determinations by the department. The department is planning to take the following actions to bring this review to a satisfactory resolution and to clarify certain policies and procedures that have been at issue.

- Review the files submitted by the department and the provider to assure that claims identified as duplicates were actual duplicates in instances where findings were listed as questionable costs.

- Amend the Ohio Administrative Code related to the certification of providers to clarify that each provider site needs to be certified for each service the provider wishes to render.

- Specify the correct procedure for the unbundling of services. This includes issuing appropriate guidance and revising the cost reporting mechanism to support the appropriate unbundling of services.

- Amend the Ohio Administrative Code related to the certification standards for Crisis Intervention.

- Research and issue guidance related to third party liability for payment of services.

Thank you for your continued cooperation and assistance. If you have further questions or concerns related to the Netcare review or the proposed actions the department will be taking as a result please contact Angie Bergefurd at 387-2983 or Brett Jones at 466-9982.

Sincerely,

Donald C. Anderson
Deputy Director
Administrative Services

APPENDIX I

**Table 1: Summary of Record Analysis of Netcare Corporation
For the Period January 1, 1999, to June 30, 2001
All Projections Done at a 95% Confidence Level**

Description	Audit Period January 1, 1999, to June 30, 2001
Undocumented Services and Duplicate Payments in the Crisis Intervention Sample	
Type of Examination	Stratified Statistical Random Sample of 133 Potentially Duplicated Service Dates
Number of Mental Health Services Sampled	882
Amount Paid for Services Sampled	$64,115.61
Total Actual Paid by Medicaid for Crisis Intervention Mental Health Services	$975,990.36
Projected Correct Population Amount	$971,115.11
Upper Limit Correct Population Amount	$971,398.78
Lower Limit Correct Population Amount	$955,982.51
Projected Overpayment (Actual less Correct)	$4,875.25
Invalid Miles House Claims in the Crisis Intervention Sample	
Type of Examination	Stratified Statistical Random Sample of 133 Potentially Duplicated Service Dates
Number of Mental Health Services Sampled	882
Amount Paid for Services Sampled	$64,115.61
Total Actual Paid by Medicaid for Crisis Intervention Mental Health Services	$975,990.36
Projected Correct Population Amount	$756,255.80
Upper Limit Correct Population Amount	$850,531.08
Lower Limit Correct Population Amount	$661,980.52
Projected Overpayment (Actual less Correct)	$219,734.56
Questioned Costs	
Type of Examination	Stratified Statistical Random Sample of 133 Potentially Duplicated Service Dates
Number of Mental Health Services Sampled	882
Amount Paid for Services Sampled	$64,115.61
Total Actual Paid by Medicaid for Crisis Intervention Mental Health Services	$975,990.36
Upper Limit at 95% Confidence Level	$733,351.24
Lower Limit at 95% Confidence Level	$515,679.08
Projected Questioned Costs	$624,515.16

Note: The population totals in this table have been adjusted to take into account claims that were reversed by ODMH subsequent to initial payment.

APPENDIX I (continued)

The Federal Financial Participation portion of our findings represents that portion of Medicaid costs (generally about 59 percent) that was funded by the federal government. It also represents the amount charged to the Ohio Department of Job and Family Services by the Ohio Department of Mental Health. The balance represents costs paid by local funds through the Franklin County ADAMH Board. The federal share of our findings was calculated by multiplying the error rate for claims in our population times the federal share amount for those claims.

Table 2: Breakout of Audit Findings by Federal and Non Federal Share

Overpayment Category	Total Finding	Federal Share of Finding	Non Federal Share of Finding
Invalid Crisis Intervention Claims at Mile House	**$219,734.56**	**$129,492.17**	**$90,242.39**
Duplicate and Undocumented Crisis Intervention Claims	**$4,875.25**	**$2,852.18**	**$2,023.07**
Duplicate and Undocumented Pre-Hospital Screenings & Diagnostic Assessments	**$7,085.02**	**$4,193.90**	**$2,891.12**
Undocumented, Duplicated, and Other Incorrectly Billed Claims for Over 12 Hours of Service	**$23,356.97**	**$13,673.79**	**$9,683.18**
TOTALS	**$255,051.80**	**$150,212.04**	**$104,839.76**

PROVIDER REMITTANCE FORM

Make your check payable to the Treasurer of State of Ohio and mail check along with this completed form to:

Ohio Department of Mental Health
Attn: Mr. Donald Anderson, Deputy Director
Administrative Services
30 East Broad Street, 8th Floor
Columbus, Ohio 43266-0414

Provider Name & Address:	**Netcare Corporation** **199 South Central Avenue** **Columbus, Ohio 43223**
Provider Number:	2589 (MACSIS Identifier)
Review Period:	January 1, 1999, to June 30, 2001
AOS Finding Amount:	$150,212.04
Date Payment Mailed:	
Check Number:	

IMPORTANT:
To ensure that our office properly credits your payment, please also fax a copy of this remittance form to: Charles T. Carle at (614) 728-7398

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PROVIDER REMITTANCE FORM

Make your check payable to the Franklin County ADAMH Board and mail the check along with this completed form to:

Mr. David A. Royer, Chief Executive Officer
Franklin County ADAMH Board
447 E. Broad Street
Columbus, Ohio 43215

Provider Name & Address:	**Netcare Corporation** **199 South Central Avenue** **Columbus, Ohio 43223**
Provider Number:	2589 (MACSIS Identifier)
Review Period:	**January 1, 1999, to June 30, 2001**
AOS Finding Amount:	$104,839.76
Date Payment Mailed:	
Check Number:	

IMPORTANT:
To ensure that our office properly credits your payment, please also fax a copy of this remittance form to: Charles T. Carle at (614) 728-7398

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STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140
Telephone 614-466-4514
800-282-0370
Facsimile 614-466-4490

NETCARE CORPORATION

FRANKLIN COUNTY

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
NOVEMBER 7, 2002