

**Memorandum**

Date DEC 4 2000

From June Gibbs Brown  
Inspector General *June G Brown*

Subject Review of Outpatient Psychiatric Services at Psychiatric Hospitals for Calendar Year 1998  
(A-01-99-00530)

To Michael Hash  
Acting Administrator  
Health Care Financing Administration

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's final audit report entitled, "Review of Outpatient Psychiatric Services at Psychiatric Hospitals for Calendar Year 1998." The objective of this review was to determine whether psychiatric services rendered on an outpatient basis at psychiatric hospitals were billed for and reimbursed in accordance with Medicare requirements.

We estimate that for Calendar Year (CY) 1998, psychiatric hospitals in the 10 locations reviewed submitted claims for approximately \$57 million in unallowable or unsupported outpatient psychiatric services. We reviewed 200 statistically selected claims from psychiatric hospitals located in California, Connecticut, the District of Columbia, Florida, Illinois, Louisiana, Massachusetts, New York, Pennsylvania, and Texas. These locations were selected as having the largest dollar volume of outpatient psychiatric services at psychiatric hospitals nationwide. In this regard, these 10 locations accounted for nearly \$149 million, or 82 percent of the approximately \$182 million claimed for these services nationwide in CY 1998.

The 200 claims reviewed, totaling \$180,153 were for services charged on behalf of patients in partial hospitalization programs (PHP) and for other outpatient psychiatric services. Our review showed that \$75,413 of these charges (involving 88 claims) did not meet Medicare criteria for reimbursement. In this regard, these services were:

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

Further analysis showed that of the \$75,413 found in error, \$56,434 were associated with PHP services and \$18,979 were associated with other outpatient psychiatric services. We also noted that medical reviewers considered an additional 7 claims (not part of the 88 claims noted above) for 169 PHP services totaling \$20,236 as not reasonable and necessary. The medical reviewers indicated, however, that some level of outpatient

psychiatric care would have been allowable, but not at the intensity of a PHP. They could not specifically quantify the amount of appropriate care. We, therefore, have not included these seven claims as improper payments. Thus, the above estimated \$57 million in unallowable or unsupported services is understated.

We recommended that the Health Care Financing Administration (HCFA): (1) require Medicare fiscal intermediaries (FI) to increase post-payment reviews of outpatient psychiatric service claims; (2) require Medicare FIs to initiate recovery of payments for claims found in error; and (3) further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, educational sessions, and newsletters.

In response to our draft report (see APPENDIX B), HCFA concurred with our recommendations. Specifically, HCFA is instructing FIs to: (1) enact new program safeguard instructions and approaches during implementation of the hospital outpatient prospective payment system; (2) recover any funds paid in error; and (3) use their newsletters, bulletins, and contractor staff education contacts to emphasize and clarify documentation requirements.

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-01-99-00530 in all correspondence relating to this report.

Attachments

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT  
PSYCHIATRIC SERVICES AT  
PSYCHIATRIC HOSPITALS FOR  
CALENDAR YEAR 1998**



**JUNE GIBBS BROWN  
Inspector General**

**NOVEMBER 2000  
A-01-99-00530**

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## EXECUTIVE SUMMARY

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The Medicare program reimburses psychiatric 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 settlement.

The objective of our review was to determine whether psychiatric services rendered on an outpatient basis by psychiatric hospitals 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 202,158 claims from psychiatric hospitals for outpatient psychiatric services valued at \$182,091,709 nationwide in Calendar Year (CY) 1998. We selected for review claims from the 10 locations with the highest dollar volume of outpatient psychiatric claims. The locations selected included California, Connecticut, the District of Columbia, Florida, Illinois, Louisiana, Massachusetts, New York, Pennsylvania, and Texas. We then identified 150,998 outpatient psychiatric claims valued at \$148,961,271 (82 percent of the nationwide total) in CY 1998 from these 10 locations.

We statistically selected for review 200 claims which totaled \$180,153 for the 10 locations. These services were charged on behalf of patients in partial hospitalization programs (PHP) and other outpatient psychiatric programs. Our analysis showed that \$75,413 of these charges (involving 88 claims) did not meet Medicare criteria for reimbursement. In this regard, these services were:

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

Further analysis showed that of the \$75,413 found in error, \$56,434 was associated with PHP services and \$18,979 was associated with other outpatient psychiatric services. We also noted that medical reviewers considered an additional 7 claims (not part of the 88 claims noted above) for 169 PHP services totaling \$20,236 as not reasonable and necessary. The medical reviewers indicated, however, that some level of outpatient psychiatric care would have been allowable, but not at the intensity of a PHP. They could not specifically quantify the amount of appropriate care. We, therefore, have not included these seven claims as improper payments. Thus, the estimated \$57 million in unallowable or unsupported services is understated.

We estimate, based on our statistical sample, that for CY 1998 psychiatric hospitals submitted claims to Medicare totaling \$56,936,287 (approximately 38.2 percent of the amount claimed) for unallowable or unsupported outpatient psychiatric hospital services in the 10 locations reviewed.

## **RECOMMENDATIONS**

We recommended that HCFA :

- ① Require Medicare FIs to increase post-payment reviews of outpatient psychiatric service claims.
- ② Require Medicare FIs to initiate recovery of payments for claims found in error.
- ③ Further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, educational sessions, and newsletters.

In response to our draft report (see APPENDIX B), HCFA concurred with our recommendations. Specifically, HCFA is instructing FIs to: (1) enact new program safeguard instructions and approaches during implementation of the hospital outpatient prospective payment system; (2) recover any funds paid in error; and (3) use their newsletters, bulletins, and contractor staff education contacts to emphasize and clarify documentation requirements.

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## INTRODUCTION

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### **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 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." [HCFA Medicare Intermediary Manual 3112.7]
  
- ◇ "The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution." [42 CFR 482.61]

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 claims data for CY 1998, psychiatric hospitals submitted 202,158 claims totaling \$182,091,709 for outpatient psychiatric services. Claims for outpatient psychiatric services 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 psychiatric 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 at psychiatric hospitals were billed for and reimbursed in accordance with Medicare requirements. Our review covered claims with dates of service during CY 1998.

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 202,158 claims for outpatient psychiatric hospital services valued at \$182,091,709 nationwide in CY 1998,
- ◇ used the DSAF to identify 150,998 outpatient psychiatric claims valued at \$148,961,271 in CY 1998 from psychiatric hospitals in the 10 locations with the highest dollar volume of outpatient psychiatric claims,
- ◇ employed a simple random sample approach to select a statistical sample of 200 outpatient psychiatric claims from the 10 locations,
- ◇ 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 locations 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), and
- ◇ provided FIs with the results of our claim reviews for their review and adjudication.

Our field work was conducted from September 1999 to March 2000 at psychiatric hospitals located in the 10 locations of California, Connecticut, the District of Columbia, Florida, Illinois, Louisiana, Massachusetts, New York, Pennsylvania, and Texas.

Our draft report was issued to HCFA on July 24, 2000. The HCFA's response to the draft report, dated October 20, 2000, is appended to this report (see APPENDIX B) and HCFA's technical comments are addressed on page 11.

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## **FINDINGS AND RECOMMENDATIONS**

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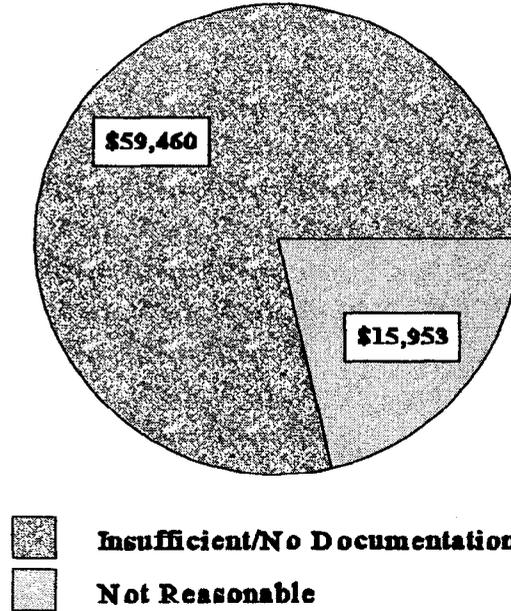
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We estimate that for CY 1998 psychiatric hospitals billed Medicare approximately \$57 million (approximately 38.2 percent of the amount claimed) for unallowable or unsupported PHP and other outpatient psychiatric services in the locations reviewed. The psychiatric hospitals in these 10 locations represented \$148,961,271 or about 82 percent of the \$182,091,709 claimed nationwide in CY 1998.

We statistically selected 200 claims for review totaling \$180,153. Of these, we found that \$75,413 in 88 claims did not meet Medicare reimbursement requirements. In this regard, these services were:

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

### **Types and Amounts in Error From Sample Results**



Further analysis showed that of the \$75,413 found in error, \$56,434 were associated with PHP services and \$18,979 were associated with other outpatient psychiatric services. We also noted that medical reviewers considered an additional 7 claims (not part of the 88 claims noted above) for 169 PHP services totaling \$20,236 as not reasonable and necessary. The medical reviewers indicated, however, that some level of outpatient psychiatric care would have been allowable, but not at the intensity of a PHP. They could not specifically quantify the amount of appropriate care. We, therefore, have not included these seven claims as improper payments. Thus, the above estimated \$57 million in unallowable or unsupported services is understated.

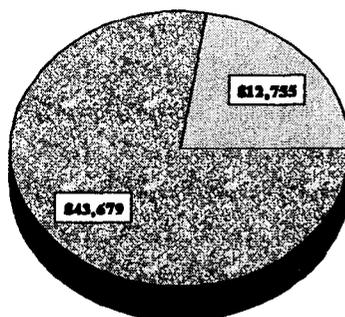
### ***PARTIAL HOSPITALIZATION PROGRAM***

Section 1861(ff)(1) of the Act defines PHP services as being prescribed by 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, 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.

### Error Categories For PHP Services



Not Reasonable  
 Insufficient/No Documentation

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 56 claims for PHP services totaling \$125,414. Of these, 41 claims totaling \$88,825 were coded by the hospitals as PHP services. However, an additional 15 claims totaling \$36,589 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's and FIs' ability to monitor PHP utilization.

Based on our review, 39 claims<sup>1</sup> for 620 services totaling \$56,434 were for services which were determined to be unsupported and/or not reasonable and necessary. Findings from our review of medical records supporting the PHP claims are described in detail below.

#### Services Not Documented in Accordance With Medicare Requirements

We 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 23 claims for 522 services totaling \$43,679 were not adequately supported by documentation in the medical record.

The 42 CFR 482.61 states that, "The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution."

The 42 CFR 482.61(c) further requires that a plan of treatment include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of

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<sup>1</sup>The total number of claims found in error was 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. This does not, however, effect the number of units or dollars found in error.

each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

### ***Insufficient Documentation***

This category includes situations where the medical record contained 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 511 services totaling \$42,009 for which insufficient documentation was provided. Examples in this category include:

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

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A claim for 14 days of group and individual therapy totaling \$1,803. The medical reviewer noted that "...the documentation is extremely limited. For the week of 11/14/98, for example, there is none [documentation] for each group attended. There is an overall weekly note, which attempts to cover all groups and is insufficient for that purpose...."

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### ***No Documentation***

The errors in this category include situations where a provider could not locate documentary support for specific services. In this regard, we found 11 services totaling \$1,670 for which no documentation was provided.

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 treatment provides little guidance to physicians and therapists to guide future treatment.

### **Services Not Reasonable and Necessary**

During the course of our review, we found that 16 claims for 98 services totaling \$12,755 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 services provided 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."

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

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A claim for \$1,606 which included \$380 for music and movement therapy. The medical reviewers noted that "Music and movement not necessary for treatment of condition."

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A claim for \$1,803 which included \$455 for group therapy. The medical reviewers noted that "It is reasonable to ask why this person is even being treated with intensive group therapy, when it is apparent from the discharge summary that, for the most part, he could tolerate no more than fifteen minutes and often, none at all."

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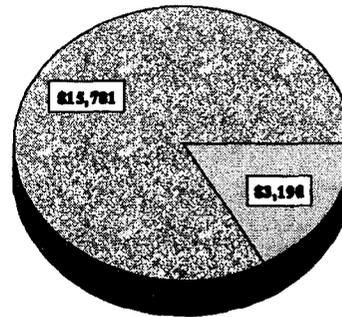
We also noted that medical reviewers considered an additional 7 claims for 169 services totaling \$20,236 as not reasonable and necessary. The medical reviewers indicated, however, that some level of outpatient psychiatric care would have been allowable, but not at the intensity of a PHP. They could not specifically quantify the amount of appropriate care. We, therefore, did not include these claims in the amounts used in our projection of the amount of improper payments.

## **OTHER OUTPATIENT PSYCHIATRIC SERVICES**

There are a wide range of services and programs that hospitals may provide to 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.

Based on our review, we determined that 63 claims<sup>2</sup> containing 176 services totaling \$18,979 were for services which were determined to be unsupported or unreasonable. Findings from our review of medical records supporting the other psychiatric service claims are described in detail below.

**Error Categories For Other Psychiatric Services**



**Services Not Documented in Accordance With Medicare Requirements**

Our review showed that a significant percentage of other outpatient psychiatric services were not documented in accordance with Medicare requirements.



Many of the errors in this category included situations where the medical record included 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 46 claims for 138 services valued at \$15,781 were not documented in accordance with Medicare requirements.

The 42 CFR 482.61 states that, “The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.”

The 42 CFR 482.61(c) further requires that a plan of treatment include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

***Insufficient Documentation***

This category includes situations where the medical record contained 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 provided, provided at the level billed, and/or medically necessary. In this regard, we found 135 services totaling \$15,446 for which insufficient documentation was provided. Examples in this category include:

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<sup>2</sup>The total number of claims found in error was 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 resulted 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.

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A claim for electroconvulsive therapy totaling \$570. The medical reviewer noted that, "There is no documentation to indicate that ECT treatment was indicated."

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A claim that included 8 group therapy sessions totaling \$1,654. A review of the medical record showed, however, that group therapy was not included in the treatment plan.

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*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 three services totaling \$335 for which no documentation was provided. An example is shown below:

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A claim for 2 individual therapy sessions totalled \$260. A review of the medical record showed, however, that there was no documentation for the period claimed.

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Without complete medical record documentation, including a description of what took place in a therapy session and 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 treatment provides little guidance to physicians and therapists to guide future treatment.

**Services Not Reasonable and Necessary**

During the course of our review, we found that 17 claims for 38 services totaling \$3,198 were not reasonable and necessary for the treatment of the patient's condition. Errors in this category included 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."

An example of services found not medically reasonable include:

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A claim for \$320 in which medical reviewers determined that the therapy provided was not therapeutic in nature. Specifically, the medical reviewer noted, "Group #1: walking/writing/artwork does not constitute group psychotherapy in the usual sense. It is a leisure time group, usually considered to be occupational therapy. Group #3: leisure activity, not group psychotherapy. Appears to be occupational/recreational therapy, not medically necessary (artwork, journal writing, poetry)."

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## ***CONCLUSION***

During CY 1998, psychiatric hospitals submitted 202,158 claims totaling \$182,091,709 for outpatient psychiatric services. We statistically selected 200 claims which totaled \$180,153 from 10 locations which comprised \$148,961,271 (82 percent) of the nationwide total. Extrapolating the results of the statistical sample over the population from the 10 locations using standard statistical methods, we estimated that psychiatric hospitals claimed \$56,936,287 for potentially unallowable or unsupported outpatient psychiatric services. The precision of this estimate at the 90 percent confidence level is  $\pm 36.01$  percent (see APPENDIX A).

## ***RECOMMENDATIONS***

We recommended that HCFA :

- ① Require Medicare FIs to increase post-payment reviews of outpatient psychiatric service claims.
- ② Require Medicare FIs to initiate recovery of payments for claims found in error.
- ③ Further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, educational sessions, and newsletters.

## ***AUDITEE COMMENTS AND OIG RESPONSE***

### **Auditee Comments**

The HCFA, in its comments dated October 20, 2000 (see APPENDIX B), concurred with our recommendations. Specifically, HCFA is instructing FIs to: (1) enact new program safeguard instructions and approaches during implementation of the hospital outpatient prospective payment system; (2) recover any funds paid in error and; (3) use their newsletters, bulletins and contractor staff education contacts to emphasize and clarify documentation requirements.

The HCFA also provided technical comments to our draft report.

## OIG Response

We appreciate HCFA's comments and concurrence with our recommendations. With respect to HCFA's technical comments, we offer the following:

- The report clearly states that, in cases where the medical reviewers indicated that a lower level of care would have been appropriate, we did not include these seven claims in our projection of the amount of improper payments. Thus, the projection of \$57 million in improper payments is based on the medical review results of the remaining 193 claims.
- As described in the Scope section of the report, we identified 150,998 outpatient psychiatric claims in CY 1998 from all psychiatric hospitals in the 10 locations included in our review. We then employed a simple random sample approach to select a statistical sample of 200 outpatient psychiatric claims from the 10 locations. Accordingly, each claim in the population had an equal chance of being selected for inclusion in the sample.
- Since hospital outpatient departments provide a broad range of psychiatric services, there may not be a direct correlation between the results of our review of PHP services rendered in this setting and in a community mental health center.
- In the example of services found not reasonable and necessary, the amount of \$380 for music and movement therapy was determined to be improper by the medical reviewers.

# **APPENDICES**

REVIEW OF OUTPATIENT  
PSYCHIATRIC SERVICES  
AT PSYCHIATRIC HOSPITALS  
FOR CALENDAR YEAR 1998

**STATISTICAL SAMPLE INFORMATION**

POPULATION

Items: 150,998  
Dollars: \$148,961,271

SAMPLE

Items: 200 Claims  
Dollars: \$180,153

ERRORS

Items: 88  
Dollars: \$75,413

PROJECTION OF SAMPLE RESULTS

Precision at the 90 Percent Confidence Level

Point Estimate: \$56,936,287  
Lower Limit: \$36,431,215  
Upper Limit: \$77,441,360



DEPARTMENT OF HEALTH & HUMAN SERVICES

The Administrator  
Washington, D.C. 20201

DATE: OCT 20 2000

TO: June Gibbs Brown  
Inspector General

FROM: Michael M. Hash *Michael M. Hash*  
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Outpatient Services at Psychiatric Hospitals for Calendar Year 1998," (A-01-99-00530).

Thank you for your letter to Nancy-Ann Min DeParle concerning the above-mentioned draft report. As Acting Administrator, I am responding to this report. This report is the result of a 10-state review of services rendered on an outpatient basis at psychiatric 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). At the end of 1998, we launched a 10-point plan to address improper payments in CMHCs. As part of that 10-point plan, HCFA undertook a comprehensive review of Medicare's mental health benefits delivered in all settings for the purpose of developing appropriate recommendations for change. We also required our contractors to intensify efforts in protecting against improper payments for partial hospitalization programs (PHP), including PHP services delivered in both acute care and psychiatric 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.

First, the OIG noted that poor documentation was the primary reason for improper payment in psychiatric OPDs, as it was in acute care hospital OPDs, rather than the eligibility of the beneficiary (as was the case in CMHCs). 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 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

Page 2 – June Gibbs Brown

billed) rather than payment. Therefore, we disagree with the statement made several times in the report, that “although a lower level of care would have been allowable, they could not specifically quantify the amount of appropriate care. Thus, the estimated \$57 million in unallowable or unsupported services is understated.” For this reason, we believe the estimated amount is overstated. Since it is reasonable to assume that outpatient psychiatric services other than PHP would be appropriate in many cases, the total of \$57 million does not represent the true savings.

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 psychiatric hospital outpatient services, including PHP. The new payment system was implemented in August 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.

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

OIG Recommendation

Require HCFA to increase post-payment reviews of outpatient psychiatric service claims.

HCFA Response

We concur. The hospital Outpatient PPS went into effect in August 2000. This new payment system will apply to psychiatric hospital OPD services, including PHP. New program safeguard instructions and approaches have been implemented alongside the new payment system. Over time, these instructions will have to be evaluated and adjusted as indicated.

OIG Recommendation

Require Medicare Fiscal Intermediaries (FIs) to initiate recovery of payments for claims found in error.

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HCFA Response

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

OIG Recommendation

Further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, educational sessions and newsletters.

HCFA Response

We concur. We will request that the FIs use their newsletters, bulletins, and contractor staff education contacts to emphasize and clarify documentation requirements.

Attachment

**Technical Comments**

If the reviewers could not specifically quantify the lower level of care that would have been allowable, then the statement that "the estimated \$57 million is understated" is speculative and potentially misleading. We recommend eliminating this statement in the Executive Summary and elsewhere.

On page 3, the number of psychiatric hospitals which were associated with the 200 sample claims should be stated. Did the study design involve a random sample of psychiatric hospital providers, so as to minimize the number of psychiatric providers to be visited? If so, this should be stated, as it could influence statistical inferences.

The deficiency rate for PHP appears to be 45% (from p. 4: \$56,434 / \$125,414), which is substantially better than the rate found for the 1998 CMHC study. If this is a valid comparison, it could inform policy makers.

On page 6, an example of unreasonable services was given as: "A claim for \$1,606 which included \$380 for music and movement therapy." In the deficient claim figures, which figure would have been used: the \$380 or the \$1,606? The footnotes on p.5 do not indicate which would have been used.