

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CARRIER DETERMINATION OF
COPAYMENTS
FOR MEDICARE MENTAL
HEALTH SERVICES**



Daniel R. Levinson
Inspector General

October 2006
OEI-09-04-00221

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.



OBJECTIVE

To determine the extent to which Medicare carriers:

1. consistently calculate beneficiary copayments for mental health services, and
2. correctly calculate copayments for mental health services rendered to beneficiaries diagnosed with Alzheimer's disease or related disorders.

BACKGROUND

The Outpatient Mental Health Treatment Limitation

The “outpatient mental health treatment limitation” (the limitation) reduces payments from Medicare’s Supplementary Medical Insurance Benefits for the Aged and Disabled (Part B) to 62.5 percent of the expenses (Medicare approved amount) for services in connection with the treatment of mental disorders. Mental disorders that occur most frequently for Medicare beneficiaries include affective psychoses, senile psychotic conditions, schizophrenic disorders, and neurotic disorders. Services include such things as psychotherapy, psychiatric pharmacologic management, and evaluation and management. Mental health services are typically rendered by psychiatrists, clinical psychologists, licensed clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants.

While the usual copayment for medical services is 20 percent, the limitation commonly results in a copayment for the beneficiary of 50 percent of the approved amount (Medicare pays 80 percent of 62.5 percent of the approved amount). The limitation applies to services that are furnished in connection with the treatment of a mental, psychoneurotic, or personality disorder and either:

- o furnished by physicians and other practitioners, whether furnished directly or as incident to those practitioners’ services, or
- o provided by a comprehensive outpatient rehabilitation facility.

Pursuant to 42 CFR § 410.155(b)(2), some services are exempt from the limitation, such as services furnished to a hospital inpatient, diagnostic services, and medical management services furnished to a patient diagnosed with Alzheimer’s disease or a related disorder. However, carriers must interpret the meaning of “mental health

treatment” and “mental, psychoneurotic, and personality disorders” to determine whether they should apply the limitation to specific claims.

Application of the Limitation by Carriers

The Centers for Medicare & Medicaid Services (CMS) contracts with private companies, called “carriers,” to process and pay physicians’ and nonphysician practitioners’ Part B claims. CMS authorizes carriers to process and pay claims submitted by providers in CMS-defined geographic service areas. In most cases, an individual service area is one State. However, some States (such as New York and Missouri) have two service areas. While most carriers process and pay claims for multiple service areas, each service area is represented by only one carrier. In 2003, 19 carriers processed claims from providers in the 57 service areas that encompassed all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

Claims Processing

Physicians and other practitioners submit Medicare claims to their respective carriers. Carriers are responsible for applying the limitation via their automated claims processing systems. Carriers customize their systems and apply the limitation according to their individual payment policies. The application of the limitation does not affect coverage. Instead, the limitation determines the proportion of expenses that will be borne by a beneficiary.

Methodology

We used multiple methods to accomplish our objectives. To determine the extent to which Medicare carriers consistently calculate beneficiary copayments for mental health services and correctly calculate copayments for beneficiaries diagnosed with Alzheimer’s disease and related disorders, we surveyed (by mail, telephone, and e-mail) the carriers and analyzed a 1-percent sample of claims from the Medicare National Claims History for services rendered from 2001 through 2004. In addition, we reviewed all relevant statutes, regulations, and CMS guidance.

FINDINGS

Beneficiary copayments can be more than double for the same mental health service in different service areas. Medicare beneficiaries can be responsible for either 20 percent or 50 percent of the cost of exactly the same mental health service, based on their geographic locations.

Individual beneficiaries who move from one State to another may see dramatic changes in their Medicare liability.

Because their payment policies are inconsistent, carriers do not uniformly apply the outpatient mental health treatment limitation. Among the 57 carrier service areas, we identified 9 different payment policies for application of the limitation. Carriers' policies vary regarding the services that trigger the limitation and the psychiatric illnesses that trigger the limitation.

Carriers overstated copayments for beneficiaries with Alzheimer's disease and related disorders by approximately \$27 million during a 4-year period. Both the regulations and CMS guidance clearly state that medical management for patients diagnosed with Alzheimer's or a related disorder should not be subject to the limitation. Only psychotherapy services are subject to the limitation for these patients. However, from 2001 to 2004, carriers applied the limitation to medical management services for approximately 488,000 beneficiaries with Alzheimer's and related disorders.

RECOMMENDATIONS

Due to carriers' inconsistent policies regarding application of the limitation, carriers do not uniformly calculate beneficiaries' copayments. In addition, some carriers are incorrectly applying the limitation to services for beneficiaries with Alzheimer's disease and related disorders.

To address this, CMS should:

- Issue new guidance to carriers regarding the outpatient mental health treatment limitation and ensure that the limitation is consistently applied among all carriers.
- Require its carriers to adjust the copayments for beneficiaries who were overcharged.

AGENCY COMMENTS

CMS agreed to take steps to address our recommendations. CMS plans to issue more precise guidance that will establish policy for application of the outpatient mental health treatment limitation, create and post educational materials to its Web site, and, to the extent operationally feasible, require its carriers to reopen and adjust incorrectly processed claims.

► T A B L E O F C O N T E N T S

EXECUTIVE SUMMARY	i
INTRODUCTION	1
FINDINGS	11
Unequal beneficiary copayments	11
Inconsistent carrier payment policies	13
Overstated copayments for Alzheimer’s patients	18
RECOMMENDATIONS	20
Agency Comments	21
APPENDIXES	22
A: Glossary of Terms	22
B: Alzheimer’s-Related Disorders	24
C: Procedure Codes	25
D: Agency Comments	26
ACKNOWLEDGMENTS	28

OBJECTIVE

To determine the extent to which Medicare carriers:

1. consistently calculate beneficiary copayments for mental health services, and
2. correctly calculate copayments for mental health services rendered to beneficiaries diagnosed with Alzheimer’s disease or related disorders.

BACKGROUND

Outpatient Mental Health Services and Psychiatric Disorders

Outpatient mental health services commonly rendered¹ 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, reverse or change maladaptive patterns of behavior, and encourage personality growth and development;²
- **Psychiatric pharmacologic management:** pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy;³ and
- **Evaluation and management (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 in complexity.⁴

Psychiatric disorders that occur most frequently for Medicare beneficiaries⁵ include:

- affective psychoses (e.g., major depressive disorder and bipolar affective disorder);

¹ Based on the Office of Inspector General (OIG) analysis of a 1-percent sample of Medicare claims for 2003.

² AMA, “Current Procedural Terminology, Professional Edition,” 2003.

³ Ibid.

⁴ Ibid.

⁵ Based on OIG analysis of a 1-percent sample of Medicare claims for 2003.

I N T R O D U C T I O N

- senile psychotic conditions;
- schizophrenic disorders; and
- neurotic disorders (e.g., neurotic depression and adjustment reaction).

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

Practitioners who render mental health services to Medicare beneficiaries include psychiatrists, clinical psychologists, licensed clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants.

The Outpatient Mental Health Treatment Limitation

Medicare’s Supplementary Medical Insurance (Part B) covers physicians’ services, outpatient care, and some other services not covered by Medicare’s Hospital Insurance (Part A). In general, beneficiaries are responsible for copayments of 20 percent of the approved amount for most Part B services. Outpatient mental health services are covered under Part B. However, Federal law limits Medicare payments to 62.5 percent of the expenses (Medicare approved amount) for mental health services.⁶ Specifically, the law limits payments for services in connection with the treatment of “mental, psychoneurotic, and personality disorders.” For these services, beneficiaries face greater cost-sharing liability.

Federal statute and regulations. The implementing regulations for section 1833(c) of the Social Security Act (the Act) are called the “outpatient mental health treatment limitation” (the limitation).⁷ Pursuant to 42 CFR § 410.155(b), services subject to the limitation include those “furnished in connection with the treatment of a mental, psychoneurotic, or personality disorder (that is, any condition identified by a diagnosis code within the range of 290 through 319)” and either:

- furnished by physicians and other practitioners, whether furnished directly or as incident to those practitioners’ services, or

⁶ Section 1833(c) of the Act (42 U.S.C. 1395I).

⁷ 42 CFR § 410.155.

I N T R O D U C T I O N

- o provided by a comprehensive outpatient rehabilitation facility.

Pursuant to section 1833(c) of the Act, services not subject to the limitation include the following:

- o services furnished to a hospital inpatient;
- o brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, or personality disorders; and
- o partial hospitalization services that are not directly provided by a physician.

In addition, the regulations at 42 CFR § 410.155(b)(2) prohibit application of the limitation to:

- o diagnostic services, such as psychological testing, that are performed to establish a diagnosis; and
- o medical management, as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.

The regulation contains examples of how the limitation affects provider reimbursement and beneficiary copayments. The example below from 42 CFR § 410.155(c) illustrates why the limitation results in a 50-percent beneficiary copayment for mental health services:

A clinical psychologist submitted a claim for \$200 for outpatient treatment of a beneficiary's mental disorder. The Medicare approved amount was \$180. Since clinical psychologists must accept assignment, the beneficiary is not liable for the \$20 in excess charges. The beneficiary previously satisfied the \$100 annual Part B deductible. The limitation reduces the amount of incurred expenses to 62 ½ percent of the approved amount. After subtracting any unmet deductible, Medicare pays 80 percent of the remaining incurred expenses. Medicare payment and beneficiary liability are computed as follows:

1. Actual charges	\$200.00
2. Medicare approved amount	180.00
3. Medicare incurred expenses (0.625 x line 2)	112.50
4. Unmet deductible	0.00
5. Remainder after subtracting deductible (line 3 minus line 4)	112.50
6. Medicare payment (0.80 x line 5)	90.00
7. Beneficiary liability (line 2 minus line 6)	90.00

Source: 42 CFR § 410.155(c).

I N T R O D U C T I O N

The application of the limitation in the example on the preceding page results in a beneficiary liability of 50 percent of the Medicare approved amount for the service. While Medicare approved the entire physician fee schedule amount for the service, it limited the incurred expenses to 62.5 percent and reimbursed the provider 80 percent of that limited amount. The provider collected the remaining reimbursement from the beneficiary.

For other Part B services, beneficiaries are typically liable for 20 percent of the Medicare approved amount, as opposed to 50 percent under the limitation. Using the example provided in 42 CFR § 410.155(c) (above), Table 1 compares the Medicare payment calculation for mental health services (limitation is applied) and medical services (limitation is not applied).

Table 1
Comparison of Medicare Payment Calculations:
 By law, Medicare incurs less for mental health services, resulting in higher copayments for beneficiaries.

Medicare Payment Calculation: Mental Health vs. Other Medical Services		
	Mental Health Services	Other Medical Services
1. Actual charges	\$200.00	\$200.00
2. Medicare approved amount	\$180.00	\$180.00
3. Medicare incurred expense	\$112.50 <i>(62.5 percent of approved amount)</i>	\$180.00 <i>(100 percent of approved amount)</i>
4. Unmet deductible	0.00	0.00
5. Remainder after subtracting deductible (line 3 minus line 4)	\$112.50	\$180.00
6. Medicare payment (0.80 x line 5)	\$ 90.00	\$144.00
7. Beneficiary liability (line 2 minus line 6)	\$90.00	\$36.00
8. Beneficiary liability as percent of approved	50 percent	20 percent

Source: Office of Inspector General analysis of Medicare payment policies, 2005.

CMS guidance. The Centers for Medicare & Medicaid Services (CMS) issues binding guidance to its carriers in the form of claims processing manuals and memoranda. CMS has issued guidance on the limitation in the Medicare Carriers Manual and its Internet Only Manuals.⁸ In 1995, at least three CMS regional offices also issued to their respective carriers memoranda that contained additional clarification on the application of the limitation.

CMS guidance⁹ interprets and implements regulations¹⁰ concerning the limitation by identifying (1) the disorders that are subject to the limitation, (2) the services that are subject to the limitation, and (3) the services that are not subject to the limitation. However, the guidance lacks the specificity necessary for carriers to apply the limitation to claims without additional interpretation of the regulations. In particular, the guidance lacks specificity in two areas. One is the definition of “mental, psychoneurotic, and personality disorders.” The other is the definition of “mental health treatment.”

CMS guidance defines the phrase “mental, psychoneurotic, and personality disorders” as the specific psychiatric conditions described in APA’s DSM-III-R.¹¹ The guidance also provides that, if the primary diagnosis is the “same as or equivalent to a condition described in the APA’s DSM-III-R,” the service is subject to the limitation. CMS guidance does not mention the range of diagnosis codes that are specified in the regulation, i.e., 290 through 319, nor does it mention the ICD-9. The ICD-9 lists diagnosis codes for all diseases and conditions, including mental illness, and contains 192 diagnosis codes for mental illness that are not in the DSM-III-R.

To identify services that are subject to the limitation, CMS guidance instructs carriers to apply the limitation to “professional services that represent mental health treatment.”¹² However, the guidance does not list the specific procedure codes (i.e., AMA’s “Current Procedural

⁸ “Medicare General Information, Eligibility, and Entitlement Manual,” Publication 100-1, Chapter 3, sections 30.0 through 30.3 and “Medicare Claims Processing Manual,” Publication 100-4, Chapter 12, sections 210 and 210.1.

⁹ “Medicare Claims Processing Manual,” Publication 100-4, Chapter 12, section 210.1.

¹⁰ 42 CFR § 410.155.

¹¹ “Medicare Claims Processing Manual,” Publication 100-4, Chapter 12, section 210.1(B).

¹² “Medicare Claims Processing Manual,” Publication 100-4, Chapter 12, section 210.1(C).

Terminology” (CPT codes)) that qualify as mental health treatment services.

To identify services that are not subject to the limitation, CMS provides additional guidance for the following exceptions: diagnosis of Alzheimer’s disease or related disorders, brief office visits for monitoring or changing drug prescriptions, diagnostic services, and partial hospitalization services not directly provided by a physician.¹³ CMS guidance on exceptions relevant to this report are discussed in more detail later.

Application of the Limitation by Carriers

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. In most cases, a carrier service area is a single State; however, some States (such as New York and Missouri) have two service areas. Most carriers process and pay claims for multiple service areas. In 2003, 19 carriers processed claims from providers in the 57 service areas that encompassed all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

Unlike Local Coverage Determinations (LCD), application of the limitation is a payment decision, not a coverage decision. The LCD is a decision by a carrier to cover a particular item or service. In contrast, the application of the limitation does not affect coverage. Instead, the limitation determines the proportion of expenses that will be borne by a beneficiary. Carriers are required by law to apply the limitation; however, they make decisions on its application to specific services on the basis of national payment policy in conjunction with their interpretation of that policy (CMS guidance and memoranda).

Claims Processing

Physicians and other practitioners submit Medicare claims to their respective carriers. They submit claims electronically in a uniform format that includes, among other things:

- demographic information about the patient,
- the patient’s Medicare identification number,

¹³ “Medicare Claims Processing Manual,” Publication 100-4, Chapter 12, section 210.1(D).

- codes used to describe the services rendered,¹⁴ and
- codes used to describe the patient’s diagnosis.¹⁵

Using their automated claims processing systems, carriers determine if Medicare covers the services billed by physicians and other practitioners. If the services are covered, prior to paying the claim, carriers transmit the claim information to one of nine “host sites” for the Common Working File (CWF). The CWF system reviews the claim and beneficiary information and authorizes payment, based on the payment rules. However, carriers are solely responsible for applying the limitation via their automated claims processing systems. Carriers customize their systems and apply the limitation according to their individual payment policies, which, as previously mentioned, are a combination of national payment policy and carriers’ interpretations of national payment policy.

Companion Report

This report is the first of two reports on Medicare Part B mental health services rendered in 2003. The second report will describe the results of a medical review of a representative sample of Medicare claims for mental health services rendered in 2003.

METHODOLOGY

Because CMS has not provided the carriers with comprehensive guidance on the limitation, we focused on how consistently the carriers calculate beneficiary copayments. However, since carriers can determine whether the limitation applies to services rendered to beneficiaries diagnosed with Alzheimer’s and related disorders based on the plain language of the CMS guidance, we determined the extent to which carriers correctly calculate copayments for these beneficiaries.

We used multiple methods to accomplish our objective. To determine the extent to which carriers consistently calculate beneficiary copayments for mental health services, we surveyed each carrier and analyzed a 1-percent sample of claims from the Medicare National Claims History for claims received in calendar year 2003. To determine the extent to which carriers are correctly calculating copayments for beneficiaries diagnosed with Alzheimer’s disease or related disorders,

¹⁴ Procedure codes are from AMA’s “Current Procedural Terminology.”

¹⁵ Diagnosis codes are from AMA’s ICD-9.

we analyzed a 1-percent sample of claims from the Medicare National Claims History for claims received in calendar years 2001 through 2004. In addition, we reviewed all relevant statutes, regulations, and CMS guidance.

Carrier Survey

We sent a written survey to 18 of the 19 carriers that had paid claims in calendar year 2003. All 18 carriers responded to our survey. The carrier that processed claims for Rhode Island in 2003 was no longer a Medicare contractor at the time we conducted our survey (October 2004) and was, therefore, not included in our survey. The carriers that responded to our survey represented at least 1 of all 57 Part B service areas in 2003, except Rhode Island.

We asked the carriers to provide detailed explanations of their payment policies for applying the limitation to the claims they paid for services rendered in 2003. After receiving their completed surveys, we contacted many of the carriers by telephone, fax, and/or e-mail to clarify their survey responses.

2003 Medicare Claims Data and Carrier Payment Policy Analysis

We analyzed a 1-percent sample of claims from the Medicare National Claims History for claims received in calendar year 2003. We analyzed the claims to (1) verify that carriers followed their stated payment policies for application of the limitation in 2003 and (2) calculate Medicare reimbursements and beneficiary liabilities for claims paid under the limitation.

We analyzed the carriers' payment policies in four categories:

1. **Psychiatric pharmacologic management services.** See page 1 for the definition.
2. **E&M services.** See page 1 for the definition.
3. **Diagnosis lists used to trigger the limitation.** As mentioned on page 5, there are two professionally recognized sources for diagnosis codes for mental illnesses: (1) AMA's ICD-9 and (2) APA's DSM-III-R. The ICD-9 is the international standard for a comprehensive listing of all diseases and conditions, and is not limited to mental illnesses. The DSM-III-R is the standard diagnostic manual used by mental health practitioners, and is limited to mental illnesses. In addition to listing the diagnosis codes, it contains other information, such as diagnostic criteria.

4. **Services to treat Alzheimer’s and related disorders.** Federal regulations¹⁶ prohibit application of the limitation to “medical management, as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer’s disease or a related disorder.” Alzheimer’s-related disorders comprise 12 different diseases, as defined by the DSM-III-R. See appendix B for a complete listing of the diseases.

Policy verification analysis. We verified that the carriers were following their payment policies in each of these four categories of claims by analyzing their paid claims in the 2003 1-percent sample. Based on the results of our analysis, we included a service area in our findings if at least 99.5 percent of the paid claims in that service area were processed in accordance with the carrier’s payment policies. For example, if a carrier stated that it applied the limitation to E&M services in a particular service area, we included that service area in our findings if at least 99.5 percent of paid claims showed that the carrier had followed its stated payment policy. If fewer than 99.5 percent of the service area’s claims were paid in accordance with the payment policy, we excluded that service area from our findings for that category of claims only (E&M services in the example). The service area could still be included in our findings related to the three other categories if the 99.5 percent-criterion were met for those particular services. See Table 2 for details about the carriers and service areas that we excluded.

Table 2
Excluded Carriers and Service Areas:
Carriers’ stated payment policies for specific claim categories could not be verified in 2003 paid claims data.

Carriers and Service Areas Excluded from this Report’s Analyses			
Categories for Application of the Limitation	Carriers* (n=19)	Service Areas (n=57)	Percent Service Areas
Psychiatric pharmacologic management services	3	4	7%
Evaluation and management services	8	11	19%
Diagnosis lists used to trigger the limitation	10	14	25%
Services to treat Alzheimer’s and related dementia disorders	5	7	12%

*This column indicates that at least one service area for the carrier was excluded, not that the entire carrier was excluded from our analysis.

Source: Office of Inspector General analysis of a 1-percent sample of calendar year 2003 Medicare claims, 2005.

¹⁶ 42 CFR § 410.155(b)(2)(v).

I N T R O D U C T I O N

The carriers in Table 2 could not accurately describe their payment policies for applying the limitation. Determining why the carriers could not accurately describe their payment policies was outside of the scope of this study. However, a few carriers provided information that suggests they do not keep accurate written records of their limitation policies and are unable to query their payment systems to obtain past payment policies (e.g., the limitation policy in 2003).

We also excluded from our verification analysis all claims for which the primary payer was not Medicare. These claims represented less than 1 percent of the claims in our sample.

We analyzed carriers' payment policies that were in effect on December 31, 2003. For most carriers and most service areas, the limitation policies that were in effect on December 31, 2003, represented the policies that were in effect throughout the calendar year.

We asked the carriers if they changed their limitation policies for claims that were processed in 2004 and 2005. Eight carriers had added specific procedure codes to the list of services that were subject to the limitation and/or had added specific diagnosis codes to trigger the limitation. One carrier changed its limitation policies from 2003 to 2004 because of a change in its claims processing system; however, the carrier was unable to explain how its policies had changed.

Medicare reimbursement and beneficiary liability estimates

We analyzed a 1-percent sample of paid claims for services rendered in 2003 to determine actual Medicare reimbursement and beneficiary liability for services subject to the limitation. During claims processing, carriers code individual claims to indicate whether the limitation has been applied. In comparing the copayments among beneficiaries in different States, we factored in the difference in fee schedule amounts to make comparisons of beneficiary liability stemming from the limitation. We relied on these codes to identify the individual claims for cost estimates.

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.

See appendix A for a glossary of the terms used in this report.

Beneficiary copayments can be more than double for the same mental health service in different service areas

Beneficiaries' financial liability for Medicare mental health services vary based on the geographic location in which they receive the services. In one service area, the beneficiary

copayment might be 20 percent, while in another the copayment could be 50 percent for the same service. For example, approximately 7,600 Medicare beneficiaries received psychiatric pharmacologic management services on December 31, 2003. Carriers applied the limitation to the services for approximately 83 percent of these beneficiaries. For two of these beneficiaries, one in Florida and the other in Utah, Medicare approved approximately \$53 and \$46 for the services, respectively. Because carriers that serve Florida and Utah have different payment policies regarding the limitation, the beneficiary in Florida was responsible for approximately \$11, while the beneficiary in Utah was responsible for approximately \$23. This is one example among thousands in which beneficiaries pay significantly different amounts for the same Medicare-covered mental health services. In 2003, Medicare approved approximately \$1.2 billion for claims for which carriers applied the limitation. Beneficiaries were liable for \$662 million of that amount.

Beneficiaries who move from one State to another may see dramatic changes in their Medicare liability for the same Medicare-covered services

To illustrate the effect the carriers' inconsistent limitation policies can have on Medicare beneficiaries, the scenarios depicted in Figure 1 include two real Medicare beneficiaries. In each scenario, the beneficiaries hypothetically moved from their home State to a State served by a carrier with a different limitation policy. The number of services reported in figure 1 were the actual number of services these beneficiaries received in their home States in 2003.¹⁷

- *Scenario 1:* Beneficiary A received 50 E&M services in California and was liable for 50 percent copayments for all Medicare mental health services. The carrier applied the limitation to services that appear in the psychiatric section of the AMA's "Current Procedural Terminology," as well as E&M services where a mental disorder appeared on the claims. If the beneficiary moved to Ohio

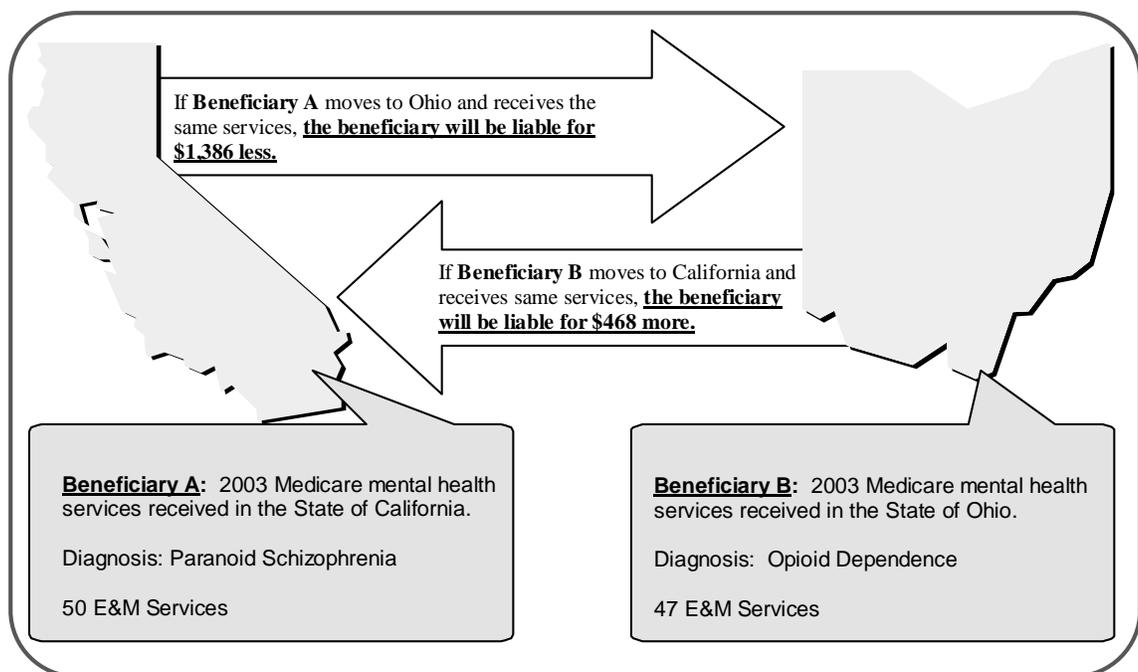
¹⁷ Approximately 3 percent of beneficiaries in 2003 received 50 or more E&M services.

FINDINGS

and received exactly the same services, the beneficiary would be liable for approximately \$1,386 less in copayments.¹⁸

- *Scenario 2:* Beneficiary B received 47 E&M services in Ohio, avoided the limitation for these services, and was liable for the standard 20 percent copayment. The local carrier does not apply the limitation to E&M services for patients with a mental disorder in that service area. If the beneficiary moved to California, the beneficiary's liability for copayments for the same services would increase by approximately \$468.¹⁹

Figure 1
Beneficiaries
Who Move to
Another
Service Area:
Hypothetical
movement of
two real
Medicare
beneficiaries
to States with
different
limitation
policies.



Note: While the two beneficiaries received a similar number of E&M services, beneficiary A received services of a higher level of complexity, and therefore the fee schedule amounts were higher than the services for beneficiary B.

Source: Office of Inspector General analysis of 1-percent sample of calendar year 2003 Medicare claims, 2005.

¹⁸ Of this total, \$1,157.25 of the difference is attributed to the variance in the outpatient mental health treatment limitation policy, and \$229.00 is attributed to the change in fee schedule amounts. The total approved amount for this beneficiary's services in California was \$4,315.

¹⁹ Of this total, \$432.86 of the difference is attributed to the variance in the outpatient mental health treatment limitation policy, and \$36.58 is attributed to the change in fee schedule amounts. The total approved amount for this beneficiary's services in Ohio was \$1,978.

Because their payment policies are inconsistent, carriers do not uniformly apply the outpatient mental health treatment limitation

Among the 57 service areas, we identified 9 distinctive payment policies for application of the limitation, based on the 4 categories listed below. In some cases, the

payment policies vary within the carriers themselves. Among the 13 carriers that have multiple service areas, at least 6 carriers have more than 1 distinctive payment policy in effect, which reflects variations within the carriers across service areas.

Carriers' payment policies vary in four categories

Significant Medicare payment policy variance among the carriers occurs primarily in four categories:

1. psychiatric pharmacologic management services,
2. E&M services,
3. diagnosis lists²⁰ used to trigger the limitation, and
4. services to treat Alzheimer's disease and related disorders.

These four categories include most Medicare Part B claims for mental health services. Among all claims in 2003 for mental health services and/or beneficiaries with a psychiatric diagnosis, these four categories apply to 58 percent of the claims and 90 percent of the beneficiaries. The remaining 42 percent of the claims were for psychotherapy services, for which carriers were mostly consistent in applying the limitation.

For the first three categories, CMS guidance lacks the specificity necessary for carriers to apply the limitation to claims without additional interpretation. Carriers must interpret the meaning of "mental health treatment" and "mental, psychoneurotic, and personality disorders" in order to determine whether the limitation should apply to claims. For the fourth category, CMS guidance is unequivocal. Nevertheless, carriers still vary in their application of the limitation to services for beneficiaries with Alzheimer's and related disorders.

²⁰ AMA's ICD-9 or APA's DSM-III-R.

Psychiatric pharmacologic management is not always subject to the limitation

In 86 percent of the service areas, carriers subject psychiatric pharmacologic management to the limitation. However, in approximately one-fourth of those service areas, psychiatric pharmacologic management is subject to the limitation only if the patient has a diagnosis recognized by the carrier to trigger the limitation (e.g., a mental disorder according to the ICD-9 or DSM-III-R). In two-thirds of the service areas, psychiatric pharmacologic management is subject to the limitation regardless of diagnosis. See Table 3 for details on how carriers’ payment policies differ.

Table 3
Psychiatric Pharmacologic Management:
 Carriers did not always apply the limitation to these claims in 2003.

Psychiatric Pharmacologic Management – CPT 90862			
Application of the Limitation	Carriers*	Service Areas	Percent Service Areas
Never	2	4	7%
Always	13	36	63%
Based on Diagnosis	6	13	23%
Unknown – carriers’ stated payment policies could not be verified in claims data	3	4	7%
Total	24	57	100%

*There were 19 carriers in 2003; this column totals 24 because 5 carriers use different policies among their service areas.
 Source: Office of Inspector General analysis of carriers’ payment policies, 2005.

AMA defines psychiatric pharmacologic management (CPT 90862) as a psychiatric service consisting of “pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.” AMA’s definition does not explicitly indicate whether psychiatric pharmacologic management is a therapeutic (treatment) service only, as opposed to a therapeutic service with diagnostic and evaluative features. CMS guidance²¹ exempts “tests and evaluations performed to establish or confirm the patient’s diagnosis” from the limitation. Moreover, CMS guidance provides that diagnostic services should take more than one visit only in “rare cases,” and that, in those rare cases, carriers should “request documentation to justify the reason for more than one diagnostic visit.”

Carriers inconsistently apply the limitation to E&M services

E&M services are sometimes subject to the limitation in at least 72 percent of the service areas. In at least 9 percent of the service areas, E&M services will never trigger the limitation. See Table 4 for details.

²¹ “Medicare Claims Processing Manual,” Publication 100-4, Chapter 12, section 210.1(D)(3).

F I N D I N G S

Table 4
Evaluation and
Management
Services:
 Carriers in most
 States applied
 the limitation in
 2003.

E&M Services			
Application of the Limitation	Carriers*	Service Areas	Percent Service Areas
Never	3	5	9%
Based on Diagnosis	13	41	72%
Unknown – carriers' stated payment policies could not be verified in claims data	8	11	19%
Total	24	57	100%

*There were 19 carriers in 2003; this column totals 24 because 5 carriers use different policies among their service areas.
 Source: Office of Inspector General analysis of carriers' payment policies, 2005.

Further, carriers that apply the limitation based on diagnosis may use different lists of diagnoses to trigger the limitation for E&M services. The diagnosis lists that carriers use to trigger the limitation represent the most complex aspect of the limitation, and accordingly, result in significant inconsistency among the carriers and the service areas. All carriers that subject E&M services to the limitation do so based on the patient's diagnosis, which appears on the claim. Each carrier that applies the limitation to E&M services uses a list of diagnoses coded into their claims payment systems to trigger the limitation. Typically, a carrier will use one list of diagnoses to "include" E&M services as subject to the limitation. At least one carrier uses another list of diagnoses to "exclude" E&M services from the limitation. Among the carriers, and even within some carriers, these lists vary. See Table 5 for details.

F I N D I N G S

Table 5
Diagnostic Triggers
 Vary:
 Carriers' used
 different lists of
 diagnoses to
 trigger the
 limitation for E&M
 claims received in
 2003.

DSM-III-R and Non-DSM III-R Psychiatric Diagnoses Used to Apply the Limitation to E&M Services in 2003			
Application of the Limitation to E&M Services	Carriers*	Service Areas	Percent Service Areas**
E&Ms are never subject to the limitation	3	5	9%
DSM-III-R Included Only DSM-III-R diagnoses trigger the limitation	4	12	21%
DSM-III-R and non-DSM-III-R Included Both DSM-III-R and non-DSM-III-R diagnoses trigger the limitation	10	25	44%
Non-DSM-III-R Excluded Non-DSM-III-R diagnoses <i>prevent</i> the application of the limitation to any claim	1	1	2%
Unknown Carriers' stated payment policies could not be verified in claims data	10	14	25%
Overall Total	28	57	101%

*There were 19 carriers in 2003; this column totals 28 because 9 carriers use different policies among their service areas.

**The "percent of service areas" column equals 101 percent due to rounding.

Source: Office of Inspector General analysis of carriers' payment policies, 2005.

Carriers' diagnosis lists are not consistent

The differences in carriers' diagnosis lists can be explained, at least in part, by the source(s) that carriers use to develop them. The ICD-9 and DSM-III-R do not contain the same diagnoses. In its "mental disorders" sections, the ICD-9 contains 192 diagnoses²² not found in the DSM-III-R. As shown in Table 5, carriers covering 12 service areas use only DSM-III-R diagnoses, and therefore, none of these 192 diagnoses listed only in the ICD-9 will trigger the limitation. In contrast, carriers covering 25 service areas use both DSM-III-R and some of these 192 non-DSM-III-R diagnoses to trigger the limitation. Many of the 192 diagnoses excluded from the DSM-III-R are subcategories of diseases, specifying, for example, a recurrent episode or chronic condition. For example, in service areas in which carriers rely solely on

²² In 1995, at least three CMS regional offices issued to their respective carriers memoranda that listed each diagnosis code as found in the ICD-9 but not in the DSM-III-R. We used these memoranda as our source for identifying the non-DSM-III diagnoses.

F I N D I N G S

the DSM-III-R, diagnoses that providers code more specifically (e.g., schizo-affective type, chronic, code 295.72) will not trigger the limitation while diagnoses coded more broadly (e.g., schizo-affective type, unspecified, code 295.70) will trigger the limitation.

The ICD-9 and DSM-III-R are not fully compatible, and regulations and CMS guidance do not specify how carriers should reconcile the differences to consistently apply the limitation. The most recent CMS guidance states that, for purposes of applying the limitation, a mental disorder is “. . . defined as the specific psychiatric condition described in the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders, Third Edition – Revised.”²³ However, the regulations state, without mentioning the DSM-III-R or the ICD-9, that for the purpose of applying the limitation a mental disorder is “any condition identified by a diagnosis code within the range of 290 through 319.”²⁴ The range of codes in the “mental disorders” section of the ICD-9 is “290 through 319,” while the range of codes in the DSM-III-R is “290 through 319” in addition to other codes (e.g., 780.50, 780.54, 799.90). In addition, as mentioned earlier, there are 192 diagnoses in the ICD-9’s mental disorders section that do not appear in the DSM-III-R.

Carriers incorrectly subject E&M services for Alzheimer’s patients to the limitation in approximately half of the service areas

Contrary to Federal regulations and CMS guidance,²⁵ in approximately one-half of the service areas, carriers subject E&M services to the limitation for patients diagnosed with Alzheimer’s and related disorders. Eleven carriers representing twenty-six service areas apply the outpatient mental health treatment limitation to E&M services rendered to Alzheimer’s and dementia patients. See Table 6 for details. We could verify the payment policies of 11 of the 19 carriers that reported that they apply the limitation to E&M services for beneficiaries diagnosed with Alzheimer’s disease or related disorders.

²³ “Medicare Claims Processing Manual,” Publication 100-4, Chapter 12, sections 210 and 210.1(B).

²⁴ 42 CFR § 410.155(b).

²⁵ 42 CFR § 410.155 and “Medicare General Information, Eligibility, and Entitlement Manual,” Publication 100-1, Chapter 3, section 30.2.

Table 6
Diagnoses of
Alzheimer's or
Related Disorders:
 Carriers' payment
 policies for
 application of the
 limitation to E&M
 claims received in
 2003.

Diagnoses of Alzheimer's Disease or Related Disorders as a Trigger for Applying the Limitation to E&M Services			
Application of the Limitation to E&M Services	Carriers*	Service Areas	Percent Service Areas
No regardless of diagnosis.	3	5	9%
Yes but not to Alzheimer's or dementia disorders.	7	19	33%
Yes to some but not all Alzheimer's and dementia disorders.	11	26	46%
Yes to all Alzheimer's and dementia disorders.	0	0	0%
Unknown Carriers' stated payment policies could not be verified in claims data.	5	7	12%
Overall Total	26	57	100%

*The total number of carriers in 2003 was 19, however, the carriers' column totals 26 because 7 carriers use different policies among their service areas.

Source: Office of Inspector General analysis of carriers' payment policies, 2005.

Carriers overstated copayments for beneficiaries with Alzheimer's disease and related disorders by approximately \$27 million during a 4-year period

The regulations at 42 CFR § 410.155(b)(2)(v) prohibit application of the limitation to “medical management, as opposed to psychotherapy, furnished to a patient

diagnosed with Alzheimer's disease or a related disorder.” In its guidance to carriers, CMS elaborates:

When the primary diagnosis reported for a particular service is Alzheimer's Disease (coded 331.0 in the “International Classification of Diseases, 9th Revision”) or Alzheimer's or other disorders coded 290.XX in the APA's DSM-III-R, carriers look to the nature of the service that has been rendered in determining whether it is subject to the limitation. Typically, treatment provided to a patient with a diagnosis of Alzheimer's Disease or a related disorder represents medical management of the patient's condition (rather than psychiatric treatment) and is not subject to the

F I N D I N G S

limitation. However, when the primary treatment rendered to a patient with such a diagnosis is psychotherapy, it is subject to the limitation.²⁶

Both the regulations and CMS guidance clearly state that medical management for these patients should not be subject to the limitation. Only psychotherapy services are subject to the limitation for patients diagnosed with Alzheimer’s or a related disorder. The regulations do not specifically define an “Alzheimer’s related disorder;” however, CMS guidance identifies the specific range of diagnosis codes as “290.XX.” See appendix B for a complete list of diagnoses referenced in the guidance.

CMS guidance on 42 CFR § 410.155 is consistent with the regulation. However, carriers are applying inappropriately the outpatient mental health treatment limitation to medical management services²⁷ for beneficiaries diagnosed with Alzheimer’s disease or related disorders. Consequently, Medicare underpaid providers for these services. As a result, the beneficiaries were responsible for copayments in excess of what is mandated by Federal regulations. See Table 7 below for the total copayments miscalculated by year and Appendix C for the services in 2004 for which the copayments were miscalculated.

Table 7
Diagnoses of
Alzheimer’s or
Related
Disorders:
Incorrect
application of
the limitation
for claims
received 2001
through 2004.

Incorrect Application of the Limitation for Patients with Alzheimer’s Disease or Related Disorders					
Year Services were Rendered	Beneficiaries	Medicare Total Approved	Total Beneficiary Liability (by Carriers)	Total Beneficiary Liability (Correct)	Medicare Under-payment
2001	158,000	\$20,489,000	\$10,245,000	\$4,098,000	\$6,147,000
2002	178,000	\$22,587,000	\$11,294,000	\$4,517,000	\$6,776,000
2003	197,000	\$27,503,000	\$13,752,000	\$5,501,000	\$8,251,000
2004	146,000	\$20,091,000	\$10,046,000	\$4,018,000	\$6,027,000
Total	488,000	\$90,671,000	\$45,336,000	\$18,134,000	\$27,201,000*

*This table represents projections from a 1-percent sample of Medicare claims. The projections are rounded to the nearest 1,000. The 95 percent confidence interval for the point estimate of \$27,201,000, rounded to the nearest thousand is \$26,213,000 to \$28,190,000.

Source: Office of Inspector General analysis of 1-percent sample of calendar years 2001, 2002, 2003, and 2004 Medicare claims, 2005.

²⁶ “Medicare Claims Processing Manual,” Publication 100-4, Chapter 12, section 210.1(D)(1).

²⁷ These services include E&M and psychiatric pharmacologic management. See Appendix B for a complete list of the procedure codes in 2004.

Due to carriers' inconsistent policies regarding application of the outpatient mental health treatment limitation, carriers do not uniformly calculate beneficiaries' copayments. In addition, some carriers are incorrectly applying the limitation to services for beneficiaries with Alzheimer's disease and related disorders, resulting in beneficiary overpayments.

To address this, CMS should:

Issue new guidance to carriers regarding the outpatient mental health treatment limitation and ensure that the limitation is consistently applied among all carriers

In the new guidance, CMS should instruct its carriers (using a comprehensive list of specific CPT and ICD-9 codes) how the outpatient mental health treatment limitation applies to services for:

- psychiatric pharmacologic management;
- evaluation and management;
- patients with diagnoses that appear in the ICD-9 list of psychiatric illness, but do not appear in the DSM-III-R;
- patients with diagnoses that appear in the DSM-III-R, but do not appear in the ICD-9; and
- patients diagnosed with Alzheimer's disease and related disorders.

CMS should instruct its carriers that, pursuant to 42 CFR § 410.155 and the "Medicare General Information, Eligibility, and Entitlement Manual," Publication 100-1, Chapter 3, section 30.2, they should discontinue applying the limitation to any services, except psychotherapy, for patients with Alzheimer's disease (diagnosis code 331.0) or related disorders (diagnosis codes 290.XX).

Require its carriers to adjust the copayments for beneficiaries who were overcharged

CMS should instruct its carriers to identify claims for all nonpsychotherapy services (e.g., E&M services and psychiatric pharmacologic management) for patients with Alzheimer's disease or related disorders that were subjected to the limitation. Carriers should reopen these claims in accordance with 42 CFR § 405.841 and

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

determine if beneficiary copayments for the claims were calculated improperly and need to be adjusted.

AGENCY COMMENTS

CMS agreed to take steps to address our recommendations. CMS believes that providing more precise guidance is in the best interest of the Medicare program. Accordingly, CMS plans to issue new guidance to carriers to eliminate variations in the application of the mental health treatment limitation. Additionally, CMS indicated that it would create educational materials for the Medicare Learning Network located on its Web site. Finally, to the extent operationally feasible, CMS will require its carriers to reopen and adjust incorrectly processed claims for patients with Alzheimer's disease and related disorders. See Appendix D for the complete CMS response.

Glossary of Terms

Approved amount	The amount Medicare allows as total reimbursement to the provider for a service, including Medicare’s share and the beneficiary’s copayment.
Beneficiary liability	The Medicare approved amount less the practitioner reimbursement. Usually 50 percent of the approved amount for claims processed under the limitation.
Carrier	A private insurance company working under contract with CMS to process Part B Medicare claims. In 2003, there were 19 separate carriers.
Copayment	The amount the Medicare beneficiary is liable for any given service. Typically, this amount is either 20 percent (medical services) or 50 percent (mental health services) of the Medicare approved amount.
CPT	“A listing of descriptive terms and identifying codes for medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties.” (AMA, “Current Procedural Terminology, 2003, Professional Edition,” Forward, p. vii.)
DSM-III-R	“The standard diagnostic tool used by mental health professionals worldwide to promote reliable research, accurate diagnosis, and thus appropriate treatment and patient care. Each psychiatric disorder with its corresponding diagnostic code is accompanied by a set of diagnostic criteria . . .” (American Psychiatric Association, “Diagnostic and Statistical Manual of Mental Disorders Third Edition Revised” (DSM-III-R), available online at www.psychiatryonline.org . Accessed on November 15, 2005.)

E&M	Evaluation and Management services (CPT codes 99201-99499). These include office visits, hospital visits, and consultations. E&M services typically involve three key components: history, physical examination, and medical decisionmaking. E&M services can vary in complexity and can be rendered by practitioners for patients with mental disorders.
ICD-9	Comprehensive source for disease classification. Diseases are classified with a 5-digit code, such as 295.00, schizophrenia, simple type, unspecified. (AMA’s “International Classification of Diseases, 9 th Revision” (ICD-9).)
Limitation	The Medicare outpatient mental health treatment limitation. Statutory limitation of 62.5 percent of the Medicare Physician Fee Schedule amount on mental health services.
Mental disorder	Includes 281 diagnoses listed in the “International Classification of Diseases” (ICD-9) under Section 5, Mental Disorders (290-319).
Psychiatric Pharmacologic Management	AMA defines psychiatric pharmacologic management (CPT 90862) as a psychiatric service consisting of “pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.”
Psychiatric procedures	Includes 42 procedures listed in AMA’s “Current Procedural Terminology (CPT) 2003,” under Medicine, Psychiatry.
Reimbursement (Medicare payment)	The amount Medicare pays to the practitioner for services.
Service area	Includes 57 geographic areas represented by 1 of the 19 carriers in 2003. Most service areas follow State lines; however, three States (e.g., California, Missouri, and New York) are divided into multiple service areas.

▶ A P P E N D I X B

Table 8
Diagnosis Code
and Names for
Alzheimer's-
Related
Disorders:
 Complete list
 based upon to
 CMS guidance
 on 42 CFR
 § 410.155.

Alzheimer's-Related Disorders			
ICD-9 Code	ICD-9 Diagnosis Name	DSM-III-R code	DSM-III-R Diagnosis Name
290.0	Senile dementia uncomplicated	290.00	Dementia of the Alzheimer's type, senile onset, uncomplicated
290.10	Presenile dementia uncomplicated	290.10	Dementia of the Alzheimer's type, presenile onset, uncomplicated.
290.11	Presenile dementia with delirium	290.11	Dementia of the Alzheimer's type, presenile onset, with delirium
290.12	Presenile dementia with delusional features	290.12	Dementia of the Alzheimer's type, presenile onset, with delusions
290.13	Presenile dementia with depressive features	290.13	Dementia of the Alzheimer's type, presenile onset, with depressed mood
290.20	Senile dementia with delusional features	290.20	Dementia of the Alzheimer's type, senile onset, with delusions
290.21	Senile dementia with depressive features	290.21	Dementia of the Alzheimer's type, senile onset, with depressed mood
290.3	Senile dementia with delirium	290.30	Dementia of the Alzheimer's type, senile onset, with delirium
290.40	Vascular dementia uncomplicated	290.40	Multi-infarct dementia, uncomplicated
290.41	Vascular dementia with delirium	290.41	Multi-infarct dementia, with delirium
290.42	Vascular dementia with delusions	290.42	Multi-infarct dementia, with delusions
290.43	Vascular dementia with depressed mood	290.43	Multi-infarct dementia, with depression

Source: Office of Inspector General analysis of "The Medicare Claims Processing Manual Publication," 100-4, Chapter 12, section 210.1(D)(1); AMA, "International Classification of Diseases, 9th Revision" (ICD-9); and the American Psychiatric Association, "Diagnostic and Statistical Manual of Mental Disorders Third Edition – Revised" (DSM-III-R), 2005.

➤ A P P E N D I X C

Table 9
Diagnoses of
Alzheimer's
or Related
Disorders:
Incorrect
application
of the
limitation for
claims
received in
2004.

Incorrect Application of the Limitation for Patients with Alzheimer's Disease or Related Disorders (from a 1-Percent Sample of Claims)						
HCPSC	Beneficiaries	Total Allowed	Total Beneficiary Liability (by Carriers)	Total Beneficiary Liability (Correct)	Medicare Underpayment	
90862	508	\$78,127	\$39,063	\$15,625	\$23,438	
90870	1	\$97	\$49	\$19	\$29	
96151	1	\$24	\$12	\$5	\$7	
99203	3	\$294	\$147	\$59	\$88	
99204	6	\$764	\$382	\$153	\$229	
99205	1	\$162	\$81	\$32	\$49	
99211	1	\$26	\$13	\$5	\$8	
99212	34	\$1,490	\$745	\$298	\$447	
99213	263	\$17,638	\$8,819	\$3,528	\$5,291	
99214	184	\$19,665	\$9,833	\$3,933	\$5,900	
99215	39	\$5,206	\$2,603	\$1,041	\$1,562	
99217	1	\$77	\$38	\$15	\$23	
99218	1	\$73	\$36	\$15	\$22	
99220	1	\$170	\$85	\$34	\$51	
99231	1	\$96	\$48	\$19	\$29	
99232	1	\$51	\$26	\$10	\$15	
99243	1	\$84	\$42	\$17	\$25	
99263	1	\$62	\$31	\$12	\$18	
99282	2	\$58	\$29	\$12	\$17	
99283	4	\$264	\$132	\$53	\$79	
99284	4	\$509	\$255	\$102	\$153	
99285	3	\$457	\$228	\$91	\$137	
99301	9	\$908	\$454	\$182	\$272	
99302	9	\$829	\$415	\$166	\$249	
99303	18	\$2,205	\$1,103	\$441	\$662	
99311	187	\$13,980	\$6,990	\$2,796	\$4,194	
99312	277	\$38,412	\$19,206	\$7,682	\$11,523	
99313	106	\$14,826	\$7,413	\$2,965	\$4,448	
99315	2	\$120	\$60	\$24	\$36	
99316	1	\$74	\$37	\$15	\$22	
99322	1	\$51	\$26	\$10	\$15	
99323	1	\$76	\$38	\$15	\$23	
99331	5	\$283	\$142	\$57	\$85	
99332	15	\$1,932	\$966	\$386	\$579	
99333	7	\$414	\$207	\$83	\$124	
99344	1	\$173	\$86	\$35	\$52	
99348	3	\$346	\$173	\$69	\$104	
99349	3	\$352	\$176	\$70	\$106	
99350	3	\$538	\$269	\$108	\$161	
Total from 1 percent sample	1460	\$200,912	\$100,456	\$40,182	\$60,274	
Total projected	146,000	\$20,091,000	\$10,046,000	\$4,018,000	\$6,027,000	

Source: Office of Inspector General analysis of 1-percent sample of calendar year 2004 Medicare claims, 2005.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AUG 22 2006

DATE:

TO: Daniel R. Levinson
Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

Mark B. McClellan
OFFICE OF INSPECTOR GENERAL
2006 AUG 23 AM 10:58
RECEIVED

SUBJECT: Office of Inspector General's (OIG) Draft Report: "Carrier Determination of Copayments for Medicare Mental Health Services" (OEI-09-04-00221)

Thank you for the opportunity to review and comment on the OIG's draft report entitled, "Carrier Determination of Copayments for Medicare Mental Health Services." We appreciate the OIG's efforts to ensure that Medicare carriers appropriately process claims for covered mental health services. The OIG identified discrepancies in the application of the mental health treatment limitation amongst carriers. These discrepancies in some carrier areas led to beneficiaries potentially paying significantly more than their share of the charges for these services. The Centers for Medicare & Medicaid Services (CMS) is concerned about these variations and is taking steps to increase consistency between contractors. A series of educational articles and manual instructions will serve to provide the level of precision needed by carriers to ensure that the limitation is applied correctly and beneficiaries pay the appropriate amounts.

Section 1861 of the Social Security Act provides the authority for Medicare to pay for certain outpatient mental health services. Payment for these services is reduced through application of "outpatient mental health treatment limitation" (the limitation), codified by Federal regulations at 42 CFR 410.155. This section requires that all payments made for outpatient mental health services be reimbursed at 62.5 percent of the expenses incurred. "Expenses incurred" is defined as the Medicare allowed amount. After applying beneficiary co-payments, beneficiaries are typically financially liable for 50 percent of the allowed charges for these services. Certain services are exempt from this reduction, including hospital inpatient services, diagnostic services, and medical management services furnished to a patient with Alzheimer's disease or a related disorder.

These services are paid from the Part B Trust fund via local carriers. Many carriers service multiple States. Each carrier is required to process claims from physicians practicing within their jurisdiction, applying the outpatient mental health treatment limitation to claims appropriately.

In the absence of national guidance, or in areas where national guidance allows for interpretation, local carriers are permitted to develop local coverage determinations

Page 2 – Daniel R. Levinson

and/or policy articles which guide the manner in which coverage is determined and in which claims are processed. CMS expects that these local policy statements will not conflict with national guidance.

OIG Recommendation

The CMS should issue new guidance to carriers regarding the outpatient mental health treatment limitation and ensure that the limitation is consistently applied among all carriers.

CMS Response

The CMS appreciates the OIG's recommendation and believes that providing more precise guidance to our local carriers is in the best interest of the Medicare program. CMS plans to issue new guidance that establishes national policy for discretionary issues pertinent to the outpatient mental health treatment limitation. This guidance will also identify diagnosis codes, procedure codes, and place of service codes to which the limitation applies.

In addition, CMS will provide educational materials, in the form of Medicare Learning Network Matters articles that will be posted on the CMS Web site and that will further emphasize the correct application of the mental health treatment limitation.

OIG Recommendation

The CMS should require its carriers to adjust the copayments for beneficiaries who were overcharged.

CMS Response

As a part of the guidance above, to the extent it is operationally feasible, we will require local carriers to identify incorrectly processed claims, reopen, and adjust them appropriately.

The CMS thanks the OIG for their efforts on this report. These findings provide us with invaluable information we can use to help us take action towards our commitment to pay claims correctly. We look forward to working together with you in the future as we address the recommendations in this report.



A C K N O W L E D G M E N T S

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. Other principal Office of Evaluation and Inspections staff who contributed include:

Steven Zerebecki, *Project Leader*

Robert Gibbons, *Lead Analyst*

Silvia Chin, *Program Analyst*

China Tantameng, *Program Analyst*

Thomas Purvis, *Program Analyst*

Doris Jackson, *Program Specialist*

Tricia Davis, *Director, Medicare Branch*