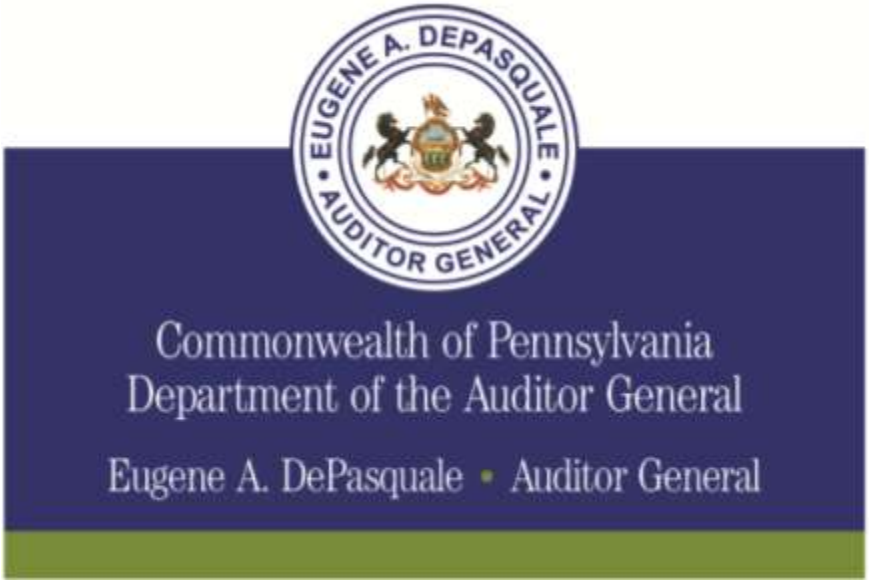
PERFORMANCE AUDIT

Clarks Summit State Hospital

Lackawanna County, Pennsylvania

October 2014



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EUGENE A. DEPASQUALE
AUDITOR GENERAL

Honorable Tom Corbett
Governor
Commonwealth of Pennsylvania
Harrisburg, Pennsylvania 17120

Dear Governor Corbett:

This report contains the results of a performance audit of the Clarks Summit State Hospital (Clarks Summit) of the Department of Public Welfare (Department) for the period July 1, 2009, through June 30, 2013, unless indicated otherwise in the report. The audit was conducted pursuant to Section 402 of The Fiscal Code and in accordance with generally accepted government auditing standards.

This report revises our report dated August 28, 2014. Additional information received by my office resulted in the modification of Recommendation No. 11 of Finding No. 5 contained in this report.

The report details our audit objectives, scope, methodology, findings, and recommendations. Our objectives were:

- To determine if Clarks Summit maximized Medicare Part B revenue; and

- To determine if Clarks Summit maintained effective controls over the monitoring of contracted medical services and whether the contract was cost effective.

Our audit resulted in the following findings that are detailed in the report:

Finding 1	Clarks Summit's psychiatrists and medical physicians did not visit patients in compliance with the expectations of the Department's Chief Psychiatric Officer.
Finding 2	Clarks Summit did not maximize Medicare Part B reimbursements.

Finding 3	Clarks Summit experienced a failure of internal controls related to the distribution of pneumococcal vaccinations.
Finding 4	Clarks Summit effectively monitored the medical contract for psychiatry services.
Finding 5	Clarks Summit's inability to hire a full-time psychiatrist resulted in the use of contracted services at an extra cost of approximately $150,000 per year.

We discussed the contents of the report with the management of the institution, and all appropriate comments are reflected in the report. We would like to thank the management and staff of Clarks Summit for the courtesy and professionalism they extended to us during the audit.

Sincerely,

Eugene A. DePasquale
Auditor General

October 1, 2014

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Clarks Summit State Hospital
Department of Public Welfare

Background Information

History, mission, and operating statistics

Department of Public Welfare

The Pennsylvania Department of Public Welfare (Department) operates six state hospitals for persons with serious mental illness. These hospitals provide special intensive treatment services for patients needing extended psychiatric inpatient services.[1] Within the Department, the Office of Mental Health and Substance Abuse Services oversees the six state hospitals. According to the Department's website, the hospitals operate under the following mission and vision statement.

> *Every individual served by the Mental Health and Substance Abuse Service system will have the opportunity for growth, recovery, and inclusion in their community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family members and friends.*[2]

The Office of Mental Health and Substance Abuse Services oversees behavioral health services, services provided to adults, and a wide range of services provided to children and adolescents. According to the Department's website, the current goals of the Office of Mental Health and Substance Abuse services are to:

- Transform the children's behavioral health system to a system that is family driven and youth guided.
- Implement services and policies to support recovery and resiliency in the adult behavioral health system.
- Assure that behavioral health services and programs support, recognize, and accommodate the unique needs of older adults.[3]

Admission of persons committed under the Mental Health Procedures Act[4] is made through the County Mental Health/Mental Retardation program after short-term treatment has been provided in the community.[5]

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[1] http://www.dpw.state.pa.us/foradults/statehospitals/index.htm Accessed: January 14, 2014.
[2] http://www.dpw.state.pa.us/dpworganization/officeofmentalhealthandsubstanceabuseservices/ Accessed: January 14, 2014, verified June 30, 2014.
[3] Ibid.
[4] 50 P.S. § 7101 *et seq.*
[5] http://www.dpw.state.pa.us/dpworganization/officeofmentalhealthandsubstanceabuseservices/deputysecretaryformentalhealthsubstanceabuseservices/index.htm Accessed: January 14, 2014, verified June 30, 2014.

County Mental Health System

Community mental health services are administered through county Mental Health/Mental Retardation (MH/MR) program offices. These offices are part of county government and are overseen by a county MH/MR administrator. The county MH/MR offices serve as a referral source. Most actual mental health services are delivered by local provider agencies under contract with the county MH/MR office. The county MH/MR office determines a person's eligibility for service funding, assesses the need for treatment or other services, and makes referrals to appropriate programs to fit treatment and/or other service needs.[6]

The Mental Health and Intellectual Disability Act of 1966,[7] as amended, requires the county MH/MR office to provide community mental health services, including short-term inpatient treatment, partial hospitalization, outpatient care, emergency services, specialized rehabilitation training, vocational rehabilitation, and residential arrangements.[8] MH/MR offices can also provide information about any additional mental health services the county offers.

There are a wide variety of mental health services available to children and adults. The cost of these services varies depending upon the type of service. Pennsylvania's Medical Assistance Program, either through a managed care organization or the traditional fee-for-service system, pays for many of these services when rendered to eligible individuals. People who use services, but who are not on Medical Assistance and do not have access to other insurance, are assessed on their ability to pay for those services by the county MH/MR office.[9]

Clarks Summit State Hospital

Clarks Summit State Hospital, which we refer to as Clarks Summit or the hospital in this report, is an extended acute care psychiatric hospital serving 11 counties in northeastern Pennsylvania. The facility is located

[6] http://www.dpw.state.pa.us/forchildren/omhsas/index.htm Accessed: January 14, 2014, verified June 30, 2014.
[7] In 2011, the General Assembly sought through Act 105 to modernize the act by updating and modernizing certain terminology, including among others, changing the title of the act from "The Mental Health and Mental Retardation Act of 1966" to the "The Mental Health and Intellectual Disability Act of 1966" and for example, adding a definition of "Intellectual disability."
[8] 50 P.S. § 4101 *et seq.*
[9] http://www.dpw.state.pa.us/provider/mentalhealth/countymentalhealthsystem/index.htm Accessed: January 14, 2014, verified June 30, 2013.

approximately eight miles north of the city of Scranton in a suburban setting.[10]

The table below presents unaudited Clarks Summit operating statistics for the fiscal years ending June 30, 2010, through June 30, 2013.

	Fiscal year ending June 30,			
	2010	2011	2012	2013
Operating expenditures[11]				
State	$43,788,789	$45,129,169	$44,495,371	$45,008,647
Federal	7,795,384	7,421,405	7,039,251	7,436,960
Total Operating Expenditures	$51,584,173	$52,550,574	$51,534,622	$52,445,607
Employee complement at year end[12]	566	585	539	539
Average daily patient population [13]	212	220	219	219
Bed Capacity at year end	242	226	225	222
Actual patient days of care	77,247	80,101	79,974	79,935
Available patient days of care[14]	88,330	82,490	82,350	81,030
Percent utilization (based on days of care)	87%	97%	97%	98%
Average patient cost per day[15]	$668	$656	$644	$656
Average patient cost per year[16]	$243,820	$239,440	$235,704	$239,440

[10] http://www.dpw.state.pa.us/foradults/statehospitals/clarkssummitstatehospital/index.htm Accessed: January 14, 2014, verified June 30, 2014.
[11] Operating expenses were recorded net of fixed assets, an amount that would normally be recovered as part of depreciation. In addition, regional level direct and indirect costs were not allocated to the totals reported here.
[12] Employee complement includes salary and wage employees.
[13] Average daily patient population was calculated by dividing the actual patient days of care for the year by the number of calendar days in the year.
[14] Available patient days of care were calculated by multiplying the bed capacity at year end by the number of calendar days in the days in the year. There were 366 days for the fiscal year ending June 30, 2012.
[15] Average patient cost per day was calculated by dividing the total operating expenses by the combined actual patient days of care for nursing and domiciliary care. Note: This rate is not the same as a certified per diem rate since the total operating expenses exclude depreciation and allocated direct and indirect costs from region and department level office.
[16] Average patient cost per year was calculated by multiplying the average patient cost per day by the number of calendar days in the year. There were 366 days for the fiscal year ending June 30, 2012.

Objectives, Scope, and Methodology

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our performance audit of Clarks Summit had two objectives. The specific audit objectives were as follows:

One To determine if Clarks Summit maximized Medicare Part B revenue. (Findings 1, 2, and 3)

Two To determine if Clarks Summit maintained effective controls over the monitoring of contracted medical services and whether the contract was cost effective. (Findings 4 and 5)

Unless indicated otherwise, the scope of the audit was from July 1, 2009, through June 30, 2013.

To accomplish our objectives, we obtained and reviewed records and analyzed pertinent regulations, policies, procedures, and agreements of the Commonwealth of Pennsylvania, the Department, and Clarks Summit. We interviewed various Department and facility management and staff. The audit results section of this report contains more details on the specific inquiries, observations, tests, and analyses for each audit objective.

We also performed inquiries, observations, and tests as part of, or in conjunction with, our current audit to determine the status of the implementation of the recommendations made during our prior audit. Those recommendations addressed absence without leave incident reporting, the maintenance work order system, controls over fixed assets, and employee pay incentives.

Clarks Summit management is responsible for establishing and maintaining effective internal controls to provide reasonable assurance that Clarks Summit is in compliance with applicable laws, regulations, contracts, grant agreements, and administrative policies and procedures. In conducting our audit, we obtained an understanding of Clarks Summit's internal controls. The controls included information systems controls that we considered to be significant within the context of our audit objectives. We assessed whether those controls were properly designed and implemented. Any deficiencies in internal controls that were identified

during the conduct of our audit and determined to be significant within the context of our audit objectives are included in this report.

Audit Results

In the pages that follow, we have organized our audit results into two sections, one for each objective. Each of the two sections is organized as follows:

- Statement of the objective
- Relevant regulations and policies
- Audit scope in terms of the period covered, types of transactions reviewed, and other parameters that define the limits of our audit
- Methodologies used to gather sufficient and appropriate evidence to meet the objective
- Finding(s) and/or observations
- Recommendation(s), where applicable
- Response by Clarks Summit management, where applicable
- Our evaluation of Clarks Summit's management's response, where applicable

Audit Results for Objective One

Medicare Part B

The objective

Objective one of our performance audit was to determine if Clarks Summit maximized Medicare Part B revenue.

Relevant regulations and policies

Based on the Social Security Administration's booklet regarding its regulations, patients who are age 65 or older or patients younger than age 65 who for example, have been receiving Social Security disability benefits for 24 consecutive months may be eligible to participate in the Medicare Part B insurance program.[17] Therefore, Clarks Summit's patients who qualify under these criteria could participate in the Medicare Part B program. Upon admission and yearly thereafter, Clarks Summit's revenue office staff utilizes the Commonwealth's Medical Assistance Office's Income Eligibility Verification System to determine a patient's eligibility.

Social Security regulations allow Clarks Summit to seek reimbursement for each eligible patient who receives qualifying Medicare Part B procedures performed by its psychiatrists and medical physicians.[18]

Clarks Summit's Medical Staff Rules and Regulations (hospital rules and regulations) establish minimum patient management requirements for psychiatric and non-psychiatric (medical) physicians. According to these hospital rules and regulations, after completion of a patient's two-month admission period, psychiatric and medical physicians must evaluate each patient without acute medical problems, such as bronchitis or pneumonia, at least once per month and complete progress notes to document each visit.[19]

After delivering services to eligible patients, Clarks Summit's physicians record the visits/procedures in the patients' medical charts and document each billable Medicare procedure on an encounter form. Nursing staff from each of the hospital's seven units collects the encounter forms at the end of each month and forwards the forms to the medical records office. Each month, staff from the medical records office completes a review of the encounter forms as well as the patients' charts. The encounter forms

[17] http://www.ssa.gov/pubs/EN-05-10043.pdf , see pages 4, 5, Accessed: December 6, 2013, verified June 30, 2014.
18 Ibid.; *see* also pertinent guidance from the Center for Medicare & Medicaid Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf. Accessed: June 17, 2014, verified June 30, 2014.
[19] Clarks Summit State Hospital, Medical Staff Rules and Regulations, "Patient Management," Section III, dated November 1998 and revised January 2012.

are then forwarded to Clarks Summit's revenue office for billing to the Center for Medicare and Medicaid Services (Medicare). The revenue office electronically submits bills for eligible procedures to Medicare for reimbursement.

During our audit period, July 1, 2009, through June 30, 2013, Clarks Summit received reimbursement of $1,079,030 for eligible Medicare Part B procedures.

Scope and methodologies to meet our objective

To satisfy this objective, we performed the following:

We reviewed the Social Security Administration's Medicare Part B eligibility regulations. Also, we reviewed Clarks Summit's Medical Staff Rules and Regulations to determine the minimum number of visits the psychiatrists and medical physicians must provide to each patient monthly.

We interviewed Clarks Summit's facility reimbursement officer, abstractor,[20] medical records director, quality assurance risk management director, chief of clinical services, chief of psychiatry, and the chief executive officer/superintendent. In addition, we interviewed the chief psychiatric officer responsible for directing clinical programming at all of the state hospitals and management staff from the Department's Bureau of Financial Operations-Reimbursement Operations Section, including the administrator and management analyst. These interviews were conducted to obtain an understanding of Medicare Part B eligibility requirements, Clarks Summit's policies and procedures regarding Medicare Part B, medical services provided to patients, and the processing of eligible Medicare Part B encounter forms.

For the period June 1, 2013, through June 30, 2013, we reviewed Clarks Summit's list of 223 active patients who were enrolled in Medicare Part A[21] and/or Part B and/or other insurance programs. We determined that 138 of the 223 patients were enrolled in Medicare Part B.

We also verified that Clarks Summit's revenue office staff was properly determining the Medicare Part B eligibility of each patient admitted to

[20] Abstractors are responsible for reviewing patient treatment charts and ensuring that all billable procedures are documented on each patient's medical chart and recorded on encounter forms for Medicare billing purposes

[21] Medicare Part A insurance helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care and hospice care. *See* http://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html Accessed: June 17, 2014.

Clarks Summit. We selected for review eight (8) of the eighty (80) patients who were not enrolled in the Medicare Part A or Part B program. Using information from the Commonwealth's "Income Eligibility Verification System." We ensured that none of the eight (8) were eligible for Medicare Part A or B.

In addition, we interviewed Clarks Summit's social worker manager to determine why five of the 223 active patients were enrolled in Medicare Part A and not enrolled in Medicare Part B. (See Finding 3.)

We verified that all of the psychiatrists and medical physicians employed at Clarks Summit as of August 28, 2013, were enrolled in the Medicare Part B program. Psychiatrists and medical physicians must be enrolled in the Medicare program which will provide them a unique national provider identifier (NPI) number. The NPI number is required for all billing transactions. Without this number, Medicare will not provide reimbursement for services.

We reviewed the Department's quarterly fee-for-service reports[22] for fiscal years ending June 30, 2010, 2011, and 2012, and the most recently issued quarterly fee-for-service report, which was for the period April 1, 2012, through March 31, 2013, to identify procedures that Clarks Summit did not bill Medicare, and compare with other state mental hospitals. We also reviewed the physician activity reports[23] for the period April 1, 2012, through March 31, 2013, to determine the average number of approved Medicare Part B billings submitted by each psychiatrist and medical physician per Medicare Part B eligible patient per unit per month. As of March 31, 2013, the ending period of our analysis, 135 patients at Clarks Summit were enrolled in the Medicare Part B program.

We reviewed the monthly Medicare Part B Abstracting Reports[24] from October 2012, the first time the report was prepared and issued, through June 2013, to determine the amount of missed billings by each of the hospital's psychiatrists and medical physicians.

[22] Quarterly fee-for-service reports compare the Medicare Part B data of all of the state-owned psychiatric hospitals across the Commonwealth and include reports such as the fee-for-service procedure statistical reports and Clarks Summit physician activity reports. These reports are generated through the "MediB Log" which is the Department of Public Welfare's in-house accounting program that tracks Medicare Part B billings and produces financial reports and statistical reports related to Medicare Part B billings and reimbursements for each state hospital.

[23] Physician activity reports list the number of Medicare Part B procedures billed and approved by Medicare and the amount of reimbursement received from Medicare for each of Clarks Summit's physicians over a specified time period.

[24] Abstracting reports list the number of billable procedures each psychiatric and medical physician failed to record onto each Medicare Part B eligible patient's encounter form on a monthly basis. Clarks Summit's abstractor compiles these reports after conducting the monthly review of the patients' medical charts.

Finding 1 Clarks Summit's psychiatrists and medical physicians did not visit patients in compliance with the expectations of the Department's Chief Psychiatric Officer.

Clarks Summit physicians failed to conduct patient visits in accordance with the expectations of the Department of Public Welfare's Chief Psychiatric Officer (CPO). The CPO is responsible for providing medical mental health service guidance to all six state hospitals, including Clarks Summit. According to the CPO, psychiatrists and medical physicians should visit with patients, on average, once per week. Visiting patients more often could also help improve the quality of care being offered to those patients. The CPO stated the weekly patient visits are billable under the Medicare "evaluation and management" procedure codes because the visits are considered medically necessary due to the patients' hospitalization status.

Our review indicates that patients at Clarks Summit were not seen weekly by their psychiatrists and medical physicians. Also, Clarks Summit's Medical Staff Rules and Regulations (rules and regulations) have not been updated to require weekly patient visits. Instead, the current rules and regulations require psychiatric and medical physicians to evaluate patients without acute medical problems at least once per month.

Also, since 2009, Clarks Summit's chief of clinical services has verbally communicated to the hospital's medical staff the following expectations for patient care:

- Psychiatrists are to visit each patient twice per month.
- Medical physicians are to visit patients with chronic conditions, such as diabetes or hypertension, once per month.
- Medical physicians are to visit patients with acute medical problems as often as necessary.
- Medical physicians are to visit each patient without chronic or acute medical problems once per month.

Neither Clarks Summit's Medical Rules and Regulations nor the chief of clinical services' expectations complied with the expectations of the CPO that patients be seen, on average, weekly by their psychiatrists and medical physicians.

In addition, Clarks Summit's Medicare billing indicates the weekly visits did not occur. Because these visits are billable, they should be reflected in Clarks Summit's Medicare billing. One patient visit a week results in 4.33

visits per month (52 visits per year). We examined Clarks Summit's Medicare Part B billing during our audit period and we determined that Clarks Summit billed Medicare for an average of 1.59 visits per month (19 visits per year). This indicates that psychiatrists and medical physicians saw patients about one-third (1/3) as often as expected by the CPO.

The table on page 46 in the Appendix of this report details the results of our analysis of Clarks Summit's Medicare Part B patient by unit and physician activity report for the period April 1, 2012, through March 31, 2013,[25] and it provides the average number of monthly Medicare Part B billings by each physician[26] per eligible Medicare Part B patient on the physician's unit.[27]

Because patients did not receive weekly visits from their psychiatrists and medical physicians, Medicare Part B revenues were not maximized. In addition, increasing patient visits could help add to the quality of patient care and patient care is of primary importance. Patient visits must occur with the frequency expected by the CPO.

Recommendations For Finding 1

1. Clarks Summit's medical department management should revise the Medical Staff's Rules and Regulations to comply with the expectations of the Department of Public Welfare's CPO which would require both psychiatric and medical physicians to visit each of their patients, on average, once per week.
2. Clarks Summit's medical department management should establish internal controls to monitor and ensure that all psychiatrists and physicians are meeting the patient care expectations of the hospital's chief of clinical services by properly documenting patient interactions.
3. DPW should develop a procedure to ensure that future guidance for documenting required patient interaction and visits is formally communicated to Clarks Summit's medical staff and made part of the Medical Staff Rules and Regulations.

[25] We analyzed this time period because when we began our analysis, the report for this time period was the most recently available report issued by the Department of Public Welfare.
[26] We did not include the billings of Clarks Summit's chief of clinical services and chief of psychiatry.
[27] According to the chief psychiatric officer for all of the state hospitals, each unit of a hospital consists of an average of 30 patients. According to the chief psychiatric officer, generally, the hospital assigns to each psychiatrist, the responsibility for one unit and to each medical physician, the responsibility for two units.

Clarks Summit State Hospital
Department of Public Welfare

Management Response

Recommendation 1: Partial Agreement

a. Clarks Summit State Hospital is staffed by physicians that have two distinct areas of practice.

- The medical physician has completed a residency program in Family Medicine or Internal Medicine, which meets the requirements of the American Board of Medicine or American Osteopathic Board of Medicine, and possesses a current Pennsylvania medical license, DEA certification, and Basic Life Support Certificate. The medical physician is primarily responsible for care and treatment of all physically ill consumers and related medical functions of assigned units ensuring consumer safety at all times.

- The psychiatrist has completed a residency program in Psychiatry which meets the certification requirements of the American Board of Psychiatry and Neurology, or the American Osteopathic Board of Neurology and Psychiatry, and possesses a current license to practice medicine in the Commonwealth of Pennsylvania, DEA certification, and Basic Life Support Certificate. The psychiatrist provides care and treatment to chronically mentally ill consumers, and works as unit Director and head of a treatment team. Duties also include full professional responsibility for diagnosis, determination of appropriate treatment, and leadership in the implementation of treatment plans.

b. Medical and psychiatric physicians met the minimum performance standards consistent with the ratified Rules and Regulations that were in effect at the time of the performance audit. There are minimum standards set forth in the rules and regulations, which are consistent with the standards set forth in CMS guidelines, with the expectation that additional consumer visits occur based on a consumer's clinical presentation and medical necessity. A consumer who has a chronic and stable presentation will not be assessed as often as one who is acutely ill or has a frequently changing clinical presentation.

c. In a teleconference among the statewide Chief Psychiatric Officer (CPO) and Clarks Summit State Hospital (CSSH) Clinical Services leadership and the CSSH CEO, the CPO shared information that he had talked with a representative from the audit team and explained that medical necessity for interventions from medical physicians may differ in frequency than those of psychiatrists, based on clinical presentation.

d. Evaluation and Management (E/M) Services Guidelines are used to select a level of E/M Service when reporting medical services and procedures performed by physicians. A consumer's nature of the presenting problem, interval history, examination, medical decision making, counseling, coordination of care, and time are used to determine the appropriate level of service.[2]

e. CSSH Medical Staff Rules and Regulations will not be revised that both medical and psychiatric physicians visit their consumers, on average, once per week.

f. CSSH Medical Staff Rules and Regulations will be revised to reflect that psychiatrists will see consumers a minimum of twice monthly (for Medication Review and Treatment Team meeting), and for additional encounters as medically necessary. It is the expectation that while a consumer is receiving active treatment at CSSH there is an interaction with the psychiatrist no less than weekly. Where the threshold is met for a billable encounter, an E/M code will be assigned based on current AMA procedural code guidelines and a claim will be made for the reimbursement of professional services. Medical physicians will continue to see consumers a minimum of once monthly for Medication Review, and for additional encounters as medically necessary. Changes to the Medical Staff Rules and Regulations will be communicated to the Medical Staff.

g. It is agreed that education in Medicare Part B billable procedures will provide for enhanced development of skills related to the recognition of services provided as being appropriate for submission to Medicare. It will also serve to enhance skills of documentation requirements, as needed.

h. It is agreed that if and when further direction is formally given by the CPO, after additional statewide training and discussion, that the CSSH Medical Staff Rules and Regulations will be modified to reflect the decisions of OMHSAS leadership. It is anticipated that

the guidelines will be applied across the state hospital system with uniformity and consistency.

Recommendation 2: Partial agreement

a. Education in Medicare Part B billable procedures will enhance skills related to the documentation requirements, as needed, and the recognition of services performed as being appropriate for submission for reimbursement.

b. Clarks Summit State Hospital Clinical Services leadership has cooperatively worked with the Medical Records Department to establish internal controls to monitor and ensure that all psychiatrists and medical physicians are meeting the performance standards consistent with the current ratified Medical Staff Rules and Regulations.

c. To support enhanced monitoring relative to capturing eligible medical and psychiatric encounters, a CSSH abstractor will affix a Medicare Part B prompt on the chart to alert physicians to utilize the corresponding Medicare Part B documentation log.

d. The Medicare Part B documentation log has been placed in a standard location on all charts of consumers participating in Medicare Part B coverage.

e. The CSSH abstractor conducts monthly chart reviews of all consumers enrolled in Medicare Part B, to ensure that the encounters documented in the consumer chart are also recorded on the service log. The abstractor will add codes and dates for any missed billable encounter to the service log prior to submission to the Revenue staff. The Clinical Services leadership receives a copy of the Medicare Part B Abstracting Report and shares the information with all physicians to improve subsequent billing accuracy

f. The CSSH abstractor will also use key prompts from the Physician's Order Sheets to discern that a service has occurred. Follow through will be done to assess documentation and eligibility relative to Medicare Part B billing. This audit will be done monthly and the report will be forwarded to Clinical Services. Clinical Services leadership will facilitate and/or conduct remedial action that may be supported by audit findings. Documentation of the remediation will be maintained in the Clinical Services department.

g. CSSH Medical Staff Rules and Regulations will not be revised to require that both medical and psychiatric physicians visit their consumers, on average, once per week.

h. CSSH Medical Staff Rules and Regulations will be revised to reflect that psychiatrists will see consumers a minimum of twice monthly (for Medication Review and Treatment Team meeting), and for additional encounters as medically necessary. It is the expectation that while a consumer is receiving active treatment at CSSH there is an interaction with the psychiatrist no less than weekly. Where the threshold is met for a billable encounter, an E/M code will be assigned based on current AMA procedural code guidelines and a claim will be made for reimbursement of professional services. Medical physicians will continue to see consumers a minimum of once monthly for Medication Review, and for additional encounters as medically necessary. Changes to the Medical Staff Rules and Regulations will be communicated to the Medical Staff.

i. It is agreed that if and when further direction is formally given by the CPO, after additional statewide training and discussion, that the CSSH Medical Staff Rules and Regulations will be modified to reflect the decisions of OMHSAS leadership. It is expected that the guidelines will be applied across the state hospital system with uniformity and consistency.

Recommendation 3: Agree

a. In a teleconference among the statewide CPO, CSSH Clinical Services leadership and the CSSH CEO yielded support from the CPO to proceed with obtaining Medicare Part B Education for CSSH psychiatrists, medical physicians and abstractors. The education will be delivered initially and a refresher will be embedded into the CSSH annual training for all applicable staff. Education in Medicare Part B billable procedures will enhance skills related to the documentation requirements, as needed, and the recognition of services performed as being appropriate for submission for reimbursement.

b. Medicare Part B Billing Audit Reports will be discussed at monthly Medical Staff meetings. Clinical Services leadership will facilitate and/or conduct remedial action that may be supported by audit findings.

c. CSSH Medical Staff Rules and Regulations will be revised to reflect that psychiatrists will see consumers a minimum of twice

monthly (for Medication Review and Treatment Team meeting), and for additional encounters as medically necessary. It is the expectation that while a consumer is receiving active treatment at CSSH there is an interaction with the psychiatrist no less than weekly. Where the threshold is met for a billable encounter, an E/M code will be assigned based on current AMA procedural code guidelines and a claim will be made for reimbursement of professional services. Medical physicians will continue to see consumers a minimum of once monthly for Medication Review, and for additional encounters as medically necessary. Changes to the Medical Staff Rules and Regulations will be communicated to the Medical Staff.

Auditors' Conclusion

We are pleased that Clarks Summit State Hospital's management agreed in whole or in part with our recommendations and that management has already taken action to implement most of the recommendations. During our next audit, we will evaluate whether our recommendations have been implemented.

Finding 2 Clarks Summit did not maximize Medicare Part B reimbursements.

Our audit disclosed that Clarks Summit could receive additional Medicare Part B reimbursement if it took the following actions:

- Provided annual training to its abstractors and medical staff;
- Monitored documentation and billing of reimbursable procedures; and
- Performed weekly patient visits to comply with the expectations of the CPO.

Training and Monitoring

During the seven years 2007 through 2013, the Department of Public Welfare (DPW) provided only one Medicare Part B billable procedures training to Clarks Summit's psychiatrists, medical physicians (physicians) and abstractors. That training occurred in 2012. DPW has no training related to Medicare Part B scheduled in 2014. Subsequent to our audit, Clarks Summit's chief of clinical services conducted in-house Medicare Part B billing procedures training in November 2013. Training is critical for staff to stay current with Medicare Part B billing requirements, which include, but are not limited to, medical procedures that are billable (eligible encounters) and billing codes.

According to both the CPO and Clarks Summit's chief of clinical services, annual Medicare Part B training for the physicians and medical records staff acting as abstractors would likely increase Medicare Part B revenues.

During two separate interviews, Clarks Summit's chief of clinical services stated that the facility's physicians are not Medicare Part B billing experts and that he believes that Clarks Summit's physicians and the hospital's abstractors require annual training.

Clarks Summit's superintendent did implement an internal control process in an attempt to ensure all billable procedures documented in the patients' charts are recorded on encounter forms for billing.

There is no process to identify procedures that were performed but not recorded in the patients' charts. Recording of procedures in patient files is critically important for maintaining quality patient medical care and also in providing the ability to accurately bill any 3rd party provider coverage for the patient services provided.
Our audit found that Clarks Summit's abstractor conducts monthly reviews of the charts of all patients enrolled in the Medicare Part B program. The purpose of the review is to ensure that all eligible encounters documented by the physician on the patient's charts are also recorded by the physician on the encounter forms. If an eligible encounter from a patient chart was not recorded on the encounter form, the abstractor will add the missed encounter to the form for billing.

However, if the encounter is never recorded on the patient chart by the physician or if the abstractor does not recognize the encounter as billable, it will not be billed to Medicare. The abstractor then compiles a report referred to as the Medicare Part B Abstracting Report (abstracting report). The abstracting report is an internal document that lists the number of procedures each psychiatric and medical physician failed to record onto an encounter form.

Each month, Clarks Summit's chief of clinical services and chief of psychiatry receive a copy of the abstracting report and share the results with the psychiatrists and medical physicians to improve the billing accuracy for the following month.

Clarks Summit and Department officials both stated that without adequate training, the psychiatrists and medical doctors may not know what procedures are billable under Medicare Part B regulations. As a result, they might not document a billable procedure on the patient's chart. Medical procedures must be documented in the patient's chart in order to

be billed for reimbursement. In addition, the abstractor needs adequate training in order to identify and properly document all billable encounters that are recorded in the patient's chart.

Clarks Summit prepared its first abstracting report for physician services provided during the month of October 2012. Prior to that period, Clarks Summit's patient care coordinator reviewed the patients' medical charts for missed eligible encounters that needed to be added to the Medicare Part B billing. The patient care coordinator prepared a monthly Medicare Part B summary report. According to Clarks Summit's quality assurance risk management director, the summary report was not as detailed as the current abstracting report.

Our review of the abstracting reports for the period October 2012 through June 2013, found that although the reports indicate the number of missed billable procedures decreased from 247 in October 2012 to 131 in June 2013, Clarks Summit's physicians still continue to fail to record a substantial amount of billable procedures onto encounter forms. Eight of the 13 physicians missed, on average, 10 or more billings every month. The following chart illustrates the number of missed billings by each physician and the total number of missed billings for each month.

Missed Medicare Procedure Billings by Physician From October 1, 2012 to June 30, 2013[28]

Physician Type	Oct-2012	Nov-2012	Dec-2012	Jan-2013	Feb-2013	Mar-2013	Apr-2013	May-2013	Jun-2013	Total/Average number of missed procedures per month for the period October 2012 to June 2013
Psychiatrist 1	25	17	5	0	2	6	10	10	9	84/9
Psychiatrist 2	35	36	21	39	24	20	21	30	20	246/27
Psychiatrist 3	11	16	9	9	7	8	5	12	16	93/10
Psychiatrist 4	1	1	1	5	1	1	1	0	1	12/1
Psychiatrist 5	15	16	10	11	10	10	12	14	4	102/11
Psychiatrist 6	24	30	23	18	16	19	12	38	15	195/22
Psychiatrist 7	49	41	36	34	16	29	41	34	37	317/35
Psychiatrist 8	6	2	3	11	0	0	2	0	2	26/3
Medical Physician 1	0	3	2	2	1	0	2	3	2	15/2

[28] Data for this table was obtained from our review of the Abstracting Reports for the services provided during the period October 2012 to June 2013. Clarks Summit's quality assurance risk management director provided us with copies of the Abstracting Reports.

Medical Physician 2	6	0	0	5	4	7	1	4	1	28/3
Medical Physician 3	34	40	40	33	9	4	8	7	2	177/20
Medical Physician 4	24	24	17	12	11	8	13	14	13	136/15
Medical Physician 5	17	12	8	15	5	13	11	5	9	95/11
Total Missed Billings	247	238	175	194	106	125	139	171	131	1,526[29]/169

Clarks Summit provided the following reasons for the high number of eligible procedures not being recorded on encounter forms by physicians. First, the physicians did not realize that the patient was Medicare Part B eligible because Clarks Summit failed to identify the charts of eligible Medicare Part B patients. To easily identify all eligible patients, the abstractor plans on adding stickers to the outside of all Medicare Part B eligible patients' charts. Second, Clarks Summit's physicians did not follow uniform steps when documenting billable visits with the patients.

In November 2013, Clarks Summit's chief of clinical services conducted an in-house training session to reduce the amount of missed billings by providing all of the physicians with uniform instructions to follow when documenting billable visits.

Annual training sessions would increase the physicians and abstractor's understanding of billable procedures, decrease the number of missed billings, and increase Medicare Part B revenue. In addition, during the training the Department's chief psychiatric officer would have a formal opportunity to convey his expectation that psychiatrists and medical physicians visit their patients weekly. The CPO is of the opinion that annual training should be provided to staff at all of the state hospitals.

Clarks Summit's chief executive officer/superintendent agreed that state-wide training would be beneficial. Specifically, physicians would benefit from training that would expand their knowledge of Medicare billing regulations and clarify the process of documenting visits in each patient's medical chart.

Compliance with the CPO's Expectations

According to the CPO, weekly visits with patients would be billable under the Medicare and Medicaid "evaluation and management" procedure codes because the visits are considered medically necessary due to the patients' hospitalization status.

[29] During October 2012 to June 2013, Clarks Summit's abstractor caught 1,526 billable procedures that were missed by Clarks Summit's physicians. This equates to $63,070 (1,526 procedures) times $41.33 (average amount per procedure).

Complying with the CPO's expectations during the audit period would have helped to ensure adequate patient care and it would have resulted in increased Medicare Part B billing.

The table on the next page illustrates a potential $439,816 increase in Medicare Part B billing for the 12 month period of April 1, 2012 through March 31, 2013, if Clarks Summit's psychiatrists and medical physicians had provided patient visits in compliance with the expectations of the CPO.

Potential Increase In Medicare Part B Revenue Based On The Department's Chief Psychiatric Officer's Expectations							
Column A	Column B	Column C	Column D[1/]	Column E	Column F[2/]	Column G[3/]	Column H[4/]
Physician Type	Medicare Part B revenue collected	Number of approved Medicare Part B procedures billed	Average Medicare Part B revenue per approved procedure	Average number of Medicare Part B patients on the physician's unit per month	Number of patient visits required to meet chief psychiatric officer's expectations	Number of patient visits required minus the number of approved Medicare Part B procedures billed	Potential increase in Medicare Part B revenue
Psychiatrist 1	$13,034	313	$41.64	14	728	415	$17,281
Psychiatrist 2	$31,809	704	$45.18	21	1092	388	$17,530
Psychiatrist 3	$16,429	357	$46.02	15	780	423	$19,466
Psychiatrist 4	$7,764	156	$49.77	18	936	780	$38,821
Psychiatrist 5	$31,679	711	$44.56	22	1144	433	$19,294
Psychiatrist 6	$19,351	446	$43.39	29	1508	1062	$46,080
Psychiatrist 7	$20,934	518	$40.41	23	1196	678	$27,398
Psychiatrist 8	$12,857	296	$43.44	18	936	640	$27,802
Medical Physician 1	$4,045	83	$48.73	18	936	853	$41,567
Medical Physician 2	$20,085	428	$46.93	29	1508	1080	$50,684
Medical Physician 3	$19,353	580	$33.37	35	1820	1240	$41,379
Medical Physician 4	$23,469	669	$35.08	50	2600	1931	$67,739
Medical Physician 5	$16,151	472	$34.22	23	1196	724	$24,775
Totals	**$236,960[30]**	**5,733[31]**	**$41.33[32]**		**16,380**	**10,647**	**439,816**

[1/] We calculated Column D by dividing Column B by Column C.
[2/] We calculated Column F by multiplying Column E by 52 the number of visits that the physicians should be providing to the patients (one per week according to the chief psychiatric officer) the required visits for one year
[3/] We calculated Column G by subtracting Column C from Column F.
[4/] We calculated Column H by multiplying Column G by Column D.

[30] Although not included in the calculations, $14,456 and $8,533 in Medicare Part B revenue was collected on behalf of the chief of clinical services and chief of psychiatry, respectively.
[31] Although not included in the calculations, 380 and 224 in approved Medicare Part B procedures were billed on behalf of the chief of clinical services and chief of psychiatry, respectively.
[32] The average price per procedure, and therefore, potential revenue, could fluctuate depending on the nature of the procedure.

Failure to Identify all Eligible Medicare Part B Patients

Our audit found that upon admission, and annually thereafter, Clarks Summit's revenue office staff utilized the income eligibility verification system to determine a patient's Medicare Part B eligibility. However, due to an oversight by Clarks Summit, one eligible patient admitted to the hospital was not enrolled in Medicare Part B.

Clarks Summit's active patient list for the period June 1, 2013 through June 30, 2013, was comprised of 223 active patients. Of the 223 active patients, eighty five (85) were not enrolled in Medicare Part B. Five of these 85 patients were enrolled in Medicare Part A. We selected these five patients to determine if they should have been enrolled in Medicare Part B.

According to Clarks Summit's social worker manager, one of the five patients should have been enrolled in the Medicare Part B program. The patient was admitted to Clarks Summit on December 27, 2012 upon release from a prison. The patient's Social Security disability benefits and Medicare Part B insurance were terminated during incarceration. Upon admission at the hospital, the patient's social worker reinstated the patient's Social Security disability benefits and mistakenly assumed that the patient's Medicare Part B insurance would automatically restart.

If the patient's social worker had reapplied for the patient's Medicare Part B insurance during the general enrollment period, which is January through March of each year, the patient would have been eligible for Medicare Part B beginning July 1, 2013, according to Social Security regulations.[33]

After we brought this matter to the social worker's attention, Clarks Summit took steps to re-enroll the patient into the Medicare Part B program.

We selected eight (8) of the remaining eighty (80) patients and determined if any were eligible for Medicare Part B. We found that none of the eight (8) patients was eligible for Medicare Part B.

[33] According to the federal government's website managed by the Centers for Medicare & Medicaid Services, "If you drop Part B, you generally won't be able to enroll in Part B again until the next General Enrollment Period (January 1 – March 31st) and you may have to pay a late enrollment penalty." *See* http://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/when-how-to-sign-up-for-part-a-and-part-b.html. Accessed June 30, 2014.

Failure to Bill Vaccinations to Medicare

During our review of Clarks Summit's quarterly fee-for-service procedure statistical reports for the period July 1, 2009 through March 31, 2013, we determined that Clarks Summit did not bill Medicare for pneumococcal vaccines.

According to Clarks Summit's chief of clinical services, the facility's pharmacy sent the pneumococcal vaccines directly to the hospital's units but did not notify Clarks Summit's infection control nurse who has a role in billing for vaccines. According to Clarks Summit's process, the infection control nurse is to send a list of patients who received any type of vaccine to Clarks Summit's revenue office for billing to the Center for Medicare and Medicaid Services (Medicare). Because the chief pharmacist did not inform the infection control nurse that pneumococcal vaccines were distributed to the hospital's units, the infection control nurse did not notify the revenue office of the vaccinations. Therefore, the revenue office did not bill Medicare for the pneumococcal vaccines. Note that this incident reveals a greater issue related to internal controls (see Finding 3).

During the period January 1, 2013 through November 26, 2013, pneumococcal vaccines were provided to 22 of Clarks Summit's Medicare Part B eligible patients. The facility will receive Medicare Part B reimbursement of $1,273 because we brought this error to the attention of Clarks Summit management. In addition, Clarks Summit now has a process in place to bill for the administration of all future pneumococcal vaccinations.

All Psychiatrists and Medical Physicians Enrolled in Medicare Part B

Our audit found that Clarks Summit properly enrolled all of the physicians into the Medicare program and obtained unique NPI numbers for all physicians employed at the hospital.

When Clarks Summit hires a physician, the hospital's facility financial manager completes a Medicare enrollment application and obtains a unique national provider identifier (NPI) number for the psychiatrist or medical physician. Medicare requires the use of the ten digit NPI number for all billing transactions. The NPI number anonymously identifies the provider in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Recommendations For Finding 2

4. Clarks Summit, in coordination with the Department of Public Welfare, should provide annual statewide Medicare Part B billable procedures training to Clarks Summit's psychiatrists, medical physicians, and abstractors.
5. DPW and Clarks Summit must establish internal controls to monitor whether all eligible encounters are being documented by psychiatrists and medical doctors so that medical charts and encounter forms are complete.
6. Clarks Summit should continue to monitor psychiatrists and medical doctors' encounter forms for accuracy, consistency, and completeness in accordance with the Medicare Part B program.
7. Clarks Summit management should establish policies and procedures to ensure that the hospital bills Medicare for all pneumococcal vaccinations administered to patients eligible for the Medicare Part B program.
8. Clarks Summit should develop internal controls to ensure all eligible patients are enrolled in the Medicare Part B program.

Management Response

Recommendation 4: Agree

a. A teleconference* among the statewide Chief Psychiatric Officer (CPO) and Clarks Summit State Hospital (CSSH) Clinical Services leadership and the CSSH CEO yielded support from the CPO to proceed with obtaining Medicare Part B education for CSSH psychiatrists, medical physicians , and abstractors. The education will be delivered initially and a re-fresher will be embedded into the CSSH annual training curriculum for applicable staff.

b. Clinical Services leadership (Chief of Psychiatry and Supervisory Physician) and the CEO will facilitate identifying vendor source(s) to provide Medicare Part B billable procedures education to include, at a minimum, guidance on eligible encounters, corresponding coding, and necessary documentation. Among, but not limited to, potential sources are: the American Health Information Management Association, and Novitas Solutions.

c. Clinical Services leadership and the CEO will submit to the CPO the proposed source/vendor and curriculum for support as an initial step in the procurement process.

d. Clinical Services leadership will facilitate working with DPW/OMHSAS leadership and central procurement to support procurement and payment to the selected source for the deliverable (education).

e. Clinical Services leadership will document physician participation in the aforementioned, initial and annual, education and maintain a record of same in the Clinical Services department.

f. The Chief Performance Improvement Executive and Medical Record Director will document abstractor and other staff, as assigned, participation in the aforementioned education, initial and annual, and maintain a record of same in the respective departments.

g. Clinical Services leadership with share with the statewide CPO, the selected vendor source contact and cost information, and materials included in the education for consideration as to its utility for further distribution and method of distribution statewide for sister facilities.

* The CPO also shared information that he (CPO) had talked with a representative from the audit team and explained that the medical necessity for medical interventions from medical physicians and medical interventions for behavioral health from psychiatrists may differ in frequency. The CSSH team, at the time of the audit, also shared that E&M codes will vary depending on the level of care rendered.

Recommendation 5: Agree

a. In addition to the aforementioned education, to support enhanced monitoring relative to capturing eligible encounters (psychiatrist and medical physician encounters), a CSSH abstractor will affix a Medicare Part B prompt on the chart to alert physicians to utilize the corresponding Medicare Part B documentation log. Prescribed key prompts from the Physicians' Order Sheets will also be used by a member of the CSSH abstractor group as a basis to discern that a service has occurred and follow it through to assess eligibility and documentation relative to Medicare Part B billing. The abstractor staff, that has participated in the education, as above, will be assigned to the monthly audit. The audit design will be a random, hospital wide sample representing a 20% random sample of each psychiatrist's and medical physician's monthly orders sheets to billing encounters. If a chart is pulled that was previously reviewed in a random sample, a replacement

chart will be randomly selected. Data will be *reviewed by* Clinical Services leadership. Clinical Services leadership will facilitate and/or conduct remedial action that may be supported by audit findings. Documentation of the remediation will be maintained in the Clinical Services department. The aforementioned audit design will be administered for no less than 12 contiguous months.

Recommendation 6: Agree

a. CSSH will continue to monitor psychiatrist and medical physician encounter forms for accuracy, consistency, and completeness in accordance with the Medicare Part B program using the current system.

Recommendation 7: Agree

a. Clarks Summit State Hospital's management has implemented the following policies and procedures to ensure that the hospital bills Medicare Part B for all pneumococcal vaccinations administered to consumers eligible for the Medicare Part B program:
   - The Pharmacy will report Pneumococcal vaccines ordered by the physician to the Infection Control Nurse.
   - The Infection Control Nurse will receive the distribution list from the Pharmacy, collect the date of administration of the immunization from each unit / physician, and verify the administration of the vaccine.
   - The Infection Control Nurse will forward the confirmed immunization administration to Medical Records.
   - There is a CMS billing code for each individual vaccine and a separate billing code for the administration of the vaccine. CMS provides the ICD codes. The medical record director and/or designee will be responsible for updating the ICD codes as they are published.
   - The Medical Records director or designee will apply the correct billing codes to the log provided by the infection control nurse that confirmed administration of the vaccine and will forward to the Revenue office staff.
   - The Revenue Office staff will enter the billing codes into the electronic billing system to process for reimbursement.

Recommendation 8: Agree

a. Each admission referral/intake document will be reviewed by the Social Services staff assigned to the Unit receiving the admission to assess the insurance coverage/eligibility documentation.

b. The Unit Social Worker will initiate e-mail contact with the local Social Security office within 1 (one) working day of the admission [Admission day is day -0- (zero)].

c. Upon response from the local Social Security Office as to eligibility for Medicare Part B, The Unit Social Worker will forward the response e-mail to the Social Services Manager, or designee, and copy the Medical Record Director, or designee, and the Revenue Office staff designee.

d. The Social Services Manager will facilitate development and use of a tracker tool which will serve to document and monitor steps taken to verify and, where applicable, accommodate enrollment in Medicare Part B and communicate same to applicable CSSH staff. It will also serve as a record of those consumers who decline to give consent to make contact with Social Security and any consumer who may be eligible but declines to approve enrollment and premium payment.

e. The Social Services Manager, or designee, will conduct a monthly audit of the tracking tool, comparing the month's admissions to the documented disposition of the elements associated with eligibility and enrollment into Medicare Part B. Any remedial action that may need to be engaged will be facilitated by and documented by the Social Services Manager, or designee.

f. The Social Services Manager, or designee, will provide a report of the findings from the previous month to Executive Staff at the Executive Staff meeting on a monthly basis (June admissions reported in July and so on).

Auditors' Conclusion

We are pleased that Clarks Summit State Hospital's management agreed with our finding and recommendations and that it is already taking action to implement our recommendations. During our next audit, we will determine whether management has complied with our recommendations.

Finding 3 Clarks Summit experienced a failure of internal controls related to pneumococcal vaccinations.

During our review of Clarks Summit's quarterly fee-for-service procedure statistical reports for the period July 1, 2009 through March 31, 2013, we determined there was a breakdown in Clarks Summit's internal control

process. This breakdown occurred when the infection control nurse was not informed by the pharmacy that pneumococcal vaccines were distributed to patients.

That breakdown in internal control was not detected or addressed by Clarks Summit and the infection control nurse remained unaware that the vaccines were distributed until our audit brought this error to the attention of infection control nurse and Clarks Summit management. Effective internal controls ensure that medical protocols, such as the administration of vaccines, are followed.

An effective internal control would have alerted the infection control nurse to timely investigate whether the vaccines had been distributed and if they had not been to take appropriate action. Break-downs in internal controls related to infectious diseases can have dire consequences. Therefore, they must be prevented or detected very quickly to avert harm to patients, staff and visitors to the hospital.

Recommendations For Finding 3

9. Clarks Summit management should ensure that the chief pharmacist informs the infection control nurse of all pneumococcal vaccines being distributed to the hospital's units.
10. Clarks Summit should determine the cause of the breakdown in internal control described in this finding and take corrective action to ensure breakdowns in internal controls are prevented or detected in a timely manner.

Management Response

Recommendation 9: Agree

Management has implemented the following:

a. The Pharmacy will report Pneumococcal vaccines ordered by the physician to the Infection Control Nurse.

b. The Infection Control Nurse will receive the distribution list from the Pharmacy and collects the date of administration of immunization from each unit/physician and verifies the administration of the vaccine.

c. The Infection Control Nurse will forward the confirmed immunization administration to Medical Records.

d. There is a CMS billing code for each individual vaccine and a separate billing code for the administration of the vaccine. CMS provides the ICD codes. The medical record director and/or designee will be responsible for updating the ICD codes as they

are published.

e. The Medical Records director or designee will apply the correct billing codes to the log provided by the infection control nurse that confirmed administration of the vaccine and will forward to the Revenue Office staff.

f. The Revenue Office staff will enter the billing codes into the electronic billing system to process for reimbursement.

Recommendation 10: Agree

There was a lack of communication between the Pharmacy and the Infection Control Nurse with exchange of information. It was not clear-cut how the notification of the delivery and administration of the vaccine should flow and that created the breakdown in reporting. Management has implemented the following procedure:

a. The Pharmacy will report Pneumococcal vaccines ordered by the physician to the Infection Control Nurse.

b. The Infection Control Nurse will receive the distribution list from the Pharmacy and collects the date of administration of immunization from each unit/physician and verifies the administration of the vaccine.

c. The Infection Control Nurse will forward the confirmed immunization administration to Medical Records.

d. There is a CMS billing code for each individual vaccine and a separate billing code for the administration of the vaccine. CMS provides the ICD codes. The medical record director and/or designee will be responsible for updating the ICD codes as they are published.

e. The Medical Records director or designee will apply the correct billing codes to the log provided by the infection control nurse that confirmed administration of the vaccine and will forward to the Revenue Office staff.

f. The Revenue Office staff will enter the billing codes into the electronic billing system to process for reimbursement.

Auditors' Conclusion

We are pleased that Clarks Summit State Hospital's management agreed with our finding and that it is already taking action to implement our recommendations. During our next audit, we will determine whether management has complied with our recommendations.

Audit Results for Objective Two

Contract for Medical Services

The objective

Objective two of our performance audit was to determine if Clarks Summit effectively monitored contracted medical services and whether the contract was cost effective.

Relevant contract and law

The Department of Public Welfare entered into a contract with a medical contractor to provide medical services to patients under a department-wide contract,[34] effective from March 10, 2009 through March 9, 2011 and renewed through June 9, 2014. During our audit period, Clarks Summit utilized this contract for psychiatric services using two separate purchase orders from January 18, 2012 through June 30, 2012,[35] and from July 1, 2012 through June 30, 2013.[36] During that period, Clarks Summit paid approximately $422,336 for contracted psychiatric services.

According to the contract, the psychiatrists of Clarks Summit are:

> …responsible for the care and treatment…for individuals with a mental or physical injury or illness, dysfunctional behavior and/or developmental disability. Duties include full professional responsibility for the diagnosis, determination of treatment methods and leadership in the implementation of treatment plans.[37]

The contract also states the following:

> For certain medical service staffing positions, the Commonwealth is required to attempt to hire Commonwealth employees through the regular Commonwealth recruiting process prior to acquiring contract staffing.[38]

[34] Contract No. 4400004062 between the Commonwealth of Pennsylvania and Liberty Healthcare Corporation, effective Date March, 27, 2009; valid from March 10, 2009 through June 9, 2014. Please refer to: http://www.emarketplace.state.pa.us/. accessed June 30, 2014.
[35] Purchase Order No. 4300318899, effective date January 18, 2012; valid from April 2, 2012 through June 30, 2012 ($83,464.88 for 487.5 hours – rate $171.2 per hour).
[36] Purchase Order No. 4300340576, effective date June 29, 2012; valid from July 1, 2012 through June 30, 2013. ($338,871 for 1,950 hours – rate $173.78 per hour).
[37] *See* Contract No. 4400004062, page 22.
[38] *See* Statement of Work, IV-1, page 1.

We focused our review on the contracted psychiatric services received at Clarks Summit and whether Clarks Summit properly monitored these contracted services in accordance with Chapter 54 of the Pennsylvania Department of General Services *Procurement Handbook*. Part 1, Chapter 54 of the handbook entitled "Contact Person Responsibilities" states the following:

> Monitoring and control are essential to ensure the contractor uses and manages its resources in a manner that will provide the agency exactly what it has contracted for in terms of quality, timeliness, and economy of cost.[39]

Scope and methodologies to meet our objective

To satisfy this objective, we performed the following:

We reviewed the contract between the Department of Public Welfare and the medical contractor. We focused our review on the sections related to the number of hours of service that are to be provided and the hourly rate that is to be billed by the medical contractor.

We interviewed Clarks Summit's purchasing agent and facility financial manager. In addition, we interviewed the human resource director involved in the recruitment of psychiatrists, the chief of clinical services, and the director of psychiatry responsible for monitoring the medical contract for hours of service provided and for ensuring patients received the required health care services, as well as the clerk typist who was responsible for maintaining the attendance sheets (daily time records) for all of Clarks Summit's physicians.

Further, we obtained a report detailing all payments made to the medical contractor during the 18 month period January 2012 through June 2013.

We selected five (5) of the eighteen (18) months for testing. We obtained five (5) invoices from each of the five (5) months selected. All 25 invoices showed amounts paid by Clarks Summit for services rendered by the contractor. We recalculated the invoices for mathematical accuracy and verified that the invoices were properly approved.

For 15 of the 25 invoices, we obtained the attendance sheets (daily time records) for the one contracted doctor and matched his hours on the

[39] The DGS *Procurement Handbook*, Part I, Chapter 54.A.

attendance sheet to the hours billed to Clarks Summit as shown on the invoice.

In addition, we obtained the medical charts and reviewed progress notes[40] for six of the contracted doctor's 24 patients for three consecutive months in order to confirm that the contracted doctor provided the services as stipulated in the contract.

We also analyzed the costs associated with contracting for psychiatric services versus hiring in-house or state employee staff psychiatrists for the fiscal year July 1, 2012 through June 30, 2013, and calculate the potential savings of hiring in-house or state employee staff psychiatrists.

[40] Progress note entries are the part of a medical record where health care professionals record details to document a patient's clinical status. The progress notes serve to communicate findings, opinions, and plans between physicians and allow review of case details.

Finding 4 Clarks Summit effectively monitored the medical contract for psychiatry services.

Our audit found that Clarks Summit effectively monitored the medical contract for hours of psychiatry services provided.

We found that Clarks Summit's chief of psychiatry monitored the medical contract. Specifically, the chief of psychiatry verified the hours of service provided by the contracted employee and ensured the hours recorded on monthly invoices were accurate. In addition, the chief of psychiatry approved each invoice and Clarks Summit facility financial manager stated that invoices were not paid unless properly approved by Clarks Summit's chief of psychiatry.

In addition, we reviewed the progress notes recorded in medical charts of the contracted doctor's patients which confirmed that specific medical services were performed by the contracted doctor.

Finding 5 Clarks Summit's inability to hire a full time psychiatrist resulted in the use of contracted services at an extra cost of approximately $150,000 per year.

Our audit found that during the fiscal year ending June 30, 2013, Clarks Summit paid a vendor approximately $338,871 for the full-time services of a contracted psychiatrist.[41] According to the applicable purchase order, the hourly rate for these services was $173.78.

During the same fiscal year, Clarks Summit paid an average annual salary, benefits, and incentives of $181,350 to its three full-time psychiatrists and one part-time psychiatrist. The average hourly rate Clarks Summit paid to both the full-time and part-time staff psychiatrists was $93[42] which included benefits and incentives. The hourly rate drops to approximately $69 when benefits and incentives are not included.

Clarks Summit pays its full-time staff psychiatrists' benefits such as health insurance, pension contributions, and vacation/sick/personal time. In comparing the pay for contracted versus staff psychiatrists, we considered the cost of benefits for the full-time psychiatrists and the absence of these costs for contracted psychiatrists.

[41] Full-time is approximately 1,950 hours per year.

[42] Our calculation includes the average salary and associated benefit rate for regular work hours (no overtime), board certification bonuses, and quality assurance/longevity incentives for the 3.5 staff psychiatrists.

The chart below presents a comparison of the costs of a full-time staff psychiatrist to the cost of the full-time contracted psychiatrist procured through a vendor. The comparison shows that if Clarks Summit had hired a staff psychiatrist, instead of contracting with a vendor for the services of a psychiatrist, the hospital would have saved approximately $157,521 per year.

Contracted Psychiatrist Hourly Rate Comparison			
	Hourly Rate	**Hours Worked/Year (Fulltime)**	**Total Cost of Compensation**
Contracted Psychiatrist	$173.78	1,950	$338,871
Clarks Summit Psychiatrist	$ 93.00[43]	1,950[44]	$181,350
Difference (Savings)			**$157,521**

According to Clarks Summit officials, they have been unsuccessful at recruiting and hiring a psychiatrist for the hospital. Clarks Summit utilized social media including internet web-sites, print periodicals, as well as Job-Net (Pennsylvania State Civil Service Commission's online bulletin for announcing state employee vacancies) for recruiting purposes.

According to Clarks Summit's human resources director, there are two reasons why recruiting psychiatrists has been difficult. The first reason is salary disparity and the second reason is a lack of available candidates.

Also according to the director, the Pennsylvania State Civil Service Commission is technically the recruitment and hiring department for the state hospitals. As such, the Commission determines the salary and benefit packages.

Finally, the director stated that the compensation the Commission sets for prospective candidates appears low in comparison to other locations across the United States. For example, the annual salary range listed on the 2010 – 2012 postings on Job-Net to attract a psychiatrist to Clarks Summit was $116,851 to $143,944. However, the United States Bureau of Labor Statistics[45] reported that for May 2012, the annual mean wage for a psychiatrist employed in psychiatric and substance abuse hospitals was $177,670.

[43] Ibid
[44] A total of 1,950 represents the average number of hours worked per year for the contracted physician as well as one of Clarks Summit's physicians.
[45] http://www.bls.gov/oes/current/oes291066.htm. Accessed: October 21, 2013, verified June 30, 2014.

Based on our interviews and review of salary related statistics, it appears the salary and benefits offered for the position are not competitive enough to attract interest from psychiatrists.

Recommendation For Finding 5

11. Clarks Summit and Department management should work with the Commonwealth's Office of Administration to develop a salary and benefit package for psychiatrists that would create more interest from qualified candidates. Also, given the long standing difficulty attracting a psychiatrist to accept employment at the state hospital, the Department should work directly with the Civil Service Commission to enhance efforts to recruit psychiatrists for employment at Clarks Summit and other state hospitals.[46]

Management Comments

Following prescribed process through chain of command.

a. CSSH is one of 6 state mental hospitals and 1 long term care facility. The Office of Mental Health and Substance Abuse Services (OMHSAS) facilities provide safety and administer appropriate care for some of our most vulnerable PA citizens. Clarks Summit has been experiencing great difficulty filling critical medical professional positions due to lackluster interest in Commonwealth employment and substantial differences in salary between the private and public sector. As a result of these recruitment difficulties, CSSH has been acquiring services through an outside contract in order to provide necessary care and treatment and remain in compliance with regulatory guidelines. Contract salaries are negotiated between the service provider and the Commonwealth and negotiated rates are outside of the control of the facility.

b. Select Federal and State regulations address the need to provide various treatment services to consumers served by the facility, in addition to maintaining sufficient staffing levels in all areas of direct care. Failure to maintain compliance with regulations and requirements can mean the loss of important funding and lead to deficiencies in treatment and care services.

c. The Department of Public Welfare (DPW) is primarily a Civil Service agency. The positions that CSSH fills within the agency are covered by the State Civil Service Commission Act and Rules. As such, there is a defined process to be used when recruiting for all positions covered by the Civil Service Commission. The facility has been routinely and actively recruiting to fill psychiatrist vacancies since the

[46] It is important to note that other state hospitals have faced similar ongoing difficulties in recruiting and maintaining suitable psychiatrists. *See* for example the special performance audit of Torrance State Hospital issued in February 2012.

first quarter of calendar year 2012. Recruitment efforts include posting job vacancies through the Civil Service employment system. In addition CSSH has advertised job vacancies in professional journals, local and interstate newspapers, and online recruitment sites including Monster and Career Builder.

d. Regardless of which recruitment method has been used, the number of interested candidates generated was none to minimal. Advertising generates a few candidates initially interested but when contact is made to discuss the position and the minimum starting salary, most candidates withdraw interest expressing a desire for employment with a higher starting salary.

e. DPW Bureau of Human Resources (BHR) can exercise the option to request appointment of a new hire at a higher starting salary however, such requests are ultimately approved and /or denied by the Governor's Office of Administration (GOA) Pay Division. Approvals are typically based on a comparison of pay rates for current facility staff working in the same capacity, those request that create a pay inequity will not be honored. In addition, GOA typically limits the pay level to be approved for a higher starting rate. Candidates are asked what pay rate they would consider for employment. Most have an expectation to match a current salary and that current rate tends to require a move to the upper most level of the Commonwealth pay scale designated for psychiatrist titles.

f. DPW Bureau of Human Resources (BHR) has been working with the Civil Service Commission and Governor's Office of Administration in an effort to identify specialized recruitment avenues and discuss obstacles due to the starting salary. The Civil Service has offered suggestions for advertising on specialized websites, participating in job fairs, and recruitment on college campuses that have psychiatric degrees. The Civil Service has also provided contact information with sources that have more direct interaction with professionals in the field of psychiatry. The Governor's Office is in the process of conducting a job study that includes a review of work duties and a salary comparison for the three medical professional titles that are used in the facilities. The objective of the study is to determine the need for increasing the salary pay scale based on comparison of salaries on a nationwide basis in public and private sectors. Assessments and final reports for proposal changes can take months to complete in addition to the time for final approvals through various levels of the Commonwealth including an Executive Board approval.

g. The process of recruiting to fill psychiatrist critical vacancies in an OMHSAS facility requires involvement from various departments and entities across the Commonwealth. All immediate options continue to be exercised or have been exhausted. CSSH continues to have a need to use contracted services while other long term options are being developed or considered.

Auditors' Conclusion

We recognize the condition cited in this finding is not within the complete control of Clarks Summit State Hospital's management. We recommend management continue to work with the Civil Service Commission and the Governor's Office of Administration. However, if these efforts do not result in effective changes, management should seek another alternative (including possible legislative changes) for recruitment and hiring of psychiatrists at Clarks Summit and other state hospitals. In order to provide necessary care to patients, we recognize Clarks Summit State Hospital will need to continue the use of contracted psychiatric services despite the high cost.

Status of Prior Audit

Our prior audit report of Clarks Summit covered the period July 1, 2007, through March 10, 2010, and contained 12 findings. Seven of the findings (Findings 1, 2, 3, 5, 8, 11, and 12) were positive and thus had no recommendations. The remaining findings (Findings 4, 6, 7, 9, and 10), accompanying recommendations, and the status of Clarks Summit's implementation of the recommendations are presented below

Scope and methodologies of our audit work

To determine the status of the implementation of the recommendations made during the prior audits, we held discussions and made inquiries with appropriate hospital personnel and performed tests as part of, or in conjunction with the current audit.

Prior Finding 4 Clarks Summit could not provide documentation to verify that completed absent without leave incident reports were forwarded to the Office of Mental Health and Substance Abuse Services (OMHSAS). (Resolved)

Clarks Summit State Hospital's absence without leave (AWOL) policy includes a requirement to notify the Office of Mental Health and Substances Abuse Services (OMHSAS) of AWOL incidents. During our prior audit we found that Clarks Summit management did not:

- Maintain documentation of notification to OMHSAS
- Use one complete, comprehensive checklist to verify all the steps listed in the AWOL policy were completed or were necessary

We recommended that Clarks Summit management should ensure the following:

- All incident reports forwarded OMHSAS are documented and maintained.

- Development of one comprehensive checklist to insure that required staff completed all AWOL procedures. The list should include the date and time it was completed and the details of what had occurred.

The Department of Public Welfare responded that to comply with our recommendations, Clarks Summit State Hospital's management:

- Revisited its Patient Absence without Leave Policy A-045 on to reflect that the hospital will consider all events that meet the definition of an absence without leave (AWOL) as outlined in the policy reportable to OMHSAS. The hospital's nursing department, in conjunction with the safety department, will promptly initiate and complete the OMHSAS notifications of UA/AWOL event form and e-mail the form within one hour to OMHSAS.
- Developed an AWOL response checklist form and added it as an attachment to hospital's policy in order to serve as a prompt to aid staff in determining that all procedures required by the policy have been followed.
- Developed and implemented a comprehensive checklist as an audit tool to ensure that staff completed the following AWOL documentation for every AWOL:
    - Incident Report (SI- 815)
    - OMHSAS Notification of UA/AWOL Event Form
    - AWOL Risk Reduction Critique Form
    - AWOL Team Review Form

Status as of this audit.

Our current audit found that Clarks Summit State Hospital revised its AWOL policy on March 28, 2012. The policy now states:

> The hospital will consider all events that meet the definition of an absence without leave (AWOL) as outlined in the policy reportable to OMHSAS.

Clarks Summit State Hospital's management developed an AWOL comprehensive checklist form and added it as an attachment to Policy A-045 Patient Absence Without Leave.

Additionally, auditor testing of five of 17 events that occurred during the period July 1, 2012, through June 30, 2013, disclosed that Clarks Summit State Hospital management notified OMHSAS of each event and maintained documentation of notification and properly completed the following forms:

- AWOL Response Checklist
- Incident report
- Safety Incident
- AWOL Organizational Risk Reduction Critique
- AWOL Team Review

As a result of our review, we concluded that Clarks Summit State Hospital implemented our prior audit recommendations.

Prior Finding 6 Clarks Summit did not have adequate policies and procedures in place to monitor its maintenance work orders effectively (Resolved)

Our prior audit identified two issues that impacted the efficiency of its operations:

- Management did not require supervisors to sign off on all completed work orders.
- Management did not require laborers to include materials or material costs on completed work orders.

We recommended that Clarks Summit management develop policy and procedures for supervisory review, and approval of completed work orders and for the inclusion of materials and cost of materials on the completed work order.

The Department of Public Welfare responded that to comply with our recommendations, Clarks Summit State Hospital revised and implemented an internal work order policy in June 2011 requiring supervisory review, approval of completed work orders and inclusion of material cost over $100 in value. This action will identify the responsible supervisor and assign material cost/quantities to work activities.

Status as of this audit.

Our current audit found that Clarks Summit revised Facility Services Policy and Procedure Number FS-035 in June 2011. The policy now states:

> Upon completion of work, tradesmen will in their time, list materials used on the work order, including cost for items over $100, and have "completion approval" signed to verify work is completed. Foreman signs to verify completion and returns maintenance work order to the facility maintenance manager to verify information on work order is complete before it's updated in the Mapper system.

Our review of 15 work orders (ten maintenance work orders and five preventative maintenance work orders) found that all work orders tested had supervisor approval of completion. Also, we found that of the ten maintenance work orders tested, five of the work orders required materials; however, the work orders did not include a listing of materials and/or the estimated or actual cost of the materials.

Management responded that the computerized system currently used to track work orders cannot list materials and their associated cost. Clarks Summit management requested a new computerized system through the Governor's Office of Administration, Office of Information Technology. We reviewed purchase orders for the materials used on each of the five work orders and determined that there was proper justification and approval for the materials purchased.

As a result of our review, we concluded that Clarks Summit implemented our prior audit recommendations.

Prior Finding 7 Clarks Summit's fixed asset records were inaccurate, and controls and other safeguards over fixed assets need improvement. (Resolved)

Our prior audit found that Clarks Summit's fixed asset listing was inaccurate in terms of completeness, location, and the use of tag numbers. In addition, Clarks Summit management did not complete annual physical inventories on all fixed assets as required by policy.

We recommended that Clarks Summit management should:

- Ensure that all assets valued greater than $5,000 are tagged and recorded in the fixed asset listing.

- Ensure that all fixed assets that have been scrapped and/or transferred away from the hospital are removed from the fixed asset listing.

- Reinstate the use of fixed asset transfer documentation to assist in keeping track of internal movement of fixed assets and property control items.

- Ensure that a physical inventory is conducted on the entire inventory of fixed assets and property control items annually.

The Department of Public Welfare responded in order to comply with our recommendations, Clarks Summit will consolidate the existing four fixed asset files into one fixed asset database. The database will be reviewed for completeness and updated with any appropriate missing information. When an annual physical inventory is conducted, missing fixed asset property tags will be replaced and documented. In addition, changes in asset locations will be documented during the audit. As of November 30, 2011, the four fixed asset files were consolidated into one database. The annual physical inventory of fixed assets was completed on February 8, 2012. Property tags have been attached to any assets that were missing property tags.

Status as of this audit.

During our current audit, we found through interviews, observation, and testing that:

- All assets valued from $5,000 to $24,999 were tagged upon receipt and tag numbers were posted into the Bureau of Financial Reporting Fixed Asset Database.

- All assets valued over $25,000 were posted into SAP where an asset number is generated. The asset number was then posted into the Bureau of Financial Reporting fixed asset database.

- A complete asset inventory listing was printed from the database and distributed to department managers to review and revise, if necessary, on a yearly basis. Each department manager notes

whether any assets are moved, scrapped or transferred. The approved inventory listing is then sent to the accounting department. Accounting department personnel will conduct existence testing of a number of assets located in each department.

In addition, we reviewed a copy of the annual physical inventory completed on February 8, 2012, and performed existence testing of 14 assets listed on the consolidated database. We found that all 14 assets were properly tagged and located in the listed location. Furthermore, we selected five assets found at the hospital and ensured that all five items were recorded into the consolidated database listing. We did not find any errors.

As a result of our review, we concluded that Clarks Summit implemented our prior audit recommendations.

Prior Finding 9 and Prior Finding 10 — Clarks Summit approved incorrect pay incentive calculations for medical staff and lacked effective segregation of duties for implementing employee pay incentives. (Resolved)

During our prior audit, we found that two incorrect employee pay incentives totaling $3,083 in overpayments were made to the hospital's medical staff. These overpayments occurred because the hospital did not have a system in place to review and approve incentive payment data calculations. Additionally, our review of documentation revealed that Clarks Summit lacked effective segregation of duties for implementing employee pay incentives.

We recommended that Clarks Summit management ensure:

- $3,083 in overpayments made to medical staff is recovered
- Every employee pay incentive memo is reviewed by the hospital's accounting department for accuracy, and approved by management before being sent to the Office of the Budget's Bureau of Commonwealth Payroll Operations
- Employee pay memorandum are copied and filed at the facility
- The human resources personnel, not the training director or the chief of clinical services, is responsible for calculating bonus

payment, verifying the eligibility of each employee entitled to bonuses, and preparing the appropriate memoranda.

The Department of Public Welfare responded, in order to comply with our recommendations, Clarks Summit will pursue recovery of $3,083 of overpayments made to two medical staff employees. The Bureau of Commonwealth Payroll Operations was contacted to start the process of the recovery of funds.

The hospital's human resources staff will determine eligibility of medical staff for pay incentive and will prepare the appropriate memorandum. Every memorandum will be reviewed and approved by the hospital's accounting department for accuracy and appropriateness before submission to the Bureau of Commonwealth Payroll Operations. Employee pay incentive memorandums will be copied and kept in the accounting department.

Status as of this audit.

Our current audit found that:

- Clarks Summit management recovered the overpayment erroneously made to one staff member in the amount of $1,800. However, Clarks Summit was not able to collect the overpayment of $1,283 made to the other staff member due to his death on August 22, 2009.

- Clarks Summit management developed a process to ensure all bonuses calculated and generated by the medical office are reviewed and recalculated by the human resources office, sent to the facility financial manager for approval, and reviewed by the chief executive officer before submission to the Bureau of Commonwealth of Payroll Operations for processing. Finally, all memorandums are filed in Clarks Summit's accounting office.

- To provide additional evidence to support the process implemented by Clarks Summit, we obtained a listing of the bonuses paid to Clarks Summit's medical staff for the period July 1, 2012 through June 30, 2013, and recalculated the specialty board certification and quality assurance program pay incentives made to five members of the medical staff for accuracy. We did not find any exceptions. Additionally, we obtained copies of the employee pay incentive memorandums that were forwarded to the Bureau of Commonwealth Payroll Operations for processing and filed in

Clarks Summit's accounting office as well as copies of each of the five employees' specialty board certificates.

As a result of our review, we concluded that Clarks Summit implemented our prior audit recommendations.

APPENDIX

Average Number of Medicare Part B Billings per Eligible Patient per Month by Clarks Summit Physicians April 1, 2012, to March 31, 2013				
Column A	Column B	Column C	Column D[1/]	Column E[2/]
Physician Type	Number of approved Medicare Part B procedures billed	Total number of Medicare Part B patients on the physician's unit for the period	Average number of Medicare Part B patients on the physician's unit per month	Average number of Medicare Part B billings per patient per month[47]
Psychiatrist 1	313	169	14	1.85
Psychiatrist 2	704	250	21	2.82
Psychiatrist 3	357	179	15	1.99
Psychiatrist 4[48]	156	218	18	.72
Psychiatrist 5	711	258	22	2.76
Psychiatrist 6	446	292	29	1.53
Psychiatrist 7	518	279	23	1.86
Psychiatrist 8	296	218	18	1.36
Medical Physician 1[49]	83	218	18	.38
Medical Physician 2	428	344	29	1.24
Medical Physician 3	580	419	35	1.38
Medical Physician 4	669	603	50	1.11
Medical Physician 5	472	279	23	1.69
AVERAGE				**1.59**

[1/] We calculated Column D by dividing Column C by twelve months.
[2/] We calculated Column E by dividing Column B by Column C.

[47] Note: These percentages include the billings these physicians missed during the period October 1, 2012, through March 31, 2013, but were caught by Clarks Summit's abstractor. The chart on page 19 shows the total billings missed by each physician during the nine month period, October 2012 through June 2013. We found that, on average, the psychiatrists and medical physicians billed for visits with their Medicare Part B patients 1.59 times per month.
[48] Psychiatrist 4 worked a part-time schedule.
[49] Medical Physician 1 worked a part-time schedule.

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