MEDICARE OUTPATIENT PSYCHIATRIC SERVICES

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MAJOR FINDINGS

1. HCFA has interpreted the statutory limitation on Medicare Part B outpatient psychiatric services in two ways:

   a. since the 1965 law, to only physician-rendered services provided in outpatient settings such as community mental health centers, physicians' offices or outpatient hospitals and

   b. since 1982, to both physician and nonphysician services provided specifically through Comprehensive Outpatient Rehabilitation Facilities (CORFs).

2. When developing the CORF regulations, HCFA admitted that this dichotomy exists, but argued that it would be "too drastic" a step to limit reimbursement that has been available since the 1960s when the original regulations were written. Thus, only CORFs are covered by the stricter limitation as Congress intended.

3. The results of the inconsistent regulations and their policy interpretations are variations in carriers' claims administration as well as in provider billing practices.

4. All but four of the nation's carriers apply the limit to both physician- and nonphysician-rendered services in all settings. In CY 1983, the four who have not applied the limit to nonphysician care paid approximately $3.4 million for care exceeding the limit.

5. Many carriers reported that overutilization and billing problems occur primarily in community mental health centers (CMHCs). Even those carriers who have very tight controls over the outpatient psychiatric limit continue to monitor CMHCs closely. Phases I and III of this study found that most costs for nonphysician services exceeding the limit occurred in CMHCs.

RECOMMENDATIONS

- HCFA should revise the regulations and carrier instructions implementing the statutory limitation of outpatient psychiatric services (a) to reflect the original Congressional intent, i.e., to cap both physician- and nonphysician-rendered services and (b) to assure consistent administrative practices among the nation's carriers.

- HCFA should advise carriers to establish review procedures to monitor utilization and billing patterns in community mental health centers and take corrective actions as necessary.

INTRODUCTION

When Congress passed the Medicare Part B legislation in 1965, it included a statutory limitation on outpatient psychiatric services. In developing the program regulations, the predecessor to the Health Care Financing Administration (HCFA) interpreted the statute liberally and imposed the limit only on physician-rendered services, allowing unlimited nonphysician services rendered "incident to" a physician's care. In 1982, when developing regulations for Comprehensive Outpatient Rehabilitation Facilities (CORFs) based on the same statutory language, HCFA applied the limitation to both physician and nonphysician services. In doing so, HCFA admitted that this broader application was in keeping with Congress's original intent, but chose not to apply it to all outpatient psychiatric services.

In 1984, the Office of Inspector General began to study the federal policies and practices which implement the statutory limitation in order to determine the fiscal implications of (a) HCFA's regulatory position and (b) the carriers' administrative practices. The study was undertaken in three phases. Phase I of this study focused on computerized analyses of the carriers' Part B claims records for the states of Washington, Wisconsin, New Hampshire, Vermont, Massachusetts and Connecticut, plus a review of HCFA's regulatory position. We found that the carriers administered the psychiatric coverage limitation in significantly different ways.

As a result of these diverse Phase I findings, we surveyed all the remaining carriers in the country during Phase II to inventory their specific procedural applications in processing outpatient psychiatric claims and found that most carriers are applying the limit to both physician and nonphysician services. Among those who did not was a large carrier, Blue Shield of California. Thus, the final Phase III focused on a computerized analysis of this Northern California carrier's Part B claims records. The methodology used in each phase is described on page 20.

STATUTORY AND REGULATORY BACKGROUND

Section 1833(c) of the Social Security Act places a cap on each Medicare beneficiary's psychiatric outpatient costs incurred during a calendar year. Specifically, the statute allows as incurred expenses $312.50 or 62½ percent of the charge, whichever is smaller. (As applied, .625 x $500 = $312.50.) It should be noted, however, that the amount actually paid is less because each beneficiary's copayment of 20 percent reduces the amount to $250 (i.e., Medicare reimburses 80 percent of the allowed $312.50).

The statute places a limit on expenses incurred in connection with treatment of mental, psychoneurotic and personality disorders. It does not restrict the psychiatric limit to physician services. Further, Section 1861(s) defines medical and health services as both physicians' services and those services and supplies "furnished as incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly rendered without charge or included in the physicians' bills."

It was HCFA regulation rather than the statute which introduced the distinction between physician and nonphysician services and applied the psychiatric limit only to direct physician care. Specifically, the regulation (42 C.F.R. 405.243 as it read prior to December 15, 1982) stated:

> Expenses incurred for services furnished by health personnel other than physicians, including home health services and outpatient services...are not subject to such limitation even though the services are in connection with a condition which is included in the definition of mental, psychoneurotic, or personality disorder.

In 1982, HCFA was faced with applying the same statutory limitation to regulations for Comprehensive Outpatient Rehabilitation Facilities (CORFs). In doing so, HCFA eliminated the distinction between physician and nonphysician services. In the preamble to the proposed CORF regulations, HCFA discussed its interpretation of Section 1833(c):

> The variations between the statute and the regulations originated when the Medicare program was first developed in the late 1960s. At that time, the decision was made to limit the psychiatric services limitation to only physicians' services [because]...physicians' services generally represent the greatest cost factor in the outpatient care of psychiatric illnesses.... Significant changes in the practice of medicine and in the Medicare program over the last 15 years no longer support this rationale. (47 Fed. Reg. 20095-20096, May 10, 1982.)

Although HCFA chose to apply the $250 payment cap to all psychiatric services (i.e., both physician and nonphysician) provided by a CORF, it did not extend the limitation to all Part B outpatient psychiatric services, e.g., those provided in a physician's office or a community mental health clinic. HCFA continued in the preamble to the proposed regulations to say, "We believe that would be too drastic a step to take at this time since it would limit reimbursement that is currently available...."

The preamble to the final CORF regulations reaffirmed that the justification for the previous regulation was no longer valid:

> As explained in the preamble to the proposed rules, the regulation did not conform literally to the language of the statute, which does not restrict the pyschiatric limit to physician services. As further discussed, we do not believe it would be in the best interest of the public and the program to extend the limitation to other benefits that have long been available to beneficiaries. Accordingly, we proposed to amend the regulation by applying the psychiatric limit to CORF services (whether furnished by physicians or nonphysicians) as required by law. This is not a limit separate from the limit on physicians' services. (47 Fed. Reg. 56287-56288, December 15, 1982)

Thus, the final regulations state that "the psychiatric services limitation applies to physicians services and CORF services (furnished by physicians or nonphysicians)...." (42 CFR 405.243(b))

The Region X Office of General Counsel, in an informal review of the law and regulations, said that "we agree with HCFA's conclusion [in the 1982 CORF regulations] that the intent of the statute was to place an across-the-board limit on all expenses incurred in connection with mental illness...."

Yet, this dichotomy exists between Congressional intent and Departmental policy and practice. Our study documents the effect of the dichotomy and the extent of the variations among provider billing patterns and carrier administrative practices in applying the statutory limitation.

BRIEF OVERVIEW: PHASES I, II AND III

This study progressed sequentially, since the findings from the initial phases led to new areas of inquiry. The Region X Office of Analysis and Inspections (OAI) began studying the issue after Region X HCFA alerted our office to discrepencies in provider billing practices for outpatient mental health services in Washington State. To determine the extent of the discrepencies, we began a comparative analysis of the Washington and Wisconsin Part B claims records. During this period, the Region II Office of Audit researched the issue at three carriers who administer Part B in New Hampshire, Vermont, Connecticut and Massachusetts.

The five carriers studied in Phase I administered the psychiatric coverage limitation in significantly different ways:

- Washington Physician Services applied the limit only to physician-rendered care, allowing virtually unlimited nonphysician services. Medicare B paid a total of $2.97 million for outpatient psychiatric services, of which $2.17 million was for care exceeding the limit.

- New Hampshire/Vermont Health Service applied the limit only to physician-rendered care. Medicare B paid a total of $588,996 for outpatient psychiatric services, of which $310,000 was for care exceeding the limit which was provided in Community Mental Health clinics.

- Wisconsin Physician Services applied the limit to both physician and nonphysician services, automatically curtailing the volume and cost of care. Medicare B paid a total of $536,477 for outpatient psychiatric care, of which $54,980 was for care exceeding the coverage limit.

- Massachusetts Blue Shield did not distinguish between physician and nonphysician services, automatically applying the limit to both. Medicare B paid a total of $1,030,254 for outpatient psychiatric services, of which none was for care exceeding the limit.

- Connecticut General did distinguish between physician and nonphysician care but applied the limit to both. Medicare B paid a total of $477,781 for outpatient psychiatric care, of which $9,916 was for nonphysician services.

During Phase II, we surveyed the remaining carriers who were not part of the Phase I analyses to inventory their specific procedural applications in processing outpatient psychiatric claims. All but three said they apply the coverage limitation to both physician and nonphysician outpatient psychiatric services. Two carriers, Blue Shield of Kansas and Blue Shield of Utah, were converting their coding systems and did not know how their new systems would apply the limit. The third exception, Blue Shield of California, clearly distinguishes between physician and nonphysician services in applying the limit. Since this is one of the largest carriers in the country, we proceeded to determine the fiscal implications of this administrative practice.

Thus, in Phase III, this Northern California carrier's claims records were analyzed. Although the available computer files contained several gaps, resulting in incomplete data, we determined that Medicare B paid at least $4,008,256 for outpatient psychiatric services, of which at least $646,808 was for care exceeding the limit.

Detailed analyses of each phase of this study are reported later.

FISCAL IMPACT OF DIFFERING CARRIER PRACTICES

Currently, three Medicare carriers--Washington, New Hampshire/Vermont, and Northern California--pay virtually unrestricted costs for nonphysicians services furnished "incident to" a physician's care. OIG staff analyzed the claims records of these carriers.

TABLE 1
CY 1983 MEDICARE PART B PSYCHIATRIC DATA

	Total Part B Payouts	Total B Psychiatric Payouts	% Psychiatric of Total	Total B Outpatient Psychiatric Payouts	Outpatient Dollars Paid >$250	% Paid >$250 of Outpatient Psychiatric Payments
Washington	$ 219,625,401*	$4,099,057	1.9	$2,968,883	$2,167,602	73.0
New Hampshire/ Vermont	74,437,854*	$ 823,287	1.1	$ 588,996	$ 310,000	52.6
Northern California	$1,275,164,545	$7,633,064	.6	$4,008,256	$ 646,808	16.1

*Unpublished Data prepared by Health Care Financing Administration, Bureau of Data Management and Strategy.

Since the Utah carrier's old coding system also excluded nonphysicians from the limit, we estimate it paid as high as $1,031,242 for outpatient psychiatric care in CY 1983, of which $752,807 exceeded the limit. Table 2 shows the high and low estimates of Utah outpatient psychiatric expenditures, using the Washington and Northern California carriers actual data as the models. The high estimates are based on the Washington experience and the low estimates on the Northern California experience. Although Blue Shield of Kansas does not know whether its new coding system will apply the limit to nonphysician services, its old system did apply the limit to both physician and nonphysician care. We, therefore, are excluding this carrier from any estimates of expenditures exceeding the outpatient psychiatric limit.

TABLE 2
CY 1983 ESTIMATES OF UTAH PSYCHIATRIC EXPENDITURES

	Actual Total B Payouts	Estimated Total B Psychiatric Payouts	Estimated Total B Outpatient Psychiatric Payouts	Estimated Outpatient Dollars Paid >$250
Utah	$ 74,966,781	(h) $ 1,424,369 (l) 449,801	(h) $ 1,031,243 (l) 236,146	(h) $ 752,807 (l) 38,020

(h) = high (l) = low

Thus, we estimate that for these four carriers, Medicare Part B paid between $3.2 million and $3.9 million for care which exceeded the outpatient psychiatric limit:

	High	Low
Washington (actual)	$ 2,167,602	$2,167,602
New Hampshire/Vermont (actual)	310,000	310,000
Northern California (actual)	646,808	646,808
Utah (estimate)	752,807	38,020
	$ 3,877,217	$3,162,430

CONCLUSIONS

At the time it passed the Medicare legislation in the 1960s, Congress approved Part B coverage of outpatient psychiatric services with the proviso that such services be limited to an actual payment cap of $250 per beneficiary per year. Implementing regulations applied the limit to only those services delivered directly by physicians, thus enabling physicians to bill Medicare for unlimited care rendered by their nonphysician staffs. Essentially, psychotherapy may be provided by either a physician or a nonphysician, but the Department requires that the treatment be counted against the limit only when provided by the physician. Medicare pays for unlimited nonphysician services until the physician-rendered services reach the payment cap. Once that limit is reached, Medicare ceases to pay for any outpatient psychiatric services for the remainder of the calendar year. HCFA interpreted the statute differently for CORFs versus all other outpatient settings.

Most of the nation's carriers report that they do not follow HCFA's liberal regulations in applying the outpatient psychiatric limitation in non-CORF settings. In other words, they apply the limit to both physician- and nonphysician-rendered services. The four carriers who do not apply the limit to nonphysician services until the physician-rendered services hit the payment ceiling paid more than $3 million for care exceeding the limit in CY 1983. The fact that carriers are practicing disparate procedural applications is, in and of itself, inequitable to the nation's beneficiaries.

DETAILED CLAIMS RECORDS ANALYSES
PHASE I: WASHINGTON AND WISCONSIN

WASHINGTON

During calendar year 1983, Medicare Part B reimbursed 8,260 Washington beneficiaries $4,099,058 for all psychiatric services they received from 679 providers. Table 3 shows the amounts allowed and paid for inpatient and outpatient services. The ratio of inpatient to outpatient expenditures is 1:3.

TABLE 3
WASHINGTON PART B PSYCHIATRIC CLAIMS
CY 1983

	Amount Allowed	Total $ Paid
Inpatient diagnostic	$ 5,200	$ 4,128
Inpatient therapeutic	1,447,448	1,126,046
Outpatient diagnostic	173,033	125,521
Outpatient therapeutic	3,681,687	2,843,362
Total "B"	$5,307,368	$4,099,057

The carrier's billing procedures distinguish between physician- and nonphysician-rendered services, enabling us to identify the portion of services given by doctors and those given "incident to" the doctors' care by nonphysician staff. Since the cap excludes not only inpatient charges but also diagnostic procedures, we focus our attention on the outpatient therapeutic services. Table 4 compares the doctor and staff expenditures for all beneficiaries reimbursed for outpatient therapeutic care.

TABLE 4
PHYSICIAN AND NONPHYSICIAN
OUTPATIENT THERAPEUTIC EXPENDITURES
IN WASHINGTON, CY 1983

	Physician Services	Nonphysician Services	Totals
No. of beneficiaries	3,945	2,489	5,793*
No. of services	19,580	133,533	153,113
Amount paid	$289,451	$2,553,911	$2,843,362

*This total represents an unduplicated count of beneficiaries, some of whom received both physician and nonphysician services.

Approximately 88% of the dollars spent exceeded the $250 limit. Table 5 compares the doctor and staff expenditures for only those beneficiaries whose Medicare Part B reimbursement exceeded $250.

TABLE 5
CY 1983 OUTPATIENT THERAPEUTIC EXPENDITURES
FOR BENEFICIARIES EXCEEDING CAP
WASHINGTON

	Physician Services	Nonphysician Services	Totals
No. of beneficiaries	437	1,459	1,466*
No. of services	2,757	124,979	127,736
Amount paid	$ 34,293	$2,460,041	$2,494,334

*This total represents an unduplicated count of beneficiaries, some of whom received both physician and nonphysician services.

Thus, 25% of the beneficiaries received 88% of the outpatient therapeutic payout, with an average payment of $1,701, or $1,451 over the cap. If we were to include the outpatient diagnostic costs, the figure would be even greater. This is an important consideration because some therapeutic procedural codes allow for continuing diagnostic evaluation and are excluded from coverage under the payment cap in numerous cases. If there is a question whether such a service is therapeutic or diagnostic, the benefit of doubt leans toward diagnostic judgment call. Circumstantial evidence plants a nagging suspicion, however, that some providers may be abusing this administrative allowance. For example, one doctor saw a patient 17 out of 22 consecutive days and billed Medicare only for diagnostic services. Thus, none of the $724 paid by Medicare was counted against the cap as therapeutic. From the claims record, it looks like this patient was "diagnosed" almost every day for three weeks, and none of the services was billed as psychotherapy.

This practice pattern appears to be minor, however, when compared to the practice among some providers of billing almost exclusively for nonphysician-rendered services. The 1,466 beneficiaries whose outpatient therapeutic reimbursement exceeded the cap were treated by 34 doctors, 5 of whom did not bill at all for their direct services and many of whom billed rarely for their direct services. For example, one provider received $598,786 for treating 253 beneficiaries. Interestingly, the doctor was paid only $456 for physician services and only for 8 patients. He did not bill for any direct physician care to the remaining 245 patients. He received $598,330 for nonphysician care. That equates to $1,312 in nonphysician reimbursement for every $1 in physician reimbursement. Furthermore, 213 (84%) of this provider's patients received more than $250 for outpatient therapeutic care. Only 6 of these were billed for direct physician care, while all 213 were billed for nonphysician care. Of the $594,137 reimbursed, only $441 was for physician care. Payment for these 213 "overlimit" beneficiaries ranged from $252 (i.e., $2 over limit) to $10,487 ($10,237 over limit).

Ten of the 34 providers who treated overlimit beneficiaries received 93% of the overlimit dollars (i.e., $2,314,752 out of $2,494,334). Table 6 shows the billing pattern of the ten highest paid providers of outpatient thereapy to beneficiaries whose reimbursement exceeded the $250 cap. Most of these are Community Mental Health Centers.

TABLE 6
WASHINGTON, CY 1983
TEN HIGHEST PAID PROVIDERS OF OUTPATIENT THERAPY
EXPENDITURES FOR OVERLIMIT BENEFICIARIES
PHYSICIAN VS. NONPHYSICIAN SERVICES

	Physician Treatment			Nonphysician Treatment		
	Dollars	# Services	# Persons	Dollars	# Services	# Persons
Provider Z	$ 441	33	6	$ 593,696	19,183	213
Provider Y	178	11	10	442,982	17,560	211
Provider X	1,836	111	54	286,462	38,086	128
Provider W	656	72	23	257,136	8,828	140
Provider V	2,435	277	52	174,011	6,534	151
Provider U	0	0	0	173,392	10,393	149
Provider T	750	70	28	172,654	5,975	72
Provider S	195	22	12	114,946	3,818	88
Provider R	344	16	4	52,845	1,842	22
Provider Q	470	40	11	39,323	1,852	19
TOTALS	$7,305	652	200	$2,307,447	114,071	1,193

In summary, the data reveal that Medicare Part B is paying a few providers the bulk of the outpatient therapeutic dollars spent in Washington. Table 7 shows the rate of payment per doctor. Please note that these figures include care for both overlimit and underlimit beneficiaries. Thus, 85% of the doctors received 3% of the payout, while 1% of the doctors received 83% of the payout.

TABLE 7
WASHINGTON, CY 1983
OUTPATIENT THERAPEUTIC CARE
PROVIDER REIMBURSEMENT

Range of Payout	# Doctors in Range	Percent of Doctors	Amount Paid to Group	Percent of Dollars Paid
>$0 - $1,000	572	84%	$ 84,269	3%
>$1,000 - $5,000	82	12%	157,343	6%
>$5,000 - $10,000	8	1%	54,523	2%
>$10,000 - $50,000	8	1%	201,040	7%
>$50,000	9	1%	2,346,188	83%
TOTALS	679	99%*	$2,843,363	101%*

*Not exactly 100% due to rounding.

WISCONSIN

During calendar year 1982, Wisconsin providers billed Medicare Part B a total of $4,130,385 for psychiatric services. (CY 1982 tapes were the most recent ones available at the time of the analysis.) Table 8 shows the amount allowed (i.e., the reasonable charge) and the amount paid for inpatient and outpatient services. The ratio of inpatient to outpatient expenditures was 2:1.

TABLE 8
WISCONSIN PART B PSYCHIATRIC CLAIMS
CY 1982

	Amount Allowed	Total $ Paid
Inpatient	$1,685,353	$1,196,447
Outpatient	1,369,234	536,477
Total "B"	$3,054,587	$1,732,924

There is a variety of reasons why the amount paid differs from the amount allowed—e.g., the 20 percent copayment was required of the beneficiary, the annual deductible had to be paid and/or another insurance plan served as primary payor.

Medicare reimbursed 6,694 beneficiaries for outpatient services and 3,259 for inpatient care. These totals undoubtedly include some duplication of individuals who received both outpatient and inpatient services. Few of these beneficiaries received outpatient care that exceeded the $250 expenditure cap. As Table 9 reveals, only 331 persons, 5 percent of those reimbursed for outpatient care, received more than $250 for that care.

TABLE 9
PAYOUT FOR WISCONSIN PART B
OUTPATIENT PROCEDURES, CY 1982

Range of Payout	Number of Beneficiaries	Percent of Beneficiaries	Amount Paid for Group	% Dollars Paid
>$0-$250	6,363	95%	$398,837	74%
>$250-$500	272	4%	$ 90,596	17%
>$500-$750	37	<1%	$ 21,595	4%
>$750-$1000	14	<1%	$ 11,893	2%
>$1000	8	<1%	$ 13,556	3%
TOTALS	6,694	100%	$536,477	100%

Approximately 26% ($137,640) of the dollars spent exceeded $250. Even though 5% of the beneficiaries received 26% of the payout, the average payment for these beneficiaries was $416 ($137,640 ÷ 331) or $166 per beneficiary over the $250 cap. If the payment cap were applied strictly, the maximum amount of questionable claims would be $54,890 or 10% of all outpatient psychiatric expenditures ($137,640 - [$250 x 331] = $54,890). We cannot determine from the computer extract why some claims exceeding $250 were paid and others were not. We can identify the many cases where claims where rejected once the $250 cap was reached, but we cannot identify the reasons why others were paid in excess of the cap.

During 1982, the Wisconsin carrier did not distinguish by procedure code between physician-rendered and nonphysician-rendered services. Thus, we cannot determine whether the overlimit services actually were provided by the doctor or by a staff nonphysician. We were told, however, that midyear in 1983, the carrier added specific procedure codes to identify staff-rendered services. The extent to which this change affected total outpatient practice patterns and costs is unknown. For CY 1982, we can identify, however, which procedures were billed most frequently. Table 10 shows that individual medical psychotherapy (varying from 15-60 minutes) accounts for 96% of all billed services.

TABLE 10
PROCEDURE FREQUENCY
WISCONSIN, CY 1982
(excluding inpatient hospitals as the place of service)

Procedure	# Services Rendered	Percent of Total Volume
- Medical psychotherapy (15-60 minutes)	34,578	96.0%
- Group medical psychotherapy	387	1.0%
- Unlisted procedure or psychotherapy over 1 hour	256	.7%
- Psychologic testing	252	.7%
- Electroconvulsive therapy	208	.6%
- 11 other procedures	223	.6%
TOTALS	35,904	100.0%

Viewed from an expenditure perspective (see Table 11), again individual psychotherapy accounts for 95% of all dollars paid for outpatient psychiatric care.

TABLE 11
AMOUNT PAID PER PROCEDURE
WISCONSIN, CY 1982
(excluding inpatient hospitals as the place of service)

Procedure	Dollars Paid	Percent of Total Payout
- Medical psychotherapy (15-60 minutes)	$508,003	95.0%
- Electroconvulsive therapy	$ 11,340	2.0%
- Psychologic testing	$ 9,823	2.0%
- Group medical psychotherapy	$ 3,483	.6%
- 12 other procedures	$ 3,661	.7%
TOTALS	$536,310*	100.0%

*This total is $167 less than the actual payout, due to truncation.

Of the 576 providers reimbursed by Medicare for outpatient psychiatric services, 415 (72%) received less than $1,000. Table 12 shows the range of expenditures per doctor.

TABLE 12
OUTPATIENT CARE
PROVIDER REIMBURSEMENT
WISCONSIN, CY 1982

Range of Reimbursement	# of Doctors in Range	Percent of Doctors	Amount Paid to Group	% of Dollars Spent
>$0 - $1,000	415	72%	$ 74,792	14%
>$1,000 - $5,000	143	25%	310,781	58%
>$5,000 - $10,000	13	2%	84,666	16%
>$10,000 - $15,531	5	1%	66,238	12%
TOTALS	576	100%	$536,477	100%

The providers receiving the largest total reimbursement did not receive the greatest reimbursement for individual patients, i.e., they treated many Medicare patients. For example, the most the highest paid doctor (i.e., $15,531) received for an individual patient was $291. There were, however, some providers who received much more for the care of an individual beneficiary. The doctor paid the most for an individual patient also served the beneficiary in the state who received the highest Medicare outpatient reimbursement, i.e., Medicare paid $3,671.40 for a beneficiary served by a single provider. Viewed another way, of the eight beneficiaries who were reimbursed more than $1,000, two were treated by only one doctor, four were treated by two doctors, one was treated by three doctors, and one by four doctors.

COMPARISON

The Wisconsin and Washington carriers have administered the psychiatric coverage limitation in significantly different ways. The fact that Wisconsin did not apply procedure codes to distinguish between physician and nonphysician services automatically curtailed the volume and cost of outpatient psychiatric care during 1982. The result of its mid-1983 procedural revisions to differentiate between these two levels of care is unknown.

Washington, on the other hand, based its discrete procedural applications on less strict federal guidance and paid virtually unrestricted costs for nonphysician services furnished "incident to" a physician's care. In March 1984, the Region X HCFA staff queried their headquarters' Office of Coverage Policy for clarification of the regulations. In a May 1984 memorandum, HCFA headquarters responded that Section 1861(s) of the Social Security Act:

has been interpreted to provide that...nonphysician services must be furnished "incident to" a physician's professional services, i.e., they must be furnished as an integral part of a covered physician's professional service in the course of diagnosis or treatment of an injury or illness. In the case of a CMHC, this means that a physician must first render a covered personal professional service to which the services of the nonphysicians can be considered an incidental, although integral, part and the CMHC must submit a claim for this service to its Part B carrier. Until a claim for a physician's service has been processed by the carrier, there has been no adjudication of and thus no determination made on whether the physician's service is in fact covered. In addition, a physician must continue to provide covered personal professional services to the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, change the treatment regimen.

The result of applying this recent policy clarification in Washington is yet to be seen. Also, this policy clarification has been disseminated only in response to Region X's direct inquiry, with copies of the memorandum sent to the other regions. How this information is used by each regional HCFA staff depends entirely on their judgment. In other words, there is no headquarters directive to instruct individual carriers to require physicians to bill for continued personal care periodically and sufficiently often before nonphysician care will be covered. This allows for continued variation in the ways providers bill for and carriers administer outpatient psychiatric reimbursement.

In comparing the results of their two diverse administrative approaches in Wisconsin and Washington, we find disproportionately greater Medicare physchiatric outlay for Washington even though Wisconsin's Medicare population and expenditures are slightly larger. Table 13 compares applicable Medicare data for the two states.

TABLE 13
WASHINGTON AND WISCONSIN
MEDICARE PART B PSYCHIATRIC DATA

	Total Part B Enrollees*	Total Part B Payout*	Total B Psych. Payouts	Total Outpatient Psych. Payouts	Number of Benef's Reimbursed for Outpatient Care**	Number of Outpatient Benef's Paid >$250**	Outpatient Dollars Paid >$250**
WA	479,014	$219,625,401	$4,099,057	$2,968,883	5,793	1,466	$2,167,602
WI	627,954	$262,873,703	$1,732,924	$ 536,477	6,694	331	$ 54,980
Ratio WA:WI	1:1	1:1	2:1	6:1	1:1	4:1	39:1

*Unpublished Data prepared by Health Care Financing Administration, Bureau of Data Management and Strategy.

**Excludes diagnostic expenditures.

CARRIER SURVEY
PHASE II

PROCEDURAL APPLICATIONS OF THE LIMIT

During Phase II, Region X Office of Analysis and Inspections staff surveyed by telephone the remaining carriers who were not a part of the Phase I analyses.[1] Of these 42 carriers,[2] 39 said they apply the coverage limitation to both physician and nonphysician outpatient psychiatric services. Of the remaining three, only one--Blue Shield of California--clearly distinguishes between physicians and nonphysicians in applying the limit. Basically, this northern California carrier applies the coverage limit to physician services and will pay for auxiliary staff services until the physician-rendered services reach the payment limit. In order to meet the "incident to" requirement and to avoid unlimited auxiliary staff care without physician involvement, the carrier requires physicians to treat and bill routinely.

The other two carriers, Blue Shield of Kansas and Blue Shield of Utah, were in the process of converting their coding systems to the HCFA Common Procedure Coding System (HCPCS), and did not know at the time of our discussions if their new systems will apply the payment limit to both physician and nonphysician services. Blue Shield of Kansas began conversion from the Kansas Relative Value System to HCPCS in January 1985. The new HCPCS codes include procedure codes which identify services by nonphysician staff, but the carrier did not know whether the new system would exclude or include these auxiliary staff services under the limit. Blue Shield of Utah began converting its old coding system to HCPCS in March 1985. Under the old system, the carrier did not apply the limit to nonphysician care. Like Blue Shield of Kansas, their experience with the new system is too recent, and they're not sure how the limit will be applied. The carrier's spokesman did say, however, that in 1983, the HCFA regional office instructed all carriers not to apply the limit to nonphysician-rendered care, and the carrier complied under the old system. This HCFA instruction was mentioned also by another carrier in Region VIII, who said they essentially ignored the instruction because their procedures were already in place and continued to apply the limit to both physician and auxiliary staff care.

Eleven other carriers said that although their coding systems allow them to distinguish whether a service was delivered by a physician or nonphysician, they apply the payment limit to both, thus curtailing the volume and cost of outpatient psychiatric services. Many carriers reported that overutilization and billing problems occur primarily in community mental health centers (CMHCs). Even those carriers who have very tight controls over the outpatient psychiatric limit continue to monitor CMHCs closely. For example, some CMHCs bill frequently or routinely for nonphysician care without documentation that the services are incident to a physician's care. Most carriers monitor billing practices through postpayment reviews.

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1 One carrier studied in Phase I (Blue Shield of Massachusetts) was included in the Phase II survey because it also covers Maine, and its administration of claims records from Maine was excluded during Phase I.

2 Note that some carriers cover substate geographic areas and some multi-state areas. See Appendix for a listing of the carriers contacted in Phase II.

Even though the statutory payment cap excludes both inpatient and diagnostic psychiatric procedures, carriers do differ in their application of the limit for diagnostic services. Some carriers said they apply the limit only to outpatient therapeutic care with no limit on diagnostic services. This practice could be costly if, as was found in Washington State during Phase I, some providers are billing almost daily for extended diagnostic treatment, with little or no psychotherapy being documented or billed.

Two other potentially costly issues surfaced during our Phase II discussions with carriers:

- Some providers bill for both physician- and nonphysician-rendered psychiatric services as medical rather than psychiatric procedures, thus circumventing the payment limit. For example, as a result of postpayment reviews of two CMHCs' claims, one carrier (Blue Shield of Western New York) found ancillary personnel were billing office visits (i.e., medical codes) which were not being picked up under the psychiatric limit. The carrier denied these claims and has recently issued a newsletter warning providers that such medical claims will not be paid. Some carriers catch these medical codes by reviewing primary diagnosis and treatment codes and applying the limit if the primary diagnosis is psychiatric. Other systems, however, won't pick up any medical treatment procedures regardless of who billed for them (i.e., psychiatrist or nonpsychiatrist) or what the original diagnosis was (i.e., psychiatric or medical).

- Some psychiatrists practice "gang visits" to nursing homes and submit suspiciously large numbers of therapy claims. Carrier attention to this issue is selective.

DETAILED CLAIMS RECORDS ANALYSIS
PHASE III: NORTHERN CALIFORNIA

The OIG's copy of Northern California carrier's source files contains defects which resulted in lost data for claims paid during the fourth quarter of 1983. The magnitude of this loss is unknown and cannot be determined without substantial expenditure of staff time and computer resources. The following analysis, therefore, is limited to the available data, and the results are conservative.

During calendar year 1983, Medicare Part B reimbursed 29,909 Northern California beneficiaries $7,633,064 for all psychiatric services they received from 3,406 providers. Table 14 shows the amounts allowed and paid for inpatient and outpatient services. The ratio of inpatient to outpatient expenditures is 1:1.

TABLE 14
NORTHERN CALIFORNIA PART B PSYCHIATRIC CLAIMS
CY 1983

	Amount Allowed	Total $ Paid
Inpatient diagnostic	$ -0-	$ -0-
Inpatient therapeutic	4,625,000	3,624,808
Outpatient diagnostic	434,515	339,250
Outpatient therapeutic	5,055,252	3,669,006
Total "B"	$10,114,767	$7,633,064

As in Washington, the Northern California carrier's system differentiated between physician- and nonphysician-rendered services. Table 15 compares the doctor and staff expenditures for all beneficiaries reimbursed for outpatient therapeutic care.

TABLE 15
PHYSICIAN AND NONPHYSICIAN
OUTPATIENT THERAPEUTIC EXPENDITURES
IN NORTHERN CALIFORNIA, CY 1983

	Physician Services	Nonphysician Services	Totals
No. of beneficiaries	29,812	906	29,909*
No. of services	176,124	20,117	196,241
Amount paid	$2,985,712	$683,293	$3,669,006

*This is an unduplicated count of beneficiaries, some of whom received both physician and nonphysician services.

Approximately 17% of the dollars spent on outpatient psychiatric services exceeded the $250 limit. Table 16 compares the doctor and staff expenditures for only those beneficiaries whose Medicare Part B reimbursement exceeded $250.

TABLE 16
CY 1983 OUTPATIENT THERAPEUTIC EXPENDITURES
FOR BENEFICIARIES EXCEEDING CAP
NORTHERN CALIFORNIA

	Physician Services	Nonphysician Services	Totals
No. of beneficiaries	750	679	790*
No. of services	7,593	19,618	27,211
Amount paid	$137,793	$667,061	$804,854

*This total represents an unduplicated count of beneficiaries, some of whom received both physician and nonphysician services.

Less than 3% of the beneficiaries received 22% of the outpatient therapeutic payout, with an average payment of $1,019, or $769 over the limit. It should be noted that 98% of payments for nonphysician care were made to beneficiaries whose reimbursement exceeded the cap.

On the other hand, these 790 beneficiaries whose outpatient therapeutic reimbursement exceeded the cap were treated by 84 providers (approximately 2% of the 3,406 providers whom Medicare reimbursed for outpatient psychiatric care). Of these 84, 60% are group practices, primarily CMHCs. A few are psychiatric day care centers or other types of outpatient clinics.

Sixteen of the 84 providers received 84% of the Medicare Part B dollars paid for outpatient psychiatric therapy to overlimit beneficiaries. Table 17 illustrates the billing pattern of these 16 highest paid providers.

TABLE 17
NORTHERN CALIFORNIA, CY 1983
HIGHEST PAID PROVIDERS OF OUTPATIENT THERAPY
EXPENDITURES FOR OVERLIMIT BENEFICIARIES
PHYSICIAN VS. NONPHYSICIAN SERVICES

	Physician Treatment			Nonphysician Treatment		
	Dollars	# Services	# Persons	Dollars	# Services	# Persons
Provider A	$ 4,962	633	77	$154,379	7,469	89
Provider B	3,676	245	45	96,224	2,016	46
Provider C	6,432	301	37	72,810	2,070	38
Provider D	25,504	1,024	100	42,125	931	91
Provider E	4,096	267	26	40,952	931	27
Provider F	4,017	355	26	36,117	797	27
Provider G	2,246	124	21	37,166	796	28
Provider H	9,031	420	46	19,488	572	44
Provider I	730	90	33	20,972	437	36
Provider J	1,150	53	11	19,500	480	19
Provider K	1,350	83	7	17,281	477	11
Provider L	572	33	9	12,731	330	12
Provider M	72	2	1	12,696	277	14
Provider N	1,665	148	10	7,996	189	11
Provider O	1,112	59	7	7,305	165	9
Provider P	262	24	2	7,713	201	4
TOTALS	$66,877	3,861	458	$605,456	18,138	506

Thus, the data reveal that a small percentage of providers rendering outpatient psychiatric care are receiving most of the overlimit Medicare Part B expenditures, and most of these are community mental health clinics or other group practices where most of the services are provided by nonphysicians.

METHODOLOGY

PHASES I and III

The Wisconsin claims were analyzed using programs written in the SAS computer language. An extract of the claims history file was created which contained only psychiatric codes performed during calendar year 1982. This extract was further divided into two files--inpatient and outpatient claims.

For both files, beneficiaries were listed in ascending order based on total payments. A paper output was produced with summary data for each beneficiary.

The Washington and Northern California claims were analyzed using programs written in COBOL. An extraction program created a file consisting of all 1983 psychiatric claims. This file was sorted two ways--by provider so that practice patterns could be characterized and by beneficiary to identify patients treated by more than one psychiatric provider.

Next, each sort was run against a COBOL program which categorized each claim according to place of service, whether the service was physician- or nonphysician-rendered and whether the service was diagnostic or therapeutic. Outpatient therapeutic services were subtotaled under each beneficiary listing into two classes: (a) physician-rendered and (b) nonphysician-rendered.

Summaries of beneficiary and provider activity were written to paper and, in expanded form, to electronic files. The disk files were downloaded (i.e., electronically transferred via telephone lines) to personal computers and further analyzed using dBase III and BASIC programs.

The Office of Audit performed computerized analyses of the New Hampshire/Vermont and Connecticut CY 1983 and Massachusetts CY 1982 Medicare payment files, using Easytrieve computer language.

PHASE II

All Medicare Part B contractors who were not part of the Phase I analysis were surveyed by telephone to inventory their specific procedural applications in processing outpatient psychiatric claims.

APPENDIX
PHASE II CARRIER CONTACTS

CARRIER	GEOGRAPHIC COVERAGE
Blue Shield of Massachusetts	Massachusetts, Maine
Blue Shield of Rhode Island	Rhode Island
Group Health, Inc.	Queens
Blue Shield of Western New York	45 upstate counties
Blue Cross/Blue Shield of Greater New York	16 downstate counties
Triple S	Puerto Rico, Virgin Islands
Prudential	New Jersey, Georgia, North Carolina
Pennsylvania Blue Shield	Pennsylvania, Delaware, D.C.
Blue Shield of Maryland	Maryland
Travelers of Virginia	Virginia
South Carolina Blue Shield	South Carolina
Equitable	Tennessee
Blue Shield of Alabama	Alabama
Travelers	Mississippi
Florida Blue Shield	Florida
Kentucky Blue Shield	Kentucky
Travelers	Southeast Minnesota
Blue Cross/Blue Shield of Minnesota	11-county metropolitan area
Blue Cross/Blue Shield of Michigan	Michigan
Nationwide Mutual	Ohio, West Virginia
Mutual Medical	Indiana
Illinois Health Care Service Corp.	Illinois
Arkansas Blue Cross/Blue Shield	Arkansas, Louisiana
Aetna	Oklahoma
Blue Cross/Blue Shield of Texas	Texas
Equitable	New Mexico
Mutual of Omaha	Nebraska
Blue Shield of Iowa	Iowa
Blue Shield of Kansas City	Metropolitan Kansas City area in both Kansas and Missouri
Blue Shield of Kansas	All Kansas except two counties in Metropolitan Kansas City area
General American Life	All Missouri except four counties in Metropolitan Kansas City area
Montana Physicians Service	Montana
Equitable	Wyoming
Blue Shield of Utah	Utah
Colorado Blue Shield	Colorado
Blue Shield of North Dakota	North Dakota, South Dakota
Aetna	Arizona, Nevada
Aetna	Hawaii
Blue Shield of California	51 northern California counties
Transamerica Occidental	7 southern California counties
Aetna	Oregon, Alaska
Equitable	Idaho