

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**Medicare Part B Payments for  
Mental Health Services**



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OEI's Philadelphia Regional Office prepared this report under the direction of Robert A. Vito, Regional Inspector General, and Linda M. Ragone, Deputy Regional Inspector General. Principal OEI staff included:

#### **REGION**

Amy Sernyak, *Project Leader*  
Lauren McNulty, *Program Analyst*  
Tanaz Dutia, *Program Analyst*  
Stacey Uhl, *Program Analyst*

#### **HEADQUARTERS**

Bambi Straw, *Program Specialist*  
Barbara Tedesco, *Mathematical Statistician*  
Linda Moscoe, *Technical Support Staff*

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# EXECUTIVE SUMMARY

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## PURPOSE

To assess the appropriateness of Medicare Part B payments for mental health services provided to Medicare beneficiaries in the following outpatient settings: practitioners' offices, community mental health centers, beneficiaries' homes, and custodial care facilities.

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## BACKGROUND

Medicare and its beneficiaries paid an estimated \$1.2 billion for Part B mental health services in 1998. Payments for mental health services provided in outpatient settings accounted for about 62 percent of this total (\$718 million).

Part B claims for mental health services are processed and paid by Medicare carriers that contract with the Health Care Financing Administration (HCFA). 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." To date, HCFA has not established a national medical review policy for all carriers to follow in assessing the appropriateness of claims for mental health services. Rather, carriers develop local medical review policies that 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 selected a stratified random sample of 1998 claims for outpatient mental health services. The sample included claims for individual psychotherapy, group psychotherapy, psychological testing, and pharmacologic management. We collected mental health records from Medicare providers in support of sampled services. An independent medical review contractor examined the records to make determinations about the medical necessity and appropriateness of mental health services.

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## FINDINGS

### **Medicare allowed \$185 million in 1998 for inappropriate outpatient mental health services**

One-third of outpatient mental health services provided to Medicare beneficiaries were medically unnecessary, billed incorrectly, rendered by unqualified providers, and undocumented or poorly documented. For 25 percent of all sample mental health services, independent medical reviewers determined that beneficiaries' medical records

did not support claims reimbursed by Medicare. For another 6 percent of services, mental health service providers did not submit beneficiaries' medical records after three written OIG requests; and for another 3 percent of services, providers submitted a response that did not contain any medical documentation.

### **Problems were found with all types of mental health services reviewed, but psychotherapy and psychological testing were particularly problematic**

Fifty percent of group therapy and 34 percent of individual therapy services reviewed were inappropriate, along with over 40 percent of psychological testing services. To a lesser extent, we also found inappropriate pharmacologic management services and services that were rendered by unqualified providers.

### **While some beneficiaries received excessive therapy services, others did not receive needed medication management services**

Twenty-two percent of medical records revealed that patients received mental health services beyond what was medically indicated and necessary. In these cases, medical records did not justify the duration or frequency of psychotherapy services. More than 8 percent of medical records indicated that beneficiaries may not have received needed services. According to many of these records, patients who were receiving psychotherapy services should have been evaluated for psychotropic medication.

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## **RECOMMENDATIONS**

**In order to address Medicare program vulnerabilities discussed in this report, we recommend that the Health Care Financing Administration:**

- C Target problematic mental health services for pre-payment edits or post-payment medical review.**
- C Promote provider awareness of documentation and medical necessity requirements for Part B mental health services.** The HCFA and its carriers could enhance provider understanding of and compliance with Medicare requirements through seminars, education workshops, and newsletters.
- C Work with both carriers and mental health professionals to develop a specific and comprehensive listing of psychological assessments that can be correctly billed under psychological testing code 96100.** Our office made a similar recommendation in a recently issued report entitled "Medicare Payments for Psychiatric Services in Nursing Homes: A Follow-up," which found similar problems with psychological testing instruments.

- C **Require Medicare carriers to initiate recovery of payments for the inappropriate outpatient mental health services identified in this report.** Our office will provide a listing of these claims to HCFA.

## **AGENCY COMMENTS**

The Health Care Financing Administration concurred with these recommendations. The HCFA will ask Medicare carriers to conduct data analysis of mental health services provided in outpatient settings with particular attention to psychological testing and psychotherapy services. The HCFA stated that they plan to explore a number of provider educational services that will focus on issues of medical necessity, medical record documentation, provider qualifications, and appropriate billing and coding of outpatient mental health services. In addition, HCFA will have the carrier clinical workgroup on psychiatric services consider our report in developing a local medical review policy template for outpatient mental health services. Finally, HCFA will direct Medicare carriers to recover overpayments for the inappropriate services identified in our report. To assist HCFA with this effort, we have provided claim data for the inappropriate services to them. In response to HCFA's technical comment, we revised Appendix A of the report to reflect the most current Medicare provider qualifications as cited in Title 42, Part 410 of the Code of Federal Regulations. The full text of HCFA's comments is presented in Appendix E.

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# INTRODUCTION

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## PURPOSE

To assess the appropriateness of Medicare Part B payments for mental health services provided to Medicare beneficiaries in the following outpatient settings: practitioners' offices, community mental health centers, beneficiaries' homes, and custodial care facilities.

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## 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.

The Medicare program covers people under age 65 with disabilities as well as those over age 65. Over half of Medicare beneficiaries receiving mental health services in the outpatient settings we examined qualified for Medicare on the basis of disability rather than age. Fortunately, treatment interventions such as psychotherapy and medication can benefit individuals with mental illness in all age groups when tailored to meet the specific needs of each patient. 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.

### Medicare Payments for Mental Health Services

Medicare and its beneficiaries paid an estimated \$1.2 billion for Part B mental health services in 1998. Payments for mental health services provided in outpatient settings accounted for about 62 percent of this total (\$718 million). According to Medicare claims data, about 90 percent of outpatient mental health services occurred in office settings or in community mental health centers. The following services accounted for the majority of Medicare allowances for outpatient mental health services in 1998: individual psychotherapy with and without medical evaluation and management, pharmacologic management, group psychotherapy, diagnostic interview exam, and psychological testing.

While Medicare pays 80 percent of the allowed amount for most Part B services, the program pays only 50 percent of the cost for therapeutic mental health services provided in outpatient settings. Therefore, the beneficiary is responsible for a much larger Medicare co-payment for therapeutic outpatient mental health services. For diagnostic services such as psychological testing, the beneficiary is responsible for the standard 20 percent co-payment.

## **Medicare Part B Coverage of Mental Health Services**

Part B claims for mental health services are processed and paid by Medicare carriers that contract with the Health Care Financing Administration (HCFA). 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.” To date, HCFA has not established a national medical review policy for all carriers to follow in assessing the appropriateness of claims for mental health services. Rather, carriers develop local medical review policies based on Medicare coverage and documentation guidelines. These local policies describe the medical criteria beneficiaries must meet for particular mental health services to be considered medically necessary and appropriate. These policies also specify criteria for satisfactory documentation of mental health services.

**Local Medical Review Policy Coverage Criteria.** Generally, a patient must have a psychiatric illness and/or emotional or behavioral symptoms for psychiatric therapeutic procedures such as individual and group psychotherapy to be covered. Symptoms, goals of therapy, and the patient’s capacity to participate in and benefit from psychotherapy must be documented in the patient’s medical record. Psychotherapy should improve or maintain a patient’s health status and functioning. Coverage of psychotherapy does not include teaching grooming skills, monitoring activities of daily living, recreational therapy, or social interactions. Individual psychotherapy with medical evaluation and management is covered for physicians only, with exceptions in certain States for appropriately licensed nurse practitioners, clinical nurse specialists, or physician assistants.

Psychological testing is covered when it aids in determining a patient’s diagnosis and therapeutic planning. The patient’s medical record must indicate the presence or symptoms of mental illness, and document specific psychological tests performed, number of hours of testing, scoring, and interpretation of test results.

Pharmacologic management is covered for in-depth management of a patient who is taking psychotropic medications. Evidence of mental illness should be documented in the patient’s medical record, along with the patient’s response to medication, side effects, medication or dosage changes, and compliance with the medication regimen. Pharmacologic management is covered for physicians only, with exceptions in certain States for appropriately licensed nurse practitioners, clinical nurse specialists, or physician assistants.



## **Mental Health Service Providers**

According to current Medicare reimbursement guidelines, physicians, clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants are permitted to submit claims for mental health services provided to beneficiaries in outpatient settings. However, a provider must be qualified to perform the specific mental health service being billed to Medicare. Medicare definitions of these provider types are presented in Appendix A. Typically, qualified providers bill for mental health services using the Physician's Current Procedural Terminology (CPT) codes published by the American Medical Association.

## **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, and partial hospitalization programs. The OIG found that many mental health services provided to beneficiaries in nursing facilities were medically unnecessary, highly questionable, and/or poorly documented. Reports identified problems including psychotherapy provided to patients who did not have the cognitive capacity to benefit from these services, and psychological testing services that were billed incorrectly.

In addition, the OIG found that many outpatient mental health services billed by hospitals and partial hospitalization programs did not meet Medicare reimbursement requirements. These services were not supported by adequate documentation, were not medically necessary or appropriate for patients' conditions, and were not rendered by licensed personnel. A listing of OIG reports on Medicare mental health services is provided in Appendix B.

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## **METHODOLOGY**

### **Sample Design**

The sample for this inspection consisted of outpatient individual psychotherapy services with and without evaluation and management; group psychotherapy services; pharmacologic management services; and psychological testing services. We included these services when provided in the following settings: practitioners' offices, community mental health centers, beneficiaries' homes, and custodial care facilities. We did not include services provided in partial hospitalization programs. Definitions of sample procedure codes are presented in Appendix C.

We designed a sample with five strata based on type and place of service. We selected a stratified random sample of 650 claims from a 1 percent file of paid 1998 Part B claims. This 1 percent file was created from HCFA's 1998 National Claims History file, which was 98 percent complete at the time of sample selection. After eliminating 8 claims for

providers under review by the Office of Investigations, our working sample consisted of 642 claims. A description of the sample is presented in Table 1 below.

**Table 1. Outpatient Mental Health Services Sample**

Strata	Description	Sampling Frame	Selected Sample	Working Sample
1	Home and Custodial Care Facility Claims	5,057	175	170
2	Psychological Testing Claims	402	100	100
3	Group Psychotherapy Claims	7,789	70	69
4	75-80 Minute Psychotherapy Claims	1,794	85	85
5	All Other Claims	81,414	220	218
<b>TOTAL</b>		<b>96,456</b>	<b>650</b>	<b>642</b>

## Data Collection and Analysis

We collected data from Medicare providers and a medical review contractor from February 2000 to August 2000. We also collected local medical review policies for mental health services from Medicare carriers. Point estimates and confidence intervals for all statistics presented in the findings of this report are provided in Appendix D.

**Local Medical Review Policies.** Since HCFA has not established a national medical review policy for mental health services, we requested local medical review policies for mental health services from each of the Medicare carriers. We systematically reviewed these policies to determine coverage and documentation requirements among the carriers.

**Medical Records.** Using HCFA's Unique Provider Identification Number (UPIN) database, we identified the names and addresses for the providers of the sample outpatient mental health services. We mailed providers written requests for Medicare beneficiaries' medical records in support of sample services. Specifically, we requested each beneficiary's initial psychiatric evaluation; psychological test results; all notes and documentation specific to the sample service; notes and documentation of services provided to the beneficiary three months prior to and three months after the sample date of service; and copies of providers' State licenses. We sent a follow-up request to providers who did not respond to the initial request. A third and final request informed non-respondents that, for the purposes of our study, we would consider sample services undocumented if beneficiaries' records were not submitted.

We received responses for 547 of the 642 mental health services in our working sample. Of these responses, 14 contained no supporting medical documentation and were, therefore, considered inappropriate. Three responses were in Spanish and four were submitted after the data collection cutoff date. We did not consider these seven services to be inappropriate. The remaining 526 responses were forwarded to a medical review contractor.

We did not receive responses for 95 mental health services. For 52 of the 95 services, provider addresses in the UPIN database were inaccurate, and our requests for medical documentation were returned as undeliverable. We did not consider these services to be inappropriate. However, for the other 43 services, providers did not submit medical records after 3 written requests. We deemed these services to be inappropriate.

**Medical Review.** We forwarded 526 mental health records to an independent medical review contractor for evaluation of medical necessity and appropriateness. For each beneficiary, we also included a listing of all 1998 outpatient mental health claims for sampled procedure codes. Mental health professionals employed by the contractor conducted the medical review of sample services using a data collection instrument jointly developed by OIG and the contractor. We developed this medical review instrument using guidelines common among Medicare carriers' local medical review policies. The instrument included questions regarding symptoms, diagnosis, treatment goals and progress, medications, time spent with the patient, provider type, and provider qualifications.

Three registered nurses and a master's-level psychologist used the medical review instrument to examine the mental health records. These first-level reviewers recorded information about the appropriateness of the mental health services provided and the nature of the supporting documentation. When first-level reviewers identified questionable mental health services or documentation, the records were provided to the appropriate second-level reviewer, either a psychiatrist or clinical psychologist.

Fifty-eight percent of the records (303 of 526) were referred to a second-level reviewer. The second-level reviewers determined whether beneficiaries' records supported the sample mental health services that were billed to the Medicare program; and used the medical review instrument to record determinations about medical necessity, appropriateness of the services billed, provider qualifications, and documentation. These reviewers also examined beneficiaries' medical records and claim histories to determine if beneficiaries received more services than necessary, or were in need of services that were not provided.

**Computation of Allowances for Inappropriate Services.** To compute Medicare payments for inappropriate services, we totaled the allowed amounts for all inappropriate services and weighted the estimate to reflect our stratified sample design. However, we used *adjusted* allowed amounts in our calculation for 62 outpatient mental health services. For 59 individual psychotherapy services, medical reviewers determined that the service billed was inappropriate, but a shorter individual therapy session was substantiated. In these cases, only the difference in allowances for these services was included in the calculation. For three psychological testing services, reviewers determined that fewer hours of testing should have been billed. Again, we included only the difference between the allowed amount for the number of hours actually billed and the amount that would have been allowed for fewer hours of psychological testing.

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

# FINDINGS

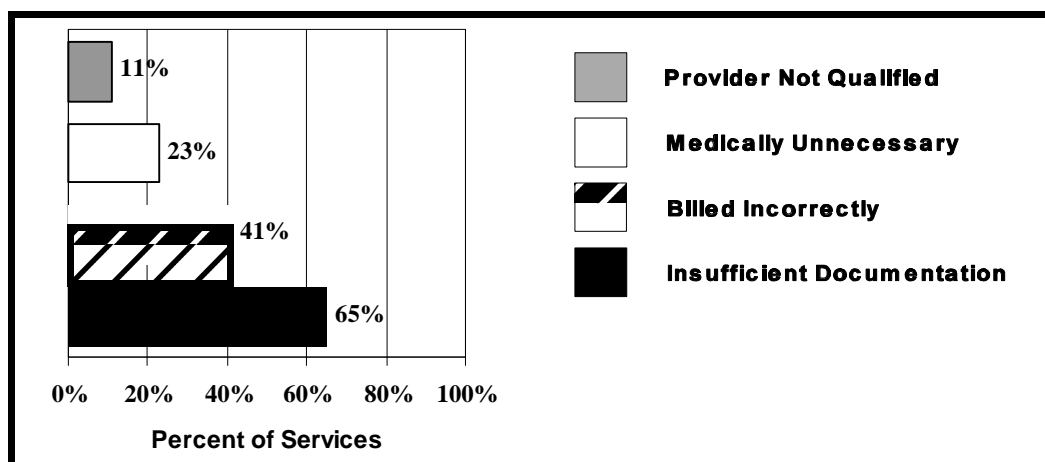
## Medicare allowed \$185 million in 1998 for inappropriate outpatient mental health services

One-third of outpatient mental health services provided to Medicare beneficiaries were medically unnecessary, billed incorrectly, rendered by unqualified providers, and undocumented or poorly documented. Payments for these inappropriate services totaled an estimated \$185 million, which represents 31 percent of the \$598 million reimbursed in 1998. The estimate of \$185 million includes beneficiary co-payments of 20 percent or 50 percent, depending on the type of service.

For 25 percent of all sample mental health services, independent medical reviewers determined that beneficiaries' medical records did not support claims reimbursed by Medicare. For 6 percent of services, mental health service providers did not submit beneficiaries' medical records after three written OIG requests. For another 3 percent of services, providers submitted responses that did not contain any medical documentation.

The following information pertains to the 25 percent of sample mental health services that were not supported by patients' records. Medical reviewers classified these inappropriate services into four general categories. As shown in Chart 1 below, 23 percent of these services were not medically necessary. Forty-one percent of services were billed incorrectly since providers billed Medicare for non-covered services, billed using the wrong code, or billed excessively. Eleven percent of services were rendered by providers who were not qualified to perform the services. Finally, 65 percent of services were insufficiently documented because medical records lacked critical information about patients' conditions and details of the care provided. Many services were inappropriate for more than one of these reasons.

Chart 1. Medical Review Determinations for Inappropriate Mental Health Services\*



\* Percentages sum to over 100% because many services had more than one type of problem

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## **Problems were found with all types of mental health services reviewed, but psychotherapy and psychological testing were particularly problematic**

While 16 percent of pharmacologic management services were inappropriate, between one-third and one-half of psychotherapy and psychological testing services were inappropriate. In addition, one out of every nine inappropriate services was rendered by an unqualified provider.

### **Half of the group psychotherapy services reviewed were inappropriate**

Fifty percent of group psychotherapy services were deemed inappropriate for one or more reasons. Medical records indicated that Medicare paid for group therapy that was non-covered, medically unnecessary, and/or poorly documented.

About 40 percent of inappropriate group therapy services were non-covered services such as “social activity,” “exercise and discussion,” “community skills,” and “reality orientation” groups. Carriers’ local medical review policies specify that socialization, recreational activities, excursions, sensory stimulation, meals, and the like do not constitute group psychotherapy. In one inappropriate case, a therapist ran social activity groups rather than group psychotherapy. Activities included games, music, picnics, and sewing.

Over one-quarter of inappropriate group psychotherapy services were not medically necessary because patients lacked the cognitive or communication skills necessary to participate in and benefit from group therapy; or because group psychotherapy was not the appropriate treatment for patients.

Over half of inappropriate group therapy services were not adequately documented. Beneficiaries’ medical records lacked one or more critical elements including treatment plans and goals, progress in treatment, documentation of diagnosis and ability to participate in group therapy, and information about the content of group sessions. Some of the group therapy progress notes reviewed were very brief, or used “canned” language to describe each group session. Documentation for a few inappropriate group sessions did not include any evidence of who rendered the group psychotherapy services.

### **Thirty-four percent of individual therapy services reviewed were inappropriate**

Over one-third of individual psychotherapy services were inappropriate for two main reasons: extended length sessions were not justified, and documentation of individual therapy sessions lacked critical elements.

For most 75 to 80 minute individual therapy services, documentation in patients’ records did not substantiate medical necessity, and practitioners did not provide justifications for treating patients with extended psychotherapy sessions. Carrier guidelines set forth

special documentation requirements for extended length individual psychotherapy services. These services “should not be routinely used. They are reserved for exceptional circumstances. The provider must document in the patient’s medical record the medical necessity of these services and define the exceptional circumstances.” Reviewers indicated that shorter therapy sessions of 45 to 50 minutes, or 20 to 30 minutes, were documented and medically indicated in most of these cases.

In addition to inappropriate extended length therapy services, documentation of individual therapy lacked critical elements. Some therapy notes were very brief, including a case where notes for several psychotherapy sessions merely stated “same.” Patient records lacked treatment plans and goals, and evidence of patients’ diagnoses and progress. Progress notes for inappropriate services were often illegible and unsigned. As with group psychotherapy, documentation for a few individual therapy services also contained “canned” language, some of which appeared to be computer-generated. A number of inappropriate individual psychotherapy services with medical evaluation and management were not sufficiently documented. Patient records reflected therapy only, with no documentation of the evaluation and management component; or medication management only, with no documentation of therapy.

### **Over 40 percent of psychological testing services were billed incorrectly and poorly documented**

Overall, 42 percent of the psychological testing services reviewed were inappropriate. Almost half of these inappropriate services consisted mainly of self-administered, self-scored, or cognitive function screening tests like the Beck Depression Inventory, the Geriatric Depression Scale, the McGill Overall Pain Scale, and the Folstein Mini-Mental Status Exam. While carriers’ policies do not contain comprehensive lists of psychological tests that are correctly billed under psychological testing code 96100, most state that this code should not be billed for self-administered or self-scored instruments, or for screening tests of cognitive function. These types of assessments are considered to be part of a clinical interview or evaluation and management service, and are not reimbursed separately.

Some psychological testing services were not sufficiently documented. Patients’ medical records lacked the amount or type of information necessary to support psychological testing claims. Records for about one-third of inappropriate psychological testing services did not include a written report interpreting beneficiaries’ test results and making treatment recommendations. However, carriers’ guidelines, as well as the CPT definition of psychological testing, require providers to prepare such a report. Medical records for a few inappropriate psychological testing services contained computer-generated reports, but our medical reviewer did not consider these reports to be adequate without additional written interpretation by the provider. Additionally, documentation of some inappropriate psychological testing services did not indicate who administered the psychological tests to patients.

## **Sixteen percent of pharmacologic management services were inappropriate**

Pharmacologic management services were deemed inappropriate because providers failed to record important elements in beneficiaries' charts, such as diagnosis, target symptoms, treatment goals, response to medication, side effects, and the like. In addition, reviewers were unable to determine who rendered some of these pharmacologic management services because progress notes were not initialed or signed.

Some inappropriate pharmacologic management services were provided by registered nurses who were not qualified to render these services to Medicare beneficiaries. In two of these cases nurses dispensed methadone to patients, without any documentation that physicians provided face-to-face drug management services. Carriers' guidelines explicitly state that the pharmacologic management CPT code "is not to be used for the actual administration of medication or the observation of a patient taking oral medication."

## **Eleven percent of inappropriate mental health services were rendered by unqualified providers**

Patients' records for these inappropriate services indicated that registered nurses, mental health and substance abuse counselors, master's-level, and bachelor's-level practitioners rendered mental health services that they were not qualified to provide. In addition, billing providers failed to supply rendering practitioners' licenses to perform mental health services in many of these cases. Almost half of services rendered by unqualified providers were group psychotherapy services. For two inappropriate group therapy services, providers actually acknowledged that group therapy was rendered by unlicensed practitioners. In another case, a social worker rendered individual therapy with medical evaluation and management, a service clearly outside the social worker's scope of practice.

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## **While some beneficiaries received excessive therapy services, others did not receive needed medication management services**

For the 303 cases referred for more extensive review, 22 percent of medical records indicated that patients had received more mental health services than they needed. Another 8 percent of records indicated that patients were in need of mental health services that may not have been provided.

## **Twenty-two percent of medical records revealed that patients received mental health services beyond what was medically indicated and necessary**

In many of these cases, medical records did not justify the duration or frequency of psychotherapy services. A number of chronic but stable patients received the same type of psychotherapy service on a weekly or even daily basis without justification. Some patients received individual and group psychotherapy services weekly; yet documentation did not demonstrate the need for this amount of therapy, or for both individual and group treatment. For example, a patient attended two to three individual therapy sessions per week in addition to once-per-week group therapy. In an extreme case, a provider billed for 67 extended individual psychotherapy services in 1998 without documentation of need for the 75 to 80 minute sessions, or the frequency of treatment.

Both place and type of mental health service affected whether beneficiaries received more mental health services than necessary. Excessive services were more likely to occur when provided in patients' homes and community mental health centers. Excessive services were also more likely to occur when the service reviewed was group psychotherapy.

## **More than 8 percent of medical records indicated that beneficiaries may not have received needed services**

Reviewers found that a number of patients who were receiving psychotherapy services should have been evaluated for psychotropic medication. Patients' medical records did not contain evidence that providers had considered medication as treatment for their mental disorders, nor were pharmacologic management services billed to Medicare for any of these patients in 1998. In addition, longer or more frequent individual psychotherapy services were indicated for a few patients due to their severe symptoms, but were not provided. Finally, for two psychological testing cases additional testing should have been performed to determine patients' diagnoses.



# RECOMMENDATIONS

In order to address Medicare program vulnerabilities discussed in this report, we recommend that the Health Care Financing Administration:

- C **Target problematic mental health services for pre-payment edits or post-payment medical review.**
- C **Promote provider awareness of documentation and medical necessity requirements for Part B mental health services.** The HCFA and its carriers could enhance provider understanding of and compliance with Medicare requirements through seminars, education workshops, and newsletters.
- C **Work with both carriers and mental health professionals to develop a specific and comprehensive listing of psychological assessments that can be correctly billed under psychological testing code 96100.** Our office made a similar recommendation in a recently issued report entitled “Medicare Payments for Psychiatric Services in Nursing Homes: A Follow-up,” which found similar problems with psychological testing instruments.
- C **Require Medicare carriers to initiate recovery of payments for the inappropriate outpatient mental health services identified in this report.** Our office will provide a listing of these claims to HCFA.

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## AGENCY COMMENTS

The Health Care Financing Administration concurred with these recommendations. The HCFA will ask Medicare carriers to conduct data analysis of mental health services provided in outpatient settings with particular attention to psychological testing and psychotherapy services. The HCFA stated that they plan to explore a number of provider educational services that will focus on issues of medical necessity, medical record documentation, provider qualifications, and appropriate billing and coding of outpatient mental health services. In addition, HCFA will have the carrier clinical workgroup on psychiatric services consider our report in developing a local medical review policy template for outpatient mental health services. Finally, HCFA will direct Medicare carriers to recover overpayments for the inappropriate services identified in our report. To assist HCFA with this effort, we have provided claim data for the inappropriate services to them. In response to HCFA’s technical comment, we revised Appendix A of the report to reflect the most current Medicare provider qualifications as cited in Title 42, Part 410 of the Code of Federal Regulations. The full text of HCFA’s comments is presented in Appendix E.

## Medicare Provider Requirements

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### Physicians

A qualified physician must be a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a chiropractor, a doctor of podiatric medicine, or a doctor of optometry who is licensed by the State in which services are performed. Services are covered only if the particular type of medical practitioner is operating within the scope of his or her license. [Code of Federal Regulations, Title 42, Part 410, Section 20(b)]

### Clinical Psychologists

To qualify as a clinical psychologist, a practitioner must hold a doctoral degree in psychology; and be licensed or certified at the independent practice level, by the State in which he or she practices, to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals. [Code of Federal Regulations, Title 42, Part 410, Section 71(d)]

### Clinical Social Workers

A qualified clinical social worker must possess a master's or doctoral degree in social work; have performed at least two years of supervised clinical social work; and be licensed or certified as a clinical social worker by the State in which services are performed. In a State that does not provide for licensing or certification as a clinical social worker, an individual must be licensed or certified at the highest level of practice provided by law in the State where services are performed; and have completed at least two years or 3,000 hours of post-master's degree supervised clinical social work under the supervision of a master's-level social worker in an appropriate setting such as a hospital, skilled nursing facility, or clinic. [Code of Federal Regulations, Title 42, Part 410, Section 73(a)]

### Nurse Practitioners

A qualified nurse practitioner must be a registered professional nurse authorized to practice as a nurse practitioner by the laws of the State where services are performed, and certified by a recognized national certifying body that has established standards for nurse practitioners; or a registered professional nurse authorized to practice as a nurse practitioner by the laws of the State where services are performed who has received a Medicare billing number as a nurse practitioner by December 31, 2000; or a nurse practitioner who meets the standards described above and applies for a Medicare billing number for the first time on or after January 1, 2001; or a nurse practitioner who meets the standards described above, has a master's degree in nursing, and applies for a Medicare billing number for the first time on or after January 1, 2003. [Code of Federal Regulations, Title 42, Part 410, Section 75(b)]

**Clinical Nurse Specialists**

To qualify as a clinical nurse specialist, a practitioner must be a registered nurse currently licensed by the State where services are performed and authorized to perform clinical nurse specialist services in accordance with State law; have a master's degree in a defined clinical area of nursing from an accredited educational institution; and be certified by the American Nurses Credentialing Center as a clinical nurse specialist. [Code of Federal Regulations, Title 42, Part 410, Section 76(b)]

**Physician Assistants**

A qualified physician assistant must be licensed by the State to practice as a physician assistant, as well as have graduated from a physician assistant educational program accredited by the Commission on Accreditation of Allied Health Education Programs, or have passed the national certification exam administered by the National Commission on Certification of Physician Assistants. [Code of Federal Regulations, Title 42, Part 410, Section 74(c)]

## OIG Reports on Medicare Mental Health Services

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### 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 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 Calendar 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

Reviews 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

## Sample Procedure Codes

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### Individual Psychotherapy

Procedures 90804 through 90809 are defined as the treatment of mental illness and behavior disturbances in which the physician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

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

### Group Psychotherapy

- 90853 Psychotherapy administered in a group setting (other than of a multiple-family group) with a trained group leader in charge of several patients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight and support.

## Psychological Testing

96100 Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour. Code 96100 includes the administration, interpretation and scoring of tests mentioned in the CPT description and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation and other factors influencing treatment and prognosis.

## Pharmacologic Management

90862 Code 90862 is intended for use by the physician who is prescribing pharmacologic therapy for a patient with an organic brain syndrome or whose diagnosis is in the ICD-9 range of 290.0-319, and is being managed primarily by psychotropic drugs. It may also be used for the patient whose psychotherapy is being managed by another health professional and the billing physician is managing the psychotropic medication. The service includes prescribing, monitoring the effect of medication, and adjusting the dosage. Any psychotherapy provided is minimal and is usually supportive only.

**Estimates and Confidence Intervals**

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## Estimates and Confidence Intervals

The tables below contain statistical estimates presented in the Findings section of this report. We used the Survey Data Analysis (SUDAAN) software package to compute percentages, totals, and confidence intervals. These estimates are weighted based on the stratified random sample design and are reported at the 95 percent confidence level.

**Table 1.**  
**Inappropriate Outpatient Mental Health Services**

	<b>Point Estimate</b>	<b>95% Confidence Interval</b>
Total Medicare Allowances in 1998 for Inappropriate Outpatient Mental Health Services	\$185,287,513	\$151,251,639 - \$219,323,387
Percent of Inappropriate Outpatient Mental Health Services	33.58%	28.27% - 38.89%
Percent of Sample Services Not Supported by Beneficiaries' Medical Records	25.22%	20.36% - 30.08%
Percent of Sample Services where No Response was Submitted	5.61%	3.06% - 8.16%
Percent of Sample Services where Response Contained No Documentation	2.74%	0.86% - 4.62%

**Table 2.**  
**Medical Review Determinations for Inappropriate Services**

	<b>Percent of Services</b>	<b>95% Confidence Interval</b>
Provider Not Qualified	11.03%	4.29% - 17.77%
Medically Unnecessary	22.64%	13.74% - 31.54%
Billed Incorrectly	40.80%	29.61% - 51.99%
Insufficient Documentation	64.87%	54.07% - 75.67%

**Table 3.**

**Frequency of Inappropriate Services  
by Type of Mental Health Service**

	<b>Percent of Services</b>	<b>95% Confidence Interval</b>
Group Psychotherapy	50.03%	37.33% - 62.73%
Individual Psychotherapy	34.09%	26.45% - 41.73%
Psychological Testing	41.98%	31.18% - 52.78%
Pharmacologic Management	15.65%	6.87% - 24.43%

Difference between percentages is significant at above the 95% confidence level. (Chi-square statistic=22.98, df=3, p<0.0001)

**Table 4.**

**Frequency of Inappropriate Individual  
Psychotherapy Services by Length of Session**

<b>Length of Individual Psychotherapy Session</b>	<b>Percent of Services</b>	<b>95% Confidence Interval</b>
20-30 Minutes	29.67%	14.73% - 44.61%
45-50 Minutes	33.40%	24.09% - 42.71%
75-80 Minutes	82.09%	73.51% - 90.67%

Difference between percentages is significant at above the 95% confidence level. (Chi-square statistic=56.97, df=2, p<0.0001)

**Table 5.**

**Beneficiaries Received More Services Than Necessary**

	<b>Percent of Cases</b>	<b>95% Confidence Interval</b>
Referred Cases where Beneficiaries Received More Services than Necessary	22.49%	15.65% - 29.33%

**Table 6.**

**More Services Than Necessary  
by Place of Service**

	<b>Percent of Cases</b>	<b>95% Confidence Interval</b>
Home	41.67%	25.52% - 57.82%
Community Mental Health Center	40.87%	22.45% - 59.29%
Custodial Care Facility	25.00%	7.63% - 42.37%
Office	17.24%	9.77% - 24.71%

Difference between percentages is significant at above the 95% confidence level. (Chi-square statistic=10.27, df=3, p=0.017)

**Table 7.**

**More Services Than Necessary  
by Type of Mental Health Service**

	<b>Percent of Cases</b>	<b>95% Confidence Interval</b>
Group Psychotherapy	38.34%	24.87% - 51.81%
Individual Psychotherapy without Evaluation and Management	20.27%	9.98% - 30.56%
Pharmacologic Management	20.10%	0.68% - 39.52%
Individual Psychotherapy with Evaluation and Management	19.75%	6.15% - 33.35%
Psychological Testing	4.17%	0 - 9.85%

Difference between percentages is significant at above the 95% confidence level. (Chi-square statistic=22.52, df=4, p=0.0002)

**Table 8.**

**Beneficiaries May Not Have Received Needed Services**

	<b>Percent of Cases</b>	<b>95% Confidence Interval</b>
Referred Cases where Beneficiaries May Not Have Received Needed Services	8.45%	3.82% - 13.08%

**Health Care Financing Administration Comments**

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DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator  
Washington, D.C. 20201

DATE: APR 26 2001

TO: Michael F. Mangano  
Acting Inspector General

FROM: Michael McMullan   
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Part B Payments for Mental Health Services* (OEI-03-99-00130)

Thank you for the opportunity to review the above-mentioned OIG draft report concerning inappropriate payments in 1998 for outpatient mental health services. The report reveals that one-third of outpatient mental health services (OMHS) provided to Medicare beneficiaries were either medically unnecessary, billed incorrectly, rendered by unqualified providers, or were undocumented or poorly documented in records. Psychotherapy and psychological testing services were the most problematic areas identified in the study. We believe the report provides an important contribution to our efforts to maintain the financial integrity of the Medicare program.

In order to address the problems discovered with mental health services, we are going to share this report with our Medicare carriers and request that they conduct data analysis specific to OMHS, particularly in the areas of psychological testing and psychotherapy. Based upon the results of the data analysis, the carriers will perform probe reviews to determine whether additional, in-depth reviews will be indicated for those providers whose business practices were identified as aberrant. In addition, we will refer this report to the carrier clinical workgroup on psychiatric services for its consideration as to whether to develop a local medical review policy (LMRP) template.

#### OIG Recommendation

The Health Care Financing Administration (HCFA) should target problematic mental health services for pre-payment edits or post-payment medical review.

#### HCFA Response

We concur. We will share the report with the Medicare carriers and ask them to conduct data analysis specific to OMHS and particularly in the areas of psychological testing and psychotherapy. Based upon the results of the data analysis the carriers will perform probe reviews to determine whether more in-depth review is indicated for those providers whose business practices were identified as aberrant.

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OIG Recommendation

HCFA should promote provider awareness of documentation and medical necessity requirements for Part B mental health services.

HCFA Response

We concur. We see a need for provider education in the areas of correct billing procedures for mental health services and what Medicare defines as a qualified mental health provider. More specifically, we intend to explore the following provider educational services under current funding sources:

- A web-based training module designed to educate providers on the issues of medical necessity of services, medical record documentation, definition of a qualified provider under Medicare guidelines and appropriate billing/coding procedures. (Continuing Education Unit credits may be available to providers who take this course.)
- The design of a web page to be located on the Medlearn web site, to serve as the learning resource for providers ([www.hcfa.gov/medlearn](http://www.hcfa.gov/medlearn)). This web page will provide information to providers on mental health including links to: Medicare regulations, carrier and fiscal intermediary (FI) web sites, program memoranda, Surgeon General reports, OIG reports, and various mental health organizations. We will maintain the web page with input from HCFA's subject matter experts.
- We also have an existing video product, approximately 15-20 minutes in length, featuring Dr. David Satcher, and discussing depression in the elderly. Dr. Satcher reviews the signs and symptoms of depression, treatment, and prevention of depression, and the Healthy People 2010 goals. Additionally, Dr. Satcher talks with two Medicare beneficiaries about how they maintain an active life style.
- The design and development of articles that will educate providers on the issues regarding mental health services. These articles can be placed in contractor bulletins and posted on the Medlearn web site. We can also make these articles available to state licensing boards (targeting physicians, nurses, physician assistants (PAs), nurse practitioners (NPs), and clinical social workers (CSWs). The state licensing boards may want to put these articles in their newsletters.
- The design and development of a brochure educating providers on the issues regarding mental health services. These brochures can be distributed at various conferences attended by HCFA.

OIG Recommendation

HCFA should work with both carriers and mental health professionals to develop a specific and comprehensive listing of psychological assessments that can be correctly

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billed under code 96100.

HCFA Response

We concur. We will refer this report to the carrier clinical workgroup on psychiatric services for its consideration to develop an LMRP template.

OIG Recommendation

HCFA should require Medicare carriers to initiate recovery of payments for the inappropriate OMHS identified in this report. Our office will provide a listing of these claims to HCFA.

HCFA Response

We concur. HCFA will direct the Medicare FIs and carriers identified in the report to recover the overpayments for the inappropriate OMHS identified in this report. The report in question is a draft and will not be sent to the regional offices (ROs) at this time. After issuance of the final report, OIG will be required to furnish the data necessary (provider numbers, claims information, health insurance claim numbers, etc.) for the Medicare contractors to initiate and complete recovery action. At that time, we will forward to the ROs for appropriate action the final report and information needed by the Medicare contractors to recover the overpayments. We will also forward the identity of the OIG person to be contacted if any questions arise.

Attachment

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Technical Comments

We would note that this OIG investigation sampled claims for OMHS furnished by physicians, clinical psychologists, CSWs, NPs, clinical nurse specialists, and PAs. Accordingly, the report contains a list of the Medicare qualifications for these individuals under Appendix A. However, not all of the qualifications are current. Therefore, OIG should refer to the following regulatory citations for the most current respective qualifications. They are as follows:

CPs – 42 CFR 410.71(d)  
CSWs – 42 CFR 410.73(a)  
NPs – 42 CFR 410.75(b)  
CNSs – 42 CFR 410.76(b)  
PAs – 42 CFR 410.74(c)