Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Carriers' Policies for Mental Health Services

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EXECUTIVE SUMMARY

PURPOSE

To review coverage criteria and documentation requirements set forth in Medicare carriers' local medical review policies for selected Part B mental health services.

BACKGROUND

Medicare and its beneficiaries paid an estimated $1.2 billion for Part B mental health services in 1998. Part B claims for mental health services are processed and paid by Medicare carriers that contract with the Centers for Medicare & Medicaid Services (CMS). To date, CMS has not established a national coverage policy for all carriers to follow in assessing the appropriateness of claims for mental health services. Rather, carriers are permitted to develop local medical review policies in accordance with a format published by CMS. These policies describe the medical criteria beneficiaries must meet for particular mental health services to be considered medically necessary and appropriate, as well as criteria for satisfactory documentation of mental health services.

For this inspection, we collected local medical review policies from Medicare Part B carriers for the following mental health services: individual psychotherapy with and without evaluation and management, group psychotherapy, pharmacologic management, and psychological testing. We systematically reviewed these local policies using a structured review instrument.

FINDINGS

Some carriers did not have local medical review policies for the mental health services in our review

A total of nine carriers lacked policies for one or more of the mental health services we reviewed. One carrier did not have a local medical review policy for any type of mental health service. Three carriers did not have policies addressing group psychotherapy. Another two carriers did not have policies for pharmacologic management. An additional three carriers did not have local medical review policies for psychological testing.

Not all carriers provided comprehensive and specific coverage criteria in their local policies for mental health services

The comprehensiveness and specificity with which carriers addressed the coverage criteria outlined in the local medical review policy format varied from one carrier's policy to the next.

Variations also existed within individual policies, with explicit coverage requirements for one type of mental health service, yet vague requirements for another. Few policies provided utilization guidelines for group therapy, pharmacologic management, and psychological testing. In addition, few policies indicated covered diagnoses for psychotherapy and psychological testing services. While most policies for group therapy and pharmacologic management specified qualified providers, policies for individual therapy and psychological testing did not.

Documentation requirements for therapy and pharmacologic management were also not comprehensive and consistent

According to CMS' local medical review policy format, carriers' policies must establish requirements for the documentation of services. Our review revealed that documentation requirements set forth for individual and group psychotherapy and pharmacologic management were not comprehensively and consistently addressed in carriers' policies. In contrast, the majority of carriers' policies for psychological testing outlined specific documentation that should be included in the patient's medical record.

RECOMMENDATION

We believe that all Medicare beneficiaries should have access to medically appropriate mental health services, and that providers should adequately document these services. We also believe that the quality and comprehensiveness of guidance furnished to mental health service providers should not vary depending on which carrier is processing payment for services. The lack of comprehensive guidance in local medical review policies may result in inconsistent Medicare coverage determinations and inappropriate payments for mental health services. Therefore,

- **We recommend that CMS require carriers to strengthen vague or incomplete sections of their local policies for mental health services and ensure that policies adequately address all of the elements specified in the Local Medical Review Policy Format (Medicare Program Integrity Manual, Exhibit 6).**

Comprehensive and detailed policies for mental health services might include:

- specific documentation instructions requiring that basic elements such as date of service, diagnosis, symptoms, progress, and name and credentials of practitioners rendering services be recorded in patients' medical records;
- specific utilization guidelines such as those pertaining to a reasonable number of services that may be billed per year; and
- sample progress notes for specific types of mental health services.

For additional assistance in targeting areas for inclusion in comprehensive policies, we have provided tables in Appendix A outlining the information Medicare carriers included in their local medical review policies.

COMMENTS

We received comments on the draft report from the Centers for Medicare & Medicaid Services and from two professional organizations, the American Association for Geriatric Psychiatry and the American Psychiatric Association. The full text of the comments is presented in Appendix E.

CMS Comments

The CMS concurred with our recommendation and noted that, over the last several years, it has instructed Medicare contractors to develop their local medical review policies in an open forum and to periodically review these policies to ensure consistency with national Medicare policy and changes in payment and operating systems. The CMS stated that it will require that contractors' periodic reviews of local medical review policies include strengthening vague or incomplete sections of these policies for all services. In addition, CMS will share our report with Medicare carriers and instruct them to make sure that their local policies reflect Medicare Program Integrity Manual requirements.

Comments of Mental Health Organizations

Both the American Association for Geriatric Psychiatry and the American Psychiatric Association remarked on the need for *national* standards for coverage and payment of mental health services that all Medicare carriers must follow. Consideration of the adoption of national standards was outside the scope of our review. However, the organizations' views about the need for a national policy are attached and available for consideration by CMS.

The organizations expressed concern about our suggestion that carriers might want to include specific utilization guidelines for mental health services in their local policies. They believe that these types of guidelines may pose a threat to the sickest patients who need more frequent and intensive treatment if carriers presume that services beyond the guidelines are medically unnecessary. We agree that any utilization guidelines presented in carriers' policies should not be used to impede access to appropriate mental health services.

In addition, the American Psychiatric Association inquired about the source of the descriptions of the mental health service codes provided in Appendix B. We have revised Appendix B to reflect the code descriptions in the American Medical Association's *Current Procedural Terminology*.

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INTRODUCTION

PURPOSE

To review coverage criteria and documentation requirements set forth in Medicare carriers' local medical review policies for the following Part B mental health services: individual psychotherapy with and without evaluation and management, group psychotherapy, pharmacologic management, and psychological testing.

BACKGROUND

Mental Illness and Medicare Populations

As defined by the Office of the Surgeon General, mental illness is "a term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning." People of all age groups can be affected by mental illness; and individuals in different stages of life may be susceptible to certain kinds of mental disorders. Older adults have their own special mental health problems and needs. Fortunately, treatment interventions such as psychotherapy and medication can benefit individuals with mental illness when tailored to meet the specific needs of each patient.

Medicare Part B Coverage of Mental Health Services

Medicare and its beneficiaries paid an estimated $1.2 billion for Part B mental health services in 1998. Mental health services reimbursed by Medicare include psychiatric diagnostic or evaluative interview procedures, individual psychotherapy, group psychotherapy, family psychotherapy, psychoanalysis, psychological testing, and pharmacologic management. Section 1862 (a)(1)(A) of the Social Security Act states that all Medicare Part B services, including 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."

Medicare Carriers and Local Medical Review Policies

Part B claims for mental health services are processed and paid by health insurance organizations, known as Medicare carriers, that contract with the Centers for Medicare & Medicaid Services (CMS). Carriers are identified by one or more unique numbers that correspond to the jurisdiction(s), usually States or portions of States, for which they process Medicare claims. Some carrier organizations have more than one area of jurisdiction, and some States have more than one Medicare carrier.

To date, CMS has not established a national coverage policy for all carriers to follow in assessing the appropriateness of claims for mental health services. The CMS allows, but does not require, carriers to develop their own local medical review policies based on general Medicare guidelines. Local policies for mental health services should describe the medical criteria beneficiaries must meet for particular services to be considered medically necessary and appropriate. Exhibit 6 of the Medicare Program Integrity Manual indicates a general format that carriers must use when writing their local policies. The most current format is presented in Appendix C. Local policies provide information about coverage, including appropriate diagnosis and utilization guidelines; documentation requirements; and coding and billing of services.

Documentation of Mental Health Services

Section 1833 (e) of the Social Security Act requires providers to maintain sufficient documentation of the services they render to Medicare beneficiaries in order to support claims for reimbursement. When carriers have local policies in place, these policies should specify criteria for satisfactory documentation of mental health services. Record-keeping guidelines published by the American Psychological Association state that well-documented mental health services are critical to patient care. Thorough documentation ensures continuity of care should a patient seek treatment from another health care provider for either mental or physical conditions; enables mental health professionals to better plan for and monitor treatment; and substantiates mental health claims submitted to the Medicare program and other insurers.

Previous OIG Work

Since 1996 the Office of Inspector General (OIG) has issued a number of reports on mental health services provided to Medicare beneficiaries in nursing facilities, hospital outpatient departments, partial hospitalization programs, and other outpatient settings. The OIG found that many mental health services provided to beneficiaries in these settings were medically unnecessary, highly questionable, billed incorrectly, and undocumented or poorly documented.

In a January 2001 report on psychiatric services in nursing homes, the OIG found that Medicare carriers' local medical review policies addressed psychiatric services in nursing homes, but that utilization guidelines were inconsistent and unclear. An OIG report issued in May 2001 revealed that Medicare allowed $185 million in 1998 for inappropriate mental health services provided in practitioners' offices, community mental health centers, beneficiaries' homes, and custodial care facilities. A listing of selected OIG reports on Medicare mental health services is provided in Appendix D.

METHODOLOGY

We requested 1998 local policies from each of the Medicare Part B carriers for the following mental health services: individual psychotherapy with and without evaluation and management, group psychotherapy, pharmacologic management, and psychological testing. Descriptions of these services are provided in Appendix B.

We did not receive responses to our request from carriers representing 3 of 57 unique carrier numbers. One carrier responded to our request, but stated that they did not have a local policy in place for the mental health services in our review. The remaining carriers, representing 53 unique carrier numbers, submitted either a single policy covering all of the Part B mental health services under review, or separate policies for each type of mental health service. We created a structured review instrument and systematically reviewed the local policies, focusing on coverage criteria and documentation requirements. We focused our review on these elements as they make up the essence of local medical review policies.

We recorded the results of our analysis of local policies in terms of unique carrier numbers. However, to improve the readability of this report, we will refer to these unique carrier numbers as "carriers." Detailed tables containing all of the analysis results presented in this report are provided in Appendix A.

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

FINDINGS

Some carriers did not have local medical review policies for the mental health services in our review

A total of nine carriers lacked policies for one or more of the mental health services we reviewed. One carrier did not have a local medical review policy for any type of mental health service. Three carriers did not have policies addressing group psychotherapy. Another two carriers did not have policies for pharmacologic management. An additional three carriers did not have local medical review policies for psychological testing.

Table 1. Nine Carriers Lacked Policies For One Or More Mental Health Services

Medicare Part B Carrier			Mental Health Services Reviewed (X indicates that carrier had policy covering the service)			
Number	**Name**	**State**	**Individual Therapy**	**Group Therapy**	**Pharmacologic Management**	**Psychological Testing**
00870	Rhode Island Blue Shield	RI				
00650	Kansas Blue Shield	KS	X		X	X
00651	Kansas Blue Shield	MO	X		X	X
00655	Kansas Blue Shield	NE	X		X	X
00590	Florida Blue Shield	FL	X	X		X
00880	Palmetto GBA	SC	X	X		X
16360	Nationwide	OH	X	X	X	
16510	Nationwide	WV	X	X	X	
31140	National Heritage Insurance Co.	CA	X	X	X	

Source: OEI analysis of 1998 local medical review policies collected between September and December 1999.

Not all carriers provided comprehensive and specific coverage criteria in their local policies for mental health services

The comprehensiveness and specificity with which carriers addressed coverage criteria for the mental health services we reviewed varied from one carrier's local medical review policy to the next. Variations also existed within individual policies, with explicit coverage requirements for one type of mental health service, yet vague requirements for another.

Few policies provided utilization guidelines for group therapy, pharmacologic management, and psychological testing

The CMS' local medical review policy format (provided in Appendix C) suggests that carriers' policies describe the typical usage of covered services. However, few policies delineated utilization guidelines for group psychotherapy, pharmacologic management, and psychological testing services. Four policies stated the number of group psychotherapy services that may be billed per year. Three policies stated the number of pharmacologic management services that may be billed per year. Nine policies specified the number of hours that may be billed per beneficiary per psychological testing service, while five policies specified the number of psychological testing services that may be provided in a 12-month period.

In contrast, the majority (about two-thirds) of local policies we reviewed provided utilization guidelines for individual psychotherapy services. These policies specified that prolonged treatment with individual psychotherapy may be subject to medical review, with most policies defining "prolonged treatment" as treatment in excess of 20 sessions per episode of illness. One individual psychotherapy policy provided greater detail, basing utilization guidelines on additional criteria such as place of service (inpatient or outpatient) and whether a patient's illness is chronic or acute.

Few policies clearly indicated covered diagnoses for psychotherapy and psychological testing services

The local medical review policy format published by CMS states that policies must contain a list of diagnosis codes for which a service is generally covered. Although local medical review policies for mental health services usually contained a general list of covered diagnosis codes, only eight policies clearly indicated which diagnoses are associated with each type of mental health service we reviewed. However, the typical policy governing pharmacologic management did specify a range of diagnosis codes that are covered for pharmacologic management services.

Most policies for group therapy and pharmacologic management specified qualified providers, unlike individual therapy and psychological testing policies

While the local medical review policy format does not explicitly state that carriers' policies must list the types of providers qualified to render services, many local policies specified the types of providers that are permitted to render group psychotherapy and pharmacologic management services. These policies generally stated that group psychotherapy "must be led by a person authorized by the state to perform this service," but also provided a list of practitioner types that are usually qualified to perform group therapy, including psychiatrists, psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists. Most policies specified that pharmacologic management is a physician service, with exceptions for other types of practitioners that may be licensed by individual States to prescribe medication, such as nurse practitioners, advanced practice nurses, and physician assistants.

In contrast to group therapy and pharmacologic management services, local medical review policies usually did not identify the specific types of providers that are permitted to render individual psychotherapy and psychological testing services. Typical policies for individual psychotherapy merely stated that the service "must be performed by a person authorized by the state to perform psychotherapy." Only one-quarter of policies stipulated that clinical psychologists and licensed clinical social workers are *not* qualified to render individual psychotherapy with an evaluation and management component, a service clearly outside the scope of practice for these practitioners. For psychological testing, nine policies specified the types of providers that may render these services.

Documentation requirements for therapy and pharmacologic management were also not comprehensive and consistent

Our review revealed that documentation requirements set forth for individual and group psychotherapy and pharmacologic management were not comprehensively and consistently addressed in carriers' policies. In contrast, the majority of carriers' policies for psychological testing outlined specific documentation that should be included in the patient's medical record.

According to CMS' local medical review policy format, carriers' policies must establish requirements for the documentation of services. Documentation should include "specific information from the medical records or other pertinent information that would be required to justify the item/service."

Individual and Group Psychotherapy. Many local medical review policies did not address the documentation of some very basic elements of psychotherapy services. Less than half of policies for individual and group psychotherapy specified that a patient's diagnosis should be documented in the medical record. Very few carriers stipulated that the date of an individual or group psychotherapy session should be recorded in patients' medical records. Just over half of policies for individual psychotherapy required documentation that treatment is expected to stabilize patients with chronic illness.
Forty-two percent of policies for group psychotherapy contained a similar requirement.

However, local medical review policies for individual and group psychotherapy services did provide consistent documentation requirements with respect to other important elements. For example, almost all policies for both individual and group psychotherapy required documentation of the goals of therapy and the estimated duration of treatment. As individual psychotherapy is billed in increments of time, most local medical review policies for this service stipulated that the amount of face-to-face time spent with the patient in an individual therapy session should be documented.

Pharmacologic Management. Most policies for pharmacologic management either did not address documentation of pharmacologic management services at all, or did so using very vague language. Of the 53 carrier policies reviewed, only 9 policies contained explicit standards for the documentation of pharmacologic management services. Two of these policies provided a detailed list of elements that should be documented for this service, including "the patient's diagnosis, pertinent signs and symptoms, the medication prescribed, side effects, related monitoring of laboratory tests if appropriate, responses to treatment, and any orders for changes in the regimen." Another policy provided examples of progress notes that contain appropriate documentation of pharmacologic management services.

Psychological Testing. Overall, most local medical review policies for psychological testing services provided detailed documentation requirements. For example, over three-quarters of policies stated that a patient's medical record must indicate the presence or signs of mental illness that necessitate psychological testing, the specific psychological tests performed, and the psychological test results and/or test scores. Most policies also required psychological testing providers to prepare a report interpreting a patient's test results. In addition, the majority of carriers' policies required documentation of the time involved in administering, scoring, interpreting, and reporting psychological test results.

RECOMMENDATION

We believe that all Medicare beneficiaries should have access to medically appropriate mental health services, and that providers should adequately document these services. We also believe that the quality and comprehensiveness of guidance furnished to mental health service providers should not vary depending on which carrier is processing payment for services. The lack of comprehensive guidance in local medical review policies may result in inconsistent Medicare coverage determinations and inappropriate payments for mental health services. Therefore,

- **We recommend that CMS require carriers to strengthen vague or incomplete sections of their local policies for mental health services and ensure that policies adequately address all of the elements specified in the Local Medical Review Policy Format (Medicare Program Integrity Manual, Exhibit 6).**

Comprehensive and detailed policies for mental health services might include:

- specific documentation instructions requiring that basic elements such as date of service, diagnosis, symptoms, progress, and name and credentials of practitioners rendering services be recorded in patients' medical records;
- specific utilization guidelines such as those pertaining to a reasonable number of services that may be billed per year; and
- sample progress notes for specific types of mental health services.

For additional assistance in targeting areas for inclusion in comprehensive policies, we have provided tables in Appendix A outlining the information Medicare carriers included in their local medical review policies.

COMMENTS

We received comments on the draft report from the Centers for Medicare & Medicaid Services and from two professional organizations, the American Association for Geriatric Psychiatry and the American Psychiatric Association. The full text of the comments is presented in Appendix E.

CMS Comments

The CMS concurred with our recommendation and noted that, over the last several years, it has instructed Medicare contractors to develop their local medical review policies in an open forum and to periodically review these policies to ensure consistency with national Medicare policy and changes in payment and operating systems. The CMS stated that it will require that contractors'

periodic reviews of local medical review policies include strengthening vague or incomplete sections of these policies for all services. In addition, CMS will share our report with Medicare carriers and instruct them to make sure that their local policies reflect Medicare Program Integrity Manual requirements.

Comments of Mental Health Organizations

Both the American Association for Geriatric Psychiatry and the American Psychiatric Association remarked on the need for *national* standards for coverage and payment of mental health services that all Medicare carriers must follow. Consideration of the adoption of national standards was outside the scope of our review. However, the organizations' views about the need for a national policy are attached and available for consideration by CMS.

The organizations expressed concern about our suggestion that carriers might want to include specific utilization guidelines for mental health services in their local policies. They believe that these types of guidelines may pose a threat to the sickest patients who need more frequent and intensive treatment if carriers presume that services beyond the guidelines are medically unnecessary. We agree that any utilization guidelines presented in carriers' policies should not be used to impede access to appropriate mental health services.

In addition, the American Psychiatric Association inquired about the source of the descriptions of the mental health service codes provided in Appendix B. We have revised Appendix B to reflect the code descriptions in the American Medical Association's *Current Procedural Terminology*.

APPENDIX A

Selected LMRP Review Results by Carrier Number

Appendix A contains four tables, one for each of the following types of mental health services included in our inspection: individual psychotherapy with and without evaluation and management, group psychotherapy, pharmacologic management, and psychological testing. These tables display selected results of our analysis of carriers' local medical review policies, as discussed in the findings of this report. We collected local medical review policies for the year 1998 from the Medicare Part B carriers between September and December 1999.

APPENDIX A

TABLE 1: INDIVIDUAL PSYCHOTHERAPY

Carrier		Utilization		Diagnosis	Qualified Providers		Documentation Requirements					
Number	State	Guidelines Provided	Prolonged Treatment = More Than 20 Sessions	How LMRP Specified Covered Diagnoses	How LMRP Specified Qualified Provider Types	Certain Provider Types Cannot Bill Evaluation and Management Codes	Therapy Goals	Time Spent	Estimated Duration of Treatment	Therapy Will Stabilize Chronic Illness	Patient Diagnosis	Date of Session
00510	AL	X	X	G	A		X	X	X			
00511	GA	X	X	G	A		X	X	X			
00520	AR	X	X	G	A		X	X		X	X	
00521	NM	X	X	G	A		X	X	X	X	X	
00522	OK	X	X	G	A		X	X	X	X	X	
00523	MO	X	X	G	A		X	X	X	X		
00528	IA	X	X	G	A	X	X	X	X	X	X	
00590	FL			S	L		X	X	X	X	X	
00630	IN			S	A		X	X	X	X		
00650	KS			S			X	X				X
00651	MO			S			X	X				X
00655	NE			S			X	X				X
00660	KY			S	A		X	X	X	X		
00751	MT	X		G	A		X	X	X		X	
00801	NY			G	I	X	X	X				
00803	NY			G	I	X	X	X				
00820	ND	X	X	G	A		X	X	X			
00824	CO	X	X	G	A		X	X	X			
00825	WY	X	X	G	A		X	X	X			
00826	IA	X	X	G	A		X	X	X			
00831	AK	X	X	G	A		X	X	X			
00832	AZ	X	X	G	A		X	X	X			
00834	NV	X	X	G	A		X	X	X			
00835	OR	X	X	G	A		X	X	X			
00836	WA	X	X	G	A		X	X	X			
00860	NJ	X	X	S	A		X	X	X	X	X	
00865	PA	X	X	S	A		X	X	X	X	X	
00870	RI	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	NP
00880	SC			S	I		X	X			X	X
00889	SD	X	X	G	A		X	X	X			
00900	TX				A		X	X	X	X		
00901	MD				A		X	X	X	X		
00902	DE	X	X	S	A		X	X	X	X	X	
00903	DC	X	X	S	A		X	X	X	X	X	
00910	UT			S	A		X	X	X			
00951	WI	X		G	A	X	X	X	X	X	X	
00952	IL	X	X	G	A		X	X	X			
00953	MI	X	X	G	A		X	X	X			
02050	CA	X		S	A			X			X	
05130	ID	X	X	G	A		X	X	X	X		
05440	TN	X	X	G	A		X	X	X	X	X	
05535	NC	X	X	G	A		X	X	X	X		
10230	CT			S	L		X	X				
10240	MN	X	X		A		X	X	X	X		
10250	MS	X	X		A		X	X	X	X		
10490	VA	X		S	A		X		X	X	X	X
14330	NY			G	I	X	X	X				
16360	OH			S	A	X	X	X	X	X	X	X
16510	WV			S	A	X	X	X	X	X	X	X
31140	CA			S		X	X	X	X			X
31142	ME	X				X	X		X	X	X	
31143	MA	X				X	X		X	X	X	
31144	NH	X				X	X		X	X	X	
31145	VT	X				X	X		X	X	X	

KEY: X=Policy contained column criteria; Shaded Box=Policy did not contain column criteria; NP=No policy; G=Policy specified covered diagnoses in general way; S=Policy specified covered diagnosis in clear and specific way; A=Qualified provider types not listed, policy only specified that providers must be authorized by State; L=Policy listed qualified provider types

APPENDIX A

TABLE 2: GROUP PSYCHOTHERAPY

Carrier		Utilization	Diagnosis	Qualified Providers	Documentation Requirements				
Number	State	Specified Number of Services That May Be Billed Per Year	How LMRP Specified Covered Diagnoses	Specific List of Qualified Provider Types	Therapy Goals	Estimated Duration of Treatment	Patient Diagnosis	Therapy Will Stabilize Chronic Illness	Date of Session
00510	AL		G	X	X	X			
00511	GA		G	X	X	X			
00520	AR		G	X	X		X	X	
00521	NM		G	X	X	X	X	X	
00522	OK		G	X	X	X	X	X	
00523	MO		G	X	X	X		X	
00528	LA		G	X	X	X	X	X	
00590	FL		S	X	X	X	X		
00630	IN		S	X	X	X		X	
00650	KS	NP	NP	NP	NP	NP	NP	NP	NP
00651	MO	NP	NP	NP	NP	NP	NP	NP	NP
00655	NE	NP	NP	NP	NP	NP	NP	NP	NP
00660	KY		S	X	X	X		X	
00751	MT		G	X	X	X	X		
00801	NY		G	X	X				
00803	NY		G	X	X				
00820	ND		G	X	X	X			
00824	CO		G	X	X	X			
00825	WY		G	X	X	X			
00826	IA		G	X	X	X			
00831	AK		G	X	X	X			
00832	AZ		G	X	X	X			
00834	NV		G	X	X	X			
00835	OR		G	X	X	X			
00836	WA		G	X	X	X			
00860	NJ		S	X	X	X	X	X	
00865	PA		S	X	X	X	X	X	
00870	RI	NP	NP	NP	NP	NP	NP	NP	NP
00880	SC		S	X	X		X		X
00889	SD		G	X	X	X			
00900	TX			X	X	X		X	
00901	MD			X	X	X		X	
00902	DE		S	X	X	X	X	X	
00903	DC		S	X	X	X	X	X	
00910	UT		S	X	X	X			
00951	WI		G	X	X	X	X	X	
00952	IL		G	X	X	X			
00953	MI		G	X	X	X			
02050	CA		S	X			X		
05130	ID		G		X	X		X	
05440	TN		G	X	X	X	X	X	
05535	NC		G	X	X	X		X	
10230	CT		S	X	X		X		
10240	MN			X	X	X		X	
10250	MS			X	X	X		X	
10490	VA		S		X	X	X	X	X
14330	NY		G	X	X				
16360	OH		S		X	X	X	X	X
16510	WV		S		X	X	X	X	X
31140	CA		S	X			X		
31142	ME	X			X	X	X		
31143	MA	X			X	X	X		
31144	NH	X			X	X	X		
31145	VT	X			X	X	X		

KEY: X=Policy contained column criteria; Shaded Box=Policy did not contain column criteria; NP=No policy; G=Policy specified covered diagnoses in general way; S=Policy specified covered diagnosis in clear and specific way

TABLE 3: PHARMACOLOGIC MANAGEMENT						
Carrier		Utilization	Diagnosis	Qualified Providers	Documentation Requirements	
Number	State	Specified Number of Services That May Be Billed Per Year	How LMRP Specified Covered Diagnoses	How LMRP Specified Qualified Provider Types	Addressed Documentation Using Vague Language	Provided Explicit Documentation Guidelines
00510	AL		S	PO	X	
00511	GA		S	PO	X	
00520	AR		S	PO	X	
00521	NM		S	PO	X	
00522	OK		S	PO	X	
00523	MO		S	P	X	
00528	LA		S	PO	X	
00590	FL	NP	NP	NP	NP	NP
00630	IN		S	PO		
00650	KS	X	S			X
00651	MO	X	S			X
00655	NE	X	S			X
00660	KY		S	PO		
00751	MT		G	PO	X	
00801	NY		S	PO	X	
00803	NY		S	PO	X	
00820	ND		S	PO	X	
00824	CO		S	PO	X	
00825	WY		S	PO	X	
00826	IA		S	PO	X	
00831	AK		S	PO	X	
00832	AZ		S	PO	X	
00834	NV		S	PO	X	
00835	OR		S	PO	X	
00836	WA		S	PO	X	
00860	NJ		S	PO		X
00865	PA		S	PO		X
00870	RI	NP	NP	NP	NP	NP
00880	SC	NP	NP	NP	NP	NP
00889	SD		S	PO	X	
00900	TX		S	PO	X	
00901	MD		S	PO	X	
00902	DE		S	PO	X	
00903	DC		S	PO	X	
00910	UT		S	PO	X	
00951	WI		S	PO	X	
00952	IL		S	PO	X	
00953	MI		S	PO	X	
02050	CA		S	P		
05130	ID		S	PO	X	
05440	TN		S	PO	X	
05535	NC		S	PO	X	
10230	CT		S	PO		X
10240	MN		S	PO	X	
10250	MS		S	PO	X	
10490	VA		S			
14330	NY		S	PO	X	
16360	OH		S	P		X
16510	WV		S	P		X
31140	CA		S	P		X
31142	ME					
31143	MA					
31144	NH					
31145	VT					

KEY: X=Policy contained column criteria; Shaded Box=Policy did not contain column criteria; NP=No policy; G=Policy specified covered diagnoses in general way; S=Policy specified covered diagnosis in clear and specific way; PO=Policy specified physicians and other provider types licensed by State to prescribe medication; P=Policy only specified physicians

TABLE 4: PSYCHOLOGICAL TESTING

Carrier		Utilization		Diagnosis	Qualified Providers	Documentation Requirements				
Number	State	Specified Number of Hours That May Be Billed Per Service	Specified Number of Services That May Be Provided Per Year	How LMRP Specified Covered Diagnoses	Indicated Type Or Types That May Render Service	Presence Or Signs of Mental Illness	Specific Tests Performed	Test Results and/or Test Scores	Report Interpreting Test Results	Time Involved In Testing
00510	AL			G		X	X	X	X	X
00511	GA			G		X	X	X	X	X
00520	AR			G		X	X	X	X	X
00521	NM			G		X	X	X	X	X
00522	OK			G		X	X	X	X	X
00523	MO			G		X	X	X	X	X
00528	LA			G		X	X	X	X	X
00590	FL						X		X	X
00630	IN	X		S			X	X	X	X
00650	KS			S			X	X	X	X
00651	MO			S			X	X	X	X
00655	NE			S			X	X	X	X
00660	KY	X		S		X	X	X	X	X
00751	MT			G		X	X	X	X	X
00801	NY			G		X	X	X	X	X
00803	NY			G		X	X	X	X	X
00820	ND			G		X	X	X	X	X
00824	CO			G		X	X	X	X	X
00825	WY			G		X	X	X	X	X
00826	IA			G		X	X	X	X	X
00831	AK			G		X	X	X	X	X
00832	AZ			G		X	X	X	X	X
00834	NV			G		X	X	X	X	X
00835	OR			G		X	X	X	X	X
00836	WA			G		X	X	X	X	X
00860	NJ	X		S		X	X	X	X	X
00865	PA	X		S		X	X	X	X	X
00870	RI	NP	NP	NP	NP	NP	NP	NP	NP	NP
00880	SC				X	X				
00889	SD			G		X	X	X	X	X
00900	TX					X	X	X	X	X
00901	MD					X	X	X	X	X
00902	DE					X	X	X	X	X
00903	DC					X	X	X	X	X
00910	UT			S		X	X	X	X	X
00951	WI		X	S	X	X	X	X	X	X
00952	IL			G		X	X	X	X	X
00953	MI			G		X	X	X	X	X
02050	CA			S	X		X			X
05130	ID			G		X	X	X	X	X
05440	TN			G		X	X	X	X	X
05535	NC			G		X	X	X	X	X
10230	CT			S	X	X	X	X	X	
10240	MN					X	X	X	X	X
10250	MS					X	X	X	X	X
10490	VA	X		S	X	X		X	X	X
14330	NY			G		X	X	X	X	X
16360	OH	NP	NP	NP	NP	NP	NP	NP	NP	NP
16510	WV	NP	NP	NP	NP	NP	NP	NP	NP	NP
31140	CA	NP	NP	NP	NP	NP	NP	NP	NP	NP
31142	ME	X	X	S	X					
31143	MA	X	X	S	X					
31144	NH	X	X	S	X					
31145	VT	X	X	S	X					

KEY: X=Policy contained column criteria; Shaded Box=Policy did not contain column criteria; NP=No policy; G=Policy specified covered diagnoses in general way; S=Policy specified covered diagnosis in clear and specific way

Descriptions of Mental Health Services Reviewed

Individual Psychotherapy

90804 Individual psychotherapy, insight oriented, behavior modifying, and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.

90805 Same as procedure 90804, but with medical evaluation and management services.

90806 Individual psychotherapy, insight oriented, behavior modifying, and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.

90807 Same as procedure 90806, but with medical evaluation and management services.

90808 Individual psychotherapy, insight oriented, behavior modifying, and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient.

90809 Same as procedure 90808, but with medical evaluation and management services.

Group Psychotherapy

90853 Group psychotherapy (other than of a multiple-family group).

Pharmacologic Management

90862 Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

Psychological Testing

96100 Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R (Wechsler Adult Intelligence Scale Revised), Rorschach, MMPI (Minnesota Multiphasic Personality Inventory)) with interpretation and report, per hour.

Local Medical Review Policy Format

Medicare Program Integrity Manual

Exhibit 6 - LMRP Format - (Rev. 14, 09-26-01)

Contractor's Policy Number	Enter a unique policy identifier that the policy author designates. The numbering system is entirely up to the contractor and is used to catalog the policy for internal use.
Contractor Name	The contractor name is the proper name assigned by CMS and used in the Contractor Report of Workload Data (CROWD) system. This is a mandatory field.
Contractor Number	The contractor number is the proper name assigned by CMS and used in the CROWD system. Include only one contractor number. This is a mandatory field.
Contractor Type	Indicate if this policy is for a fiscal intermediary (FI), carrier, regional home health intermediary (RHHI) or durable medical equipment regional carrier (DMERC). Select only one contractor type. This is a mandatory field.
LMRP Title	Enter a brief, one line description of the topic or subject matter of the policy. The subject identifies the name of the medical policy. This field is used in the Keyword Search function for researching and drafting policies. To improve identifying your policies, try not to use special characters such as parentheses, slashes, and ellipses in this field. Only use these characters when absolutely necessary. This is a mandatory field.

AMA CPT Copyright Statement	Include the following statement in each LMRP that contains CPT codes. "CPT codes, descriptions and other data only are copyright 2001 American Medical Association (or such other data of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."
CMS National Coverage Policy	Indicate any associated CMS National Coverage Determination or Coverage Provision in an Interpretive Manual. Include a description if a National Coverage Determination or Provision is being expanded, adds greater clarification and/or codes. This is a mandatory field.
Primary Geographic Jurisdiction	The geographical area to which the LMRP will apply. For carriers and DMERCs, this jurisdiction is usually established based upon the contractor number. For RHHIs and FIs, this jurisdiction is established based upon the contractor number but may not include all States within CMS established jurisdiction. For example, an FI with the primary geographic jurisdiction of Connecticut, Michigan and New York may only develop a LMRP for Connecticut and not Michigan or New York. Contractors must indicate the primary jurisdiction to which this policy applies. This is a mandatory field.
Secondary Geographic Jurisdiction	RHHIs and FIs may also have a secondary geographic jurisdiction for those facilities that nominate to have the FI or RHHI process their claims. The secondary geographic jurisdiction is the State in which the provider is located. Include all States for the providers to which this policy applies.
CMS Region	List the region that retains oversight of the Medicare contractor's LMRP development process. Include only one region. This is a mandatory field.

CMS Consortium	List the consortium for the regional office listed above. Include only one consortium. This is a mandatory field.
DMERC Region LMRP Covers	List the region that this policy covers. This is a mandatory field for DMERCs only.
Original Policy Effective Date	List the original date this policy became effective. For example, all policy rules, requirements and limitations became effective for services performed on and after this date. The format is MM/DD/YYYY. This is a mandatory field.
Original Policy Ending Date	The date for which the policy is no longer effective. For example, all policy rules, requirements and limitations within this policy are no longer effective for services performed after this date. This date may be the same as, but not before the final revision ending effective date. The format is MM/DD/YYYY. This is a mandatory field for terminated policies.
Revision Effective Date	The beginning date for which a revision becomes effective. For example, all policy rules, requirements and limitations within this revision are effective for services performed after this date. The format is MM/DD/YYYY. This is a mandatory field for revised policies.
Revision Ending Date	The date for which this revision is no longer effective. For example, all policy rules, requirements, and limitations within this revision are no longer effective for services performed after this date. The format is MM/DD/YYYY. This is a mandatory field if a revised policy is itself subsequently revised or if a revised policy is terminated without a subsequent revision.

LMRP Description	Characterize or define the item/service and explain how it operates or is performed. Use this field to enhance the policy subject. This is a mandatory field.
Indications and Limitations of Coverage and/or Medical Necessity	List the general indications for which an item/service is covered and/or considered reasonable and necessary. Also, list limitations such as least costly alternative reductions. This is a mandatory field.
CPT/HCPCS Section and Benefit Category	Define the CPT/HCPCS section to which the policy applies. Also state the appropriate benefit category. For example: physician services, DME, diagnostic services, prosthetic devices, evaluation and management, medicine, pathology and laboratory, radiology, nuclear, ultrasound and surgery. This is a mandatory field.
Type of Bill Code	Enter the related type of bill codes for the item, service or procedure. Type of bill codes apply to FIs only. This is a mandatory field for FIs and RHHIs.
Revenue Codes	Enter the related revenue code for the item, service or procedure. Revenue codes apply to FIs only. This is a mandatory field for FIs and RHHIs.
CPT/HCPCS Codes	Enter the related HCPCS codes and any appropriate modifiers for the item/service. You may list the codes as a range. A policy may be associated with one or many HCPCS codes or a combination of all these. This is a mandatory field.
Not Otherwise Classified (NOC)	Use this field in the absence of HCPCS codes. List the NOC code and the classified codes associated text. This is a mandatory field.

ICD-9 Codes that Support Medical Necessity	List the ICD-9 codes or code ranges, using maximum specificity, for which the item/service is generally covered, and/or considered medically necessary. A policy can be associated with one or many diagnosis codes, one or many ranges of diagnosis codes, or a combination of all of these. This is a mandatory field.
Diagnoses that Support Medical Necessity	In the absence of ICD-9 codes, include the medical diagnoses that support the medical necessity for the item, service or procedure.
ICD-9 Codes that DO NOT Support Medical Necessity	List the ICD-9 codes that do not support the medical necessity of the service. Use this field when developing policies using an "exclusionary" approach in writing LMRP for which there are only limited exceptions of ICD-9 codes that would not support the medical necessity of the service.
Diagnoses that DO NOT Support Medical Necessity	In the absence of ICD-9 codes that do not support medical necessity, include the medical diagnoses that will not support medical necessity. Use this field when developing policies using an "exclusionary" approach in writing LMRP for which there are only limited exceptions of diagnoses that would not support the medical necessity of the service.
Reasons for Denials	Indicate the specific situations under which an item/service will always be denied. Also, list the reasons for denial such as "investigational, cosmetic, routine screening, dental, program exclusion, otherwise not covered, or never reasonable and necessary." This is a mandatory field.

Noncovered ICD-9 Codes	If an item/service is always denied for a certain ICD-9 code, list the ICD-9 code(s) or code range(s) and narrative that are never covered. A policy can be associated with one or many noncovered diagnosis codes, one or many ranges of diagnosis codes or a combination of all of these.
Noncovered Diagnosis	List the medical diagnoses that are not covered.
Coding Guidelines	Describe the relationships between codes and define how items/services are billed. Include information about the units of service, place of service, HCPCS modifiers, etc. An example of an appropriate coding technique is "use CPT xxxxx to bill this item/service rather than yyyyy." Include payment issues and payment considerations in the indications and limitations of coverage section.
Documentation Requirements	Describe specific information from the medical records or other pertinent information that would be required to justify the item/service. For example, progress notes, pathology report, certificates of medical necessity (CMN), or photographs. Give instructions as to how Electronic Media Claim billers should submit documentation.
Utilization Guidelines	Include information concerning the typical or expected utilization for the service. This is an optional field.
Other Comments	Include information not included in other field sections. There is NO maximum field length.

Sources of Information and Basis for Decision	List the information sources, pertinent references (other than national policy) and other clinical or scientific evidence reviewed in the development of this policy. Cite, for example: Agency for Health Care Policy and Research (AHCPR) guidelines, position papers released by specialty societies or other sources used during the development of this policy. Also include the basis for your coverage decision and references that may apply. This is a mandatory field.
Advisory Committee Notes	All contractors must include the following information regarding the development of the LMRP: the meeting date on which the policy was discussed with the advisory committee. This is a mandatory field for those contractors who hold meetings.
Start Date of Comment Period	Enter the date the LMRP was released for comment. Use MM/DD/YYYY as the format. This is a mandatory field.
End Date of Comment Period	Enter the date the comment period ended. Use MM/DD/YYYY as the format. This is a mandatory field.
Start Date of Notice Period	Enter the date the medical community was notified about the LMRP. Use MM/DD/YYYY as the format. When no day is provided, enter 01 as the day. This is a mandatory field.

Revision History	The revision history includes the revision number, the effective date of the revision and an explanation of the revisions made to the policy. Any revision to LMRP that increase restrictions on coverage requires the usual notice and comment period. Revisions to utilization guidelines that increase restrictions on coverage are also subject to the notice and comment period. The revision number is a unique identifier that allows users to recognize if a policy is changed from its original form. The numbering system is entirely up to the contractor and is used to catalog the policy for your internal use. The revision dates are listed with the most recent revision date listed first. Use MM/DD/YYYY as the format. This is a mandatory field for revisions.

All LMRPs must include the following paragraph:

"This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from [fill in appropriate specialty name]."

APPENDIX D

Selected OIG Reports on Medicare Mental Health Services

Nursing Facilities

Medicare Payments for Psychiatric Services in Nursing Homes: A Follow-up, OEI-02-99-00140

Mental Health Services in Nursing Facilities, OEI-02-91-00860

Acute Care and Psychiatric Specialty Hospitals

Review of Outpatient Psychiatric Services Provided by Provena St. Joseph Hospital for the Period September 1, 1996 through November 30, 1997, A-05-00-00034

Review of Outpatient Psychiatric Services Provided by Tomball Regional Hospital for Fiscal Year Ended June 30, 1998, A-06-99-00014

Review of Outpatient Psychiatric Services Provided by the Waterbury Hospital for the Fiscal Year Ending September 30, 1997, A-01-99-00501

Review of Outpatient Psychiatric Services Provided by the Elliot Hospital for the Fiscal Year Ending June 30, 1998, A-01-99-00502

Ten-State Review of Outpatient Psychiatric Services at Acute Care Hospitals, A-01-99-00507

Review of Outpatient Psychiatric Services Provided by the Danbury Hospital for Fiscal Year Ending September 30, 1997, A-01-99-00518

Review of Outpatient Psychiatric Services at Psychiatric Hospitals for Calender Year 1998, A-01-99-00530

Review of Outpatient Psychiatric Services Provided by St. Vincent's Hospital for Calendar Year Ended December 31, 1997, A-02-99-01010

Review of Outpatient Psychiatric Services Provided by St. Luke's-Roosevelt Hospital for Calendar Year Ended December 31, 1997, A-02-99-01016

Review of Outpatient Psychiatric Services Provided by the Franklin Medical Center for the Fiscal Year Ending September 30, 1996, A-01-98-00503

Psychiatric Outpatient Services: The Newton-Wellesley Hospital, A-01-98-00506

Psychiatric Outpatient Services: The Arbour-HRI Hospital, A-01-97-00526

Partial Hospitalization Programs

Review of Partial Hospitalization Services and Fiscal Year 1997 Cost Report - New Center Community Mental Health Services, Detroit, Michigan, A-05-00-00004

Results of Review of America's Behavioral Health Center, A-04-98-01192

Audit of the Medicare Partial Hospitalization Program at Mental Health Corporation of Denver, A-07-98-01263

Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers, A-04-98-02145

Review of Partial Hospitalization Services Provided Through Community Mental Health Centers, A-04-98-02146

Review of St. Francis Behavioral Health Center's Partial Hospitalization Program, A-04-97-02141

Review of St. Jude Behavioral Health Center's Partial Hospitalization Program, A-04-97-02142

Review of Partial Hospitalization Services and Audit of Medicare Cost Report for Community Behavioral Services, a Florida Community Mental Health Center, A-04-96-02118 and A-04-96-02124

Other Outpatient Settings: Practitioners' Offices, Community Mental Health Centers, Beneficiaries' Homes, and Custodial Care Facilities

Medicare Part B Payments for Mental Health Services, OEI-03-99-00130

APPENDIX

Comments on the Draft Report

APPENDIX

Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 29 2002

TO: Janet Rehnquist
Inspector General
Office of Inspector General

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) *Draft Report: Medicare Carrier's Policies for Mental Health Services* (OEI-03-99-00132)

Thank you for the report on the coverage criteria and documentation requirements set forth in the Medicare carriers' local medical review policies (LMRPs) for selected Part B mental health services. Your report found that some carriers did not have LMRPs for one or more of the mental health services included in your review or that variations existed within individual policies. The CMS response is outlined below.

OIG Recommendation:
We recommend that CMS require carriers to strengthen vague or incomplete sections of their local policies for mental health services and to ensure that policies adequately address all of the elements specified in the Local Medical Review Policy format (Medicare Program Integrity Manual, Exhibit 6).

CMS Response:
We concur. Over the last several years, CMS issued instructions to contractors to ensure that LMRPs are developed in an open forum, which solicits input from the local medical community, especially those directly affected by a particular LMRP. We have also instructed contractors to review their LMRPs periodically to ensure that they remain consistent with national Medicare policy as well as changes in payment and operating systems. We will further clarify these instructions to contractors by requiring that their periodic review of LMRPs include strengthening vague or incomplete sections of their local policies for all services, including mental health services.

We will share this report with our carriers and instruct them to review their policies and to revise them, as appropriate, ensuring conformance with our *Program Integrity Manual* requirements.

Comments from the American Association for Geriatric Psychiatry

March 26, 2002

Mr. George Grob
Deputy Inspector General
For Evaluation and Inspections
HHS/Office of Inspector General
Room 5660 Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Grob:

Thank you for contacting the American Association for Geriatric Psychiatry (AAGP) to allow us to provide review and comment on the draft inspection report, "Medicare Carriers' Policies for Mental Health Services."

AAGP applauds the Office of Inspector General for undertaking this review of coverage and documentation requirements set forth in Medicare carriers' local medical review policies (LMRPs) for selected Part B mental health services. This review is an important step towards development and implementation of consistent standards for all aspects of coverage for mental health services, a clear priority for AAGP.

AAGP strongly endorses the recommendation that all Medicare beneficiaries should have access to medically appropriate mental health services, that providers should adequately document these services, and that the quality and comprehensiveness of guidance furnished to mental health service providers should not vary depending on which carrier is processing payment for services. Appropriate and consistent documentation is important both to prevent inappropriate payment for services *and* to assure that patients are in fact receiving the services they need. Consistent quality and comprehensiveness of LMRPs are required not only to prevent inappropriate payment, but also to prevent inappropriate *denial* of coverage for medically necessary services. AAGP recommends that the OIG report be revised to emphasize the importance of holding carriers to a set of standards that ensures coverage for medically necessary services as required by law.

AAGP understands that this report is limited in scope. However, we are concerned that the OIG recommendation does not include

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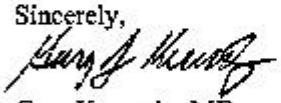
an explicit requirement that carriers meet a uniform standard in the guidance to providers. Omission of such a recommendation undermines the OIG's clearly stated principle that guidances *should not vary* by carrier. AAGP strongly recommends that carriers be required to meet a uniform national standard, or at least that a uniform standard be available for adoption by the states.

AAGP recognizes that the OIG study was designed primarily to determine the existence, comprehensiveness, and *format* of LMRPs, rather than focusing on the specific *content* of payment policies related to coverage determinations. The OIG recommendation as drafted leaves the carriers free to continue the vagaries and lack of uniformity that have made payment for mental health services, and ultimately the patients' access to those services, subject to discriminatory practices. For example, some carriers issue denials of payment for care of patients with dementia when provided by psychiatrists (e.g., using codes 331.0 or 290.0). Also, some carriers continue to apply the psychiatric reduction to coverage of medical management services (90862 and E/M codes) provided by psychiatrists. This carrier practice violates the legislative intent of OBRA 1989 and fails to comply with the instructions in the Medicare Part B Carriers Manual. AAGP urges the OIG to recommend more stringent conformity of LMRPs with the Carriers Manual, and strict enforcement of the law with regard to payment policy and determinations of coverage.

AAGP is also concerned about the risk of highly variable interpretations and potential for discriminatory practices that might result from the OIG recommendation that individual carriers consider developing specific utilization guidelines such as those pertaining to a reasonable number of services that may be billed per year. Patients treated by geriatric psychiatrists often suffer from comorbidity due to co-occurring medical and psychiatric conditions. Many of these are chronic or progressive conditions in the frail elderly, with or without acute exacerbations or medical complications, that require ongoing care. We believe it is important to prevent discrimination against the sickest patients for whom more frequent, intensive, or ongoing services are medically necessary. The risk is that utilization guidelines adopted by individual carriers will lack uniformity and may result in denial of coverage for those who need it the most. AAGP therefore recommends that the OIG delete the recommendation that individual carriers consider developing their own utilization policies based on number or frequency of services. Instead, AAGP suggests the strengthening of national standards and guidelines to promote uniformity of payment policy across carriers, consistent with both the intent of existing federal law and with scientific knowledge and clinical principles. *All* coverage policies must accommodate the medical needs of *all* geriatric patients, including those who are the most seriously ill and frail. AAGP would be pleased to assist in the development or clarification of the specific *content* of national payment policies related to coverage determinations for elderly patients who require mental health services.

Again, AAGP appreciates the opportunity to comment on this draft report. We believe that the OIG should recommend the development of a uniform standard for guidance and a requirement for their adoption by carriers. And we believe that such a uniform standard should be the beginning, not the end, of an intentional and ongoing effort to achieve uniformity in payment policy and access to mental health services for Medicare beneficiaries.

Sincerely,



Gary Kennedy, MD
President

Comments from the American Psychiatric Association

American Psychiatric Association

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March 27, 2002

George F. Grob
Deputy Inspector General for
Evaluation and Inspections
DHHS/Office of Inspector General
Room 5660
Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Deputy Inspector Grob:

On behalf of the American Psychiatric Association (APA), I want to thank you for providing our Association with the opportunity to comment on the draft inspection report "Medicare Carrier's Policies for Mental Health Services." We appreciate your positive efforts in reaching out to the APA, and view this opportunity as a concrete and important result of our December 2001 meeting.

We are certainly not surprised by the three main findings of this report:

- Some carriers did not have local medical review policies for the mental health services in our review.
- Not all carriers provided comprehensive and specific coverage criteria in their local policies for mental health services.
- Documentation requirements for therapy and pharmacologic management were also not comprehensive and consistent.

APA staff did a review of LMRPs in 1999 – 2000 and our findings were similar. As a result of that review, we have worked with CMS regional offices, carriers, local psychiatric societies, and Medicare Carrier Advisory Committee members to revise LMRPs so they will better reflect actual psychiatric practice.

We think it might have been valuable for the IG to have also included a sample from Medicare managed care programs in this study and report since many Medicare beneficiaries are covered by Medicare + Choice plans. It is important to ascertain what coverage policies, LMRPs, or review criteria are used for the Medicare beneficiaries enrolled in these programs.

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Appendix B of the draft report, "Descriptions of Mental Health Services Reviewed," provides descriptions of individual psychotherapy with and without evaluation and management (CPT-4 codes 90804 – 90809); group psychotherapy (CPT-4 code 90853); pharmacologic management (CPT-4 code 90862); and psychological testing (CPT-4 code 96100). It is unclear where the descriptions in Appendix B come from. The descriptors for individual psychotherapy CPT codes use the descriptors from the American Medical Association's CPT books for 1998 – 2002, while the descriptors for the remaining codes seem to have come from another source, perhaps from carrier LMRPs.

It is our understanding that CMS accepts the CPT- 4 codes promulgated by the AMA and their accompanying descriptors. Thus, to the extent that local carriers use different descriptors, confusion is created and the very consistency that was the intent of the CPT is undermined. In Appendix B the descriptor of 90862 is wholly at variance with the descriptor for that code provided in CPT-4. Using this appendix for reference, it would be unclear what descriptor a specific Medicare carrier was using for coding and documentation of 90862. Therefore, the report would be enhanced by the inclusion of actual LMRPs rather than the descriptors provided in Appendix B. Our analysis would have been more concrete and, hopefully, more helpful if such documents were included in the report.

The OIG might be interested to know that the APA has developed a number of educational materials and documents that address coding and documentation. The APA would be pleased to provide you with any or all of these materials. We regularly provide educational assistance and advice to our members through a variety of formats. It should be noted that the variation in LMRPs, which the OIG observed and documented, compromises our ability to effectively educate our members on matters essential to compliance with Medicare law and regulation.

The OIG's overall policy statement and recommendation for corrective action is important and merits comment. APA agrees that all Medicare beneficiaries should have access to medically appropriate mental health services, and that the quality and comprehensiveness of the guidance furnished to mental health service providers should not vary depending on which carrier is processing payment for services. While there should be uniformity in the provision of mental health services to all Medicare beneficiaries regardless of location, any documentation requirements should follow current clinical practice rather than requiring that psychiatrists change the way they practice medicine in order to comply. The APA would be

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pleased to work with CMS, Medicare Carriers and Carrier Medical Directors to develop clinically appropriate LMRPs that conform to Medicare law and regulation.

We note the IG's specific recommendations that comprehensive and detailed policies for mental health services might include:

- Specific documentation instructions requiring that basic elements such as date of service, diagnosis, symptoms, progress, and name and credentials of practitioners rendering services be recorded in patients' medical records;
- Specific utilization guidelines such as those pertaining to a reasonable number of services that may be billed per year; and
- Sample progress notes for specific types of mental health services.

APA is of the view that any documentation recommendations, including the recommendation regarding progress notes need to adhere to the Department of Health and Human Services privacy regulations and the requirements for transmitting the "minimum necessary" information for claims processing. Thus, the report needs to refer to the privacy regulations (45 CFR Parts 160 and 164) that will be finalized later this year. The APA does not support the second recommendation, that comprehensive and detailed policies for mental health services include specific utilization guidelines such as those pertaining to a reasonable number of services that may be billed per year. We note that utilization guidelines are currently optional in LMRPs and feel they should not be made mandatory. Where such guidelines do currently exist, they should serve to permit the exercise of medical judgment as to the medical necessity of specific mental health services to Medicare patients rather than serve as cutoff points where there is a presumption against medical necessity. Our experience with such guidelines is that they are usually construed to mean that services beyond the limit are de facto unnecessary.

If you have any further questions, please do not hesitate to contact APA's Nick Meyers (202) 682–6164, or Gene Cassel, (202) 682–6048 in our Division of Government Relations.

Sincerely,

Steven M. Mirin, M.D.
Medical Director

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This report was prepared under the direction of Robert A. Vito, Regional Inspector General for Evaluation and Inspections in Philadelphia, PA and Linda M. Ragone, Deputy Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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