

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**GRAND DESERT PSYCHIATRIC SERVICES:
AUDIT OF MEDICARE PAYMENTS FOR
PSYCHOTHERAPY SERVICES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Amy J. Frontz
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief

Date: April 2020

Report No. A-09-19-03018



Why OIG Did This Audit

Medicare paid approximately \$2 billion for psychotherapy services provided to Medicare beneficiaries from January 2017 through December 2018 (audit period). Prior OIG reviews found that Medicare had made millions in improper payments for mental health services, including psychotherapy services. These reviews also identified problems with psychotherapy services that were billed in conjunction with evaluation and management (E&M) services. After analyzing Medicare claim data, we selected for audit Grand Desert Psychiatric Services (Grand Desert). Our analysis showed that during our audit period, 80 percent of Grand Desert's psychotherapy services were paid in conjunction with E&M services.

Our objective was to determine whether Grand Desert complied with Medicare requirements when billing for psychotherapy services.

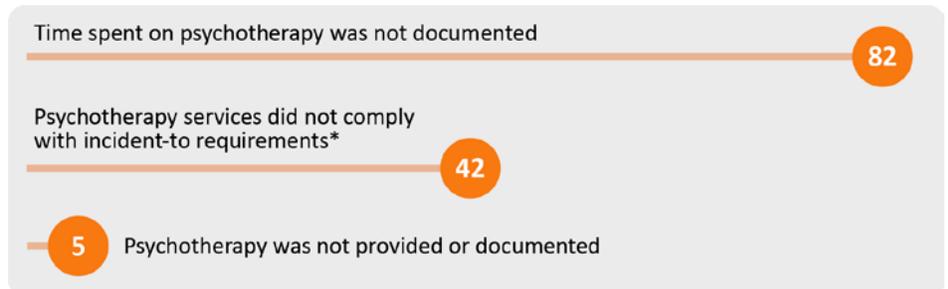
How OIG Did This Audit

Our audit covered Grand Desert's Medicare Part B claims for psychotherapy services provided during our audit period. Our sampling frame consisted of 8,542 beneficiary days, totaling \$450,663. (A beneficiary day consisted of all psychotherapy services provided on a specific date of service for a specific beneficiary for which Grand Desert received a Medicare payment.) We reviewed a random sample of 100 beneficiary days, consisting of 100 psychotherapy services. We did not determine whether the services were medically necessary.

Grand Desert Psychiatric Services: Audit of Medicare Payments for Psychotherapy Services

What OIG Found

Grand Desert did not comply with Medicare requirements when billing for psychotherapy services. Specifically, of the 100 psychotherapy services in our 100 sampled beneficiary days, only 1 service complied with the requirements. However, the remaining 99 services did not comply with the requirements (the total below exceeds 99 because 29 services had more than 1 deficiency):



* Medicare pays for services billed incident to the service of a physician by nonphysician practitioners if the services meet certain conditions.

As a result, Grand Desert received \$5,173 in unallowable Medicare payments. On the basis of our sample results, we estimated that at least \$421,272 was unallowable for Medicare reimbursement, or 93 percent of the \$450,663 paid to Grand Desert for psychotherapy services.

What OIG Recommends and Auditee Comments

We recommend that Grand Desert (1) refund to the Medicare contractor \$421,272 in estimated overpayments for psychotherapy services; (2) implement policies and procedures to ensure that psychotherapy services billed to Medicare are adequately documented, including the time spent on those services; (3) strengthen management oversight and review Medicare claims to ensure that psychotherapy services billed to Medicare meet incident-to requirements; (4) improve its billing system to ensure that Medicare claims identify the correct provider of psychotherapy services; and (5) strengthen management oversight to ensure that psychotherapy services billed to Medicare were actually provided and have supporting documentation. The report lists one more recommendation.

We issued our draft report to Grand Desert and requested that it provide us with written comments. Grand Desert informed us that it would not provide written comments.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare paid approximately \$2 billion for psychotherapy services provided to Medicare beneficiaries nation-wide from January 1, 2017, through December 31, 2018 (audit period). Prior Office of Inspector General (OIG) reviews found that Medicare had made millions in improper payments for mental health services (including psychotherapy services) that were billed incorrectly, provided by unqualified providers, undocumented, inadequately documented, or medically unnecessary.¹ The report issued in 2001 stated that psychotherapy services were particularly problematic. In addition, these prior reviews identified problems with psychotherapy services that were billed in conjunction with evaluation and management (E&M) services.²

After analyzing Medicare claim data, we selected several providers for audit, including Grand Desert Psychiatric Services (Grand Desert), which is located in Las Vegas, Nevada.³ Our analysis showed that during our audit period, 80 percent of Grand Desert's psychotherapy services were paid in conjunction with E&M services.

OBJECTIVE

Our objective was to determine whether Grand Desert complied with Medicare requirements when billing for psychotherapy services.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Part B provides supplementary medical insurance for medical and other health services. CMS contracts with Medicare Administrative Contractors (MACs) to process and pay

¹ *Medicare Payments for 2003 Part B Mental Health Services: Medical Necessity, Documentation, and Coding* ([OEI-09-04-00220](#)), issued April 2007; and *Medicare Part B Payments for Mental Health Services* ([OEI-03-99-00130](#)), issued May 2001.

² E&M services are performed by physicians and nonphysician practitioners to assess and manage a beneficiary's health.

³ The report on the first provider we selected for audit was entitled *Oceanside Medical Group Received Unallowable Medicare Payments for Psychotherapy Services* ([A-09-18-03004](#)), issued August 28, 2019.

Part B claims. During our audit period, Noridian Healthcare Solutions, LLC (Noridian), was the MAC that processed and paid Grand Desert's Medicare claims.

Psychotherapy

Psychotherapy treats mental illness and behavioral disturbances. A physician or other qualified healthcare professional establishes professional contact with the patient and, through therapeutic communication and techniques, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy can help eliminate or control troubling symptoms so that a person can function better. It can also increase well-being and healing. Problems helped by psychotherapy include difficulties in coping with daily life; the impact of trauma, medical illness, or loss; and specific mental disorders, such as depression or anxiety. Psychotherapy may be used in combination with medication or other therapies.

Medicare Coverage of Psychotherapy Services

Medicare Part B covers mental health services, such as individual and group psychotherapy, provided by qualified professionals, e.g., physicians, psychiatrists, clinical psychologists, clinical social workers, nurse practitioners, and physician assistants.⁴ To provide such services, a provider must be licensed or legally authorized to perform the services by the State in which the services are provided.⁵ Medicare also pays for services billed incident to the service of a physician or certain other practitioners.⁶

Medicare beneficiaries may receive an E&M service on the same day as a psychotherapy service provided by the same physician, psychiatrist, or other qualified healthcare professional.⁷ For a

⁴ The Social Security Act (the Act) §§ 1832(a)(1) and 1861(s); 42 CFR §§ 410.20, 410.71, and 410.73–410.75.

⁵ 42 CFR §§ 410.20, 410.71, and 410.73–410.75.

⁶ 42 CFR § 410.26(b), the Act § 1861(s)(2)(A) (incident to physician's services), § 1861(s)(2)(K)(i) (incident to physician assistant's services), § 1861(s)(2)(K)(ii) (incident to nurse practitioner's or clinical nurse specialist's services), § 1861(gg)(1) (incident to nurse-midwife's services), and § 1861(ii) (incident to qualified psychologist's services). The "incident to" provisions allow physicians and certain other practitioners to bill Medicare under their National Provider Identifier (NPI) for services furnished incident to their professional services by auxiliary personnel (e.g., a nurse practitioner employed by the same entity). To be covered as incident-to services, the services must meet certain conditions, including being an integral, although incidental, part of the physician's or other practitioner's personal professional services in the course of diagnosis or treatment of an injury or illness (42 CFR § 410.26(b)(2)).

⁷ Other qualified healthcare professionals that may provide E&M services include nurse practitioners, clinical nurse specialists, and physician assistants who practice in collaboration with a physician or under the supervision of a physician.

provider to receive Medicare payment for both the E&M and psychotherapy services, the two services must be significant and separately identifiable.⁸

Medicare requires that psychotherapy services be reasonable and necessary for the diagnosis or treatment of a beneficiary’s illness.⁹ Providers bill Medicare for individual psychotherapy services using one of six psychotherapy CPT¹⁰ codes, depending on the time spent on psychotherapy and whether the service was provided alone or in conjunction with an E&M service. (Figure 1 shows the psychotherapy CPT codes and their descriptions.)

Providers must bill the appropriate CPT code based on the actual time spent on psychotherapy. Each code has a range of time associated with it. For example, CPT codes 90832 and 90833 are billed for 16 to 37 minutes of psychotherapy. (Medicare does not cover psychotherapy services lasting less than 16 minutes.¹¹) There is also a CPT code for group psychotherapy and another for interactive complexity, which is an add-on code that can be billed with a psychotherapy service.¹²

To be paid for an individual psychotherapy service, the provider must furnish information necessary to determine the amount due to the provider.¹³

Figure 1: Psychotherapy CPT Codes and Descriptions

CPT Code	Description
90832	Psychotherapy (30 min)
90833	Psychotherapy (30 min + E&M)
90834	Psychotherapy (45 min)
90836	Psychotherapy (45 min + E&M)
90837	Psychotherapy (60 min)
90838	Psychotherapy (60 min + E&M)
90853	Group Psychotherapy
90785	Interactive Complexity

⁸ American Medical Association (AMA), *CPT [Current Procedural Terminology] 2017–2018*.

⁹ The Act § 1862(a)(1)(A).

¹⁰ **The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2016–2017 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

¹¹ AMA, *CPT 2017–2018*.

¹² AMA, *CPT 2017–2018*. “Interactive complexity” refers to specific communication factors that complicate the delivery of psychiatric procedures, including more difficult communication with discordant or emotional family members. The interactive complexity code (90785) may be used in conjunction with CPT codes for psychotherapy.

¹³ The Act § 1833(e).

Grand Desert Psychiatric Services

Grand Desert is a psychiatric clinic in Las Vegas, Nevada, that provides a wide range of treatment options for mental health patients and those with substance abuse issues. It was established in 2011 and provides a variety of services, such as psychotherapy services, psychiatric diagnostic evaluations, and E&M services. The providers at Grand Desert during our audit period included its owner (a licensed psychiatrist), four nurse practitioners, one licensed clinical social worker, one licensed alcohol and drug counselor, and two interns. Some of these providers also furnished services at a nearby facility that Grand Desert’s owner established in 2016.

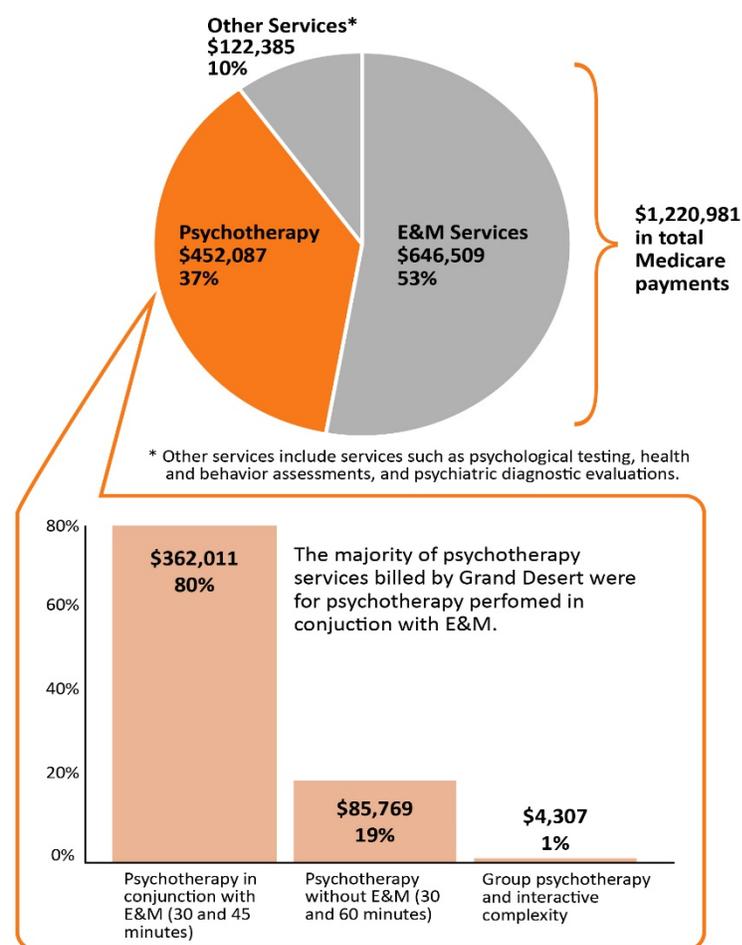
For our audit period, Medicare paid Grand Desert approximately \$1.2 million. Our analysis of Medicare claim data showed that 37 percent of the Medicare payments that Grand Desert received were for psychotherapy. The majority of the psychotherapy payments were for the CPT codes that represented 30 minutes and 45 minutes of time spent on psychotherapy provided in conjunction with an E&M service (CPT codes 90833 and 90836).

Figure 2 shows the total Medicare payments that Grand Desert received during our audit period and the amount paid by Medicare for psychotherapy services, with a breakdown of the types of psychotherapy provided.

Medicare Requirements for Providers To Identify and Return Overpayments

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.¹⁴

Figure 2: Thirty-seven Percent of Medicare Payments to Grand Desert Were for Psychotherapy



¹⁴ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

The 6-year lookback period is not limited by OIG’s audit period or restrictions on the Government’s ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.¹⁵

HOW WE CONDUCTED THIS AUDIT

Our audit covered Grand Desert’s Medicare Part B claims for psychotherapy services provided during our audit period. Our sampling frame consisted of 8,542 beneficiary days, with payments totaling \$450,663.¹⁶ We reviewed a random sample of 100 beneficiary days, consisting of 100 psychotherapy services:

- 89 services for 30 minutes of psychotherapy with an E&M service,
- 9 services for 60 minutes of psychotherapy, and
- 2 services for group psychotherapy.

We requested beneficiary medical records from Grand Desert, which provided us with supporting documentation for 98 of the 100 psychotherapy services in our sample.¹⁷ We reviewed the documentation to determine whether Grand Desert complied with Medicare requirements for billing psychotherapy services.¹⁸ However, we did not determine whether the services were medically necessary.

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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹⁵ 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual—Part 1*, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

¹⁶ A beneficiary day consisted of all psychotherapy services provided on a specific date of service for a specific beneficiary for which Grand Desert received a payment from Medicare. We excluded lines of service that were excluded from review by the Recovery Audit Contractor (RAC) and other entities. (Each line of service represented a billed service on a claim.)

¹⁷ For the remaining two services, Grand Desert provided medical records for the beneficiaries, but the records did not contain supporting documentation for the services in our sample. Therefore, the services were unallowable for Medicare reimbursement.

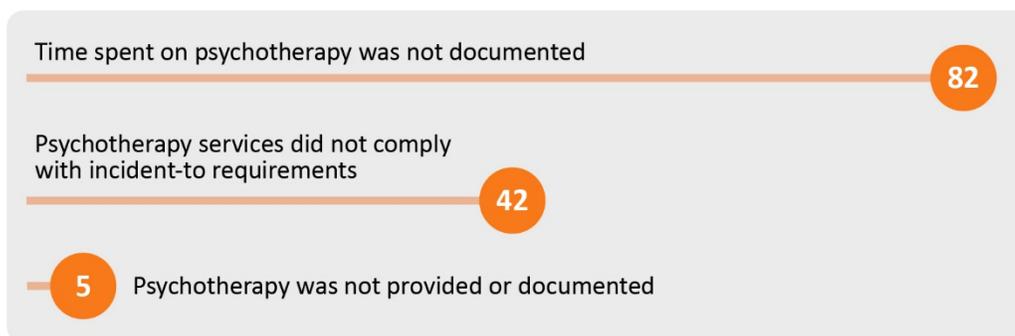
¹⁸ Our audit focused on psychotherapy services; therefore, we did not review the E&M services provided in conjunction with psychotherapy services.

Appendix A describes our audit scope and methodology, Appendix B describes our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

Grand Desert did not comply with Medicare requirements when billing for psychotherapy services. Of the 100 psychotherapy services in our 100 sampled beneficiary days, only 1 service complied with the requirements. However, the remaining 99 services did not comply with the requirements. Figure 3 shows the number of services for each type of deficiency we found.

Figure 3: Unallowable Services in Our Sample by Type of Deficiency¹⁹



As a result, Grand Desert received \$5,173 in unallowable Medicare payments. On the basis of our sample results, we estimated that at least \$421,272 was unallowable for Medicare reimbursement, or 93 percent of the \$450,663 paid to Grand Desert for psychotherapy services. These overpayments occurred because Grand Desert did not have policies and procedures or effective management oversight to ensure that psychotherapy services billed to Medicare were adequately documented, complied with incident-to requirements, and were actually provided.

GRAND DESERT DID NOT COMPLY WITH MEDICARE REQUIREMENTS WHEN BILLING FOR PSYCHOTHERAPY SERVICES

Time Spent on Psychotherapy Was Not Documented

Payment must not be made to a provider for an item or a service unless “there has been furnished such information as may be necessary in order to determine the amounts due such provider” (the Act § 1833(e)).

Psychotherapy times are for face-to-face services with the beneficiary. Providers must bill the CPT code with a time range closest to the actual time spent on psychotherapy (e.g., CPT codes

¹⁹ The total number of deficiencies is greater than 99 because 29 services had more than 1 deficiency.

90832 and 90833 for 16 to 37 minutes of psychotherapy). Providers must not bill for psychotherapy of less than 16 minutes (AMA, *CPT 2017–2018*).

To report both an E&M and a psychotherapy service, the two services must be significant and separately identifiable. The medical and psychotherapeutic components of the services may be separately identified as follows: (1) the type and level of E&M service is selected first by the provider based on the key components of history, examination, and medical decision-making; (2) the time associated with activities used to meet criteria for the E&M service is not included in the time used for reporting the psychotherapy service; and (3) a separate diagnosis is not required for the reporting of E&M and psychotherapy on the same date of service (AMA, *CPT 2017–2018*).

For 82 services, Grand Desert did not document the time spent providing the psychotherapy services:

- For 73 services, for which Grand Desert billed 30 minutes of psychotherapy in conjunction with an E&M service, the supporting documentation contained a start time and a stop time for the entire encounter with the beneficiary.²⁰ However, the documentation did not specifically show how much of that time was spent providing the psychotherapy services. Therefore, Grand Desert did not have support to show that it had spent at least 16 minutes on psychotherapy.
- For nine services, the supporting documentation did not show the time spent providing psychotherapy services.²¹ Grand Desert billed seven out of the nine services without an E&M service, and the remaining two services were billed in conjunction with an E&M service.

See the following page for an example of time spent on psychotherapy that was not documented.

²⁰ According to Grand Desert, the start and stop times in the medical records documented the total face-to-face time between the provider and beneficiary during the encounter.

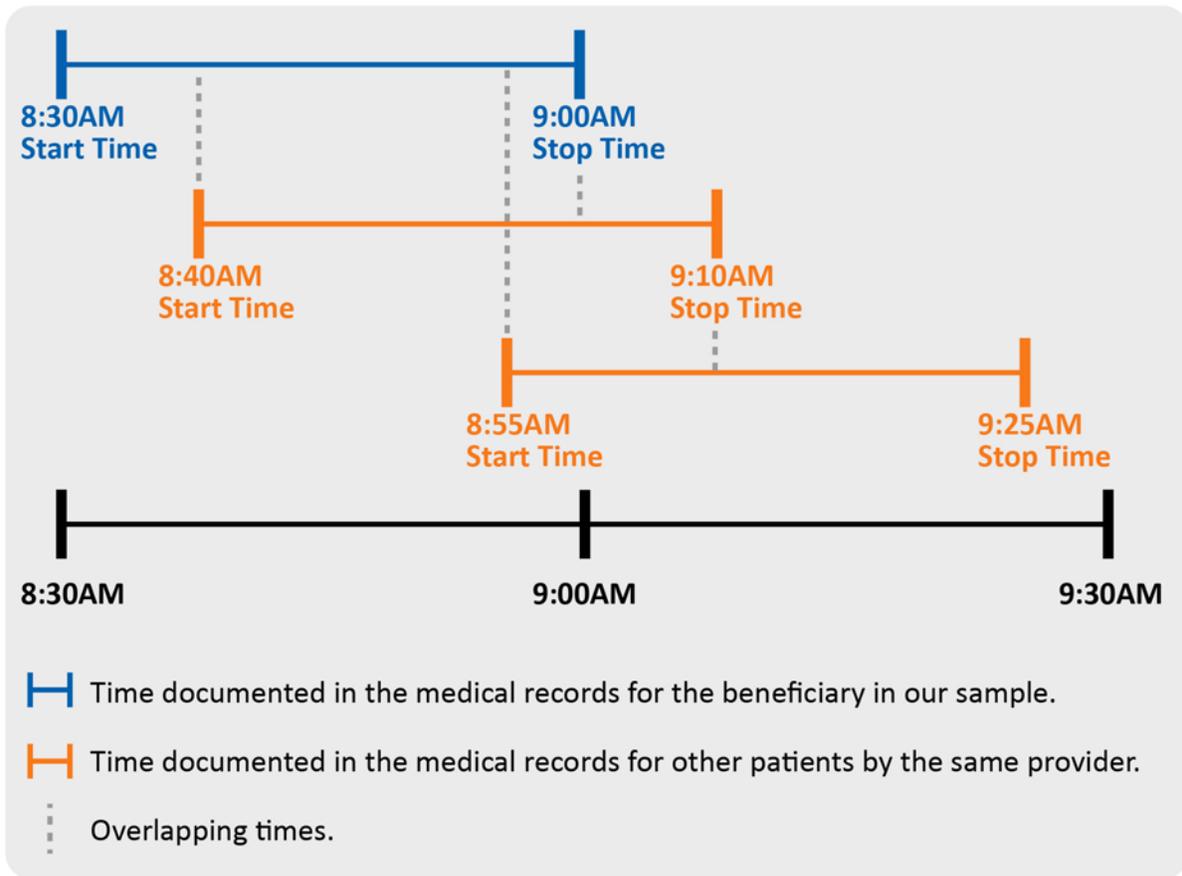
²¹ In addition to not documenting the time spent on psychotherapy, Grand Desert did not document the total face-to-face time between the provider and the beneficiary, which it had done for other psychotherapy services.

Example of Time Spent on Psychotherapy That Was Not Documented

On October 24, 2018, Grand Desert billed Medicare for a 30-minute psychotherapy service in conjunction with an E&M service. Medicare paid Grand Desert \$51 for the psychotherapy service and \$81 for the E&M service. The beneficiary medical record supporting these services stated that the start time was 8:30 a.m. and the stop time was 9:00 a.m., showing that the provider spent a total of 30 minutes with the beneficiary. The provider did not document how much of that time was spent specifically on the psychotherapy service.

In addition, Grand Desert's electronic medical records system showed that the same provider saw two other patients for individual psychotherapy around the same time as the beneficiary in our sample. One patient was seen from 8:40 a.m. to 9:10 a.m., and the other patient was seen from 8:55 a.m. to 9:25 a.m. Figure 4 shows the timeline for the provider's services from 8:30 a.m. to 9:30 a.m., likely indicating that the start and stop times were not accurate because the provider could not have seen three patients simultaneously for individual psychotherapy.

Figure 4: The Overlapping Start and Stop Times for Services Provided to Three Patients Likely Indicates the Times Were Not Accurate



Grand Desert did not have policies and procedures for documenting psychotherapy services. In addition, Grand Desert officials stated that they were aware that the time spent on psychotherapy services had to be documented; however, they were not aware that they should not have entered one range of time that included the time spent on both psychotherapy and E&M services. The officials also stated that the time spent on psychotherapy services was not documented for nine services because the provider forgot to document the time spent.

Psychotherapy Services Did Not Comply With Incident-To Requirements

Medicare Part B pays for services and supplies incident to the service of a physician (or certain other practitioners) (42 § CFR 410.26(b)). Services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness (42 CFR § 410.26(b)(2)).

Certain nonphysician practitioners have the option to provide services incident to the services of a physician and may bill under the physician's NPI if certain requirements are met, including the following:

- The services must be provided as an integral, though incidental, part of the service of a physician in the course of diagnosis or treatment of an injury or illness (42 CFR § 410.26(b)(2)).
- The incident-to services must be provided under the direct supervision of a physician. This means that the physician must be physically present in the same office suite as the nonphysician practitioner providing the incident-to service and be immediately available to provide assistance if that becomes necessary (42 CFR §§ 410.26(a)(2) and (b)(5); 42 CFR § 410.32(b)(3)(ii)).

For 42 services, the psychotherapy services were provided by nonphysician practitioners but improperly billed as if they had been provided by the psychiatrist (who was a physician). As a result, Grand Desert's payments were higher than they would have been if the services had been billed under the nonphysician practitioner's NPI. Grand Desert should not have billed these services as incident to the services of the psychiatrist for the following reasons:

- For 40 services, the psychotherapy services were not an integral part of services provided by the psychiatrist in the course of diagnosis or treatment of an injury or

How Much Are Nonphysician Practitioners Paid for Psychotherapy Services?

For psychotherapy services billed by psychiatrists and psychologists, Medicare allows for payment of 100 percent of the amount shown in the Medicare Physician Fee Schedule; however, other types of providers receive lower payments. For psychotherapy services billed by nurse practitioners and clinical social workers, Medicare allows for payments of 85 percent and 75 percent, respectively, of the Physician Fee Schedule amount. However, services provided by nonphysicians can be reimbursed at the physician rate if they are billed as incident to the services of a physician, psychiatrist, or psychologist.

illness. For each of these services, it was the nonphysician practitioner (not the psychiatrist) who diagnosed the beneficiary and established the course of treatment.

- For five services, Grand Desert was unable to provide evidence to show that the psychiatrist was physically present in the same office suite when the services were provided.²²

In addition, 34 of the 42 psychotherapy services were performed by providers who were not enrolled in Medicare but were billed under the NPI of the psychiatrist who was enrolled in Medicare.²³ Therefore, these providers would not have been paid by Medicare if they had billed for the services using their own NPIs.²⁴

Example of a Psychotherapy Service That Did Not Comply With Incident-To Requirements

On June 4, 2018, Grand Desert billed Medicare for a 30-minute psychotherapy service in conjunction with an E&M service. Medicare paid Grand Desert \$51 for the psychotherapy service and \$81 for the E&M service. Grand Desert billed these services under the psychiatrist's NPI, but the beneficiary medical record showed that a nurse practitioner provided the services. The medical record also showed that the psychiatrist did not diagnose the beneficiary or establish the course of treatment; therefore, the psychotherapy service could not be considered an integral part of a service provided by the psychiatrist. Consequently, the psychotherapy service could not be considered incident to the services of the psychiatrist. In addition, if the service had been billed under the nurse practitioner's NPI, Medicare would not have paid for the service because the nurse practitioner was not enrolled in Medicare.

Grand Desert's policies and procedures for billing Medicare stated that psychotherapy services should be billed as being provided by the psychiatrist or two nurse practitioners.²⁵ However, Grand Desert did not have effective management oversight to ensure that psychotherapy services were correctly billed to Medicare. According to Grand Desert officials, no one reviewed the claims before they were submitted to Medicare.

Grand Desert's psychiatrist was aware that services were provided by nonphysician practitioners and stated that nurse practitioners were permitted to provide services without

²² The total number of deficiencies is greater than 42 because 3 psychotherapy services had more than 1 deficiency related to incident-to requirements.

²³ Physicians, nonphysician practitioners, and other Medicare Part B suppliers must enroll in Medicare to get paid for covered services they furnish to Medicare beneficiaries.

²⁴ The remaining eight services were provided by nonphysician practitioners who were enrolled in Medicare; however, we disallowed the entire amount for these services because they had other deficiencies (i.e., the time spent on psychotherapy was not documented).

²⁵ The two nurse practitioners were enrolled in Medicare in July 2017.

the psychiatrist's supervision. However, he stated that he was not aware that the billing department had billed these psychotherapy services under his NPI as incident-to services and assumed that they had been billed under the nonphysician practitioners' NPIs. Incident-to services must be provided under the direct supervision of the psychiatrist as an integral part of his services. This supervision cannot be accomplished without the psychiatrist's knowledge.

In addition, according to the office manager who was hired in June 2019, Grand Desert's billing system identified the nonphysician practitioner who furnished the psychotherapy service as the "rendering provider" and the psychiatrist as the billing provider. However, the health insurance claim form generated by the billing system and submitted to Medicare included the psychiatrist's NPI in the "rendering provider" field.

Finally, Grand Desert stated that its billing manager, who was responsible for the providers' Medicare enrollment during our audit period, did not complete the Medicare enrollment applications for many of the providers. In addition, the billing manager after our audit period was not aware until June 2019 (after we had begun our audit) that many of Grand Desert's providers were not enrolled in Medicare. According to Grand Desert, it was in the process of enrolling all of its providers in Medicare.

Psychotherapy Was Not Provided or Documented

Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Act § 1833(e)).

For five services, Grand Desert did not provide or document psychotherapy:

- For three services, Grand Desert provided the beneficiaries' medical records, but the records did not indicate that psychotherapy had been provided. Instead, the records documented an evaluation of a beneficiary before a back surgery, a counseling session with a licensed drug and alcohol counselor, and the results of a beneficiary's urinalysis.
- For two services, Grand Desert did not have documentation to support group psychotherapy services. Grand Desert provided medical records for the beneficiaries, but the records did not contain supporting documentation for the services in our sample.

Who Is Qualified To Provide Psychotherapy in Nevada?

In Nevada, psychotherapy may be provided by a psychiatrist, psychologist, social worker, registered nurse who holds a master's degree in the field of psychiatric nursing, marriage and family therapist, or clinical professional counselor. Nevada does not permit psychotherapy services to be provided by licensed drug and alcohol counselors.

Example of a Psychotherapy Service That Was Not Provided

On June 22, 2018, Grand Desert billed Medicare for a 60-minute psychotherapy service. Medicare paid Grand Desert \$98 for the psychotherapy service. The beneficiary medical record for the date of service did not indicate that psychotherapy had been provided. Instead, the record indicated that the beneficiary had received counseling to stay sober from drugs. Grand Desert billed this service under the psychiatrist's NPI, but the medical record indicated that the service was provided by a licensed alcohol and drug counselor, who was not qualified to provide psychotherapy services in Nevada.

Grand Desert did not have effective management oversight to ensure that psychotherapy services billed to Medicare were actually provided or had supporting documentation. According to Grand Desert officials, no one compared the Medicare claims with the beneficiary medical records to ensure that psychotherapy services had been provided and documented.

For one of the three services for which the records did not indicate that psychotherapy had been provided, the psychiatrist stated that the focus of the documentation in the medical record was the evaluation for surgery; however, during the evaluation, the beneficiary discussed other issues that led the psychiatrist to conclude that he could bill for psychotherapy. He also stated that he provided psychotherapy for the sampled service but did not document in the medical record every word of the session. Grand Desert officials stated that the remaining two services were billed in error. For the service provided by the licensed drug and alcohol counselor, the officials stated that the medical record for this service did not indicate which CPT code to bill, so the biller accidentally entered the wrong one.²⁶ For the service in which the medical record showed the results of a urinalysis, the officials had no explanation for the error.

For the two services for which Grand Desert did not provide supporting documentation, Grand Desert officials stated that the group psychotherapy services were provided at a different location, and the medical records were not entered into the electronic medical records system. According to Grand Desert's office manager, the offsite location kept handwritten medical records, and the billers had to manually enter the billing information for these services. Although Grand Desert had medical records for the beneficiaries who received these two services, it could not locate the supporting documentation for the services in our sample and stated that these services were billed in error.

GRAND DESERT RECEIVED UNALLOWABLE MEDICARE PAYMENTS

Grand Desert received \$5,173 in Medicare payments for the 99 services that did not meet Medicare requirements. On the basis of our sample results, we estimated that at least

²⁶ Even if the service had been billed with the correct CPT code, it would not have been payable by Medicare because the provider was not enrolled in Medicare and the service did not meet incident-to requirements.

\$421,272 of the \$450,663 (or 93 percent) paid to Grand Desert for psychotherapy services was unallowable for Medicare reimbursement.

GRAND DESERT DID NOT HAVE POLICIES AND PROCEDURES OR EFFECTIVE MANAGEMENT OVERSIGHT TO ENSURE THAT IT COMPLIED WITH MEDICARE REQUIREMENTS

Grand Desert did not have policies and procedures or effective management oversight to ensure that psychotherapy services billed to Medicare were adequately documented, complied with incident-to requirements, and were actually provided.

Specifically, Grand Desert was not aware of Medicare's requirements for psychotherapy services and did not have policies and procedures for providing and documenting these services. Policies and procedures may have ensured that Grand Desert documented the time spent on psychotherapy.

Grand Desert did not have effective management oversight to ensure that psychotherapy services were correctly billed to Medicare. According to Grand Desert officials, no one reviewed the claims before they were submitted to Medicare. A review of the claims could have identified that most of the services were billed under the psychiatrist's NPI rather than the NPI of the provider who furnished the services. In addition, Grand Desert's billing system did not ensure that Medicare claims identified the correct provider of psychotherapy services.

Lastly, Grand Desert did not have effective management oversight to ensure that psychotherapy services billed to Medicare were actually provided and had supporting documentation. According to Grand Desert officials, no one compared the Medicare claims with the beneficiary medical records to ensure that psychotherapy services had been provided and documented. A comparison of the Medicare claims with the medical records could have identified that psychotherapy services were billed in error.

Can Improper Documentation Affect the Quality of Care Provided to Medicare Beneficiaries?

Proper documentation promotes patient safety and quality of care. According to CMS, documentation is an important aspect of patient care and is used to coordinate services among medical professionals, furnish sufficient services, and improve patient care. (CMS's presentation *Your Medical Documentation Matters*, December 9, 2015.)

CMS also stated: "Behavioral health practitioners are in the business of helping their patients. Patients are their priority. Meeting ongoing patient needs, such as furnishing and coordinating necessary services, is impossible without documenting each patient encounter completely, accurately, and in a timely manner. Documentation is often the communication tool used by and between professionals. Records not properly documented with all relevant and important facts can prevent the next practitioner from furnishing sufficient services. The outcome can cause unintended complications." (CMS's factsheet *Medicaid Documentation for Behavioral Health Practitioners*, December 2015.)

RECOMMENDATIONS

We recommend that Grand Desert Psychiatric Services:

- refund to Noridian \$421,272 in estimated overpayments for psychotherapy services;²⁷
- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule²⁸ and identify any of those returned overpayments as having been made in accordance with this recommendation;
- implement policies and procedures to ensure that psychotherapy services billed to Medicare are adequately documented, including the time spent on those services;
- strengthen management oversight and review Medicare claims to ensure that psychotherapy services billed to Medicare meet incident-to requirements;
- improve its billing system to ensure that Medicare claims identify the correct provider of psychotherapy services; and
- strengthen management oversight to ensure that psychotherapy services billed to Medicare were actually provided and have supporting documentation.

AUDITEE COMMENTS

On February 25, 2020, we issued our draft report to Grand Desert and requested that it provide us with written comments. On March 17, 2020, Grand Desert informed us that it would not provide written comments.

²⁷ OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

²⁸ This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Grand Desert's Medicare Part B claims for psychotherapy services provided from January 1, 2017, through December 31, 2018. Our sampling frame consisted of 8,542 beneficiary days, with payments totaling \$450,663.²⁹ We reviewed a random sample of 100 beneficiary days, which consisted of 100 psychotherapy services:

- 89 services for 30 minutes of psychotherapy with an E&M service,
- 9 services for 60 minutes of psychotherapy, and
- 2 services for group psychotherapy.

We requested beneficiary medical records from Grand Desert, which provided us with supporting documentation for 98 of the 100 psychotherapy services in our sample.³⁰ We reviewed the documentation to determine whether Grand Desert complied with Medicare requirements for billing psychotherapy services.³¹ However, we did not determine whether the services were medically necessary.

We did not review Grand Desert's overall internal control structure. Rather, we limited our review of internal controls to those that were significant to our objective.

We conducted our audit from May to October 2019, which included fieldwork performed at Grand Desert's clinic in Las Vegas, Nevada.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

²⁹ A beneficiary day consisted of all psychotherapy services provided on a specific date of service for a specific beneficiary for which Grand Desert received a payment from Medicare. We excluded lines of service that were excluded from review by the RAC and other entities. (Each line of service represented a billed service on a claim.)

³⁰ For the remaining two services, Grand Desert provided medical records for the beneficiaries, but the records did not contain supporting documentation for the services in our sample. Therefore, the services were unallowable for Medicare reimbursement.

³¹ Our review focused on psychotherapy services; therefore, we did not review the E&M services provided in conjunction with psychotherapy services.

- interviewed Noridian officials to obtain an understanding of Medicare reimbursement requirements for psychotherapy services;
- interviewed Grand Desert officials to obtain an understanding of Grand Desert’s policies and procedures for providing and documenting psychotherapy services;
- interviewed Grand Desert’s billing staff to obtain an understanding of the procedures for billing Medicare for psychotherapy services;
- obtained from CMS’s National Claims History (NCH) file the paid Medicare Part B claims for psychotherapy services that Grand Desert provided to Medicare beneficiaries for our audit period;³²
- created a sampling frame of 8,542 beneficiary days for psychotherapy services and randomly selected a sample of 100 beneficiary days (Appendix B);
- reviewed data from CMS’s Common Working File and other available data for the services for the sampled beneficiary days to determine whether the claim lines for the services had been canceled or adjusted;
- obtained from Grand Desert the supporting documentation for the sampled beneficiary days;
- reviewed the supporting documentation to determine whether Grand Desert complied with Medicare requirements;
- estimated the amount of the unallowable payments for psychotherapy services that Grand Desert provided (Appendix C); and
- shared the results of our audit with Grand Desert officials.

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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

³² Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS’s NCH file, but we did not assess the completeness of the file.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We obtained Medicare Part B claims data for psychotherapy services that Grand Desert provided during our audit period, representing 18,010 lines of service totaling \$1,220,981. (Each line of service represented a billed service on a claim.) We excluded 9,447 service line items that were not for psychotherapy services. We grouped the remaining lines of service by beneficiary Health Insurance Claim Number and date of service to identify the beneficiary days. We also excluded from the beneficiary days the lines of service that were excluded from review by the RAC and other entities. As a result, the sampling frame consisted of 8,542 beneficiary days, which consisted of 8,548 lines of service totaling \$450,663.³³

SAMPLE UNIT

The sample unit was a beneficiary day. A beneficiary day consisted of all psychotherapy services provided on a specific date of service for a specific beneficiary for which Grand Desert received a payment from Medicare.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiary days.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of unallowable payments for psychotherapy services. To be conservative, we recommend recovery of overpayments at the

³³ Of the 8,542 beneficiary days, 8,536 beneficiary days had 1 service line item and 6 beneficiary days had 2 service line items.

lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

No. of Beneficiary Days in Sampling Frame	Value of Beneficiary Days in Sampling Frame	Sample Size	Value of Sample	No. of Unallowable Beneficiary Days	Value of Unallowable Beneficiary Days
8,542	\$450,663	100 ³⁴	\$5,267	99	\$5,173

Table 2: Estimated Value of Unallowable Payments³⁵
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$441,861
Lower limit	421,272
Upper limit	450,663

³⁴ Each of the 100 beneficiary days in our sample was associated with a single service.

³⁵ The upper limit we calculated using the OIG/OAS statistical software for the total overpayment amount was \$462,451. We adjusted this estimate downward to reflect the known value of the sampling frame.