Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Payments for Psychiatric Services in Nursing Homes:

A Follow-up

January 2001
OEI-02-99-00140

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EXECUTIVE SUMMARY

PURPOSE

To assess the appropriateness of Medicare Part B payments for psychiatric services in nursing homes.

BACKGROUND

This inspection, a follow-up to an Office of Inspector General report issued in May 1996 entitled "Mental Health Services in Nursing Facilities" (OEI-02-91-00860), was conducted to determine what changes, if any, have occurred with Medicare reimbursement for psychiatric services in nursing homes. In the earlier report, the Inspector General found that nearly half of all Medicare psychiatric services in nursing facilities were either medically unnecessary (32 percent) or questionable (16 percent). The report also identified inadequate utilization guidelines and a lack of carrier policies and screens specific to nursing facilities.

The Nursing Home Reform Act of 1987 mandates that each nursing home resident have a comprehensive initial and periodic assessment using a standard form called the Minimum Data Set, which includes a mental health evaluation and establishes the need for psychiatric services. These services include initial testing and evaluation, individual psychotherapy, pharmacological management, and group therapy. Claims for psychiatric services are processed and paid for by Medicare carriers that contract with the Health Care Financing Administration. Medicare payments for psychiatric services in nursing homes totaled approximately $211 million in 1998 and $194 million in 1999.

Using a stratified random sample of 450 nursing home psychiatric services provided in the first 6 months of 1999, we combined 3 methods for this inspection: a medical record review, a beneficiary billing history review, and an analysis of carrier policies.

FINDINGS

Over one third of Medicare payments for psychiatric services in nursing homes are inappropriate

Our review found that 27 percent of psychiatric services provided in nursing homes are

medically unnecessary. These services may represent as much as $22.6 million of inappropriate payments made in 1999 for the total Medicare population. More than half of unnecessary services are provided to individuals whose cognitive limitations make them unable to benefit from the psychiatric intervention, and about half have an inappropriate frequency and/or duration. Additionally, many medically unnecessary services do not appear to stabilize or improve patients' conditions.

Additionally, we found that 9 percent of services are lacking any psychiatric documentation. These services may represent as much as $8.2 million of inappropriate payments made in 1999 for the total Medicare population. These are services for which there is no psychiatric documentation in the patient's nursing home records. Lastly, another 3 percent of services are questionable which may represent as much as $1.8 million in inappropriate payments made in 1999 for the total Medicare population. Some of these are services with incomplete documentation, while others are questionable because of the patient's cognitive function.

Psychological testing is the most problematic of the nursing home services reviewed

More than one third of psychological tests (39 percent) are medically unnecessary. These tests are often either too long, too frequent, or are not needed by the patient. Also, nearly one third of psychological tests being billed to HCFA under the testing code 96100 use instruments that our medical reviewer considers questionable. These are mostly questionnaires that are self-administered with no special scoring or need for professional interpretation.

Most carrier policies now specifically address psychiatric services in nursing homes; however, utilization guidelines are inconsistent and unclear

Since the prior Office of Inspector General study in 1995, more carriers have developed specific policies for psychiatric services provided in nursing homes. However, these policies are not always consistent or precise. Reimbursement guidelines are often broad; they do not clearly address appropriate diagnosis codes, treatment protocols, and parameters for frequency and duration of services. Also, some policies include specific examples of testing instruments while others do not. Lastly, carrier policies specifically address the Minimum Data Set for individual psychotherapy services only.

RECOMMENDATIONS

Since the first Office of Inspector General report was issued, Medicare continues to pay

for some inappropriate nursing home psychiatric services.

In order to address the factors identified in this report that lead to inappropriate reimbursement, we recommend that the billing process for psychiatric services in nursing homes be strengthened.

The Health Care Financing Administration may want to consider the following options:

- Work with carriers to develop guidelines for the appropriate frequency and duration of psychiatric services.
- Work with carriers and mental health providers to identify the specific instruments that can be appropriately billed as psychological testing.
- Encourage carriers to take advantage of the Minimum Data Set, particularly its assessment of patient cognitive level, by using it to assess the appropriateness of reimbursement for psychiatric services.

We believe that implementing these recommendations would result in potential savings of as much as $30 million a year.

Comments

We received comments on the draft report from the Health Care Financing Administration and they concur with our recommendations. Specifically, they will share our report with contractors and the carrier clinical workgroup on psychiatric services and work with them to strengthen the billing process for psychiatric services in nursing homes. The Health Care Financing Administration's comments are in Appendix D.

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INTRODUCTION

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The first OIG report also raised the concern that some nursing home residents may not be receiving the mental health services they need. While this continues to be a concern, an assessment of whether nursing home residents are receiving all needed mental health services is outside the scope of this study.

Mental Illness in the Elderly

As with the general population, older adults may have any of several mental disorders. The most prevalent disorders among the elderly include Alzheimer's disease and other dementias, delirium, depression, cognitive complications of neurologic disorders (such as strokes), and anxiety disorders. A 1999 article in The American Journal of Geriatric Psychiatry entitled "The Impact of OBRA '87 on Psychiatric Services in Nursing Homes" reports that the prevalence of mental illness among nursing home residents is particularly high, where two of three residents have diagnosable mental disorders and one fourth have depression. Among nursing home residents, mental illness can complicate other medical illnesses and interfere with nursing and other health care. A variety of psychiatric services are available to treat mental disorders, including individual psychotherapy, group psychotherapy, and pharmacologic management.

Nursing Home Reform Act

The comprehensive Nursing Home Reform Act (PL 100-203), enacted with the Omnibus Budget Reconciliation Act (OBRA) of 1987, expanded the requirements that nursing facilities had to meet for Medicare certification. The Nursing Home Reform Act requires pre-admission screening and annual resident reviews (PASARR) to determine: whether patients have a mental illness or mental retardation; whether they need active treatment; whether they need the level of nursing care provided by a nursing home; and whether the nursing facility can provide these needed services. Beyond the initial review, these reviews do not need to occur annually unless there is a "significant change in the physical or mental condition of a resident who is mentally ill or retarded." The Act also requires that residents be given a full range of services to address their psycho-social needs and behavioral problems.

The Nursing Home Reform Act also mandates that each nursing home resident have a comprehensive initial and periodic assessment using a standard form called the Minimum Data Set (MDS). The resident assessment addresses "cognitive patterns, mood and behavior patterns, psycho-social well-being, and special treatments and procedures." A team of facility-based staff, together with the attending or consulting physician, reviews the assessment and develops a Resident Assessment Protocol (RAP). The RAP summary addresses 18 potential problem areas, including "delirium, cognitive loss, communication, psycho-social well-being, mood state, behavioral symptoms, and psychotropic drug use." The resident assessment should be used to support the need for psychiatric services.

Medicare Coverage of Psychiatric Services

Section 1862 (a)(1)(A) of the Social Security Act states that all Medicare Part B services, including psychiatric 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 generally prohibited for medical services that are only for prevention, palliation, research, or experimentation.

Psychiatric services are classified into 1 of 50 different codes in the Common Procedure Coding System HCFA uses for billing. They include initial testing and evaluation, individual psychotherapy, pharmacological management, and group therapy. Many codes specify the length of time the service should be provided and the place of service.

The types of provider billing for psychiatric services have changed over the past several years. In 1990, the Medicare Part B psychiatric benefit was expanded to allow clinical psychologists and certified social workers, as well as psychiatrists, to bill for psychiatric services. However, beginning in 1999, certified social workers are no longer allowed to bill for psychiatric services in skilled nursing facilities.

Medicare Carriers

Claims for psychiatric services are processed and paid for by Medicare carriers that contract with the Health Care Financing Administration (HCFA). While all carriers must follow basic Medicare guidelines, each develops its own policy for screening and payment purposes. Additionally, they develop specific medical criteria which must be met in order for the service to be considered necessary. Carrier policies generally require that documentation exist on the patient's capacity to participate in and benefit from any therapy being provided. Carriers generally consider psychiatric services to be inappropriate if they are medically unnecessary, if they are not documented in the patient's medical records, or if they do not meet coverage guidelines.

Trends in Medicare Reimbursement

Following the expansion of the Medicare Part B psychiatric benefit in 1990, Medicare payments for psychiatric services in nursing facilities increased significantly in the early 1990s. More recently, Medicare reimbursement for these services declined from approximately $221 million in 1996 to approximately $207 million in 1997, but increased again to around $211 million in 1998. In 1999, Medicare payments for psychiatric services in nursing homes totaled approximately $194 million.

A few top services account for the majority of Medicare allowances for nursing home psychiatric services. They include individual psychotherapy, group psychotherapy, diagnostic interview, pharmacologic management, and psychological testing.

Related OIG Work

The Office of Inspector General has completed other studies related to psychiatric services. For example, one series of reports was recently completed on services provided in community mental health centers and outpatient departments of both acute care and psychiatric hospitals. Also, one OIG study is currently being conducted which examines Medicare Part B psychiatric services provided in physicians offices, as well as other settings outside of nursing homes. Lastly, another study is looking at mental health services provided to Medicaid nursing home residents between the ages of 22 and 64.

METHODOLOGY

We combined three methods for this inspection: a medical record review, a beneficiary billing history review, and an analysis of carrier policies.

Sample

We limited our sample to five of the top seven codes for nursing home psychiatric services. These five codes are: 90818 (individual psychotherapy, 45 minutes); 90816 (individual psychotherapy, 25 minutes); 90817 (individual psychotherapy with medical evaluation and management); 90853 (group psychotherapy); and 96100 (psychological testing). These five codes accounted for the large majority (91 percent) of all Medicare Part B nursing home psychiatric payments in 1998. They were also identified in the first OIG study as being among the most problematic codes.

From a 1 percent sample of the National Claims History File, we selected a national stratified random sample of 450 line items from the first 6 months of 1999. We stratified these line items into the following 3 strata: 161 individual psychotherapy services; 143 group psychotherapy services; and 146 psychological testing services, which is the universe of psychological testing services provided in the one percent file during our sampling time frame. We limited our sample to place-of-service codes 31 (nursing facility) and 32 (skilled nursing facility).

Medical record review

For each of the line items in our sample, we identified the beneficiary and the nursing facility where the service was provided. The 450 line items in our sample were provided to 274 different beneficiaries in 251 different nursing homes. From each of these nursing homes, we requested the beneficiary's medical records, including any psychiatric assessments. We collected records between January and April 2000.

We received a response for 365 services, for an overall response rate of 81 percent (see Appendix C for a non-respondent analysis). Of these 365:

- for 356 services, the nursing home provided a medical record; and
- for 9 services, the nursing home indicated they had no record of the patient.

We used a medical record review contractor to review the medical records. We worked with the contractor and with one of the carrier medical directors to develop a screening instrument for the initial screening of the records. The screening instrument was based upon this carrier's policies for psychiatric services and Medicare coverage guidelines. The American Association for Geriatric Psychiatry (AAGP) also commented on the draft screening instrument. A Master's level psychologist then screened the records and passed any which failed the initial review to a psychiatrist or Ph.D. psychologist, who then made a final determination on medical necessity. (See Appendices A and B for confidence intervals on key estimates and dollar projections).

Many of the initial medical records from nursing homes did not include any specific psychiatric documentation. In all of these cases, we called the nursing home and specifically asked for documentation on the psychiatric service(s) provided. Even after this follow-up, we did not receive mental health documentation for all of the services in our sample. For these cases, the medical review contractor was not always able to make a determination on the medical necessity of the service based solely on the information provided in the medical record.

Beneficiary billing history review

For each of the beneficiaries identified in our sample, we obtained their complete Medicare psychiatric billing history for the sampling time frame of the first 6 months of 1999. Using a structured review sheet, we reviewed the histories to determine any additional psychiatric services being provided, place of service, and the types of providers rendering the service(s). Since we did not sample by beneficiary, the results of this billing history review cannot be generalized to the entire Medicare population.

Analysis of carrier policies

Lastly, we requested written policies for nursing home psychiatric services from all of the 32 carriers identified in our sample, which resulted in 17 different policies. Using a structured review sheet, we evaluated each of the policies to determine what coverage guidelines and medical criteria carriers use when reimbursing for psychiatric services.

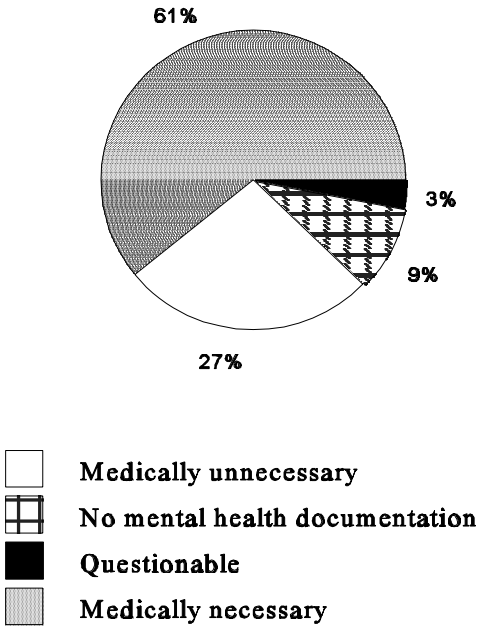
We conducted this inspection in accordance with the ***Quality Standards for Inspections*** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Over one third of Medicare payments for psychiatric services in nursing homes are inappropriate.

Our review found that 39 percent of nursing home psychiatric services are either medically unnecessary, have no mental health documentation, or are questionable.
See Chart 1 below.

Chart 1
Nursing Home Psychiatric Services:
Medical Record Review



Source: medical record review

Twenty-seven percent of services are medically unnecessary

Twenty-seven percent of psychiatric services provided in nursing homes are medically unnecessary. These services may have represented as much as $22.6 million in inappropriate payments in 1999 for the total Medicare population. (This estimate is

based on our sample from the first 6 months of 1999 which projected $11.3 million in inappropriate payments. It also assumes similar billing activity during the second half of 1999.)

Our review found two main keys that determine a lack of medical necessity: the patient's cognitive level and the frequency and/or duration of the service. First, more than half of all unnecessary services are provided to individuals who have limited cognitive ability and therefore may not benefit from the psychiatric intervention. Services are being given to patients with, for example, advanced dementia, severe agitation, delusions, and paranoia. In some cases, the patient's thinking is so disordered that he or she is not able to effectively communicate with the provider of the service. In one example, a patient with advanced dementia and depressive psychosis, who was unable to communicate verbally or non-verbally, was reportedly receiving full length individual psychotherapy sessions twice a week.

Second, half of all unnecessary services have an inappropriate frequency and/or duration. Inappropriate frequency means that a service is provided too many times. A typical example of this is the same type of service (such as individual or group therapy) being repeated more than once on the same day. Inappropriate duration means either the length of the service or the course of the treatment is too long. In some instances, the therapy session is longer than the patient's attention span. In other instances, patients are receiving individual psychotherapy for more than 6 months without any established need for the extended length of treatment.

In addition to the reasons discussed above, many medically unnecessary psychiatric services do not appear to stabilize or improve patients' conditions. One third of unnecessary services are being provided to patients who do not have the potential to benefit functionally from the psychiatric intervention: e.g., the intervention is not maintaining stability, preventing further decline, ameliorating behavioral disturbances, or relieving distressing symptoms. Further, there is often no reasonable expectation that the patient is capable of making a change as a result of the service and no evidence that the therapeutic goal has or can be achieved.

An additional nine percent of services have no psychiatric documentation

Nine percent of all services lack any psychiatric documentation. These are services for which there is no documentation in the patient's nursing home record for the psychiatric intervention payed for by Medicare. These services may represent as much as $8.2 million in payment that were inappropriately made in 1999 for the total Medicare population. (This estimate is based on our sample from the first 6 months of 1999 which projected $4.1 million in inappropriate payments. It also assumes billing activity was similar during both the first and second half of 1999.)

Even in those clinical records that do have psychiatric documentation, it is not always complete. This documentation is often missing treatment goals, patient response and progress, the amount of time spent with the provider, or the estimated duration of treatment and/or number of sessions ordered.

Another three percent of services are medically questionable

Three percent of psychiatric services are medically questionable. This represents $1.8 million that Medicare may have inappropriately paid in 1999. (This estimate is based on our sample which projected $900,00 in questionable payments for the first 6 months of 1999. It also assumes billing activity was similar during both the first and second half of 1999.) Some of these are services for which our reviewer was unable to make a final determination on medical necessity due to incomplete documentation, while others are questionable because of the patient's cognitive function.

Psychological testing is the most problematic of the nursing home psychiatric services reviewed

More than one third of psychological tests are medically unnecessary

Thirty-nine percent of testing is medically unnecessary. Psychological tests are used as an aid in the diagnosis and evaluation of mental illness or neuropsychological abnormalities. The testing code we reviewed, 96100, includes the psycho-diagnostic assessment of personality, psycho-pathology, emotionality, and intellectual abilities, with accompanying interpretation and report. Of the five codes in our sample, psychological testing is the only one which is generally provided by a psychologist rather than by a psychiatrist and is the only service that can be billed for multiple hours in the same day.

Excessive length and frequency and the lack of patient need are the main problems with psychological testing

Psychological tests are often either too long or too frequent. A test is considered too long when its length is not appropriate for the nature of the referral or for the patient's level of impairment, motivation, endurance, or ability to cooperate. Many of the tests we reviewed lasted 6 or more hours or were given to patients who lacked the ability to undergo extensive testing. Furthermore, based on carrier policies, our reviewer considered a test too frequent when it is administered within 1 year of a previous test and the patient has not experienced a suspected change in mental illness or neuropsychological abnormality. In one case, a provider appears to routinely administer psychological testing to patients in a particular nursing home every 3 months.

Additionally, testing is not always needed by the patient. First, the patient may be unable to benefit from the testing due to memory impairment, confusion, delusions, or dementia. Second, a clinical interview rather than a psychological test may be sufficient to assess the patient. Lastly, some testing is not being used to diagnose a suspected mental illness or to evaluate change in an already established mental illness, both of which are required by Medicare.

Use of questionable testing instruments is common

One third of psychological tests being billed to HCFA under the testing code 96100 use instruments that our medical reviewer considers questionable. These instruments are questionnaires that are often self-administered with no special scoring or need for professional interpretation. Often, the medical reviewer notes that these tests should have been billed as psychological evaluations, under code 90801, rather than as psychological testing.

Our reviewer identified a number of such questionable instruments that are billed under code 96100. These include the Geriatric Depression Scale, Templer Death Anxiety Exam, Abnormal Involuntary Movement Scale, and the Satisfaction with Life scale. For example, the short form Geriatric Depression Scale includes 15 'yes/no' questions, such as "Are you basically satisfied with your life? and "Do you feel life is empty?" If patients answer 'yes' to five or more of these questions, they may be considered depressed. Further, the Satisfaction with Life Scale asks patients to rate their agreement, on a scale from one to seven, with five statements that include, "I am satisfied with life" and "If I could live my life over, I would change nothing." The answers are then summed and a lower score indicates a possible need for psychiatric services.

Most carrier policies now specifically address psychiatric services in nursing homes; however, utilization guidelines are inconsistent and unclear

Carrier policies have improved since the prior OIG study

Since the prior OIG study was completed in 1995, more carriers now have specific policies for psychiatric services provided in nursing homes. In 1995, only three carrier policies directly addressed psychiatric services in nursing homes. In comparison, most of the policies we reviewed (13 of 17) directly address these services. Furthermore, 11 of the 13 policies have specific sections for individual or groups of psychiatric service codes.

Also, carrier policies now include more general information to guide reimbursement. A majority provide a description for each of the codes in our sample. Most additionally incorporate specific requirements for medical documentation. For example, most require that patients have a treatment plan and that documentation of patients' mental health symptoms be included in their medical records. Lastly, most policies discuss place of service codes and the types of providers allowed to bill for psychiatric services, including explanations of "incident to" providers.

However, utilization guidelines are not always precise

Despite the improvements noted above, our review of carrier policies reveals a lack of consistency and clarity. To begin with, a majority of policies do not provide a list of diagnosis codes that support the medical need for the services in our sample. In some instances, the reimbursement guidelines offered are very broad. For example, while most of the policies for group therapy provide a list of activities that cannot be billed under this code (such as socialization and recreational activities), only half offer a list of activities that can be appropriately billed under the group therapy code. Policies are also vague on the duration and frequency of services. One policy states, "The degree of functional impairment should be a factor in determining frequency and duration of the therapeutic services. Claims submitted for an unusual frequency or duration ... may result in a delay ... or denial," but it does not offer additional guidelines on what constitutes "unusual" frequency or duration. Also, only half of the policies call for justification of longer individual psychotherapy visits.

As discussed in the previous finding, psychological testing was the most problematic of the codes in our sample and carrier policies for this code are particularly lacking in specificity and consistency. Some policies include specific examples of appropriate testing instruments, while others do not. The policies also do not always clearly address the number of hours that can be reasonably billed under the psychological testing code. Further, carrier policies differ on what is deemed appropriate. For example, in one policy, the Beck Depression Inventory is listed as an acceptable test, while another policy specifically excludes this test.

Lastly, carrier policies only specifically address the Minimum Data Set (MDS) for individual psychotherapy services. All nursing home residents receive a comprehensive assessment using a form called the MDS. The MDS includes an evaluation of their mental health status and should support their need for psychiatric services. Carrier policies require that certain sections of the MDS relating to mental health status be filled out in a specific way in order to support the need for individual psychotherapy services.

RECOMMENDATIONS

Since the first Office of Inspector General report was issued, Medicare continues to pay for some inappropriate nursing home psychiatric services.

In order to address the factors identified in this report that lead to inappropriate reimbursement, we recommend that the billing process for psychiatric services in nursing homes be strengthened.

The Health Care Financing Administration may want to consider the following options:

- Work with carriers to develop guidelines for the appropriate frequency and duration of psychiatric services.
- Work with carriers and mental health providers to identify the specific instruments that can be appropriately billed as psychological testing.
- Encourage carriers to take advantage of the Minimum Data Set, particularly its assessment of patient cognitive level, by using it to assess the appropriateness of reimbursement for psychiatric services.

We believe that implementing these recommendations would result in potential savings of as much as $30 million a year.

Comments

We received comments on the draft report from the Health Care Financing Administration and they concur with our recommendations. Specifically, they will share our report with contractors and the carrier clinical workgroup on psychiatric services and work with them to strengthen the billing process for psychiatric services in nursing homes. The Health Care Financing Administration's comments are in Appendix D.

APPENDIX A

CONFIDENCE INTERVALS FOR KEY VARIABLES

We calculated confidence intervals for five key variables. The point estimate and 95% confidence interval are given for each.

KEY VARIABLE	POINT ESTIMATE	CONFIDENCE INTERVAL
Medically unnecessary services	27%	+/- 7.2%
Services with no mental health documentation	9%	+/- 4.8%
Questionable services	3%	+/- 2.1%
Medically necessary services	61%	+/- 7.8%
Medically unnecessary psychological testing	39%	+/- 9.1%

APPENDIX B

CONFIDENCE INTERVALS FOR DOLLAR PROJECTIONS

We calculated confidence intervals for our dollar projections. The projected total and 95% confidence interval are given for each of the following:

KEY ESTIMATE	PROJECTED TOTAL	CONFIDENCE INTERVAL
Medically unnecessary services	$11,303,058.35	+/- $3,152,785.07
Services with no mental health documentation	$ 4,149,730.04	+/- $2,054,295.24
Questionable services	$ 920,814.33	+/- $780,994.88

APPENDIX C

NON-RESPONDENT ANALYSIS

We tested for the presence of any non-response bias in our medical record review. For this analysis, a psychiatric service for which we did not receive a response is a non-respondent.

To test for non-response bias in our medical record review, we obtained information from a 1 percent file of the HCFA's National Claims History for all 450 line items in our sample. Of the 450 services, we received a response for 365 services, for an overall response rate of 81 percent. The following table illustrates the number of responses received and the response rate by strata.

STRATA	RESPONSES RECEIVED	RESPONSE RATE
1 (Codes 90816, 90817, 90818)	125	78 %
2 (Code 90853)	127	89 %
3 (Code 96100)	113	77 %

We analyzed 3 variables for the 450 services in our sample: gender, race, and place of service. These categorical variables were tested using Chi-square with the appropriate degrees of freedom. In order for the results to be statistically significant at the 95 percent confidence level, the Chi-square value must be higher than 3.84 with 1 degree of freedom.

The results of this analysis are presented in Tables A, B, and C. The Chi-square values given in the tables provide a test of the difference between the distribution of respondents and of non-respondents for the variable of interest. Also provided in the tables are the response rates by the different values of the variables.

Tables A, B, and C show no statistically significant differences between respondents and non-respondents for gender, race, and place of service. Given the results of this analysis, we believe that the inspection findings fairly represent the appropriateness of Medicare reimbursement for psychiatric services in nursing homes.

Table A
GENDER BY RESPONSE

	Respondents	Non-respondents	Total	Response rate
Male	158 (43%)	31 (36%)	189	84 %
Female	207 (57%)	54 (64%)	261	79 %
Total	**365**	**85**	**450**	**81 %**
Chi-square = 1.31 Degree of freedom = 1				

Table B
RACE BY RESPONSE

	Respondents	Non-respondents	Total*	Response rate
White	280 (78%)	68 (81%)	348	80 %
Other	80 (22%)	16 (19%)	96	83 %
Total	**360**	**84**	**444**	**81 %**
Chi-square = .405 Degree of freedom = 1			* No race reported for 6 services	

Table C
PLACE OF SERVICE BY RESPONSE

	Respondents	Non-respondents	Total	Response rate
Nursing facility	185 (51%)	50 (59%)	235	79 %
Skilled nursing facility	180 (49%)	35 (41%)	215	84 %
Total	**365**	**85**	**450**	**81 %**
Chi-square = 1.83 Degree of freedom = 1				

APPENDIX D

In this appendix, we present in full the comments from the Health Care Financing Administration.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of the Administrator
Washington, D.C. 20201

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Payment for Psychiatric Services in Nursing Homes: A Follow-Up" (OEI-02-99-00140)

The Health Care Financing Administration (HCFA) thanks you for the opportunity to review the above-referenced report concerning Medicare payment for psychiatric services in nursing homes.

The OIG inspection found that a portion of the psychiatric services in nursing homes is medically unnecessary or lacks adequate psychiatric documentation. In its inspection, OIG also conducted an analysis of carrier policies for nursing home psychiatric services. This analysis revealed "a lack of consistency and clarity," and "policies that differed on what is deemed appropriate." The OIG inspection also included a medical record review, which found that over one-third of Medicare payments for psychiatric services in nursing homes are inappropriate and that the most problematic of the services reviewed was psychological testing. OIG recommended in the report "that the billing process for psychiatric services in nursing homes be strengthened." In general, HCFA concurs with the OIG recommendations. Our specific comments follow:

OIG Recommendation #1

HCFA should work with carriers to develop guidelines for the appropriate frequency and duration of psychiatric services.

OIG Recommendation #2

HCFA should work with carriers and mental health providers to identify the specific instruments that can be appropriately billed as psychological testing.

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HCFA's Responses to #1 and #2

We concur with these recommendations, and will be sharing this report with the contractors and asking them to analyze their data for psychological testing in nursing homes and to take appropriate corrective action. In addition, we are referring this report to the carrier clinical workgroup on psychiatric services for their consideration of a local medical review policy template. Finally, we will explore the possibility of including this issue in the national coverage decision process.

OIG Recommendation #3

HCFA should encourage carriers to take advantage of the Minimum Data Set, particularly its assessment of patient cognitive level by using it to assess the appropriateness of reimbursement for psychiatric services.

HCFA Response

We concur. We will alert all carriers regarding the potential usefulness of the Minimum Data Set during claim review. We will encourage contractors whose data analysis indicates over utilization of psychiatric services to request the physician or nursing home supply a copy of the MDS to the carrier for review.