

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**PAYMENT EDITS FOR OUTPATIENT  
PSYCHIATRIC SERVICES AT THE  
MASSACHUSETTS MEDICARE PART B  
CARRIER**



**JUNE GIBBS BROWN**  
**Inspector General**

**AUGUST 1998**  
**A-01-98-00500**

# ***OFFICE OF INSPECTOR GENERAL***

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## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

This report and any finding of overpayments herein does not address whether or not there are facts or legal bases to support a criminal, or civil action under applicable criminal statutes or other authorities, such as the federal civil False Claims Act, the Program Fraud Civil Remedies Act, or the Civil Monetary Penalties Law. Nor does this report intend to conclude or suggest that the proper disposition of matters discussed herein is through administrative recoupment only.





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CIN: A-O 1-98-00500

Ms. Ann Dalton  
Account Manager  
National Heritage Insurance Company  
75 Sgt. William Terry Drive  
Hingham, Massachusetts 02043

Dear Ms. Dalton:

This report provides you with the results of our review of outpatient psychiatric claims processed by the Massachusetts Blue Shield (MABS)<sup>1</sup>. The objective of our review was to determine whether the MABS correctly applied the outpatient psychiatric payment limitation of 62.5 percent to psychiatric physician services performed in an outpatient setting. Our review covered services performed in Calendar Year (CY) 1996.

Our review of claims processed for beneficiaries residing in the four state area of Maine, Massachusetts, New Hampshire and Vermont in CY 1996, identified approximately \$2.7 million in payments to professional psychiatric providers for Current Procedural Terminology (CPT) evaluation and management (E&M) services for the treatment of mental, psychoneurotic, and personality disorders in an outpatient setting. However, contrary to Medicare regulations, these services were reimbursed at 80 percent of the Medicare allowed amount without first applying the outpatient mental health payment limitation of 62.5 percent. As a result of not applying the payment limitation, we estimate that Medicare overpaid its share by approximately \$1 million in CY 1996 for outpatient mental health services.

To prevent additional overpayments from occurring we met with the National Heritage Insurance Company (NHIC) and recommended that it adjust the outpatient psychiatric payment edit to include E&M procedure codes used by psychiatric providers for services rendered to beneficiaries with a psychiatric diagnosis code. The NHIC generally concurred with our recommendation and as of April 1, 1998 began using the new edit to correct the payment errors. We are further recommending that the NHIC:

- ☞ initiate recovery of the overpayments in accordance with HCFA guidelines and

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<sup>1</sup> On August 1, 1997 the MABS terminated its contract with the Health Care Financing Administration (HCFA) and its duties were transferred to the NHIC.

- ☞ consider expanding recovery action to include overpayments subsequent to our review period.

The NHIC generally concurs with our recommendations in response to our draft report. The NHIC, however, will request additional documentation from the provider for selected codes to determine if the limitation should be applied.

## **BACKGROUND**

Medicare helps pay for outpatient diagnostic and mental health treatment services that beneficiaries receive from professionals such as physicians, clinical psychologists, clinical social workers and other non-physician practitioners. Mental health services provided to an individual who is not an inpatient of a hospital for the treatment of “ mental, psychoneurotic, or personality disorder “ are subject to a payment limitation that is called the “outpatient mental health treatment limitation” (Limitation). The Limitation is calculated by first determining the Medicare allowed amount. This amount is then multiplied by 62.5 percent and any unsatisfied deductible subtracted from the result. The remainder is then multiplied by 80 percent to obtain the amount of Medicare payment. The beneficiary is responsible for the additional coinsurance amount.

The Medicare carrier is responsible for applying the Limitation to professional service claims for outpatient mental health treatments. However, the following services are not subject to the Limitation; 1) diagnosis of Alzheimer’s disease or related disorder, 2) brief office visits for monitoring or changing drug prescriptions, 3) diagnostic services including initial visits and consultations, and 4) partial hospitalization services not directly provided by a physician.

## **OBJECTIVES, SCOPE AND METHODOLOGY**

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine whether Medicare carriers correctly applied the Limitation of 62.5 percent to professional outpatient psychiatric claims. Our review covered claims with dates of service in CY 1996.

We limited consideration of the internal control structure to the control concerning the application of the Limitation because the objective of our review did not require an understanding or assessment of the complete internal control structure at the MABS.

To accomplish our objective, we:

- ☞ reviewed applicable Medicare laws and regulations;
- ☞ performed a computer extract of records from HCFA’s National Claims History File for professional outpatient psychiatric services rendered in CY 1996 to beneficiaries;

- ✓ residing in Maine, Massachusetts, New Hampshire and Vermont;
  - ✓ with a diagnosis of a mental, psychoneurotic or personality disorder as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM-III-R); and
  - ✓ claimed using the following CPT E&M procedure codes: 992 1 1-2 15, 9930 1-303, 99311-313, 99331-333, 99351-353, 99354-355, 99361-362, 99371-376, 99392-4 11, 992 18-220, and 9923 1-233;
- ☞ randomly selected a sample of 100 services from a population of 56,963 professional outpatient psychiatric services with E&M procedure codes valued at \$2,704,831;
  - ☞ obtained and reviewed the beneficiaries' claims histories for the sampled 100 services to verify that the population did not include any services exempt from the Limitation; and
  - ☞ discussed our results with NHIC officials.

We conducted our audit from December, 1997 through May, 1998 at the NHIC and the OIG Office of Audit Services' regional office located in Boston, Massachusetts.

The NHIC's response to the draft report is appended to this report (see Appendix) and is addressed on page 4.

## FINDINGS AND RECOMMENDATIONS

### **Limitation Not Applied to Professional Outpatient Psychiatric Claims Using E&M Codes**

The MABS did not establish adequate controls to ensure that all claims subject to the outpatient mental health payment limitation of 62.5 percent were identified. Specifically, payments to psychiatric providers for E&M services related to the treatment of mental, psychoneurotic, and personality disorders in an outpatient setting were not subject to the limitation but instead reimbursed at 80 percent of the Medicare allowed amount.

Medicare regulations require that the Limitation be applied to all outpatient psychiatric services when rendered to a beneficiary with a psychiatric condition defined in the DSM-III-R. Services excluded from the limitation include; 1) diagnosis of Alzheimer's disease or related disorder, 2) brief office visits for monitoring or changing drug prescriptions and 3) diagnostic services including initial visits and consultations.

The MABS applied the outpatient mental health limitation if claims met the following criteria:

- ☞ a psychiatric procedure code listed in the CPT section 90835-90899 was used and

☞ an outpatient place of service code was used.

We noted, however, that the application of the outpatient mental health limitation is not restricted to the CPT codes contained in the psychiatric section. In this regard, psychiatric services rendered to a patient based on a specific psychiatric diagnosis claimed using an E&M procedure code would also be subject to the limitation.

We therefore developed a computer application, based on the criteria discussed above, to identify all outpatient psychiatric claims using E&M procedure codes. We tested our results to ensure that we did not include any services which are exempt from the outpatient mental health payment limitation. Specifically, we obtained the beneficiaries' claims histories to verify that the sampled services were not initial visits exempt from the Limitation.

For CY 1996, we identified \$2.7 million in payments made to professional psychiatric providers on behalf of beneficiaries residing in Maine, Massachusetts, New Hampshire and Vermont which did not have the limitation applied. Applying the 62.5 percent limitation would have reduced the Medicare share of the payments by approximately \$1 million. In this regard, we calculated the overpayment by multiplying the paid amount \$2,704,831 by 37.5 percent, the increment overpaid by Medicare. However, it should also be noted that reducing the Medicare share of the payments increases the beneficiaries' coinsurance amount.

### **Recommendation**

To prevent additional overpayments from occurring we met with the NHIC and recommended that it adjust the outpatient psychiatric payment edit to include E&M procedure codes used by psychiatric providers for services rendered to beneficiaries with a psychiatric diagnosis code. The NHIC generally concurred with our recommendation and as of April 1, 1998 began using the new edit to correct the payment errors. We are further recommending that the NHIC:

- ☞ initiate recovery of the overpayments in accordance with HCFA guidelines and
- ☞ consider expanding recovery action to include overpayments subsequent to our review period.

### **Auditee Comments**

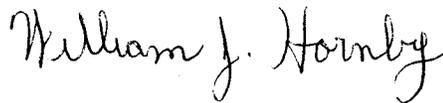
The NHIC generally concurs with our recommendations in response to our draft report. The NHIC, however, will request additional documentation from the provider for selected codes to determine if the limitation should be applied.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the U.S. Department of Health and Human Services' (DHHS) grantees and contractors are made available, if requested, to members of the press and the general public to the extent information contained therein is not subject to exemptions in the act which the DHHS chooses to exercise. (See 45 CFR Part 5).

Final determination as to actions taken on all matters reported will be made by the DHHS Action Official named below. We request that you respond to the DHHS Action Official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Please refer to Common Identification Number A-01-98-00500 in all correspondence relating to this report.

Sincerely,



William J. Hornby  
Regional Inspector General  
for Audit Services

Direct reply to DHHS Action Official:  
Roger Perez, Acting Regional Administrator, HCFA, Region I  
Health Care Financing Administration

# **APPENDIX**

**National Heritage Insurance Company**

P.O. Box 0033 • Hingham, MA 02044-0033

August 4, 1998

William J. Homby  
Regional Inspector General  
Office of Audit Services  
Region I  
John F. Kennedy Federal Building  
Boston, MA 02203

Dear Mr. Homby:

National Heritage Insurance Company (NHIC), Medicare Part B carrier for Maine, Massachusetts, New Hampshire and Vermont has reviewed the draft report of the results of your study of outpatient psychiatric claims processed by Massachusetts Blue Shield. We generally agree with the recommendations and findings in your report and have established edits to address them. However, in reviewing the CPT codes defined in your study, NHIC discovered several codes which we believe would require further documentation from the provider to ensure that the limitation should be applied. Once we determine how providers are using the codes, we will set the edits accordingly. Because there is no indication, based on the CPT definition, whether the visit is an initial evaluation or a follow-up, we would like to review the documentation from physicians to ensure the limitation would be appropriately applied for the following procedures:

- Procedures 9930 I-99303 are Comprehensive Nursing Facility Assessments. These procedures focus on 'counseling and/or coordination of care with other providers or agencies' and the review or creation of a 'medical plan of care'.
- Procedure 99375 is Care Plan Oversight. This service involves 'regular physician development and/or revision of care plans, review of reports on patient status...communication with other health care professionals and integration of new information into the treatment plan'. The patient is not present for this service.
- Procedures 992 1 8-99220 are Hospital Observation Services. Although these services are considered outpatient, they also focus on 'counseling and/or coordination of care with other providers or agencies' rather than treatment.

Edits in our system prevent payment for an Evaluation and Management code billed with an inappropriate place of service. For example, if procedure 9923 1 (Subsequent Inpatient Care) was billed with place of service 11 (Office), the service would be denied.

- Procedures 9923 1-99233 are Subsequent Hospital Care. The limitation should apply only to those services rendered in a 'partial hospitalization' setting.

As we discussed during our meeting, we believe there are no overpayments associated with the following services because they are not payable services:

- Procedures 99361-99362, 99371-99374 and 99376 are 'bundled' procedures. No separate payment is made for these services.
- Procedures 99392-994 11 are not covered by Medicare.

We have requested an extract outpatient psychiatric claims using E and M codes processed **from** 1996 through March 1998 to determine the full impact. We will keep you informed of the results of our findings.

Meanwhile, if you have any questions, or require more information, please contact me at (781) 741-3 141.

Sincerely,

A handwritten signature in cursive script that reads "Paula E. Kahakalau".

Paula E. Kahakalau  
Project Leader  
National Heritage Insurance Company

cc:P. Arinello  
A. Dalton  
N. Walsh