

**Memorandum**

Date . JAN 21 1999
From June Gibbs Brown *June G Brown*
Inspector General
Subject Payment Edits for Outpatient Psychiatric Services at Medicare Carriers (A-01-98-00520)
To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is the Department of Health and Human Services, Office of Inspector General's final report entitled, "Payment Edits for Outpatient Psychiatric Services at Medicare Carriers." Expansion of a payment edit to ensure that mental health services are reimbursed in accordance with the outpatient mental health treatment limitation of 62.5 percent would have saved the Medicare program approximately \$1 million in Calendar Year (CY) 1996 in one carrier's four State payment area.

Our review of the Medicare carrier servicing the four State area of Maine, Massachusetts, New Hampshire, and Vermont identified approximately \$2.7 million in payments to professional psychiatric providers for evaluation and management services for the treatment of mental, psychoneurotic, and personality disorders in an outpatient setting. However, contrary to Medicare regulations, these services were reimbursed at 80 percent of the Medicare allowed amount without first applying the 62.5 percent limitation. As a result of not applying the treatment limitation, we estimate that Medicare overpaid its share for outpatient mental health services by approximately \$1 million in CY 1996.

We recommended that the Health Care Financing Administration initiate overpayment recovery actions, apprise all Medicare carriers of this potential payment error, and take the necessary steps to prevent future errors from occurring. In response to our draft report, officials in your office concurred with our findings and recommendations.

Subsequently, we expanded our review to include three additional Medicare carriers: Blue Cross and Blue Shield of Florida (Florida), Empire Blue Cross and Blue Shield (New York), and Blue Cross and Blue Shield of Texas (Texas). Our review of the internal control structures revealed that the New York and Texas carriers had edit systems which correctly applied the treatment limitation. We are finalizing our review in Florida and will provide the results in a separate report, if material.

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We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-98-00520 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PAYMENT EDITS FOR OUTPATIENT
PSYCHIATRIC SERVICES AT
MEDICARE CARRIERS**



JUNE GIBBS BROWN
Inspector General

JANUARY 1999
A-01-98-00520

NOTICES

THIS REPORT IS AVAILABLE TO THE PUBLIC

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

OAS FINDINGS AND OPINIONS

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



**Memorandum**

Date . JUN 21 1999
From June Gibbs Brown
Inspector General
Subject Payment Edits for Outpatient Psychiatric Services at Medicare Carriers (A-01-98-00520)
To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This report provides you with the results of our review of payment edits for outpatient psychiatric services at Medicare carriers. The objective of our review was to determine whether Medicare carriers correctly applied the outpatient mental health treatment limitation (Limitation) of 62.5 percent to Calendar Year (CY) 1996 outpatient psychiatric claims submitted by professional psychiatric providers. These claims used certain evaluation and management (E&M) procedure codes contained in the Physician's Current Procedural Terminology (CPT).

Our review at one Medicare carrier servicing the four State area of Maine, Massachusetts, New Hampshire, and Vermont identified approximately \$2.7 million in payments to professional psychiatric providers for E&M services for the treatment of mental, psychoneurotic, and personality disorders in an outpatient setting.

Medicare overpaid its share of professional outpatient psychiatric services by approximately \$1 million

However, contrary to Medicare regulations, these services were reimbursed at 80 percent of the Medicare allowed amount without first applying the Limitation of 62.5 percent. As a result of not applying the Limitation, we estimate that Medicare overpaid its share for outpatient mental health services by approximately \$1 million in CY 1996.

We recommend that the Health Care Financing Administration (HCFA):

- ☛ apprise all Medicare carriers of this potential payment error and take the necessary steps to prevent future errors from occurring,
- ☛ initiate recovery of the overpayments, and
- ☛ consider expanding recovery action to include overpayments subsequent to our review period.

The HCFA, in its response dated November 17, 1998, concurred with the findings and recommendations contained in our draft report (see Appendix).

Subsequently, we expanded our review to include three additional Medicare carriers: Blue Cross and Blue Shield of Florida (Florida), Empire Blue Cross and Blue Shield (New York), and Blue Cross and Blue Shield of Texas (Texas). Our review of the internal control structures revealed that the New York and Texas carriers had edit systems which correctly applied the treatment limitation. We are finalizing our review in Florida and will provide the results in a separate report, if material.

INTRODUCTION

Background

Medicare covers outpatient diagnostic and mental health treatment services that beneficiaries receive from professionals such as physicians, clinical psychologists, clinical social workers, and other non-physician practitioners. Mental health services provided to an individual who is not an inpatient of a hospital for a treatment of "mental, psychoneurotic, or personality disorder" are subject to a payment limitation that is called the "outpatient mental health treatment limitation."

The Social Security Act, section 1833(c) states that "...with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only 62 ½ percent of such expenses."

Title 42 CFR section 410.155(b) further states that "The mental health treatment limitation applies to the following services...: (1) CORF services (2) Physicians' services that meet the criteria of part 405, subpart F of this chapter for payment on a fee schedule... (3) Physician assistant services... (4) Clinical psychologist services...."

The Medicare Carriers Manual section 2472.4 further states that the following services are not subject to the Limitation: 1) diagnosis of Alzheimer's disease or related disorder, 2) brief office visits for monitoring or changing drug prescriptions, 3) diagnostic services including initial visits and consultations, and 4) partial hospitalization services not directly provided by a physician.

The Limitation is calculated by first determining the Medicare allowed amount. This amount is then multiplied by 62.5 percent and any unsatisfied beneficiary deductible is subtracted from the result. The remainder is then multiplied by 80 percent to obtain the amount of Medicare payment. The beneficiary is responsible for the additional coinsurance amount.

Medicare carriers are responsible for applying the Limitation to claims submitted by professional psychiatric providers for outpatient mental health services. Specifically, the Massachusetts Blue Shield (MABS) was the Medicare carrier responsible for processing Medicare Part B claims in Maine, Massachusetts, New Hampshire, and Vermont during CY 1996. On August 1, 1997, the MABS terminated its contract with HCFA and its duties were transferred to National Heritage Insurance Company (NHIC).

Objectives, Scope, and Methodology

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine whether Medicare carriers correctly applied the Limitation of 62.5 percent to outpatient psychiatric claims submitted by professional psychiatric providers using certain E&M procedure codes in CY 1996.

We limited consideration of the internal control structure to the control concerning the application of the Limitation because the objective of our review did not require an understanding or assessment of the complete internal control structure at the carriers.

To accomplish our objective, we:

- ☞ reviewed applicable Medicare laws and regulations;
- ☞ performed a computer extract of records from HCFA's National Claims History File for professional outpatient psychiatric services rendered in CY 1996 to beneficiaries:
 - ✓ residing in Maine, Massachusetts, New Hampshire, and Vermont;
 - ✓ with a diagnosis of a mental, psychoneurotic, or personality disorder as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM-III-R); and
 - ✓ for whom claims were submitted using the following CPT procedure codes for E&M services: 99211-215, 99301-303, 99311-313, 99331-333, 99351-353, 99354-355, 99361-362, 99371-376, 99392-411, 99218-220, and 99231-233;
- ☞ randomly selected a sample of 100 services from a population of 56,963 professional outpatient psychiatric services claimed using E&M procedure codes valued at \$2,704,831;
- ☞ obtained and reviewed the beneficiaries' claims histories for the sampled 100 services to verify that the population did not include any services exempt from the Limitation; and
- ☞ discussed our results with NHIC officials.

We also expanded our scope to include internal control testing of selected professional outpatient psychiatric services in CY 1996 processed by carriers in Florida, New York, and Texas.

We conducted the MABS/NHIC phase of our audit from December 1997 through May 1998 at the NHIC and the Office of Inspector General (OIG) Office of Audit Services' regional office located in Boston, Massachusetts. The Florida, New York, and Texas phase of our audit was conducted from June 1998 through November 1998 at the individual carriers and the OIG Office of Audit Services' regional offices located in Atlanta, Georgia; New York, New York; and Dallas, Texas.

FINDINGS AND RECOMMENDATIONS

Limitation Not Applied to Professional Outpatient Psychiatric Claims Using E&M Codes

We determined that MABS did not establish adequate controls to ensure that all claims subject to the Limitation were identified. Specifically, payments to professional psychiatric providers for E&M services related to the treatment of mental, psychoneurotic, and personality disorders in an outpatient setting were not subject to the Limitation but instead were reimbursed at 80 percent of the Medicare allowed amount.

The Medicare Carriers Manual sections 2472.2 and 2472.4 require that the Limitation be applied to all outpatient psychiatric services when rendered to a beneficiary with a psychiatric condition defined in the DSM-III-R. Services excluded from the Limitation include 1) diagnosis of Alzheimer's disease or related disorder, 2) brief office visits for monitoring or changing drug prescriptions, 3) diagnostic services including initial visits and consultations, and 4) partial hospitalization services not directly provided by a physician.

The MABS applied the Limitation if claims met the following criteria:

- ☛ a psychiatric procedure code listed in the CPT section 90835-90899 was used and
- ☛ an outpatient place of service code was used.

We noted, however, that HCFA's application of the Limitation was not restricted only to the CPT codes contained in the psychiatric section as had been implemented by MABS. Rather, psychiatric services rendered to a patient based on a specific psychiatric diagnosis claimed using an E&M procedure code should also be subject to the Limitation.

We therefore developed a computer application, as previously discussed, to identify all outpatient psychiatric claims submitted by professional psychiatric providers using E&M procedure codes. We tested our results to ensure that we did not include any services which were exempt from the Limitation. Specifically, we obtained and reviewed the beneficiaries' claims histories to verify that the sampled services were not initial visits exempt from the Limitation.

For CY 1996, we identified \$2.7 million in payments made to professional psychiatric providers on behalf of beneficiaries residing in Maine, Massachusetts, New Hampshire, and Vermont for which the Limitation was not applied. Applying the 62.5 percent Limitation would have reduced the Medicare share of the payments by approximately \$1 million. We calculated the overpayment by multiplying the paid amount \$2,704,831 by 37.5 percent, the increment overpaid by Medicare.

During the course of this audit, we also noted that the 1998 edition of the CPT contained revised psychiatric procedure codes. These new psychiatric procedure codes include codes with an E&M component which would be subject to the Limitation under the MABS payment edit. We obtained data for psychiatric claims processed by the current Medicare carrier, NHIC, with dates of service in January, February, and March 1998 to determine if professional psychiatric providers have continued to submit claims for services using the E&M procedure codes identified in our sample. This data showed that professional psychiatric providers submitted 4,772 claims using the E&M procedure codes, which have not been subject to the Limitation under the MABS/NHIC payment edit.

To prevent additional overpayments from occurring, we met with NHIC officials and recommended that it adjust its outpatient psychiatric payment edit to include E&M procedure codes used by professional psychiatric providers for outpatient services rendered to beneficiaries with a psychiatric diagnosis code. The NHIC concurred with our recommendation and as of April 1, 1998 began using the new edit to correct the payment errors.

Recommendations

We recommend that HCFA:

- ☛ apprise all Medicare carriers of this potential payment error and take the necessary steps to prevent future errors from occurring,
- ☛ initiate recovery of the overpayments, and
- ☛ consider expanding recovery action to include overpayments subsequent to our review period.

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Subsequently, we expanded our review to include three additional Medicare carriers servicing the States of Florida, New York, and Texas and determined that the New York and Texas carriers had edit systems which correctly applied the Limitation. However, our review at the Florida carrier disclosed potential problems with their edit system. We are finalizing our review in Florida and will provide the results in a separate report, if material.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: NOV 17 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *NMD*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Payment Edits for
Outpatient Psychiatric Services at Medicare Carriers (A-01-98-00520)"

We have reviewed the draft report and concur with its findings and recommendations. We look forward to the final report and will communicate the findings to our Regional Offices and Medicare carriers.