Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAYMENTS FOR 2003 PART B MENTAL HEALTH SERVICES: MEDICAL NECESSITY, DOCUMENTATION, AND CODING

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EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which Medicare Part B mental health services met Medicare's coverage criteria and were coded correctly in 2003.

BACKGROUND

Medicare Coverage of and Reimbursement for Mental Health Services

Medicare's Supplementary Medical Insurance (Part B) covers physicians' services, outpatient care which also includes mental health services, and other services not covered by Medicare's Hospital Insurance (Part A). General provisions of the Social Security Act (the Act) govern Medicare reimbursement of all services, including mental health services. In general, beneficiaries are responsible for coinsurance of 20 percent of the approved amount for most Part B services; however, section 1833(c) of the Act limits payments to 62.5 percent of the expenses (Medicare-approved amount) for mental health services. Section 1862(a)(1)(A) of the Act states that "no payment may be made under Part A or Part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. . . ." Section 1833(e) requires that providers furnish "such information as may be necessary in order to determine the amounts due" to receive Medicare payment.

Mental health services covered by Medicare include psychotherapy, psychiatric pharmacologic management, and evaluation and management. Mental disorders that occur most frequently for Medicare beneficiaries include affective psychoses, senile psychotic conditions, schizophrenic disorders, and neurotic disorders. Psychiatrists, clinical psychologists, licensed clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants typically render mental health services. In addition, licensed and unlicensed staff can furnish mental health services "incident to" the billing practitioner's professional services. In these cases, the services must be furnished to noninstitutionalized patients under the direct supervision of the billing practitioner (or another physician).

In 2003, the Centers for Medicare & Medicaid Services (CMS) issued a Program Memorandum (Transmittal AB-03-037) that focused on

Part B mental health services. The memorandum explained Medicare's guidelines for payment for Part B mental health services. CMS instructed its contractors to disseminate the information to Medicare providers.

The Office of Inspector General (OIG) has issued several reports that identified vulnerabilities in Medicare payments for mental health services. In 2001, OIG issued "Medicare Part B Payments for Mental Health Services" (OEI-03-99-00130), which found that Medicare allowed $185 million for inappropriate outpatient mental health services. In response, CMS issued the aforementioned Program Memorandum.

Methodology

In 2005, we conducted a medical record review of a random sample of 452 Part B mental health services rendered by 422 billing practitioners in 2003, the most recent year for which we had Medicare claims data. Licensed psychiatrists reviewed the practitioners' medical records we received to determine the medical necessity of the sampled services. Certified professional coders reviewed the medical records to determine proper coding. In addition, we interviewed 372 of the 422 billing practitioners for the sampled services.

FINDING

Forty-seven percent of the mental health services allowed by Medicare in 2003 did not meet program requirements, resulting in approximately $718 million in improper payments. Medicare allowed approximately $2.14 billion in 2003 for Part B mental health services; 47 percent of these services did not meet Medicare requirements. Miscoded and undocumented services accounted for 26 and 19 percent of all mental health services in 2003, respectively. Medically unnecessary services and services that violated the "incident to" rule each accounted for 4 percent of all mental health services in 2003. Some services had more than one error, resulting in overlapping errors in our error rate calculation.

RECOMMENDATION

We recommend that CMS revise, expand, and reissue its 2003 Program Memorandum on Part B mental health services with an increased emphasis on proper documentation and coding. In addition, the memorandum should emphasize the requirements for mental health services billed "incident to."

In addition to this recommendation, we have forwarded information on the miscoded, undocumented, and medically unnecessary services identified in our sample to CMS for appropriate action.

AGENCY COMMENTS

In its comments on the draft report, CMS concurred with our recommendation. CMS noted that significant information on medical documentation requirements and "incident to" requirements is available on the CMS Web site and from its contractors. Nevertheless, CMS will consolidate this information for providers of mental health services.

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INTRODUCTION

OBJECTIVE

To determine the extent to which Medicare Part B mental health services met Medicare's coverage criteria and were coded correctly in 2003.

BACKGROUND

Medicare Part B Mental Health Services: Profile of 2003 Claims

Medicare and its beneficiaries paid approximately $2.14 billion for Medicare's Supplementary Medical Insurance (Part B) mental health services in 2003.[1] Allowed amounts[2] for mental health services have increased steadily since 1998; the median annual increase was 4.6 percent. Approximately 4 million Medicare beneficiaries received Part B mental health services in 2003. The number of beneficiaries who received mental health services increased modestly from 1998 to 2003; the median annual increase was 1 percent. In 2003, beneficiaries were allowed an average of $538 for mental health services.[3]

In 2003, approximately 38 percent of the mental health services consisted of individual psychotherapy. Another 38 percent of the services consisted of psychiatric diagnostic interview examinations, central nervous system testing, and evaluation and management (E&M) services; and 17 percent of the services consisted of medication management.[4] The remaining services, approximately 7 percent, consisted of other mental health services, including group and electroconvulsive therapy.

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[1] This total includes all claims with psychiatric codes (Current Procedural Terminology (CPT) codes 90801–90899) in addition to claims for E&M and central nervous system tests that are supported by a mental disorder diagnosis. All estimates are based on Office of Inspector General (OIG) analysis of a 1-percent sample of Medicare National Claims History.

[2] "Allowed amount" is the total Medicare-approved amount for a service, which includes the amount reimbursed to the provider and the beneficiary copayment.

[3] At the time of our review, 2003 was the most recent full year of Medicare claims data available.

[4] Medication management may be billed under one of two CPT codes: 90862 (psychiatric pharmacologic management) or M0064 (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders).

Overall, psychiatrists billed for 50 percent of the services, clinical psychologists billed for 17 percent, and licensed clinical social workers billed for 11 percent. Nurses, multispecialty group practices, and various physician specialties billed for the remaining 22 percent. Psychiatrists typically billed for procedures involving E&M services, while psychologists and clinical social workers were more likely to bill for individual and group psychotherapy.

Medicare Coverage for Part B Mental Health Services

General provisions of the Social Security Act (the Act) govern Medicare reimbursement of all services, including mental health services. Section 1862(a)(1)(A) of the Act states that no payment may be made for services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Section 1833(e) requires that providers furnish "such information as may be necessary to determine the amounts due" to receive Medicare payment. Related regulations at 42 CFR §§ 411.15(k)(1) and 424.5(a)(6) implement these provisions of the Medicare law.

Medicare Part B covers physicians' services, outpatient care, and other services not covered by Medicare's Hospital Insurance (Part A). In general, beneficiaries are responsible for coinsurance of 20 percent of the approved amount for most Part B services; however, the Act limits payments to 62.5 percent of the expenses (Medicare-approved amount) for mental health services.[5] Specifically, the law limits payments for services in connection with the treatment of "mental, psychoneurotic, and personality disorders."

Section 1848(a)(1) of the Act established the physician fee schedule as the basis for Medicare reimbursement for all physician services beginning in January 1992. Section 1848(c)(5) of the Act required the Secretary of the Department of Health and Human Services to develop a uniform coding system for all physician services. The American Medical Association's (AMA) "Current Procedural Terminology" (CPT) maintains a numeric coding system for physicians' services, including mental health services. In 1983, the Centers for Medicare & Medicaid Services

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[5] Section 1833(c) of the Act. This is the Outpatient Mental Health Treatment Limitation, which typically results in a beneficiary copayment of 50 percent of the Medicare-approved amount. See the companion report, "Carrier Determination of Copayments for Medicare Mental Health Services" (OEI-09-04-00221).

(CMS) adopted CPT as part of Medicare's Healthcare Common Procedure Coding System (HCPCS) and mandated that providers use HCPCS to report physicians' services to Medicare.

CMS issues binding guidance to its carriers[6] in the form of claims-processing manuals and memoranda. In 2003, CMS issued a Program Memorandum[7] to its carriers concerning Part B mental health services. The memorandum includes:

> Medicare's guidelines for payment of Part B mental health services including qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for evaluation and management (E/M) services involving a general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment.[8]

CMS instructed carriers to include the memorandum in their next bulletin to providers and to post it on their Web sites or bulletin boards.

To bill Medicare for mental health services, practitioners must be qualified to perform the services in the States in which they render services. Medicare permits the following practitioners to bill Medicare independently for mental health services, as long as the services are included in their States' scopes of practice:

- physicians (including psychiatrists),[9]
- psychologists,[10]
- licensed clinical social workers,[11]

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[6] Section 1842 of the Act authorizes CMS to contract with private companies, called carriers, to process and pay physician and nonphysician practitioner Part B claims within a given service area, which usually follows State lines.

[7] CMS, Transmittal AB-03-037, Change Request 2520, Provider Education Article: "Medicare Payments for Part B Mental Health Services," March 28, 2003.

[8] Ibid.

[9] 42 CFR § 410.20.

[10] 42 CFR § 410.71.

[11] 42 CFR § 410.73.

- nurse practitioners,[12]
- clinical nurse specialists,[13] and
- physician assistants.[14]

"Incident to" Rule

Medicare allows physicians to bill for mental health services performed by their staffs and furnished to patients if the services are rendered "incident to" the physicians' professional services.[15] These services may be performed by auxiliary personnel if the services are:

- furnished in a noninstitutional setting to noninstitiutional patients;
- 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;
- commonly furnished without charge or included in the bill of a physician (or other practitioner);
- of a type that are commonly furnished in the office or clinic of a physician (or other practitioner); and
- furnished under the direct supervision of the physician (or other practitioner). The physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the "incident to" service is based.

Outpatient Mental Health Services and Psychiatric Disorders

Outpatient mental health services commonly rendered[16] to Medicare beneficiaries include:

- psychotherapy: treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate emotional disturbances,

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[12] 42 CFR § 410.75.

[13] 42 CFR § 410.76.

[14] 42 CFR § 410.74.

[15] Section 1861(s)(2)(A) of the Act; 42 CFR § 410.26.

[16] Based on OIG analysis of a 1-percent sample of Medicare claims for 2003.

reverse or change maladaptive patterns of behavior, and encourage personality growth and development;[17]

- psychiatric pharmacologic management: including prescription, use, and review of medication with no more than minimal medical psychotherapy;[18] and
- E&M services: office visits, hospital visits, and consultations that typically involve at least one of three key components—history, physical examination, and medical decisionmaking. E&M services can vary based on these three key components, and reimbursement is based on one of five levels.[19] (See Appendix A for median reimbursements for the various E&M services and all other services that we reviewed.)

Psychiatric disorders that occur most frequently for Medicare beneficiaries[20] include:

- affective psychoses (e.g., major depressive disorder and bipolar affective disorder),
- senile psychotic conditions,
- schizophrenic disorders, and
- neurotic disorders (e.g., neurotic depression and adjustment reaction).

These disorders are described in more detail in AMA's "International Classification of Diseases, 9th Revision" (ICD-9) and the American Psychiatric Association's "Diagnostic Statistical Manual, Third Edition – Revised" (DSM-III-R).

Previous Office of Inspector General Work

Since 1996, the Office of Inspector General (OIG) has issued several audits and evaluation reports concerning Medicare mental health services. Most recently, in 2001, OIG issued "Medicare Part B Payments for Mental Health Services" (OEI-03-99-00130). Based on a medical review of mental health services rendered in 1998, OIG reported that approximately 31 percent of the claims were paid

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[17] AMA, "Current Procedural Terminology, Professional Edition," 2003, p. 353.
[18] Ibid, p. 355.
[19] Ibid, p. 5.
[20] Based on OIG analysis of a 1-percent sample of Medicare claims for 2003.

inappropriately, including 23 percent that were not medically necessary. Medicare allowed $185 million for these inappropriate outpatient mental health services. OIG recommended that CMS target certain mental health services for prepayment and postpayment review, promote provider awareness of requirements for Part B mental health services, and work with carriers and mental health professionals to develop a list of psychological assessments that can be billed correctly under CPT code 96100.

In response to the 2001 report, CMS issued a Program Memorandum (mentioned previously on page 3 of this report) in 2003 to assist carriers in "informing the provider community about requirements for payment of Part B mental health services."[21]

Other reports have focused on mental health services rendered in institutions. (See Appendix B for a listing and summary of other OIG reports.)

Companion Report

This is the second of two reports on Medicare Part B mental health services rendered in 2003. The first report, issued in October 2006, determined the extent to which Medicare carriers consistently calculate beneficiary copayments for mental health services and correctly calculate copayments for services rendered to beneficiaries diagnosed with Alzheimer's disease or related disorders ("Carrier Determination of Copayments for Medicare Mental Health Services" (OEI-09-04-00221)).

METHODOLOGY

Our methodology consisted of a medical necessity and coding review of a random sample of Part B mental health services rendered in 2003 and structured interviews of the billing practitioners for the sampled services.

We conducted a medical review of a stratified random sample of 452 mental health services for 422 billing practitioners rendered during calendar year 2003, the most recent full year of Medicare claims data available at the time of our review. We requested by mail complete medical records from each billing practitioner of the sampled

[21] CMS, Transmittal AB-03-037, Change Request 2520, "Provider Education Article: Medicare Payments for Part B Mental Health Services," March 28, 2003, p. 1.

mental health services. We contacted each billing practitioner in our sample either by mail or by telephone. The response rate was 99 percent.

We contracted with three licensed psychiatrists and two certified professional coders to conduct a medical record review using a protocol OIG developed in collaboration with the reviewers. The psychiatrists reviewed the medical records to determine whether the services were medically necessary. Certified professional coders determined the appropriate CPT codes for the sampled services based on the medical record documentation.

We attempted to interview by telephone each of the 422 billing practitioners in our sample. We used a standardized interview instrument to determine whether the billing practitioners (1) rendered the sampled services personally or (2) billed for the services "incident to" their professional services. We interviewed 372 of the 422 billing practitioners for an 88-percent response rate.

See Appendix C for a more detailed explanation of the methodology and Appendix D for details on the sampling plan.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

FINDING

Forty-seven percent of the mental health services allowed by Medicare in 2003 did not meet program requirements, resulting in approximately $718 million in improper payments

Medicare allowed approximately $2.14 billion in 2003 for Part B mental health services. Forty-seven percent of these services did not meet Medicare requirements. (Confidence intervals for all statistics are in Appendix E.) As a result, Medicare allowed approximately $718 million in improper payments in 2003 for mental health services. Table 1 groups the improperly paid services in our sample by type of error and gives statistical projections of these errors to the population.

Table 1: Improperly Paid Medicare Part B Mental Health Services—2003

Type of Error	Sample		Projected	
	Services	Allowed Amount	Services	Allowed Amount
Miscoded	140	$4,998.38	26%	$245 million
Undocumented	83	$5,813.00	19%	$356 million
Medically Unnecessary	24	$2,037.24	4%	$106 million
"Incident to" Violations	16	$1,350.23	4%	$72 million*
(Overlapping Errors)	(29)	($1,175.68)	(5%)	($62 million*)
Total	**234**	**$13,023.17**	**47%****	**$718 million****

* The confidence intervals for these estimates have at least 50-percent relative precision.

**Numbers do not add due to rounding.

Source: OIG analysis of medical review results, 2006.

Miscoded. In 2003, Medicare allowed approximately $701 million for Part B mental health services that were billed with codes that did not accurately reflect the services provided. If these services had been coded properly, Medicare would have allowed only $456 million, yielding an overpayment of $245 million for miscoded services.

Of the 140 miscoded services within our sample, 133 were "upcoded," 6 were "downcoded," and 1 was miscoded with no effect on payment. (See Table 2 on the next page.) Upcoded services are billed at a level higher than the actual level of the service performed. For example, a 20- to 30-minute individual psychotherapy service billed as a 45- to 50-minute service is an upcoded service. Conversely, a downcoded service is billed at a lower level than the actual level of the service performed.

Table 2: Miscoded Services in the Sample				
Service Type (as billed)	Upcoded	Downcoded	Miscoded (No effect on payment)	**Total**
Individual Psychotherapy	73	2	0	**75**
E&M Services	58	1	0	**59**
Psychiatric Diagnostic Interview Examinations	2	0	1	**3**
Medication Management	0	3	0	**3**
Total	**133**	**6**	**1**	**140**

Source: OIG medical review results, 2006.

Almost all miscoded individual psychotherapy claims lacked documentation to justify the time billed. Individual psychotherapy can be billed as one of three time periods: 20 to 30 minutes, 45 to 50 minutes, or 75 to 80 minutes. Because reimbursement of psychotherapy services is based on face-to-face time spent with the patient, practitioners are required to document in the medical record the time spent with the patient.[22] However, in the majority of the records for miscoded services, no time was documented. As a result, our reviewers determined that the services should have been billed at the lowest possible time period. For some practitioners who claimed to have furnished E&M services in conjunction with psychotherapy, our reviewers found no evidence for those E&M services on the same dates of service. Therefore, the practitioners should have used codes for services consisting solely of psychotherapy. For other miscoded psychotherapy services, reviewers found that the actual services were not psychotherapy but totally different services, such as E&M services, medication management,[23] psychological evaluation, and group psychotherapy.

[22] Section 1833(e) requires that providers furnish "such information as may be necessary to determine the amounts due" to receive Medicare payment.

[23] Medication management may be billed under one of two codes: 90862 (psychiatric pharmacologic management) or M0064 (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders).

Table 3: Miscoded E&M Services in the Sample		
Type of Error	**Number of Miscoded Services Billed as E&M in Sample**	**Percentage of Miscoded Services Billed as E&M Services**
Downcoded	1	2%
Not an E&M Service	1	2%
Upcoded	58	98%
By 1 level	26	44%
By 2 levels	19	32%
By 3 levels	1	2%
Established patient, not new patient or Subsequent visit, not initial visit	5	8%
Not an E&M Service	5	8%
Wrong place of service	2	3%
Total miscoded E&M services	**59**	**100%**

Source: OIG medical review results, 2006.

Most of the miscoded E&M services in our sample were billed at a higher level than the medical record documentation supported.[24] (See Table 3.) For example, a practitioner billed for an E&M service that indicated that the decisionmaking was of moderate complexity; however, reviewers found the documentation supported decisionmaking that was straightforward or of low complexity.[25] Reviewers found that some services were billed incorrectly because the services were rendered during a subsequent visit rather than an initial visit. Reimbursement rates for subsequent E&M visits are less than those for initial visits. Other miscoded E&M services should have been billed as psychiatric diagnostic interview examinations, consultations, or psychotherapy,

[24] E&M services levels vary based on (1) the extent of the patient history obtained, (2) the extent of the examination performed, and (3) the complexity of the medical decisionmaking. (AMA, "Current Procedural Terminology, Professional Edition," 2003, pp. 5–7.)

[25] The complexity of medical decisionmaking for E&Ms can be billed at one of four levels: straightforward, low, moderate, or high. (AMA, "Current Procedural Terminology, Professional Edition," 2003, p. 7.)

which are reimbursed at a lower rate. In addition, some E&M services were miscoded because the place of service (e.g., inpatient) did not match the place of service indicated in the medical record (e.g., outpatient).

Three psychiatric diagnostic interview examinations in our sample were miscoded. These examinations are "history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies."[26] Documentation for these miscoded services supported a brief medication management visit, indicated that the practitioner rendered psychotherapy in the home, or did not show evidence that the provider used "interactive" psychiatric diagnostic interview techniques (although the practitioner coded the interview as interactive). Two of these services should have been reimbursed at a lower rate, and the rate for the third would not have changed.

Three medication management services in our sample were downcoded. Documentation for two of these services supported an E&M code, and documentation for the third indicated that the practitioner furnished more than minimal psychotherapy during the visit and should have billed under a psychotherapy code. These services should have been reimbursed at a higher rate.

Undocumented. Medicare allowed approximately $356 million for undocumented services. For more than half of these services, we received no documentation for the sampled dates of service. This includes services for which we received no medical records whatsoever from the billing practitioner. For the other undocumented services, we received inadequate documentation to determine the medical necessity of the services, or the medical records indicated that a practitioner saw the patient on the date of service billed; however, the documentation was insufficient to determine a billable code.

Although some cases of missing documentation may be attributable to billing errors (e.g., putting the wrong date on the claim form), others may represent services not rendered. Claims for services that lack sufficient documentation to show that care was provided do not meet the requirements of section 1833(e) of the Act.

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[26] AMA, "Current Procedural Terminology, Professional Edition," 2003, p. 353.

Medically unnecessary. Medical reviewers determined that these services, which represent $106 million allowed by Medicare, were not medically necessary because:

- The psychotherapy session was too long.
- The patient could not benefit from the psychotherapy.
- The sessions, such as number of sessions per week, were too frequent.
- No clinical problem was documented in the record.
- The patient cancelled the session.

"Incident to" violations. Ten of the sixteen "incident to" services that were billed in error were furnished in a skilled nursing facility or a hospital and therefore violated Federal regulations.[27] The remaining six services were furnished without the level of supervision required by regulations,[28] which require that "incident to" services be furnished under direct supervision.[29] The billing practitioners reported to us that these services were furnished under general supervision.[30] The personnel who rendered these services included:

- physician assistant,
- nurse practitioner,
- licensed clinical social worker,
- licensed professional counselor,
- licensed psychiatric assistant, or
- psychology intern.

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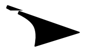
[27] Pursuant to 42 CFR § 410.26(b)(1), "incident to" services "must be furnished in a noninstitutional setting to noninstitutional patients." Pursuant to 42 CFR § 410.26(a)(5), noninstitutional settings include "all settings other than a hospital or skilled nursing facility."

[28] 42 CFR § 410.26(b)(5).

[29] Pursuant to 42 CFR § 410.26(a)(2), "direct supervision" means the level of supervision defined in 42 CFR § 410.32(b)(3)(ii), which provides that "[d]irect supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed."

[30] "General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure" (42 CFR § 410.32(b)(3)(i)).



R E C O M M E N D A T I O N

Almost half of the Medicare Part B mental health services allowed in 2003 did not meet program requirements, resulting in an estimated $718 million in improper payments. Incorrect coding and poor documentation make Medicare and its beneficiaries vulnerable to overpayments for Part B mental health services, accounting for more than $600 million of the $718 million paid improperly in 2003. The remainder of improper payments was for services that were not medically necessary or violated the "incident to" rule.

The 2003 CMS Program Memorandum[31] on Part B mental health services referenced other CMS guidance documents on requirements for medical record documentation and "incident to" services. However, it did not provide specific guidelines for documentation of face-to-face time with patients or the requirement that "incident to" services be provided under direct supervision of a physician and only billed for patients in noninstitutional settings.[32] Therefore, we recommend that CMS revise, expand, and reissue its 2003 Program Memorandum on mental health services to include:

1. an increased emphasis that "CPT and ICD-9-CM codes reported on health insurance claim forms should be supported by documentation in the medical record,"[33] including the requirement that documentation must be adequate to determine the Medicare amounts due (e.g., documentation for psychotherapy services should include the amount of face-to-face time spent with the patient);
2. an emphasis that adequate documentation in the medical record must be present when billing for psychotherapy services furnished with E&M services;
3. an increased emphasis that medical record documentation must support the level of E&M code billed; and
4. an increased emphasis on the requirements for "incident to" services, especially the (1) supervision requirements and

[31] CMS, Transmittal AB-03-037, Change Request 2520, "Provider Education Article: Medicare Payments for Part B Mental Health Services," March 28, 2003.

[32] Section 1861(s)(2)(A) of the Act.

[33] CMS, Transmittal AB-03-037, Change Request 2520, "Provider Education Article: Medicare Payments for Part B Mental Health Services," March 28, 2003.

(2) the requirement that "incident to" can be billed only for patients in noninstitutional settings.[34]

In addition to this recommendation, we have forwarded information on the miscoded, undocumented, and medically unnecessary services identified in our sample to CMS for appropriate action.

AGENCY COMMENTS

In its comments on the draft report, CMS concurred with our recommendation. CMS noted that significant information on medical documentation requirements and "incident to" requirements is available on the CMS Web site and from its contractors. Nevertheless, CMS will consolidate this information for providers of mental health services. For the full text of CMS's comments, see Appendix F.

[34] Section 1861(s)(2)(A) of the Act.

CPT Codes Included in the Medical Review

Includes Codes for the Sampled Claims and Codes Used to Correct the Miscoded Claims

CPT Code	Procedure	2003 Median Medicare Allowed Amount
	Psychiatry	
90801	Psychiatric diagnostic interview exam	$140.13
90802	Interactive psychiatric diagnostic exam, using play equipment/play devices/language interpreter/other	$88.36
90804	Individual psychotherapy; office, 20–30 minutes	$54.86
90805	Individual psychotherapy; office, 20–30 minutes with Evaluation & Management (E&M)	$68.25
90806	Individual psychotherapy; office, 45–50 minutes	$89.69
90807	Individual psychotherapy; office, 45–50 minutes with E&M	$105.04
90808	Individual psychotherapy; office, 75–80 minutes	$120.00
90809	Individual psychotherapy; office, 75–80 minutes with E&M	$141.79
90816	Individual psychotherapy; hospital, 20–30 minutes	$62.93
90817	Individual psychotherapy; hospital, 20–30 minutes with E&M	$70.00
90818	Individual psychotherapy; hospital, 45–50 minutes	$95.17
90819	Individual psychotherapy; hospital, 45–50 minutes with E&M	$103.65
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	$108.48
90853	Group psychotherapy (other than multiple-family group)	$29.14
90862	Psychiatric medication management with minimal psychotherapy	$48.38
90870	Electroconvulsive therapy (with monitoring); single seizure	$97.86
90899	Unlisted psychiatric service/procedure	$67.10

	Central Nervous System Assessments/Tests	
96100	Psychological testing, with interpretation and report, per hour	$81.52
96115	Neurobehavioral status exam, with interpretation and report, per hour	$74.04
	Evaluation and Management Services	
99203	Office/outpatient visit, new patient, three key components: detailed history, detailed exam, medical decisionmaking of low complexity	$88.97
99205	Office/outpatient visit, new patient, three key components: comprehensive history, comprehensive exam, medical decisionmaking of high complexity	$163.64
99211	Office/outpatient visit, established patient, not requiring physician presence, typically 5 minutes	$19.72
99212	Office/outpatient visit, established patient, which requires at least two of these three key components: problem-focused history, problem-focused exam, straightforward medical decisionmaking	$34.60
99213	Office/outpatient visit, established patient, which requires at least two of these three key components: expanded problem history, expanded problem exam, medical decisionmaking of low complexity	$48.81
99214	Office/outpatient visit, established patient, which requires at least two of these three key components: detailed history, detailed exam, medical decisionmaking of moderate complexity	$77.16
99215	Office/outpatient visit, established patient, which requires at least two of these three key components: comprehensive history, comprehensive exam, medical decisionmaking of high complexity	$113.37
99221	Initial hospital care, which requires these three key components: detailed or comprehensive history, detailed or comprehensive exam, medical decisionmaking that is straightforward or of low complexity	$63.12
99222	Initial hospital care, which requires these three key components: comprehensive history, comprehensive exam, medical decisionmaking of moderate complexity	$105.62
99223	Initial hospital care, which requires these three key components: comprehensive history, comprehensive exam, medical decisionmaking of high complexity	$148.08

99231	Subsequent hospital care, which requires at least two of these three key components: problem-focused interval history, problem-focused exam, medical decisionmaking that is straightforward or of low complexity	$31.95
99232	Subsequent hospital care, which requires at least two of these three key components: expanded problem-focused interval history, expanded problem exam, medical decisionmaking of moderate complexity	$53.21
99233	Subsequent hospital care, which requires at least two of these three key components: detailed interval history, detailed exam, medical decisionmaking of high complexity	$77.47
99238	Hospital discharge day management; up to 30 minutes	$66.71
99239	Hospital discharge day management; longer than 30 minutes	$91.19
99243	Office consultation, which requires these three key components: detailed history, detailed exam, medical decisionmaking of low complexity	$112.59
99244	Office consultation, which requires these three key components: comprehensive history, comprehensive exam, medical decisionmaking of moderate complexity	$160.85
99245	Office consultation, which requires these three key components: comprehensive history, comprehensive exam, medical decisionmaking of high complexity	$209.11
99252	Initial inpatient consultation, which requires these three key components: expanded problem-focused history, expanded problem-focused exam, straightforward medical decisionmaking	$ 68.29
99253	Initial inpatient consultation, which requires these three key components: detailed history, detailed exam, medical decisionmaking of low complexity	$ 93.65
99254	Initial inpatient consultation, which requires these three key components: comprehensive history, comprehensive exam, medical decisionmaking of moderate complexity	$134.74
99255	Initial inpatient consultation, which requires these three key components: comprehensive history, comprehensive exam, medical decisionmaking of high complexity	$188.52
99261	Follow-up inpatient consultation, which requires at least two of these three key components: problem-focused interval history, problem-focused exam, medical decisionmaking that is straightforward or of low complexity	$21.49

99262	Follow-up inpatient consultation, which requires at least two of these three key components: expanded problem-focused interval history, expanded problem-focused exam, medical decisionmaking of moderate complexity	$44.10
99263	Follow-up inpatient consultation, which requires at least two of these three key components: detailed interval history, detailed exam, medical decisionmaking of high complexity	$66.29
99283	Emergency department visit, which requires these three key components: expanded problem-focused history, expanded problem-focused exam, medical decisionmaking of moderate complexity	$57.84
99284	Emergency department visit, which requires these three key components: detailed history, detailed exam, medical decisionmaking of moderate complexity	$91.10
99285	Emergency department visit, which requires these three key components: comprehensive history, comprehensive exam, medical decisionmaking of high complexity	$143.60
99302	Nursing facility care, which requires these three key components: detailed interval history, comprehensive exam, medical decisionmaking of moderate to high complexity	$83.97
99303	Nursing facility care, which requires these three key components: comprehensive history, comprehensive exam, medical decisionmaking of moderate to high complexity	$103.80
99311	Subsequent nursing facility care, which requires at least two of these three key components: problem-focused interval history, problem-focused exam, medical decisionmaking that is straightforward or of low complexity	$32.67
99312	Subsequent nursing facility care, which requires at least two of these three key components: expanded problem-focused interval history, expanded problem-focused exam, medical decisionmaking of moderate complexity	$52.22
99313	Subsequent nursing facility care, which requires two of these three key components: detailed interval history, detailed exam, medical decisionmaking of moderate to high complexity	$73.77
99332	Rest home visit, established patient, which requires at least two of these three key components: expanded problem-focused interval history; expanded problem-focused exam; medical decisionmaking of moderate complexity	$50.27
	Brief Medication Management	
M0064	Visit for drug monitoring	$23.12

Source: OIG analysis of 2003 Medicare claims, 2006.

A P P E N D I X ~ B

Office of Inspector General Reports on Mental Health Services

- In 1996, the Office of Inspector General (OIG) issued "Mental Health Services in Nursing Facilities" (OEI-02-91-00860), which reviewed Part B mental health services in nursing homes. OIG found that approximately 32 percent of services were unnecessary, and another 16 percent were questionable.
- As a followup to the 1996 report, OIG issued "Medicare Payments for Psychiatric Services in Nursing Homes: A Follow-up" (OEI-02-99-00140) in January 2001. As stated in the follow-up report, approximately 27 percent of the services were not medically necessary, 9 percent were not documented, and 3 percent were medically questionable.
- In 1998, OIG issued "Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers" (A-04-98-02145). Based on this audit, approximately 92 percent of reviewed claims were not allowable or were questionable. Furthermore, many beneficiaries who received services had no history of mental illness. Other beneficiaries suffered from mental conditions, such as dementia, that would have prevented them from benefiting from the intensive program. Additionally, some of the treatment sessions involved only recreational activities.
- In 2000, OIG issued "Ten-State Review of Outpatient Psychiatric Services at Acute Care Hospitals" (A-01-99-00507). Based on this audit, approximately 58 percent of the Medicare payments for psychiatric services rendered in acute care hospitals in the 10 States were not allowable or were unsupported. The hospitals' claims were documented inadequately, and services were not reasonable or necessary. In addition, unlicensed personnel rendered some services.
- Also in 2000, OIG issued "Review of Outpatient Psychiatric Services at Psychiatric Hospitals for Calendar Year 1998" (A-01-99-00530). This audit identified that approximately 42 percent of the outpatient and partial hospitalization services in specialty psychiatric hospitals in 10 States were paid inappropriately.

Methodology

Sample Selection

We conducted a medical review of a stratified random sample of mental health services rendered during calendar year 2003, the most recent full year of Medicare claims data available to us at the time of our review. We selected our sample from the Part B Medicare National Claims History. (See Appendix D for details.) To compile this sample, we selected individual line item services that appeared in the National Claims History. We limited our universe to mental health services, which we defined as:

- psychiatric procedures (according to the American Medical Association's (AMA) "Current Procedural Terminology," 2003);
- central nervous system test procedures supported by a psychiatric disorder diagnosis; or
- evaluation and management (E&M) services supported by a psychiatric disorder diagnosis.

For sampling purposes, we defined "service" as the unique combination of:

- Medicare beneficiary health identification claim number,
- unique provider identification number,
- date of service, and
- procedure code.

Some of these services contained multiple units. In these cases, we reviewed each individual unit. Therefore, our unit of analysis for this medical review is "service-unit," which we defined as the individual unit associated with a single line-item claim. For example, a single line-item claim for psychotherapy may consist of two units. For purposes of our medical review, this line-item claim would result in two service-units in our sampling frame.

The sampling frame consisted of approximately 29.2 million service-units rendered in 2003, representing approximately $2.1 billion allowed by Medicare. To improve our estimations of improper payments, we stratified the population by allowed amount and then selected 425 services. These services represented 455 service-units. In our sample, 3 of the 425 providers were under investigation and were

excluded from this review. Therefore, our final sample consisted of 422 services, 422 practitioners, and 452 service-units. To simplify the presentation of our findings, we refer to service-units as services. The table below defines the strata and corresponding data for the sample design.

Basic Sample Design*			
Stratum	Medicare Allowed Amount	Population (Line-Item Services)	Sample (Line-Item Services)
1	Less than or equal to $65.00	14,265,228	125
2	$65.01–$125.00	12,768,731	225
3	More than $125.00	2,202,167	75
Total		**29,236,126**	**425**

Source: Office of Inspector General, 2006.

*See Appendix D for more details.

Medical Record Request

We requested by mail complete medical records from each billing practitioner of the sampled mental health services. To ensure that we obtained adequate records to determine the medical necessity of the services, we requested records that included services rendered 6 months prior to the sampled date of service through the date of the request.[35] We allowed the billing practitioners 2 weeks from the date of the initial request to send us the records. We made as many as two additional written attempts followed by two telephone calls to obtain the records. For some billing practitioners, we requested the records three times by mail and twice by telephone.

Despite our repeated attempts to obtain medical records, 6 of the 422 billing practitioners did not produce the requested documents. We categorized the sample units associated with these six billing practitioners as undocumented because we were able to contact the billing practitioner, but the practitioner did not supply the medical records.

[35] The record request occurred from December 2004 through May 2005.

Medical Review

We contracted with three licensed psychiatrists and two certified professional coders to conduct a medical record review using a protocol developed in collaboration with the reviewers. The psychiatrists reviewed the medical records to determine whether the service-units were medically necessary. The psychiatrists' criteria included, but were not limited to, Medicare's coverage criteria (e.g., section 1862(a)(1)(A) of the Act), the American Psychiatric Association's "Practice Guidelines," and their own professional judgment. Certified professional coders determined the appropriate Common Procedural Terminology (CPT) codes for the sampled services based on the medical record documentation provided. The professional coders' criteria included the definitions in AMA's CPT for 2003. The reviewers recorded their determinations on standardized medical review instruments.

Test sample review. To ensure uniformity among the reviewers and to test our medical review instrument, we conducted a preliminary review of 117 service-units, which we randomly selected using the same criteria we used for the final sample. (See "Sample Selection" on page 20.) We received records for 48 service-units. Both coders and psychiatrists reviewed all 48 service-units. We analyzed the results of the test review and presented them to the reviewers. Reviewers discussed and resolved any inconsistencies in the results and offered suggestions for revisions of the medical review instrument. The 117 test sample units were not included in the review results and are not included in this report.

Final sample review. Reviewers used a standardized medical review instrument to analyze the medical records. One psychiatrist and one coder reviewed each medical record. The medical records for the final sample were assigned randomly to the reviewers, and we analyzed the completed medical review instruments to determine uniformity among the reviewers.

Structured Interviews

We attempted to interview by telephone each of the 422 billing practitioners in our sample. We used a standardized interview instrument to determine whether the billing practitioners (1) rendered the sampled services personally or (2) billed for the services "incident to" their professional services. We asked practitioners who personally furnished the services they billed "incident to" and what level of

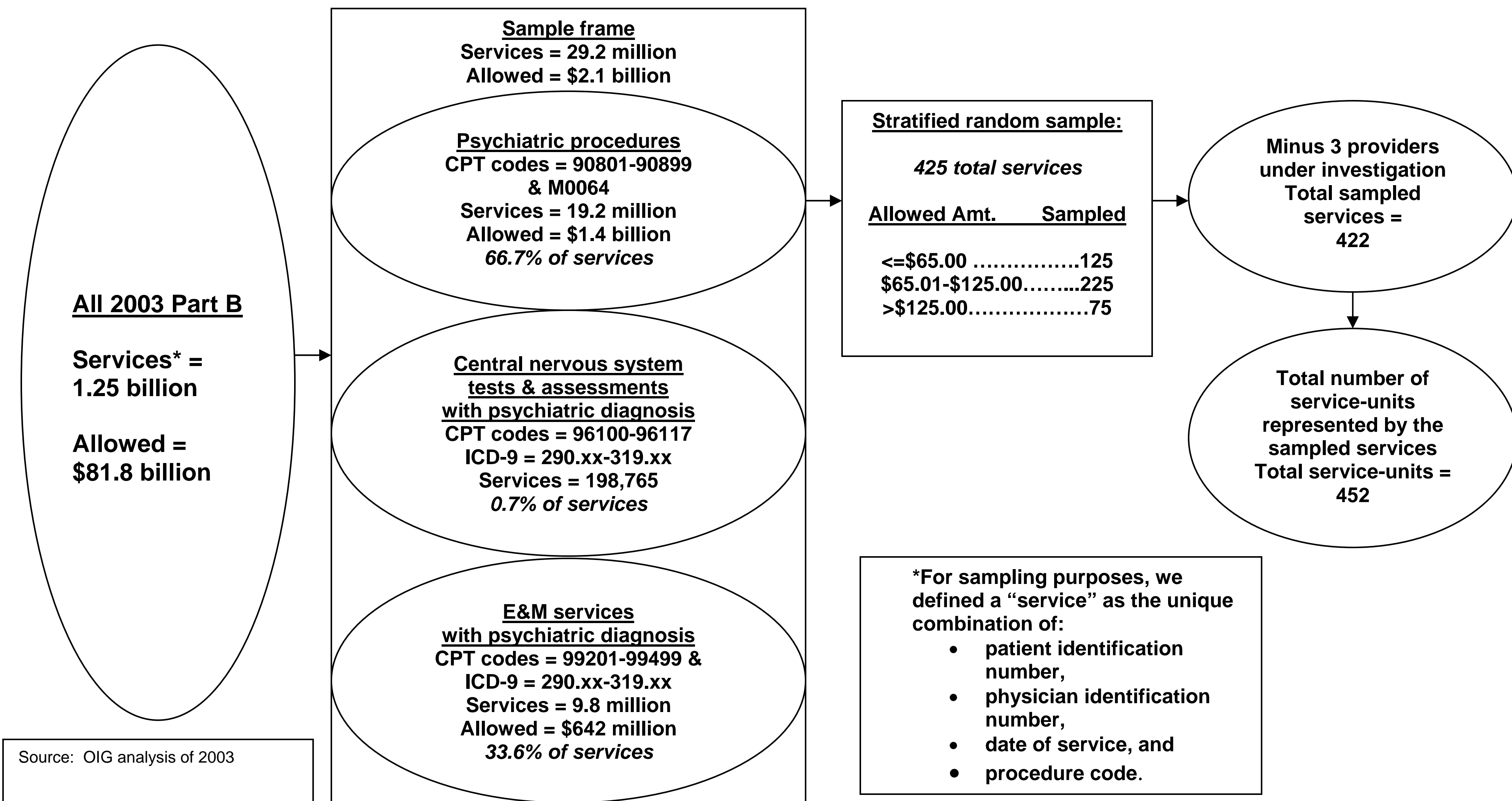
supervision they provided to the ancillary staff (e.g., general, direct, or personal).[36]

We interviewed by telephone 372 of the 422 practitioners in our sample, resulting in an 88-percent response rate. Two practitioners refused to be interviewed, 1 was deceased at the time we requested an interview, and the remaining 47 could not be reached for interviews after a minimum of three attempts. For purposes of reporting an error rate related to "incident to" services, we assumed that the practitioners we did not interview rendered the sampled services personally or complied with the "incident to" rules regarding the direct supervision requirement.

[36] See 42 CFR § 410.32(b)(3) for definitions of the three levels of supervision.

Medical Review Sample Flowchart

The sampling plan OIG used to select a stratified random sample of Medicare Part B mental health services in 2003



Source: OIG analysis of 2003 Medicare claims data, 2006.

Statistical Confidence Intervals

Statistic	Sample Size	Sample Units Found Not To Meet Medicare Requirements	Estimate of Projection to Universe	95% Confidence Interval
Percentage of services that were medically unnecessary	452	24	4%	2% to 6%
Amount allowed for medically unnecessary services	452	24	$106 million	$61.7 to $150 million
Percentage of services that were miscoded (net)	452	140	26%	22% to 30%
Allowed amount for miscoded services	452	140	$245 million	$205 to $287 million
Percentage of services that were undocumented	452	83	19%	15% to 23%
Allowed amount for undocumented services	452	83	$356 million	$281 to $431 million
Percentage of services that were paid improperly	452	234	47%	42% to 53%
Allowed amount for all improperly paid services	452	234	$718 million	$635 to $801 million

Source: OIG medical review results, 2006.

APPENDIX ~ F

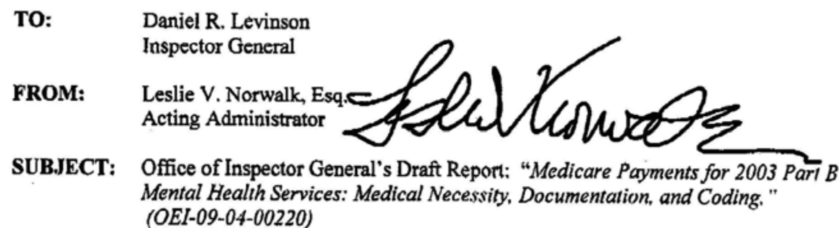
Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAR 26 2007

TO: Daniel R. Levinson
Inspector General



FROM: Leslie V. Norwalk, Esq.
Acting Administrator

SUBJECT: Office of Inspector General's Draft Report: *"Medicare Payments for 2003 Part B Mental Health Services: Medical Necessity, Documentation, and Coding." (OEI-09-04-00220)*

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report "Medicare Payments for 2003 Part B Mental Health Services: Medical Necessity, Documentation, and Coding" (OEI-09-04-00220). We appreciate the OIG's efforts to ensure that the Medicare program is paying appropriately for mental health services.

The CMS is committed to ensuring that practitioners billing the Medicare program are doing so correctly. CMS and its contractors provide all providers and suppliers with a variety of program instructions through multiple manuals and related educational materials such as MLN Matters articles to help guide the billing process. Our contractors also are required to perform medical review of claims after they have been submitted which further guides providers to make appropriate coding decisions. Despite these efforts, we recognize that providers do not always follow our requirements correctly. Consequently, the OIG conducted a medical and coding review of claims for mental health services and found in this report that 47 percent of the mental health services allowed by Medicare in 2003 did not meet program requirements, resulting in approximately $718 million in improper payments. Miscoded and undocumented services accounted for 26 percent and 19 percent of all mental health services in 2003, respectively. Medically unnecessary services and services that violated the "incident to" rule each accounted for 4 percent of all mental health services in 2003.

The CMS is focused on ensuring that we pay claims correctly for services provided to our Medicare beneficiaries. Each year we measure Medicare's national fee-for-service paid claims error rate in addition to more specific error rates based on Medicare contractor jurisdictions, services, and provider specialties. A key part of the CMS strategy for reducing improper payments was to increase the detail of the error rate information to highlight the areas in need of improvement, such as medical necessity, documentation and coding. CMS has developed corrective actions based on this information as outlined in the Agency's Error Rate Reduction Plan. Working closely with our contractors to implement these corrective actions, CMS has

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greatly reduced the Medicare fee-for-service paid claims error rate. Since 2003 the error rate has decreased from 10.8 percent to 4.4 percent in 2006; an estimated reduction of $10.6 billion. The improper payment reports are posted on the CMS website.

OIG Recommendation:

The Centers for Medicare & Medicaid Services (CMS) should revise, expand, and reissue its 2003 Program Memorandum on Part B mental health services with an increased emphasis on proper documentation and coding. In addition, the OIG recommends that the revised memorandum should emphasize the requirements for mental health services billed "incident to".

CMS Response:

Based on the OIG analysis, CMS agrees that additional focused provider education on mental health services may be warranted. However, we note that significant information on medical documentation requirements and on "incident to" services is already available on our website and from our contractors. For example, specific guidance on documentation for evaluation and management services can be found in the Claims Processing Manual (Pub. 100-04, Chapter 12, Section 30.6) and specific guidance on "incident to" services can be found in the Benefits Policy Manual (Pub.100-02, Chapter 15, Section 60.1). We expect providers, including mental health providers, to follow all applicable requirements when billing Medicare for services.

Nevertheless, we intend to consolidate this information for providers of mental health services in response to the OIG analysis.

We appreciate the OIG's efforts in conducting its investigation of Medicare payments for Part B mental health services in 2003 and we will increase our provider education efforts in this area as part of our ongoing efforts to improve the accuracy of Medicare payments.

ACKNOWLEDGMENTS

This report was prepared under the direction of Paul A. Gottlober, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Deborah W. Harvey, Assistant Regional Inspector General.

Steven Zerebecki served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the San Francisco office who contributed include Silvia Chin, Robert Gibbons, Scott Hutchison, Thomas Purvis, and China Tantameng; and central office staff who contributed include Doris Jackson and Tricia Davis.

We would like to thank our medical review contractor and the individual psychiatrists and coders who performed the review, as well as the carrier staff who assisted us in obtaining contact information for the physicians whose claims were selected for review.