

**Memorandum**

MAR 27 2000

Date

From

Michael Mangano
June Gibbs Brown
Inspector General

Subject

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

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final audit report entitled, "Ten-State Review of Outpatient Psychiatric Services at Acute Care Hospitals." The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements.

We selected for review claims from acute care hospitals in the 10 States with the highest volume of outpatient psychiatric claims. The States selected were California, Connecticut, Florida, Illinois, Louisiana, Massachusetts, Michigan, New York, Pennsylvania, and Texas. We then identified 473,976 outpatient psychiatric claims valued at \$381,941,152 (77 percent of the nationwide total) in Calendar Year (CY) 1997 from the acute care hospitals in these 10 States. We then statistically selected for review 200 claims from the 10 States which totaled \$168,857. These services were charged on behalf of patients in partial hospitalization programs (PHP) and other outpatient psychiatric programs. Our analysis showed that \$94,716 of these charges did not meet Medicare criteria for reimbursement. In this regard, these services were:

- ✓ not documented in accordance with Medicare requirements,
- ✓ not reasonable and necessary, and/or
- ✓ rendered by unlicensed personnel.

Further analysis showed that of the \$94,716 found in error, \$51,889 were associated with PHP services and \$42,828 were associated with other outpatient psychiatric services. We estimate, based on our statistical sample, that for CY 1997 acute care hospitals submitted claims to Medicare totaling \$224,466,692 (approximately 58.8 percent of the amount claimed) for unallowable or unsupported outpatient psychiatric services in the 10 States reviewed.

We recommended that the Health Care Financing Administration (HCFA):

- ① Consider implementing a first claim medical review of a random sample of new outpatient psychiatric service claims to ensure that Medicare program requirements are met.
- ② Require Medicare fiscal intermediaries (FI) to increase post-payment reviews of outpatient psychiatric service claims.
- ③ Require Medicare FIs to initiate recovery of payments for claims found in error.
- ④ Further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, education sessions, and newsletters.

In response to our draft report (see APPENDIX B), HCFA generally concurred with our recommendations, except for the first recommendation. The HCFA believed that a first claim medical review of all new outpatient psychiatric claims would not be cost beneficial because of the volume of claims involved. We acknowledge HCFA's concern and modified our recommendation to consider a random sample of new outpatient psychiatric claims rather than all new claims. With regard to recommendations 2 through 4, HCFA concurred. Specifically, HCFA is instructing its contractors to 1) increase the data analysis of psychiatric outpatient claims and increase the level of medical review based on the result, 2) recover any funds paid in error, and 3) educate providers on proper documentation through education sessions, bulletins, and seminars. The HCFA is also currently changing the methodology for reimbursing hospital outpatient services. These changes will include new program safeguard instructions and approaches.

In conjunction with our 10-State review, we are also conducting audits of 10 specific hospital outpatient psychiatric programs. These audits are ongoing and their results will be reported separately. During these audits, we found indications of problems with unsupported and medically unnecessary services similar to those discussed in this report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-99-00507 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**TEN-STATE REVIEW OF
OUTPATIENT PSYCHIATRIC SERVICES
AT ACUTE CARE HOSPITALS**



JUNE GIBBS BROWN
Inspector General

MARCH 2000
A-01-99-00507

EXECUTIVE SUMMARY

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. Medicare requirements define outpatient services as "Each examination, consultation or treatment received by an outpatient in any service department of a hospital...." Medicare further requires that charges reflect reasonable costs and services provided be supported by medical records. These records must contain sufficient documentation to justify the treatment provided. Hospital costs for such services are generally for providing the services of staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis based on submitted charges. At year end, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final reimbursement.

The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements. We used the Health Care Financing Administration's (HCFA) Decision Support Access Facility (DSAF) to identify 712,184 claims from acute care hospitals for outpatient psychiatric services valued at \$494,969,700 nationwide in Calendar Year (CY) 1997. We selected for review claims from acute care hospitals in the 10 States with the highest volume of outpatient psychiatric claims. The States selected were California, Connecticut, Florida, Illinois, Louisiana, Massachusetts, Michigan, New York, Pennsylvania, and Texas. We then identified 473,976 outpatient psychiatric claims valued at \$381,941,152 (77 percent of the nationwide total) in CY 1997 from the hospitals in these 10 States.

We statistically selected for review 200 claims which totaled \$168,857 from acute care hospitals in the 10 States. These services were charged on behalf of patients in partial hospitalization programs (PHP) and other outpatient psychiatric programs. Our analysis showed that \$94,716 of these charges did not meet Medicare criteria for reimbursement. In this regard, these services were:

- ✓ not documented in accordance with Medicare requirements,
- ✓ not reasonable and necessary, and/or
- ✓ rendered by unlicensed personnel.

Further analysis showed that of the \$94,716 found in error, \$51,889 were associated with PHP services and \$42,828 were associated with other outpatient psychiatric services. We estimate, based on our statistical sample, that for CY 1997 acute care hospitals submitted claims to Medicare totaling \$224,466,692 (approximately 58.8 percent of the amount claimed) for unallowable or unsupported outpatient psychiatric services in the 10 States reviewed.

The Office of Inspector General (OIG) also conducted reviews of PHP services provided by community mental health centers (CMHC) (CINs A-04-98-02145 and A-04-98-02146). These reports discussed findings similar to those OIG found in the acute care hospital setting. In this

regard, we determined that many CMHCs provided services that were not reasonable and necessary and claimed costs in their cost reports that were unallowable, unreasonable, and unnecessary. The HCFA agreed with our findings and implemented a 10-point initiative to address the problems that HCFA and OIG identified with the PHP benefit. As part of its initiative, HCFA is conducting a broad evaluation of the PHP benefit in both CMHCs and hospital outpatient departments.

We recommended that HCFA :

- ❶ Consider implementing a first claim medical review of a random sample of new outpatient psychiatric service claims to ensure that Medicare program requirements are met.
- ❷ Require Medicare FIs to increase post-payment reviews of outpatient psychiatric service claims.
- ❸ Require Medicare FIs to initiate recovery of payments for claims found in error.
- ❹ Further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, education sessions, and newsletters.

In response to our draft report (see APPENDIX B), HCFA generally concurred with our recommendations, except for the first recommendation. The HCFA believed that a first claim medical review of all new outpatient psychiatric claims would not be cost beneficial because of the volume of claims involved. We acknowledge HCFA's concern and modified our recommendation to consider a random sample of new outpatient psychiatric claims rather than all new claims. With regard to recommendations 2 through 4, HCFA concurred. Specifically, HCFA is instructing its contractors to 1) increase the data analysis of psychiatric outpatient claims and increase the level of medical review based on the result, 2) recover any funds paid in error, and 3) educate providers on proper documentation through education sessions, bulletins, and seminars. The HCFA is also currently changing the methodology for reimbursing hospital outpatient services. These changes will include new program safeguard instructions and approaches.

In conjunction with our 10-State review, we are also conducting audits of 10 specific hospital outpatient psychiatric programs. These audits are ongoing and their results will be reported separately. During these audits, we found indications of problems with unsupported and medically unnecessary services similar to those discussed in this report. We are also reviewing cost report issues during these audits and found that some costs claimed by the hospitals are inappropriate. For example, we found unallowable costs such as transportation, meals, and self-administered drugs as well as costs not related to patient care claimed by the hospitals for reimbursement in their cost reports. As HCFA moves towards reimbursing outpatient services on a prospective payment system, it should take a pro-active role in auditing outpatient psychiatric costs at acute care hospitals to ensure the validity of base-rate data.

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INTRODUCTION

BACKGROUND

The Medicare program established by Title XVIII of the Social Security Act (Act) provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by HCFA. Under section 1862 (a)(1)(A), the Act excludes coverage for services, including outpatient psychiatric services, which are not medically reasonable and necessary for the diagnosis or treatment of illness or injury. Outpatient psychiatric services are generally provided by hospital employees such as staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers.

The HCFA promulgated a variety of criteria which clearly delineate the Medicare requirements for the payment of benefits. In this regard:

- ◇ Psychiatric services must be “...reasonable and necessary for the diagnosis or treatment of a patient’s condition...Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.” [Medicare Intermediary Manual section 3112.7]

- ◇ “...A medical record must be maintained for every individual evaluated or treated in a hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.” [42 CFR §482.24]

In addition, for patients receiving PHP level-of-care,

- ◇ “It is reasonable to expect the plan of treatment to be established within the first 7 days of a patient’s participation in the program, and periodic reviews to be performed at least every 31 days thereafter.” [HCFA Program Memorandum, Publication 60A]

- ◇ A physician must certify and recertify that "...The individual would require inpatient psychiatric care in the absence of such services...." Further, "This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted." [HCFA Program Memorandum, Publication 60A]

Based on HCFA payment data in CY 1997, acute care hospitals submitted 712,184 claims totaling \$494,969,700 for outpatient psychiatric services. Outpatient psychiatric service claims are submitted for units of service rendered and are paid on an interim basis, based on charges submitted to the Medicare FIs. These claims are subject to Medicare deductible and coinsurance provisions. The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. At year end, the hospital submits a cost report to the Medicare FI for final settlement.

OBJECTIVE, SCOPE, AND METHODOLOGY

We conducted our audit in accordance with generally accepted government auditing standards. The objective of this review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements. Our review covered claims with dates of service during CY 1997.

We limited consideration of the internal control structure to claims submission for outpatient psychiatric services as our review did not require an understanding or assessment of the complete internal control structure at the hospitals whose claims were included in our sample.

To accomplish our objective, we:

- ◇ reviewed criteria related to outpatient psychiatric services,
- ◇ used HCFA's DSAF to identify 712,184 claims for outpatient psychiatric services valued at \$494,969,700 nationwide in CY 1997,
- ◇ used the DSAF to identify 473,976 outpatient psychiatric claims valued (charges) at \$381,941,152 in CY 1997 from acute care hospitals in the 10 States with the highest volume of outpatient psychiatric claims,
- ◇ employed a simple random sample approach to randomly select a statistical sample of 200 outpatient psychiatric claims from acute care hospitals in the 10 States,

- ◇ performed detailed audit testing on the billing and medical records for the 200 claims selected in the sample,
- ◇ utilized medical review staff from peer review organizations with responsibilities in the 10 States selected to review each of the 200 outpatient psychiatric claims,
- ◇ used a variable appraisal program to estimate the dollar impact of improper payments in the total population (see APPENDIX A),
- ◇ provided the FIs with the results of our claim reviews for their review and adjudication, and
- ◇ met with appropriate HCFA personnel at HCFA's central office.

Our field work was conducted from January 1999 through March 1999 at acute care hospitals located in the 10 States of California, Connecticut, Florida, Illinois, Louisiana, Massachusetts, Michigan, New York, Pennsylvania, and Texas.

Our draft report was issued to HCFA on June 21, 1999. The HCFA's response to the draft report, dated January 21, 2000 is appended to this report (see APPENDIX B) and comments to our recommendations are addressed on pages 12 through 13.

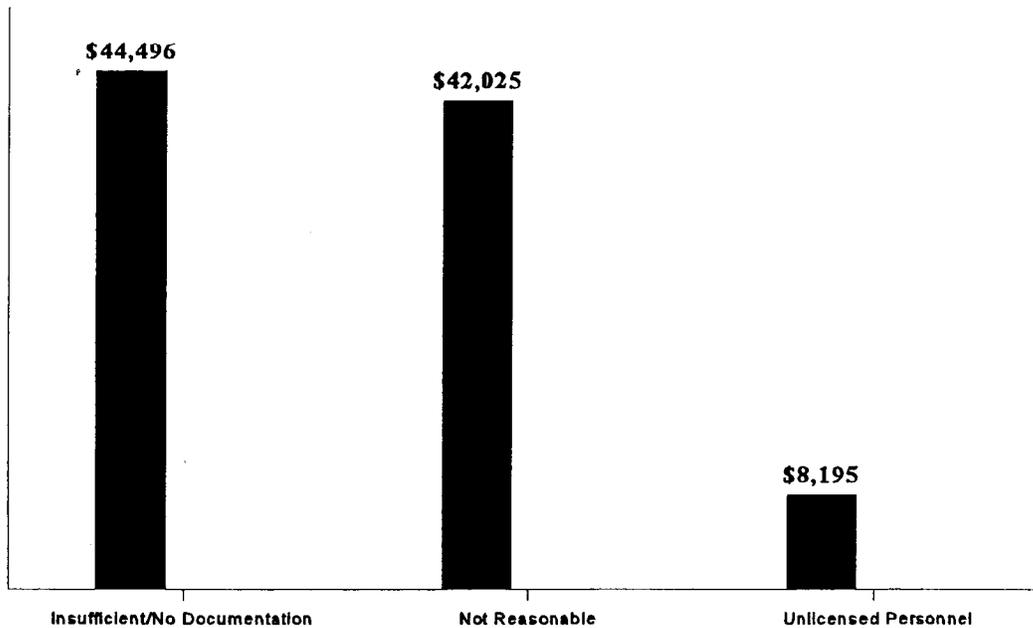
FINDINGS AND RECOMMENDATIONS

We estimate that for CY 1997, acute care hospitals billed Medicare approximately \$224 million (approximately 58.8 percent of the amount claimed) for unallowable or unsupported PHP and other outpatient psychiatric services in the 10 States reviewed. The acute care hospitals in these 10 States represented \$381,941,152 or about 77 percent of the \$494,969,700 claimed nationwide in CY 1997.

We statistically selected 200 claims for review totaling \$168,857. Of these, we found that \$94,716 did not meet Medicare reimbursement requirements. In this regard, these services were:

- ✓ not documented in accordance with Medicare requirements,
- ✓ not reasonable and necessary, and/or
- ✓ rendered by unlicensed personnel.

Types and Amounts in Error From Sample Results



Further analysis showed that of the \$94,716 found in error, \$51,889 were associated with PHP services and \$42,828 were associated with other outpatient psychiatric services¹.

PARTIAL HOSPITALIZATION PROGRAM

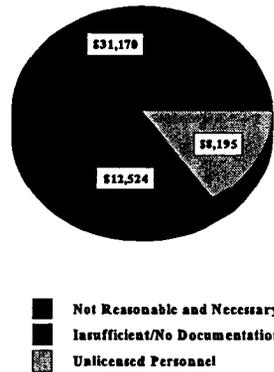
Section 1861(ff)(1) of the Act defines PHP services as being prescribed and furnished under the supervision of a physician. Further, section 1861(ff)(2) of the Act states that PHP services are those mental health services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition and are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization. Section 1835(a)(2)(F) of the Act requires physicians to certify that patients would otherwise require inpatient psychiatric care.

For Medicare purposes, PHPs provide a comprehensive structured program of services that are specified in an individualized treatment plan which is formulated by a physician and the multi-disciplinary team with the patient's involvement. Patients who require a low frequency of participation, in which case the PHP is no longer reasonable and necessary, may be managed in an outpatient or office setting on a less intense and less frequent basis.

¹Numbers may not add exactly due to rounding.

When claiming reimbursement for PHP services, providers are required to inform the Medicare FIs that the claim is specifically for PHP services. In this regard, the provider must report a condition code 41 on the claim to indicate the claim is for PHP services. We determined that our sample contained 38 claims for PHP services totaling \$100,897. Of these, 24 claims totaling \$73,141 were coded by the hospitals as PHP services. However, an additional 14 claims totaling \$27,756 were determined by medical reviewers as PHP services, but were not coded as such by the hospitals. Although this omission had no effect on reimbursement, it would effect HCFA and the FIs' ability to monitor PHP utilization.

Error Categories For PHP Services



Based on our review, we determined that 22 claims² for 428 services totaling \$51,889 were claimed in error as not reasonable and necessary, unsupported, or rendered by unlicensed personnel. Findings from our review of medical records supporting the PHP claims are described in detail below.

Services Not Reasonable and Necessary

During the course of our review, we found that 10 claims for 271 services totaling \$31,170 were not reasonable and necessary for the treatment of the patient's condition. Errors in this category include situations where there was sufficient documentation in the medical record to allow the medical review staff to make an informed decision that the medical services or products were not medically necessary.

Section 1862(a)(1)(A) of the Act states that no payment shall be made for any services which "...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

²The total number of claims found in error is less than the total derived by adding the number of claims by error categories. In this regard, individual claims may have multiple services claimed on them and accordingly, multiple reasons for denial. We included each claim in every error category used to deny the services on the claim. This results in some claims being counted more than once if the number of claims by error category is summed.

Examples of services that were found not reasonable and necessary include:

A claim for \$4,865 in which medical reviewers determined that the beneficiary was receiving partial hospitalization services, but did not suffer from a psychiatric condition. Instead, the beneficiary had a broken arm and poor gait. The medical reviewer noted that "Conclusion: I do not think her work up indicates that she meets the diagnostic criteria for Major Depression and any decrease in functional ability/capacity seems primarily to be related to her orthopaedic problem and not a direct result of any ongoing psycho pathology."

We also found an instance where the beneficiary was enrolled by the hospital in a PHP, but according to the medical reviewer did not require the intensity of services. Specifically:

A claim in which medical reviewers determined that the number of group therapies charged for a beneficiary were excessive given the patient's condition. Specifically, the medical reviewer noted that two visits per week rather than the four to five visits per week claimed would have been sufficient given the patient's condition.

It should be noted that while we were unable to quantify the effect of reducing the amount of therapy for the beneficiaries, only a small number of claims were reported in this category.

Services Not Documented In Accordance With Medicare Requirements

We also determined during the course of our review that there were instances in which there was either no documentation or insufficient documentation in a medical record to support the claimed service. In this regard, we found that 14 claims for 104 services totaling \$12,524 were not adequately supported by documentation in the medical record.

The 42 CFR, §482.24 states that, "...A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services."

The 42 CFR, §424.24(e) requires that a plan of treatment contain, "...The physician's diagnosis; the type, amount, duration, and frequency of the services; and the treatment goals under the plan."

No Documentation

The errors in this category include situations when a provider cannot locate documentary support for specific services. In this regard, we found 55 services totaling \$6,816 for which no documentation was provided. Examples include:

At several hospitals, staff were unable to locate a progress note in patient's chart which corresponded to the services in our sample or the medical record was not provided to OIG.

Insufficient Documentation

This category includes situations where the medical record contained some documentation for the services in the sample but such documentation is determined to be inconclusive to support the rendered services. Accordingly, based on the medical records provided, the medical reviewers could not conclude that some of the allowed services were actually rendered, provided at the level billed, and/or medically necessary. In this regard, we found 49 services totaling \$5,709 for which insufficient documentation was provided.

For example:

Multiple instances in which treatment plans did not indicate the type, frequency, duration, or goals of the therapy claimed or progress notes did not indicate what was discussed or accomplished.

In another example:

A claim for 6 days of group therapy totaling \$1,632 submitted by an acute care hospital. The medical reviewer noted that "...the documentation for 21 hours billed as 90857 on 2/3, 2/4, 2/5, 2/6, 2/13 and 2/27 is quite extraordinarily limited. There is no indication of what was discussed, accomplished, analyzed, worked through in each separate group, what were the intents, aims, purposes, etc." We specifically noted that in this case, the progress notes for group therapy were limited to incomplete check lists.

Without complete medical record documentation, including a description of what took place in a therapy session, the patient's interaction with group members, his/her progress compared to the treatment plan goals, and future plans of treatment, the appropriateness of the patient's level of care is unclear. Further, inadequate documentation of patient therapies and treatments provided little guidance to physicians and therapists to guide future treatment.

Services Rendered By Unlicensed Personnel

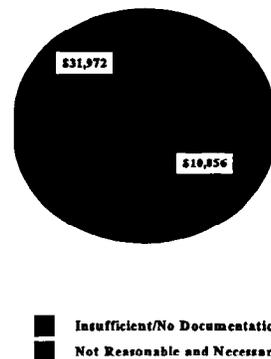
We also determined that some of the PHP services reviewed were rendered by unlicensed personnel. Medicare law, regulation, and policy prohibit coverage for services by unlicensed personnel.

According to section 1861(ii) of the Act, qualified psychologist services only include those “...which the psychologist is legally authorized to perform under State law....” During the course of our review, we found one claim which included 53 services totaling \$8,195 performed by an individual not licensed by the State to render psychological care. Therefore, these services were not reimbursable and should not have been claimed.

OTHER OUTPATIENT PSYCHIATRIC SERVICES

There are a wide range of services and programs that hospitals may provide to their outpatients who need psychiatric care, ranging from a few individual services to the comprehensive PHP services previously discussed. In order for outpatient psychiatric services to be covered, they must be provided under an individualized treatment plan established by a physician after any needed consultation with appropriate staff members. The services must also be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. In addition, the treatment must, at a minimum, be designed to reduce or control the patient’s psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient’s level of functioning.

Error Categories For Other Psychiatric Services



Based on our review, we determined that 85 claims³ containing 398 services totaling \$42,828 were claimed in error as unsupported or unreasonable. Findings from our review of medical records supporting the other psychiatric service claims are described in detail below.

Services Not Documented In Accordance With Medicare Requirements

Our review disclosed that a significant percentage of other outpatient psychiatric services were not documented in accordance with Medicare requirements. Many of the errors in this category include situations where the medical record consisting of some documentation for the services in the sample but such documentation was determined to be inconclusive to support the rendered services. Accordingly, based on the medical records provided, the medical reviewers could not conclude that some of the allowed services were actually rendered, provided at the level billed, and/or medically necessary. In this regard, we determined that 81 claims for 335 services valued at \$31,972 were not documented in accordance with Medicare requirements.

³The total number of claims found in error is less than the total derived by adding the number of claims by error categories. In this regard, individual claims may have multiple services claimed on them and accordingly, multiple reasons for denial. We included each claim in every error category used to deny the services on the claim. This results in some claims being counted more than once if the number of claims by error category is summed. However, it does not duplicate the dollar amount in error.

The 42 CFR, §482.24 states that, "...A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services."

The Medicare Intermediary Manual section 3112.7 states that, "...Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals."

Insufficient Documentation

This category includes situations where the medical record contains some documentation for the services in the sample but such documentation was determined to be inconclusive to support the rendered services. Accordingly, based on the medical records provided, the medical reviewers could not conclude that some of the allowed services were actually rendered, provided at the level billed, and/or medically necessary. In this regard, we found 239 services totaling \$25,381 for which insufficient documentation was provided. An example in this category includes:

A hospital that submitted a claim for nine group therapy sessions totaling \$1,062. The medical reviewer noted, however, that "Facility billed for nine units of group therapy but progress notes supports only seven units. Group modality not identified and no frequency of group therapy indicated. Treatment plan is missing required elements."

No Documentation

The errors in this category include situations when a provider could not locate documentary support for a specific claim. In this regard, we found 96 services totaling \$6,591 for which no documentation was provided. Examples include:

A claim that was filed for psychological testing totaling \$1,013. A review of the medical record showed there was no documentation for psychological testing for the date on the claim. In fact, only documentation in the medical record for psychological testing was from 1993.

In another instance, the medical record was not provided to support the claimed services totaling \$440 as the hospital had declared bankruptcy just prior to OIG's site visit.

Without complete medical record documentation, including a description of what took place in a therapy session, including the patient's interaction with group members, his/her progress compared to the treatment plan goals, and future plans of treatment, the appropriateness of the patient's level of care is unclear. Further, inadequate documentation of patient therapies and treatments provided little guidance to physicians and therapists to guide future treatment.

Services Not Reasonable and Necessary

During the course of our review, we found that 7 claims for 63 services totaling \$10,856 were not reasonable and necessary for the treatment of the patient's condition. Errors in this category include situations where there was sufficient documentation in the medical record to allow the medical review staff to make an informed decision that the medical services or products were not medically necessary.

The Medicare Intermediary Manual, section 3112.7 identifies a wide range of services a hospital may provide to outpatients who need psychiatric care. For such services to be covered, they must be "...reasonable and necessary for the diagnosis or treatment of the patient's condition."

An example of services found not medically necessary include:

Medical reviewers determined in one instance that the number of electroconvulsive therapy (ECT) treatments claimed by a hospital was excessive. Specifically, the hospital billed 12 ECTs over a 2-day period totaling \$1,641, but the medical reviewer felt that only 1 treatment was medically necessary given the patient's condition.

CONCLUSION

During CY 1997, acute care hospitals submitted 712,184 claims totaling \$494,969,700 for outpatient psychiatric services. We randomly selected 200 claims which totaled \$168,857 from acute care hospitals in the 10 States which comprised \$381,941,152 (77 percent) of the nationwide total. Extrapolating the results of the statistical sample over the population from the 10 States using standard statistical methods, we estimate that acute care hospitals claimed \$224,466,692 for potentially unallowable or unsupported outpatient psychiatric services. The precision of this estimate at the 90 percent confidence level is ± 33.64 percent (see APPENDIX A).

The OIG also conducted reviews of PHP services provided by CMHCs (CINs A-04-98-02145 and A-04-98-02146). These reports discussed findings similar to those OIG found in the acute care hospital setting. In this regard, we determined that many CMHCs provided services that were not reasonable and necessary and claimed costs in their cost reports that were unallowable, unreasonable, and unnecessary. The HCFA agreed with our findings and implemented a 10-point initiative to address the problems that HCFA and OIG identified with the PHP benefit. As part of its initiative, HCFA is conducting a broad evaluation of the PHP benefit in both CMHCs and

hospital outpatient departments. We support HCFA's efforts and will continue to work with them to determine how the PHP benefit should be restructured and redefined for the Medicare program.

RECOMMENDATIONS

We recommended that HCFA :

- ① Consider implementing a first claim medical review of a random sample of new outpatient psychiatric service claims to ensure that Medicare program requirements are met.
- ② Require Medicare FIs to increase post-payment reviews of outpatient psychiatric service claims.
- ③ Require Medicare FIs to initiate recovery of payments for claims found in error.
- ④ Further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, education sessions, and newsletters.

AUDITEE RESPONSE AND OIG COMMENTS

Auditee Response

The HCFA, in its comments dated January 21, 2000 (see APPENDIX B), generally concurred with our recommendations, except for the first recommendation. The HCFA believed that a first claim medical review of all new outpatient psychiatric claims would not be cost beneficial because of the volume of claims involved. With regard to recommendations 2 through 4, HCFA concurred. Specifically, HCFA is instructing its contractors to:

- increase the data analysis of psychiatric outpatient claims and increase the level of medical review based on the result;
- recover any funds paid in error; and
- educate providers on proper documentation through education sessions, bulletins, and seminars.

In addition, HCFA is currently changing the reimbursement mechanism for hospital outpatient services, including psychiatry, in accordance with the Balanced Budget Act of 1997. This new payment methodology will be implemented in July 2000. As part of this new system, HCFA is developing program safeguard instructions and approaches to be implemented along with the new payment system.

The HCFA also provided technical comments regarding our draft report.

OIG Comments

We have reviewed HCFA's comments and agree that a first claim review of all outpatient psychiatric service claims would be difficult. However, we still believe that a random sample of both PHP and other outpatient psychiatric services would be beneficial in proactively identifying problems in documentation and medical necessity.

We commend HCFA's efforts towards implementing their new outpatient prospective payment system. However, the results of this audit and others like it indicate significant errors with current outpatient reimbursements. The HCFA should be aware of this and make adjustments to the base year costs as appropriate.

With respect to HCFA's technical comments, we have made changes to the report, where appropriate.

OTHER MATTERS

In conjunction with our 10 State review, we are also conducting audits of specific hospital outpatient psychiatric programs. These audits are ongoing and their results will be reported separately. During these audits, we are finding indications that some costs claimed by the hospitals are inappropriate. For example, we found unallowable costs such as transportation, meals, and self-administered drugs as well as costs not related to patient care claimed by the hospitals for reimbursement in their cost reports. As HCFA moves towards reimbursing outpatient services on a prospective payment system, it should take a pro-active role in auditing outpatient psychiatric costs at acute care hospitals to ensure the validity of base-rate data.

APPENDICES

TEN-STATE REVIEW OF
OUTPATIENT PSYCHIATRIC SERVICES
AT ACUTE CARE HOSPITALS

STATISTICAL SAMPLE INFORMATION

POPULATION

Items: 473,976
Dollars: \$381,941,152

SAMPLE

Items: 200 Claims
Dollars: \$168,857

ERRORS

Items: 108
Dollars: \$94,716

PROJECTION OF SAMPLE RESULTS

Precision at the 90 Percent Confidence Level

Point Estimate: \$224,466,692
Lower Limit: \$148,962,942
Upper Limit: \$299,970,441

The Administrator
Washington, D.C. 20201

DATE: JAN 21 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Ten-State Review of Outpatient Psychiatric Services at Acute Care Hospitals," (A-01-99-00507)

Thank you for the opportunity to review and comment on the above-subject draft report. The report is the result of a 10-state review of psychiatric services rendered on an outpatient basis at acute care hospitals to determine if psychiatric services were billed and reimbursed in accordance with Medicare requirements.

Outpatient psychiatric services are provided to beneficiaries in a wide variety of settings including hospital outpatient departments (OPDs), practitioner's offices and community mental health centers (CMHCs). Last year we launched a 10-point plan to address improper payments in CMHCs. As part of that 10-point plan we have undertaken a comprehensive review of Medicare's mental health benefits delivered in all settings for the purpose of developing appropriate recommendations for change. We have also required our contractors to intensify efforts in protecting against improper payments for partial hospitalization programs (PHP), including PHP services delivered in hospital OPDs. And we have conducted training sessions for our contractors on understanding the PHP benefit and how to review claims.

However, there are important differences between the problems found in billing for PHP services in CMHCs and the problems found in OPDs. As a result, we have developed customized solutions for each of these settings.

First, the OIG documented that poor documentation was the primary reason for improper payment in OPDs, rather than the eligibility of the beneficiary (as was the case in CMHC's). As has been demonstrated in the Chief Financial Officer's Act audits of HCFA finances between 1996 and 1998, poor documentation is a problem that can be overcome with intense education, review and attention by both HCFA and providers. Second, CMHCs can only bill for PHP services for Medicare beneficiaries, while OPDs

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may bill for PHP services as well as a range of other outpatient psychiatric services. Hence, an error in billing for PHP services may be primarily one of coding (that is, proper claims submission would have resulted in non-PHP psychiatric services being billed) rather than payment. Third, unlike CMHCs, hospital OPDs are surveyed and subject to conditions of participation.

As a result we are instructing our contractors to:

- educate providers on proper documentation through education sessions, bulletins, and seminars.
- increase the data analysis of psychiatric OPD claims and increase the level of medical review based on the results
- recover any funds paid in error

We are also pursuing fundamental changes in payments for hospital outpatient services, as required by the Balanced Budget Act of 1997. The new payment system will apply to hospital outpatient psychiatric services, including PHP. The new payment system will be implemented in July, 2000. As part of our comprehensive plan for program integrity, we are developing program safeguards instructions and approaches to be implemented alongside the new payment system.

Our specific comments on the report recommendations are attached. We look forward to working with OIG staff to address many of these issues.

Attachment

Attachment

OIG Recommendation

HCFA should consider implementing a first claim medical review of new outpatient psychiatric service claims.

HCFA Response

We do not concur. After thorough consideration of this recommendation, we do not believe an edit to initiate first claim review would be cost beneficial because of the volume of claims involved. Unlike a partial hospitalization program (PHP) which has specific eligibility requirements and is an intensive intervention for a specific population who would otherwise require hospitalization, outpatient psychiatric services are appropriate for a wide range of beneficiaries. Additionally, there is no report finding regarding ineligibility; rather, poor documentation is cited as a problem which should be addressed through provider education.

OIG Recommendation

HCFA should require Medicare FIs to increase post-payment reviews of outpatient psychiatric service claims.

HCFA Response

We concur. On June 2, 1999, PHP training for the FIs was held in Atlanta. The focus was to help medical review staff understand the psychiatric benefit and how to medically review the claims. This training was attended by 84 people. Additionally, effective October 1, 1999, we increased the level of PHP claim review for community mental health centers (CMHCs) in 5 states, and increased the level of both CMHC and outpatient PHP claims review in all states.

OIG Recommendation

HCFA should require FIs to initiate recovery of payments for claims found in error.

HCFA Response

We fully agree with the recommendation to recover any funds which have been paid in error and will follow through with the FIs to ensure this occurs.

OIG Recommendation

HCFA should further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, education sessions, and newsletters.

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HCFA Response

We concur. We will request that the FIs use their newsletters, bulletins, and contractor staff education contacts to emphasize and clarify the documentation requirements. We will also request that the FIs emphasize the need for proper coding of PHP claims in the acute outpatient setting.