

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MENTAL HEALTH SERVICES IN
NURSING FACILITIES**



JUNE GIBBS BROWN
Inspector General

MAY 1996
OEI-02-91-00860

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EXECUTIVE SUMMARY

PURPOSE

To identify possible vulnerabilities to the Medicare program in the provision of mental health services to nursing facility residents.

BACKGROUND

Events in the past few years have focused attention on mental health care for nursing facility residents. The number of nursing facility residents with mental disorders has increased; the Nursing Home Reform Act, which provided new protections for residents and sweeping reforms of many aspects of life in nursing homes was implemented; and Medicare payments tripled in the wake of an expansion of Part B coverage of these services. Many nursing home residents have benefitted from services not previously available to them. However, some problems remain. On the one hand, some may not be getting the care they need. On the other hand, the Office of Inspector General has received allegations of abusive practices relating to these services, primarily about Medicare being billed for unnecessary or inappropriate services.

Our study is meant to draw an overall picture of the kinds of mental health services being provided in nursing facilities and to identify any potential vulnerabilities for the Medicare program.

We based our results on a review of medical records maintained by nursing homes for the five Medicare codes that were most commonly reimbursed to psychiatrists, clinical psychologists, and clinical social workers in 1993. We also interviewed knowledgeable personnel and reviewed pertinent policies and documents. We selected nursing facility records as the basis of our sampling because these records are generally used by HCFA and its contractors to assess the appropriateness and quality of care provided to Medicare beneficiaries, and they are the primary source of information for records reflecting care actually delivered to a patient during a stay in a nursing facility. These records also provide a full accounting of all services delivered. We contracted with FMAS, Inc., a medical review contractor, which employed psychiatrists, psychologists, and social workers to review the records and the services provided by their peers.

FINDINGS

In 32 percent of the records received, Medicare paid for medically unnecessary services; this projects to \$17 million, or 24 percent of all 1993 Medicare payments for mental health services for nursing home residents.

Of the 397 medical records received for review, 126 contained medically unnecessary services. In forty-one records, all services were unnecessary; and in 85 some were unnecessary. Medically unnecessary services are those which our medical reviewers

concluded were inappropriate based on information in the medical record concerning the patient's condition, need for treatment, and ability to benefit from the treatment.

In 16 percent of the records received, Medicare paid for highly questionable services; this projects to \$10 million in Medicare payments

In sixty-three records, all services were highly questionable. Highly questionable services are those where the medical record led the reviewers to raise serious questions about the medical necessity of the services, but where the evidence in the medical record was insufficient for the reviewers to make a definitive determination.

In another forty the documentation was so poor they could not be reviewed. These forty records did not contain enough information for the screeners to even refer the records to the clinical reviewers.

In 30 percent of the records, the wrong code appears to have been billed

According to the medical reviewers, in thirty percent of the 225 cases where they had enough information to determine what the correct procedure code should be, the code billed appeared to have been incorrect. In over half of these cases the service appeared to be medication management without any documentation of psychotherapy, but psychotherapy was billed.

At the same time, difficulties remain in delivering needed mental health services to beneficiaries

We found that some beneficiaries are not getting the care they need. For example, some received psychotherapy without being evaluated for medication which might have been helpful. Others received erratic, inconsistent services when they needed consistent psychotherapy. We also found that the skill levels of some providers may not have been adequate.

Certain types of procedures, providers, residents, and regions are more likely than others to be associated with unnecessary and questionable services

Psychological testing and group therapy are more likely (79 percent) to be medically unnecessary or questionable than evaluation and individual therapy (47 percent). Among the provider types, clinical psychologists and clinical social workers had the highest percentage (61 percent) of unnecessary and questionable services billed to Medicare. Among age groups, the "old, old" (over 85) were most likely to have unnecessary or questionable services. Sixty-two percent of these residents had such services compared to 47 percent of those under 85. Those residents with a mental health diagnosis of dementia including Alzheimer's disease, were more likely (58 percent) to receive questionable or unnecessary services than those with other diagnoses (45 percent). Records from nursing facilities in the South were slightly more likely to have unnecessary or questionable services than other parts of the country.

Many Factors Make Mental Health Service Billings Vulnerable To Abuse

We found the following conditions which might jeopardize Medicare payment integrity:

- Lack of physician involvement,
- Impediments of social service staff involvement,
- Missing treatment plans,
- Lack of utilization guidelines,
- Lack of carrier policies and screens specific to nursing facilities, and
- Difficulty identifying patients' nursing facilities.

RECOMMENDATION

HCFA needs to take steps to prevent inappropriate payments for mental health services in nursing facilities. The challenge lies in ensuring the integrity of Medicare payments while promoting the delivery of needed care. There probably is no one simple solution. Instead, a battery of carefully applied remedies is needed.

Based on the nature of the problems we identified, we suggest the following approaches that HCFA, in concert with the carriers, might take:

- Develop guidelines for carriers with delineation of exactly what the psychiatric procedure codes mean, what can be billed for, who can bill, and how often;
- Develop screens to implement these guidelines;
- Conduct focused medical reviews;
- Provide educational activities to providers of mental health services;
- Clarify who can provide services incident to physician or clinical psychologist services;
- Assure that the nursing facility provider number and name is on all claims for patients in nursing facilities;
- Clarify the requirements needed to become an independent mental health provider;
- Identify and disseminate information about effective ways to help residents adjust quickly to the nursing facility to prevent the need for later clinical intervention; and
- Convene a group of medical professionals to develop best practices in documenting the nursing facility medical record and provide guidance to nursing facility professionals.

OPERATION RESTORE TRUST STRATEGIES

This inspection is a part of a Department of Health and Human Services anti-fraud initiative called Operation Restore Trust designed to target fraud, waste, and abuse related to home health agencies, nursing homes, and durable medical equipment suppliers. This initiative targets California, Florida, Illinois, New York, and Texas, the five States with the highest number of Medicare and Medicaid beneficiaries.

We will work with HCFA and the Administration on Aging (AoA) to follow up on issues raised in this report in a variety of ways as they relate to Operation Restore Trust. For example, we will refer possible cases of fraud and abuse found in this inspection for additional review by HCFA and our own audit and investigations units, as appropriate. HCFA's protocol for survey and certification staff to look at mental health services in nursing facilities when on-site will be beneficial not only in preventing inappropriate payments, but also in improving the quality of services. We will also communicate with the Administration on Aging to make the State Ombudsmen aware of possible inappropriate or inadequate mental health services. We intend to issue a follow-up report providing information specific to the five project ORT States.

COMMENTS

The HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) concurred with our recommendation. The HCFA details the actions they are taking in response to carry it out. The HCFA and ASPE also made suggestions for changes in wording, clarifications of the text and technical changes which we have for the most part incorporated into the final report. The actual comments received are in Appendix D.

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INTRODUCTION

PURPOSE:

To identify possible vulnerabilities to the Medicare program in the provision of mental health services to nursing facility residents.

BACKGROUND:

Events in the past few years have focused attention on mental health care for nursing facility residents. The number of nursing facility residents with mental disorders has increased; the Nursing Home Reform Act, which provided new protections for residents and sweeping reforms of many aspects of life in nursing homes was implemented; and Medicare payments tripled in the wake of an expansion of Part B coverage of these services. Many nursing home residents have benefitted from services not previously available to them. However, some problems remain. On the one hand, some may not be getting the care they need. On the other hand, the Office of Inspector General has received allegations of abusive practices relating to these services, primarily about Medicare being billed for unnecessary or inappropriate services.

The number of individuals with psychiatric disorders residing in nursing facilities surpasses the number in psychiatric hospitals, according to the American Psychiatric Association (APA). Recent studies have also shown that psychiatric disorders and emotional, behavioral, and cognitive problems are present in a majority of nursing facility residents. However, it is difficult to precisely quantify the extent and types of problems because these conditions are not always the primary reason for institutionalization, and are not always accurately reported in patients' medical records.

The Nursing Home Reform Act

As a part of the Omnibus Budget Reconciliation Act (OBRA) of 1987, Congress passed the comprehensive Nursing Home Reform Act (PL 100-203). This expanded requirements that nursing facilities had to meet for Medicare certification. It focused on each resident's highest potential for physical, mental, and psychosocial well-being with reasonable accommodation for individual needs and preferences. The Act mandated that all applicants to Medicaid certified nursing facilities and all nursing facility residents must be screened to determine whether they have a mental illness or mental retardation, whether they need active treatment, and whether they need the level of nursing care provided by a nursing facility. This Preadmission Screening and Annual Resident Review (PASARR), implemented in 1988, is the screening process used to determine those nursing facility residents who need both specialized mental health services and nursing facility care and can stay in a nursing facility and those residents that need specialized services, but not nursing facility care, and must be transferred to a more appropriate setting unless they have lived in a nursing facility more than 30 months and choose to stay. The State is responsible for making sure that the residents get the specialized services they need.

The Nursing Home Reform Act also requires that residents appropriately placed in nursing facilities receive a full range of services to address their psychosocial needs and behavioral problems. This range of services is not precisely defined, but nursing facilities must "conduct standardized, reproducible assessments of each resident's functional capacity..." within 14 days of admission, if the patient's condition changes, and at least every 12 months to determine the appropriate services. This assessment uses the Resident Assessment Instrument which is a multidimensional, clinically focused evaluation tool. It provides a basis for identifying problems and developing a resident's plan of care. The instrument has two parts: the Minimum Data Set which is the basis of the resident assessment process and the Resident Assessment Protocols (RAPS) which identify the residents' unique problems. This information is used by the interdisciplinary team and the resident when developing the resident's individualized, comprehensive care plan. Seven of the 18 RAPS specifically address mental health problems commonly found in nursing facilities such as delirium, cognitive loss/dementia, psychosocial well-being, sad and anxious moods, behavior problems, psychotropic drug use, and use of physical restraints.

The Nursing Home Reform Act also mandated the development of regulations constraining the use of psychotropic drugs. The Health Care Financing Administration (HCFA) regulations state that residents must be free from unnecessary drugs, not be given antipsychotic drugs except to treat a specific condition, and be given gradual dose reductions.

Medicare Coverage of Mental Health Services

As with all Part B Medicare services, covered mental health services must be "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Payment is prohibited for medical services that are for prevention, palliation, research or experimentation. In the absence of national policy, local carriers determine their own policies.

Services may be provided by different professionals. Medicare defines each of these specialties for the purposes of coverage. While psychotropic drugs may be prescribed only by a physician, behavioral and psychotherapeutic approaches may be carried out by a psychiatrist, a clinical psychologist and/or a clinical social worker.

While clinical psychologists' and social workers' services are covered the same as services by a physician, they may only provide those services they are legally authorized to perform in their State. Additionally, independent clinical social workers may not bill Medicare Part B for services furnished to an inpatient of a skilled nursing facility that the facility is required to provide as a Medicare condition of participation.

Medicare Expansion of Mental Health Benefits

From 1966 until 1988, Section 1833 of the Social Security Act placed a cap on each Medicare beneficiary's psychiatric outpatient costs incurred during a calendar year. Prior to 1988, Medicare paid no more than \$250 annually for covered outpatient treatment of

mental, psychoneurotic, or personality disorders. This was based on 62.5 percent of a maximum of \$500 in reasonable charges and subject to a further reduction of 20 percent for co-insurance. Charges for initial diagnostic services, i.e., psychiatric testing and evaluation to diagnose the patient's illness, were never subject to this limitation.

The 1987 OBRA liberalized Medicare Part B coverage of outpatient psychiatric services. Beginning in 1988, reimbursement for outpatient psychiatric services increased to \$450 annually, based on 62.5 percent of \$900 in reasonable charges and a further reduction of 20 percent for co-insurance. In January 1989, this was increased to \$1100 annually, based on 62.5 percent of \$2,200 with a 20 percent co-insurance. This legislation also expanded Medicare coverage to include therapeutic services directly furnished by clinical psychologists, effective July 1988, but covered services were restricted to those furnished in certain settings such as community mental health centers.

The 1989 OBRA further expanded the Part B Medicare psychiatric benefit. It eliminated the dollar cap on outpatient psychiatric reimbursement, effective January 1, 1990, although the reasonable charges are still reduced by a 62.5 percent limitation and the 20 percent co-insurance remains in effect. Brief office visits for the sole purpose of monitoring or changing drug prescriptions and any partial hospitalization services not furnished by a physician were excluded from the 62.5 percent limitation, effective January 1989. In addition, effective July 1990, direct payment to clinical psychologists can be made in all settings and to clinical social workers in most settings.

Trends in Medicare Reimbursement

Medicare reimbursement for the five most commonly reimbursed mental health HCPCS codes for psychiatrists, clinical psychologists and clinical social workers for all Part B services show a 57 percent increase, from \$353 million in 1991 to \$555.6 million in 1993. However, these same codes for the same three provider types for services provided in nursing facilities showed a 244 percent increase, from \$20.8 million in 1991 to \$71.7 million in 1993. Definitions of the procedure codes are in Appendix A.

Concerns About Possible Fraud and Abuse

During the years prior to liberalization of the outpatient psychiatric benefit in 1988, postpayment claims monitoring by HCFA and Medicare carrier staff identified a variety of abusive and fraudulent physician practices. Among the most common were those involving nursing home and old age home patients, many often incapable of communication, whose Medicare accounts were billed for lengthy psychotherapy sessions, individual and group. In some cases no service was rendered; in many others a brief visit to check and/or adjust drug prescriptions was the actual service. However, outpatient psychiatric services were not usually given intense scrutiny by HCFA, presumably because of the cap on outpatient reimbursement.

After three and one-half years of uncapped Part B psychiatric benefits and three years of covered clinical psychologist and clinical social worker services, only limited HCFA

review of the nature and extent of these services and the practices of their providers takes place. One kind of review that carriers have available is called focused medical review which targets more in-depth medical review efforts at claims for items, services or providers that present the greatest risk of inappropriate payments. In 1992 and 1993, there was minimal Medicare carrier focused medical review of these services. However, in one identified instance of carrier focused review of psychological testing, the review established that the psychological testing conducted in nursing homes by certain clinical psychologists was excessive and unnecessary.

A HCFA-funded Medicare carrier study in Arkansas has been looking at ancillary services in nursing facilities. While reviewing beneficiary records, this carrier discovered problems involving consultation and psychotherapy services provided by non-physicians in nursing facilities. One problem involved clinical psychologists in group practice billing for therapy provided by unsupervised non-clinical social workers. After readjudicating claims from the group which billed for these services from 1988 to early 1992, the carrier has recovered nearly a quarter million dollars and may assess additional overpayments.

Cases of suspected fraudulent practices involving outpatient psychiatric services have been recently identified by carriers and referred to the OIG. An August 1992 OIG fraud alert addresses concerns about excessive and fraudulent billing for psychotherapy services provided by a clinical psychologist. It reports a pattern of aggressive marketing of psychological services to Medicare beneficiaries in certified retirement and nursing facilities.

AARP Public Policy Institute Study

A 1994 report "Barriers to Mental Health Services for Nursing Home Residents" was published by the AARP Public Policy Institute. The goal of the project was to develop data about the need of nursing home residents for mental health services, the availability of such services, and the barriers to obtaining needed care.

Policy makers and researchers who contributed to the report agreed that many mentally ill nursing home residents would benefit from increased attention from mental health professionals. These residents often respond well to short-term interventions. They go on to say that mental health services are scarce in nursing facilities because of low Medicare and Medicaid reimbursement rates; limits to mental health coverage under these programs; and difficulties that facilities face in recruiting mental health professionals to work in nursing homes.

They concluded that the presence of mental health professionals such as psychiatrists, psychologists, psychiatric and geriatric nurses, and clinical social workers in nursing facilities is the key to helping residents with mental disorders. They felt that timely treatment can forestall further decline and that attracting the necessary mental health professionals to nursing facilities would require improved reimbursement rates and fewer restrictions on services.

METHODOLOGY

We based our results on a review of medical records maintained by nursing homes for the five Medicare codes that were most commonly reimbursed to psychiatrists, clinical psychologists, and clinical social workers in 1993. We also interviewed knowledgeable personnel and reviewed pertinent policies and documents.

First, we selected a simple random sample of 540 beneficiary claims from the 1993 HCFA Common Working File which meet certain conditions. The sample consists of beneficiaries who received any one of five of the six top HCFA common procedure coding system (HCPCS) services: psychiatric diagnostic interview (90801); psychological testing with written report (90830); individual psychotherapy, 20 to 30 minutes (90843); individual psychotherapy, 45 to 50 minutes (90844); and group psychotherapy (90853) provided in a nursing facility. A more detailed description of these procedure codes is given in Appendix A. Pharmacologic management and review of medication with no more than minimal medical psychotherapy (90862) was eliminated from the universe prior to sampling because that procedure code can only be billed by a medical doctor and not a psychologist or social worker. All claims by a psychiatrist for an evaluation only were also omitted. The place of service for all sample beneficiaries was either skilled nursing facility (SNF) or nursing facility (NF). Although in the course of this study we reviewed only services billed to Medicare, the beneficiaries may have been Medicaid eligible as well.

Beneficiary claims in this sample were handled by 33 Medicare carriers who we contacted to obtain copies of claims in order to identify the nursing facility where services were provided. Next, we asked the nursing facilities to send us copies of the sample patients' medical records. We requested: the initial admission evaluation; all mental health documentation during the patient's entire stay; and for 1993, all nurse's notes, medication orders, physicians' notes, including consultations; and any patient assessments that were done.

We selected nursing facility records as the basis of our sampling for several reasons. First, these records are frequently used by HCFA and its contractors to assess the appropriateness and quality of care provided to Medicare beneficiaries. In conversations with HCFA contractors, we were told that they generally rely on records maintained at the site of service for these purposes. Thus, they are the primary source of information for records reflecting care actually delivered to a patient during a stay in a nursing facility. Second, these records contain a full accounting of all services delivered and thus provide better documentation from which to assess medical necessity than fragmented provider based records. Third, nursing facilities, like hospitals, are required to maintain patient records reflecting the care provided to their patients.

We received 397 (74 percent) of the 540 records requested. We contracted with FMAS, Inc., a medical review contractor to review the medical records which did not pass the screens. The screening was done by either the inspection team or FMAS, Inc. screeners. The instrument used for screening the records was developed by the contractor using

clinical screens generally accepted among mental health care peer review organizations. These screens are used for reviewing records for all patients requiring mental health care. In developing the screening instrument, the medical review contractor did a literature search and talked to people who had leadership roles in their professional organizations. The screening instrument included variables such as the patient's diagnosis and treatment, both medical and psychological, how the mental health treatment was initiated, its goals, indications for testing, how the tests are used, the existence of a treatment plan, and any changes in the patient's status after treatment.

The first listed service in 1993 which was one of the five sampled procedure codes was screened against the clinical guidelines in the case screening instrument (397 medical records). We will call this the sample service. In forty records documentation was so poor they could not be reviewed. Cases failing the clinical screens for this first service were referred to the contractor's clinical reviewer of the same provider type as that on the claim for further review of all 1993 mental health services (248 medical records). Those passing the screens were not reviewed any further (109 medical records). In those referred, the medical reviewers determined which services were medically necessary, which services were medically unnecessary or which were highly questionable.

We also selected a random subsample, from the sample of 540 claims, of 120 nursing facilities in which the sample beneficiaries resided to interview the administrator by telephone. We were able to contact 102 nursing facility administrators or their designees who were directors of nursing and/or social workers on their staffs to get their views on the increased utilization of the mental health benefit, any problems associated with it, its impact on nursing facility residents, barriers to services and effects of adding clinical psychologists and clinical social workers as Part B providers.

We obtained from the carriers beneficiary histories for each case to determine how many and what types of mental health professionals were involved in the beneficiary's care and how often mental health services other than those sample procedure codes were provided in each case.

We asked all 42 Medicare carriers for their policies, procedures and guidelines for mental health services, as well as any related bulletins or provider education materials. We also asked about any cases they are developing related to fraud and abuse in mental health services in nursing facilities, whether they conduct focused medical review in this area, and what their thoughts are on the inspection issues.

Lastly, we purposively selected 16 carriers from the universe of 42 to include: at least one carrier from each of the five Operation Restore Trust States (a total of 6 carriers); and another 10 carriers based on their activities in the mental health area and having a substantial number of claims in our sample. One or more officials from each of the carriers were asked about documentation of claims, complaints, monitoring, barriers to services and effects of adding clinical psychologists and clinical social workers as Part B providers.

The Chi-square statistic was used to test the statistical significance of differences in medical necessity by types of procedures, providers, residents and regions. All differences reported are statistically significant at the 95 percent confidence level. Details of this are in Appendix B. The precision for questions in the medical review screening instrument and the nursing home administrator questionnaire is reported in Appendix B. The confidence intervals for the estimates in the sample are also given in Appendix B. The results of the respondent, non-respondent analysis are in Appendix C.

Strengths and Limitations of Methodology

As discussed earlier, the strengths of this kind of review include:

- the nursing facility record presents a total picture of the patient, with a whole range of relevant information regarding the patient's condition, not just information for the particular services under review, and
- the study reflects the level of quality control and payment support available in the nursing facility, which is required by HCFA to retain all documentation about the patient in the nursing facility record.

The limitations of relying on the nursing facility medical records include:

- documentation may not reflect the actual services,
- documentation may be incomplete or in other ways inadequate, and
- other relevant documentation available elsewhere is not considered.

We conducted our review in accordance with the *Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

In 32 Percent of the Records Received, Medicare Paid for Medically Unnecessary Services; This Projects to \$17 Million, or 24 Percent of All 1993 Medicare Payments for Mental Health Services for Nursing Home Residents

Of the 397 medical records received, 126 contained medically unnecessary services. Forty-one had all 1993 services unnecessary and 85 had some of the 1993 services unnecessary.

Medically unnecessary services are those which our medical reviewers concluded were inappropriate based on information in the medical record concerning the patient's condition, need for treatment, and ability to benefit from the treatment. For example, an 85 year old woman with a mental health diagnosis of dementia had weekly billings for group therapy. The medical reviewer says the notes clearly reflect the patient had no complaints, no anxiety or depression, and no need for group therapy. Another 85 year old woman in a different facility with dementia and Parkinson's syndrome had periodic billings for longer psychotherapy sessions. The record showed she was unable to converse and had no understanding due to dementia. One psychologist who saw her stated that one to one psychotherapy was inappropriate for this patient.

Based on our sample we project that this represents \$17 million in 1993 Medicare payments. This is 24 percent of \$71.7 million for all Medicare payments for mental health services provided to residents of nursing facilities for that year.

In 16 Percent of the Records Received, Medicare Paid for Highly Questionable Services; This Projects To \$10 Million in Medicare Payments

In sixty-three records, all services were highly questionable. Highly questionable services are those where the medical record led the reviewers to raise serious questions about the medical necessity of the services, but where the evidence in the medical record was insufficient for the reviewers to make a definitive determination.

For example an 87 year old woman who is confused, cannot hear, and is severely demented had weekly billings for group therapy with occasional longer sessions of individual psychotherapy. The medical reviewer felt the patient was in need of socialization such as art or movement therapy; but the documentation did not assess how she was benefitting from group therapy. Thus he questioned the need for the group therapy. An 88 year old man with no mental health diagnosis, but a medical diagnosis of seizure disorder and stasis ulcers was billed for weekly short, individual psychotherapy. The reviewer questioned this treatment because he could not find any reasons for the referral to the psychologist and the medical record shows the patient doing very well and not in need of psychotherapy.

In another forty records the documentation was so poor they could not be reviewed. These forty did not contain enough information for the screeners to even refer the records to the clinical reviewers.

In 30 Percent of the Records, the Wrong Code Appears To Have Been Billed

Improper Coding

According to the medical reviewers, in thirty percent of the 225 cases where they had enough information to determine what the correct procedure code should be, the code billed appeared to have been incorrect. In over half of these cases the service appeared to be medication management without any documentation of psychotherapy, but psychotherapy was billed.

In 16 percent of those with the questionable code, a longer psychotherapy session was billed either with no documentation to support the longer time or with the record showing a profile of a patient who could not benefit from a longer session. The clinical reviewers found it difficult to determine whether brief psychotherapy or longer psychotherapy was the appropriate code, since the length of the psychotherapy session was rarely documented.

Often, the clinical psychologist or clinical social worker may evaluate a resident and make treatment recommendations to the primary care physician and the nursing facility staff. The clinical reviewers say there is no procedure code for a follow-up visit to see how the resident is responding to the treatment. They probably use a psychotherapy code even though no psychotherapy is performed. Another problem the reviewers mentioned was when a clinical psychologist evaluates the resident and refers her/him to a social worker. The social worker often does another evaluation and bills for it. The clinical reviewers feel this is inappropriate.

Routine Billing of Additional Codes

The majority of the beneficiary histories that contained adequate information and could be reviewed indicated that no other psychiatric codes or evaluation and management codes were billed to the program in addition to the five sample codes.

However, questionable billing practices were found in some carriers. We found billing for a variety of psychiatric codes in addition to the codes in our sample. Depending on the carrier, some codes are more popular than others. One carrier in the Northeast had psychiatrists billing for initial and follow up consultation codes as well as the evaluation and management codes on a frequent basis on each of their patients. Social workers in this carrier bill for environmental intervention on the patient's behalf repeatedly for the same beneficiary. All of this is in addition to procedure codes in our sample.

Another carrier had psychiatrists billing the code for medication management more frequently than had other carriers. This was in addition to billing for psychotherapy which includes medication management.

In other carriers, atypical billing patterns are limited to individuals or groups of providers. One such group in the South has the psychiatrist, psychologist, and social workers treat patients; and a frequently billed code is evaluation of hospital records as well as the medication management code. Another popular code used by a psychologist is the interactive diagnostic interview which is designed to utilize physical aids and non-verbal communication with patients who have difficulty in communicating. Another Southern carrier had a group alternating billing between nursing facility and office for group therapy sessions. In some instances, when the bill was denied in one location it was billed to the other location and paid.

The billing practices in some Midwest carriers indicate that psychiatrists are also billing for the evaluation and management codes on their patients as well as for the sample codes. They also bill for interactive individual psychotherapy more frequently than providers in other carriers.

At the Same Time, Difficulties Remain in Delivering Needed Mental Health Services To Beneficiaries

Some Beneficiaries Are Not Getting Needed Care

The medical reviewers found some of the patients had billings and were receiving certain kinds of services without any benefit when they really would have benefitted from different services. One 89 year old woman who had a major depressive disorder and would have really benefitted from intensive psychotherapy had irregular and inconsistent social work sessions which did not document any benefit. Another 84 year old woman with severe dementia who could not converse and was not really capable of making changes had billings for psychotherapy when she really required medication management. The reviewers also questioned the case of an 85 year old woman who had billings for longer psychotherapy sessions once or twice a month with no change when she could have benefitted from psychotropic medication which she did not get.

Seventy-eight percent of the nursing facility respondents cite barriers nursing facility residents face in getting needed mental health services. They say there are still areas in the country where providers are not available and providers who do not want to go into nursing facilities since they are not interested in this type of patient. Some say there is a stigma associated with mental health services and patients, or their families refuse needed services. At times, the attending physician reportedly feels this way and refuses to order what nursing facility staff see as needed services. Also noted is a lack of awareness of mental health illness on the part of some of the nursing facility staff working with these patients. Some nursing facility respondents mention that depression is under diagnosed and therefore not treated or sometimes leads to a misdiagnosis of dementia.

Lesser Skilled People Providing Services

In 24 percent of the records it was impossible to determine who provided the services. Either there was not enough documentation to tell or the person who signed the record could not be identified. In these services where we could not identify the provider, the person who submitted the claim was usually a psychiatrist (41 percent) or clinical psychologist (34 percent) and a lesser skilled person could well have provided the service because there were often no credentials after the name. Although Medicare permits this through "incident to billing," it is not clear that the professional who bills the service is actually in the nursing facility supervising while the service is being delivered as required. Thirty-eight percent of the carriers cited problems around services given "incident to."

The clinical reviewers also expressed concern about the effectiveness of a lesser skilled person performing psychotherapy. They reported that in many cases when the provider type submitting the bill was a psychiatrist or clinical psychologist, the record was clearly documented that the service was performed by another provider type. This included but was not limited to a person with a Bachelor of Arts (BA), a social worker (with or without licensing credentials), and a nurse (with or without nurse practitioner credentials). The reviewers consider this practice inappropriate. Typical of this was an 84 year old woman with a diagnosis of depression who had billings for four hours of psychological testing. The reviewers found that person with a BA degree administered the tests and feel that a psychologist would not be allowed by the State licensing board to delegate responsibilities in this way.

In some cases the name of the clinical psychologist who submitted the bill was documented in the medical record as an M.A. or Ed.D. rather than a Ph.D. Some carriers have questioned the carrier process of giving out provider numbers and whether people without proper qualifications are billing Medicare.

Clinical Psychologists and Clinical Social Workers Seen as Beneficial

Perhaps due, in part, to the lack of qualifications and the shortage of social service staff, seventy percent of nursing home respondents see a beneficial effect and sixty-four percent view patients as better off since clinical psychologists and certified social workers can bill Medicare independently. A psychologist in our sample treated a 94 year old resident for a major depressive disorder with suicidal ideation. The reviewer indicated that the psychotherapy was necessary and the notes were comprehensive and helpful.

Most of the nursing home respondents (70 percent) say that allowing clinical psychologists and certified social workers to bill Medicare Part B independently has had a beneficial effect on providing mental health services in nursing facilities. These respondents feel it has provided better access to mental health services, and that clinical psychologists and social workers are more available than psychiatrists and are now more willing to come into nursing facilities now that they can get paid. They say that this, in the end, provides better patient care. Almost two-thirds (64 percent) say that patients are better off now, since they are getting necessary treatment.

The carriers generally agree. Sixty-three percent see some positive results from adding clinical psychologists as Medicare providers and 44 percent see some benefit from adding social workers.

Certain Types of Procedures, Providers, Residents, and Regions Are More Likely Than Others To Be Associated with Unnecessary and Questionable Services

Psychological Testing and Group Therapy

Seventy-nine percent of psychological testing and group therapy were found to be medically unnecessary or questionable as compared to 47 percent of evaluation and individual therapy. If we separate all the procedures, eighty percent of the psychological testing and three quarters of group therapy were found to be unnecessary or questionable. However, the longer individual psychotherapy (59 percent,) evaluations (46 percent,) and brief individual psychotherapy (39 percent) still had excessive rates of questionable and unnecessary services. These rates for testing, group therapy, and the longer individual psychotherapy are all higher than the average rate of 53 percent for all types of services.

An example of unnecessary testing is the case of a 91 year old man admitted to a nursing home with terminal cancer who died within a month of admission. A psychologist billed for many hours of testing. The clinical reviewer questioned the need for testing this resident who had been admitted to the nursing facility to spend his last weeks.

Psychological testing was poorly documented with often no evidence of the actual tests in the record. Testing was often billed when rating scales were administered as opposed to those tests referred to in the CPT manual as psychological testing. The clinical reviewers feel that clarification should be provided concerning the appropriate procedure code to use for these rating scales, such as the Beck Depression Inventory or the Geriatric Depression Inventory. These rating scales may not require the same highly specialized administration and scoring as intellectual, personality, memory or neuropsychological tests. The questions on rating scales are generally self-explanatory and they are usually scored by totaling relevant response options.

Half of the carriers feel that group therapy is a problem; they point to services billed for recreational and socialization activities. Some carriers also mention each of the other services as problematic.

The reviewers noted that some of the group therapy sessions claimed were groups like the "tea time group" or the "wake up" group which appeared to be more appropriately social groups rather than psychotherapy.

Clinical Psychologists and Clinical Social Workers

Among the various provider types, clinical psychologists and clinical social workers had the highest percentage (61 percent) of unnecessary and questionable services billed to

Medicare. In comparison, 46 percent of psychiatrists' billings were either questionable or unnecessary.

For example, a psychologist billed for 10 units of testing of a 78 year old man with a diagnosis of dementia and there was no indication in the record as to why the patient was tested, and no test report or even a brief report of the findings in the record. The reviewer questioned the need for the testing and said a mental status exam or psychological evaluation would have been appropriate.

About two-fifths of the carriers reported "excessive entrepreneurialism," particularly among psychologists. They were generally less likely to see these problems with social workers. Also, half of the nursing facility respondents mention the marketing practices by groups of mental health workers to their facilities.

Residents Over 85

The "old, old" were most likely to have unnecessary or questionable services. Sixty-two percent of the residents 85 and older had such services compared to 47 percent of those under 85. Only 29 percent of those under 65 had unnecessary or questionable services. A sample case was that of a 100 year old with senile dementia who was seen by a psychiatrist in group therapy for 6 months. For service on the sample date, the resident did not attend because of medical reasons, but the bill was submitted. The reviewer was unable to determine a clear indication of any mental illness and because the resident had severe dementia, the reviewer questioned the benefit of therapy.

Dementia

Those residents with a mental health diagnosis of some sort of dementia, including Alzheimer's disease, were more likely (58 percent) to receive questionable or unnecessary services than those with other diagnoses (45 percent). An example is a 97 year old with Alzheimer's disease who was seen for individual psychotherapy weekly, for 12 months. The reviewer indicated that this patient did not need weekly therapy sessions. He felt social activities at the facility would have been helpful with occasional therapy sessions once or twice a month.

The South

Nursing facilities in the South (61 percent) were somewhat more likely than the rest of the country (49 percent) to have unnecessary or questionable services. However, the Midwest and the West each had more than half (56 percent) of their services unnecessary or questionable. Only the Northeast had less than the national average with 41 percent of unnecessary and questionable services. Some States within each region had a majority of their services either unnecessary or questionable.

A number of providers treated multiple patients in the sample. Half of these providers were from the South. Eighty-one percent of these providers had unnecessary or

questionable services. They were often members of groups that had different disciplines treating patients in a number of different nursing facilities or treating a number of patients in the same facility.

Many Factors Make Mental Health Service Billings Vulnerable To Abuse

Lack of Physician Involvement

The clinical reviewers noted that a common practice in the records was to see physician orders for psychiatric, psychological, or mental health services on an "as needed" or "prn" basis. An example is a 78 year old man with dementia who had 10 units of psychological testing. The reviewer saw no reason for the testing and could not find who referred the patient. However, there was a standing order in the record for "psych services as needed." They also question the appropriateness of these services. The reviewers recommend that physician orders for these services be based on each patient's individual needs, and that routine standing orders for these services be discouraged or not allowed.

Seventy-eight percent of the nursing facility respondents said that a physician's order was required before any mental health services could be performed. They said that if someone else in the facility or a family member requested mental health services, the attending physician had to be consulted and write the request. We found that 58 percent of the sample services had referrals by the primary care physician. Even in many of those cases there were standing orders which did not necessarily address the specific needs of the individual patient. However, in over a third of the records the reviewers could not determine who referred the patient

Impediments To Social Service Staff Involvement

Most of the nursing facilities contacted (85 percent) have a social service staff which varies in size. The educational background of staffs also varies from that of a high school graduate with no mental health educational background to a Doctorate in Social Work with many Bachelor and Masters level social workers in between. They usually provide supportive services or counseling (75 percent), take part in the psychosocial assessment (47 percent) and provide other services as needed to help the residents and families adjust to the nursing facility.

The nursing facility respondents say that the social service staff are burdened by paperwork. They say that even when their social service staff is qualified to provide psychotherapy, they do not have the time. One nursing facility administrator said, "Mental Health services could be provided in house by most facilities if the social worker were not so burdened by paperwork. The social worker doesn't have time and psychological services are not in the Medicaid rate."

Missing Treatment Plans

Twenty-eight percent of the records for patients receiving psychotherapy had no treatment plan, while another 22 percent of records of those receiving therapy or testing did not show whether the plan was carried out. In 43 percent of the records we could not determine if any goals were met. Only 15 percent of the records included the PASARR.

The lack of treatment plan and goals make it difficult to measure a patient's progress and make appropriate adjustments during a course of treatment. It also makes it more likely for a provider to provide services without need.

Lack of Utilization Guidelines

Carriers have difficulty denying services when they have no clear guidelines or utilization parameters. It is not cost effective to review services on a case by case basis. A quarter of the carriers pointed to lack of either clear HCFA guidelines or clear definitions of medically necessary mental health services and who may provide them. One carrier mentioned that the same provider is dealt with differently by different carriers. This is supported by the documents we received from the carriers as well. This is also supported by the medical review, where the variation in coverage of services is reflected in billings and inappropriate payments.

Lack of Carrier Policies and Screens Specific To Nursing Facilities

Almost all carriers have policies and procedures about outpatient mental health services; however, we found that only three have any policy specific to nursing homes.

Three-quarters of the carriers have screens or edits relating to mental health services in general, but few have any that relate specifically to mental health services in a nursing facility. Of those carriers that have screens, 61 percent have a screen which prevents evaluation and management services and psychotherapy on the same day and/or medication management on the same day as psychotherapy. Two carriers have a screen for certain diagnoses such as dementia or Alzheimer's Disease. The provider must document the medical necessity of the service.

The majority of carrier respondents report using screens and edits, requiring additional documentation, periodic reviews such as focused medical reviews, monetary settlements, referrals to investigative agencies, special reviews, and education and interagency coordination to ensure appropriate payment. They are beginning to give attention to these services in nursing facilities.

The clinical reviewers often questioned the need for the high frequency of the services provided in the records reviewed. They wondered whether there should be screens for more than one evaluation in a period of time without a documented change in the patient's status and they questioned the large number of individual and group psychotherapy sessions provided per week, sometimes more than one a day.

All but three carriers sent us educational material, but generally not specific to nursing facilities. Eighty-six percent send bulletins or newsletters to clinical psychologists and certified social workers which include information about payment. One carrier has a manual specific to mental health services. Forty-three percent of the carriers have seminars or workshops which include information about mental health services. One carrier mentioned that they meet with the psychological association quarterly to discuss concerns and issues.

Difficulty Identifying Patients' Nursing Facilities

In 30 cases we were unable to identify the nursing facility to request the records. In many other cases we used a comprehensive nursing home computer file to find the name of the facility when only an address was available. The mailing address of the beneficiary on the top of the hard copy claim form often does not include the name of the nursing facility, nor is it listed on the bottom of the form as the facility where services are rendered. On electronic claims it is even more difficult to identify the nursing facility where the beneficiary resides. Not being able to determine the facility where the beneficiary resides, it is then impossible to retrieve the records to review to determine unnecessary or questionable services in a nursing facility.

RECOMMENDATION

HCFA needs to take steps to prevent inappropriate payments for mental health services in nursing facilities. The challenge lies in ensuring the integrity of Medicare payments while promoting the delivery of needed care. There probably is no one simple solution. Instead, a battery of carefully applied remedies is needed.

Based on the nature of the problems that we identified, we suggest the following approaches that HCFA, in concert with the carriers, might take:

- Develop guidelines for carriers with delineation of exactly what the psychiatric procedure codes mean, what can be billed for, who can bill, and how often;
- Develop screens to implement these guidelines;
- Conduct focused medical reviews;
- Provide educational activities to providers of mental health services;
- Clarify who can provide services incident to physician or clinical psychologist services;
- Assure that the nursing facility provider number and name is on all claims for patients in nursing facilities;
- Clarify the requirements needed to become an independent mental health provider;
- Identify and disseminate information about effective ways to help residents adjust quickly to the nursing facility to prevent the need for later clinical intervention; and
- Convene a group of medical professionals to develop best practices in documenting the nursing facility medical record and provide guidance to nursing facility professionals.

OPERATION RESTORE TRUST STRATEGIES

This inspection is a part of a Department of Health and Human Services anti-fraud initiative called Operation Restore Trust designed to target fraud, waste, and abuse related to home health agencies, nursing homes, and durable medical equipment suppliers. This initiative targets California, Florida, Illinois, New York, and Texas, the five States with the highest number of Medicare and Medicaid beneficiaries.

We will work with HCFA and the Administration on Aging (AoA) to follow up on issues raised in this report in a variety of ways as they relate to Operation Restore Trust. For example, we will refer possible cases of fraud and abuse found in this inspection for additional review by HCFA and our own audit and investigations units, as appropriate. HCFA's protocol for survey and certification staff to look at mental health services in nursing facilities when on-site will be beneficial not only in preventing inappropriate payments, but also in improving the quality of services. We will also communicate with the Administration on Aging to make the State Ombudsmen aware of possible inappropriate or inadequate mental health services. We intend to issue a follow-up report providing information specific to the five project ORT States.

COMMENTS

We received comments on the draft report from HCFA and the Assistant Secretary for Planning and Evaluation (ASPE). They concur with our recommendation. They also provided suggestions for changes in wording, clarifications of the text and technical changes which we have for the most part incorporated into the final report. The actual comments received are in Appendix D.

The HCFA agreed with our suggestion to clarify who can provide services incident to physician or clinical psychologist services. However, they believe that they should ensure that only those individuals who bill meet the required qualifications, fulfill all the requirements under the "incident to" benefit, and assume responsibility for the services furnished by their auxiliary personnel. While we agree with that, we also believe that clarification of this requirement should be expanded to require that the direct provider of the service, not only the biller, meets certain qualifications. The performance of mental health services, such as psychotherapy and psychological testing, requires a certain skill level to be safe and effective.

The HCFA did not agree with the need to assure that the nursing facility provider number and name are on all claims for patients in nursing facilities. They do not see how requiring this can help Medicare contractors make determinations about appropriateness of the services. They also say that Medicare already requires that providers record the address if the place of service is other than "home" or "office." They feel it would be a needless additional burden on the provider to obtain and record provider numbers of the facility. We understand that contractors do not need this information to make medical necessity determinations on a case by case basis. We believe, however, that the site of service, that is the nursing facility name, address and provider number, is important for contractors and others using Medicare data to know. During the course of this inspection we found that providers did not record this information on Medicare claims in a systematic way. However, it is necessary information for any kind of proactive trend analysis; to detect whether services are part of the nursing facility inclusive rate; and/or to do any site of service comparisons. In this study it was necessary to collect the nursing facility medical record. This was difficult since the nursing home name was often missing.

The HCFA also offered several technical comments. They are concerned about an over reliance on medical doctors making decisions about the delivery of mental health services since they say that medical doctors may have no expertise in the diagnosis and treatment of mental health problems. The HCFA also says that many geriatric nurses and social workers may have extensive training and experience in providing mental health services for this population; and that as long as individuals are practicing within the scope of their State licensing laws, claims should not be denied on the basis of credentials alone. We agree with this in principle, but this did not always appear to be the case in the records we reviewed. We did not, however, question any claims on the basis of credentials alone. The peer review determinations were done on the basis of necessity of the services rendered.

The HCFA was also concerned that we did not address the possible over utilization of psychoactive medications in the nursing home population. Although we do have data about the psychoactive medications the residents in our sample were taking, decisions about the appropriateness of these medications was not within the scope of this inspection.

Finally, the HCFA believes that our recommendations should be strengthened in regard to enforcement since some of the practices described are clearly fraudulent. We agree with this need for strong enforcement. We will be referring all of the unnecessary and questionable cases and those without enough information to the appropriate agency for further development and to our Office of Investigations when appropriate.

APPENDIX A

DESCRIPTION OF PROCEDURE CODES

- 90801 Psychiatric diagnostic interview, examination including history, mental status, or disposition (may include family or other sources, ordering and medical interpretation of laboratory, or other medical diagnostic studies in lieu of the patient).
- 90830 Psychological testing by physician, with written report, per hour.
- 90843 Individual medical psychotherapy by a physician with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented behavior modifying or supportive psychotherapy, approximately 20 to 30 minutes.
- 90844 Individual psychotherapy approximately 45 to 50 minutes.
- 90853 Group medical psychotherapy (other than of multiple family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated.

APPENDIX B

SAMPLING, PROJECTIONS, CHI-SQUARE VALUES AND PRECISION

Sampling

A simple random sample was drawn for this inspection. The sample frame was the population of Medicare beneficiaries who in 1993 had one of five mental health codes in the HCFA Common Procedure Coding System (90801, 90830, 90843, 90844, and 90853) with the place of service being a nursing facility or skilled nursing facility. We excluded any beneficiary who had claims only for HCPCS 90801 billed by a psychiatrist. This left a total of 1,332 beneficiaries. We then randomly sampled 540 of the 1,332 beneficiaries.

We requested the nursing facilities to send us the medical records for these beneficiaries. We received 397 records, a response rate of about 75 percent. Based on our analyses, these 397 fell into the following three groups:

- 1) 109 - Passed the initial screening of the first service in 1993 by screeners from FMAS, Inc. (the contractor) or by the inspection team and were not referred for further review;
- 2) 248 - Were referred to contractor reviewers to review all 1993 services; and
- 3) 40 - Did not have enough documentation to review.

For the 248 records reviewed by the contractor for all 1993 services, the four outcomes were as follows:

- 1) 59 - All services were medically necessary;
- 2) 41 - All services were medically unnecessary;
- 3) 85 - Some of the services were medically necessary and some medically unnecessary; and
- 4) 63 - All services were highly questionable with respect to medical necessity.

Projections

Two projections of cost savings to the universe of 1,332 beneficiaries from which the sample was drawn were calculated based on the 189 records identified by the contractor as containing unnecessary or questionable services among the 248 records reviewed. The first projection in Table B1 below was based on categories 2 and 3 above (including the all or some medically unnecessary services) and on a sample size of 248. The second projection was based on the highly questionable, and using the same sample size.

The table below presents two projections.

Table B1

*Projections of Cost Savings For Five HCPC Codes
Based on Unnecessary or Highly Questionable Services*

Service Outcomes	Sample Size	Weighted Projections	Boundaries for 95 % Confidence Interval
1) All or some services medically unnecessary (n=126)	248	\$16,674,667	+/- \$4,447,227
2) All services highly questionable (n=63)	248	\$10,304,993	+/- \$3,631,827

The dollar amount is a conservative estimate because there were cases where we could not determine the exact dollar amount; in which case we did not include any amount.

Chi-Square Values

We computed chi-square values for differences in unnecessary and/or questionable services for each of the five variables on which such differences are reported in our findings. Chi-square values show that differences on all five variables were significant at the 95 percent confidence level.

Table B2

CHI-SQUARE Values for Testing Significance of Differences in Unnecessary and/or Questionable Services for Procedure, Provider, Age, Diagnosis, and Region

VARIABLE	DF*	CHI-SQUARE
Procedure	1	21.712
Provider	1	7.229
Age	1	6.761
Diagnoses	1	5.497
Region	1	3.958

*Degrees of Freedom

Precision

Response rates on individual items in the medical record screening document varied from item to item. Except where otherwise specified, the number of items are equal to the 357 records reviewed. We can conservatively estimate that the measured precision of the results for categorical questions is no more than 4.8 percent at the 95 percent confidence level.

Some items only applied to a portion of the sample. In those cases the precision ranged from 5.2 percent to 8.7 percent. Only one case was out of the range at 11.8 percent.

The number of responses to individual questions in the nursing home administrator's questionnaire varied from a low of 89 to a high of 102. Taking the low value of 89 as the sample size, we can conservatively estimate the measured precision of the survey results for the categorical questions as 10 percent, at the 95 percent confidence level.

APPENDIX C

ANALYSIS OF RESPONDENTS AND NON-RESPONDENTS

An important consideration in surveys of this type is the bias that may be introduced into the results if non-respondents differ from respondents to the survey instrument. For this inspection, a beneficiary whose medical record was not obtained or was incomplete is a non-respondent. To test for the presence of any bias, we first obtained information from the Common Working File (CWF) for all 540 beneficiaries whose medical records were requested, including both respondents and non-respondents. There were 183 non-respondents, including 143 beneficiaries for whom we received no records and another 40 with incomplete records. The remaining 357 beneficiaries for whom complete records were received are our respondents.

We found the following four variables related to unnecessary or questionable services among respondents: type of service (psychological testing and group therapy vs. evaluation and individual therapy), type of provider (psychiatrist vs. psychologist and social worker), age group (under 85 vs. 85 and older), and region (the South vs all other regions.) Differences between respondents and nonrespondents for each of these four variables were tested for significance using Chi-square with the appropriate degrees of freedom.

The results of this analysis are presented in tables C 1-4. The Chi-square values given in the tables provide a test of significance for the differences in the distribution of respondents and non-respondents for each variable of interest. Also provided in the tables are the response rates for the different values of the variables.

These tables show a statistically significant difference between respondents and non-respondents with respect to age and region. We therefore estimated the effect of these differences on our original findings. Assuming the non-respondents 85 and older would have had the same rate of unnecessary and questionable services as respondents 85 and older, the percent of such services for the study universe of beneficiaries from whom the sample was selected would have decreased only slightly from 52.94 percent to 52.41 percent. This change is very minor and well within the bounds of our confidence interval.

We also estimated the effect of the difference between the percent of respondents and nonrespondents by region. Assuming that the non-respondents from each region would have had the same rate of unnecessary or questionable services as respondents from the same regions, the percent of such services for the study universe would have increased very slightly from 52.94 percent to 53.73 percent. This change is also minor and well within the bounds of our confidence interval, therefore not differing significantly from the percent found among our respondents. In summary, our analysis of key characteristics of non-respondents indicates that our original results are not biased due to their non-response.

Table C (1 - 4)

**CHI-SQUARE Values for Testing Significance of Differences
Between Respondents and Non-Respondents For
(1) Type of Service, (2) Type of Provider,
(3) Age and (4) Region**

(1) TYPE OF SERVICE

	Respondents	Non-respondents	Total	Percent
Psych Testing & Group Therapy	66 (18%)	37 (20%)	103	64%
Evaluation & Individual Therapy	291 (82%)	146 (80%)	437	67%
All Services	357	183	540	66%

CHI-SQ = .235

Degrees of Freedom = 1

(2) TYPE OF PROVIDER

	Respondents	Non-respondents	Total	Percent
Psychiatrist	160 (48%)	74 (45%)	234	68%
Clinical Psychologist	133 (40%)	71 (43%)	204	65%
Clinical Social Worker	34 (10%)	16 (10%)	50	68%
Nurse Practitioner	8 (2%)	3 (2%)	11	73%
All Providers *	335	164	499	67%

CHI-SQ = .684

Degrees of Freedom = 3

* The above totals are less than the previous totals due to the elimination of some categories that were very small (such as nurse specialist) and some that could not be determined.

Table C (Continued)

(3) AGE

	Respondents	Non-respondents	Total	Percent
85 or older	138 (39%)	52 (28%)	190	73%
< 85	219 (61%)	131 (72%)	350	63%
All Ages	357	183	540	66%

CHI-SQ=5.56*

Degrees of Freedom = 1

*Significant at the .982 level

(4) REGION

	Respondents	Non-respondents	Total	Percent
Northeast	107 (30%)	26 (15%)	133	80%
Midwest	95 (27%)	52 (29%)	147	65%
South	112 (31%)	63 (35%)	175	64%
West	43 (12%)	38 (21%)	81	53%
All Regions	357	179	536	66%

CHI-SQ=18.911*

Degrees of Freedom = 3

*Significant at the .999 level

APPENDIX D

COMMENTS ON THE DRAFT REPORT

In this appendix, we present in full the comments from the Health Care Financing Administration and the Assistant Secretary for Planning and Evaluation.



The Administrator
Washington, D.C. 20201

DATE: MAR 22 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General Draft Report: "Mental Health Services In Nursing Facilities," (OEI-02-91-00860)

We reviewed the subject draft report which discusses possible vulnerabilities to the Medicare program in the provision of mental health services to nursing facility residents.

Our detailed comments are attached for your consideration. Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments further.

Attachment

IG	<input checked="" type="checkbox"/>
SAIG	<input checked="" type="checkbox"/>
FDRG	<input type="checkbox"/>
DIG-AS	<input type="checkbox"/>
DIG-ET	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
AIG-CFAA	<input type="checkbox"/>
OCC/IG	<input checked="" type="checkbox"/>
EXSEC	<input type="checkbox"/>
DATE SENT	3/27

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OFFICE OF INSPECTOR
GENERAL

Health Care Financing Administration (HCFA) Comments
On Office of Inspector General Draft Report:
“Mental Health Services in Nursing Facilities.”
OEI-02-91-00860

OIG Recommendation

HCFA needs to take steps to prevent inappropriate payments for mental health services in nursing facilities. There probably is no one simple solution. Instead, a battery of carefully applied remedies are offered.

HCFA Response

We basically agree with this premise and offer the following comments on each approach.

Approach 1

Develop guidelines for carriers with delineation of exactly what the psychiatric procedure codes mean, what can be billed for, who can bill, and how often.

HCFA Response

We agree that there is a need for a clear delineation of the psychiatric procedure codes, and in fact, such a system exists under the Physician's Current Procedural Terminology coding system. Accordingly, HCFA does not believe there is any need for further definition of these procedure codes or duplication of the American Medical Association's efforts. We also agree that clear distinctions are needed when it comes to the what, who, and intend to discuss these issues in detail in the final rule, Medicare Coverage and Payment of Clinical Psychologists, Other Psychologist, and Clinical Social Worker Services. Regarding the frequency of coverage we understand that the Psychiatry/Psychology Carrier Medical Directors' workgroup is developing model medical review policies that would establish medical review guidelines to help determine whether the frequency of services rendered to patients is reasonable and necessary based on their diagnosis and/or treatment plan.

Page 2

Approach 2

Develop screens to implement these guidelines.

HCFA Response

We will develop the proper screens for Medicare contractors to implement the final guidelines.

Approach 3

Conduct focused medical reviews.

HCFA Response

We agree that focused medical reviews will limit payments for inappropriate services, and Medicare contractors are now conducting these on mental health services.

Approach 4

Provide educational activities to providers of mental health services.

HCFA Response

We concur. Once model policy becomes available to all contractors (or HCFA revises its own policy/instructions), contractors will notify providers of the new policy and its requirements.

Approach 5

Clarify who can provide services incident to physician or clinical psychologist services.

HCFA Response

We concur. Since the statutory benefit allows only certain qualified individuals to bill for the services of their employees as if they had furnished the services themselves, HCFA believes that it should ensure that these individuals who bill meet the required qualifications, fulfill all the requirements under the "incident to" benefit, and assume responsibility for the services furnished by their auxiliary personnel.

Approach 6

Assure that the nursing facility certification number and name is on all claims for patients in nursing facilities.

HCFA Response

We disagree. We do not see how requiring a provider to record on the claims form the certification number of the nursing facility in which the beneficiary resides can help Medicare contractors make determinations about the appropriateness of the services. Medicare already requires that providers record the address if the place of service is other than "home" or "office." It would be a needless additional burden on the provider to obtain and record certification numbers.

Approach 7

Clarify the requirements needed to become an independent mental health provider.

HCFA Response

We agree that there is some confusion about who can qualify as a clinical psychologist (CP) while the statute is quite clear about the requirements for clinical social workers (CSW). A final rule which is currently under development will refine the CP qualifications that are in place under manual instructions and those proposed in the notice of proposed rulemaking on the CP benefit. The qualifications in the final rule will take into account the extensive public comments as well as numerous inquiries that HCFA has received about the CP definition and establish a precise definition.

Approach 8

Identify and disseminate information about effective ways to help residents adjust quickly to the nursing facility to prevent the need for later clinical intervention.

HCFA Response

We agree.

Approach 9

Convene a group of medical professionals to develop best practices in documenting the nursing facility medical record and provide guidance to nursing facility professionals.

HCFA Response

Components of HCFA have recently worked with various medical societies to develop documentation guidelines for evaluation and management codes. We will continue our work in this effort.

Technical/General Comments

1. There is an inaccurate statement contained in the second full paragraph on page 3 of this report. The statement reads, "In addition, effective July 1990, direct payment to clinical psychologists and clinical social workers can be made in all settings." While direct payment may be made to CPs in all settings, the law excludes the provision of direct payment to CSWs for services furnished to inpatients of a hospital or those services furnished to inpatients of a skilled nursing facility that the facility is required to furnish in order to participate in Medicare. Accordingly, the correct wording is that direct payment to CPs can be made in all settings and to CSWs in most settings.
2. We are concerned about what may be an over reliance on medical doctors in making decisions about the delivery of mental health services (e.g., "Lesser Skilled Persons Providing Services", pg. 11 and "Lack of Physician Involvement", pg. 14.) Medical doctors may or may not have expertise in the diagnosis and treatment of mental health problems, particularly relating to the geriatric population. Many geriatric nurses and social workers, for example, may have extensive training and experience in providing mental health services for this population. As long as individuals are practicing within the scope of their state licensing laws, claims should not be denied on the basis of credentials alone.
3. While we concur that depression is probably under diagnosed in the nursing home population and, therefore, under treated, we are concerned that the report makes no mention of over utilization of psychoactive medications. (See "Some Beneficiaries Are Not Getting Needed Care", pg. 10.) It is our experience that these medications are often used inappropriately for residents who are bothersome

to staff or other residents, rather than attempting less intrusive treatments which have proven effective for many individuals. Again, this relates to approach 2 above, since general practitioners may not have the expertise dealing with mental health problems in this population and, therefore, resort to psychoactive medications as the first response to people with behavioral difficulties.

4. Finally, while we agree with the educational approach taken in the recommendations, we believe the recommendations could be strengthened in regard to enforcement. Some of the practices described in the report are clearly fraudulent. We, therefore, would like to see some specific recommendations as to how those cases might be more aggressively pursued.



MAR 12 1996

RECEIVED
1996 MAR 13 P 12:05
OFFICE OF INSPECTOR
GENERAL

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report, "Mental Health Services in Nursing Facilities"
OET-02-91-00860

This office has reviewed and concurs with the OIG draft report entitled "Mental Health Services in Nursing Facilities." Staff had the following minor comments and recommendations which were shared with OIG staff on March 4, 1996.

- 1). Clarify that the scope of the report applies to both Medicare and Medicaid, skilled nursing facilities and nursing facilities.
- 2). Include in the Background Section of the report information on payment methodologies for mental health professionals.
- 3). Clarify (perhaps through a footnote) the rationale for the 62.5% limit on Medicare payments for mental health services.
- 4). Ensure that appropriate staff at the Substance Abuse Mental Health Services Administration were consulted for input into this report.

Peter B. Edelman
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IG	_____
SAIG	_____
PDIG	_____
DIG-AS	_____
DIG-EI	_____ /
DIG-OI	_____
DIG-MP	_____
AIG-CFAA	_____ /
OGC/IG	_____
EXSEC	_____ /
DATE SENT	3/13