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FROM: Stuart Wright /S/
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SUBJECT: Memorandum Report: *Medicare Part B Services During Non-Part A Nursing Home Stays: Mental Health*, OEI-06-06-00580

This memorandum report presents the results of a medical record review to determine the extent to which Part B mental health services provided to Medicare beneficiaries during non-Part A[1] nursing home[2] stays in 2006 did not meet program requirements for coverage. We used resident assessment data from the Minimum Data Set (MDS) to identify all nursing home stays nationwide during 2006 and contracted with licensed psychiatrists and professional coders to conduct medical record reviews for a sample of claims with Part B mental health services.

We found that 39 percent of Medicare Part B claims allowed for mental health services during non-Part A nursing home stays in 2006 did not meet the program requirements for coverage. Specifically, services were medically unnecessary, undocumented or inadequately documented, or miscoded. These errors resulted in an estimated $74 million in inappropriate Part B payments, of the $211 million allowed in 2006. Claims for psychotherapy services comprised the majority of these inappropriately paid claims. Additionally, we found that 71 percent of the sampled mental health claims contained inaccurate diagnosis codes or lacked adequate documentation to support the diagnosis code, although these codes did not directly affect reimbursement.

[1] Nursing home stays not paid by Medicare Part A (Part A) constitute non-Part A stays. Part A covers posthospital skilled nursing facility (SNF) care to eligible beneficiaries for up to 100 days in SNFs during which Part A will pay for mental health services as part of the nursing home's daily rate. After the 100 days or if the beneficiary does not qualify for a Part A stay, Medicare Part B (Part B) may provide coverage for mental health services. Non-Part A stays occur in Medicare-certified SNFs, Medicaid-certified nursing facilities (NF), and dually certified SNF/NFs.

[2] For purposes of this evaluation, the term "nursing home" is generic for any nursing home regardless of primary payer (e.g., Medicare, Medicaid, or private resources).

BACKGROUND

In 2006, Medicare allowed $1.7 billion for Part B mental health services that diagnose, treat, or manage psychiatric disorders.[3] This amount remained nearly constant at $1.6 billion in 2008.[4] Mental health services are assigned procedure codes from the Healthcare Common Procedure Coding System (HCPCS).[5] (See Appendix A for a list of mental health HCPCS codes included in this review.) In addition to HCPCS codes, providers must identify the appropriate diagnosis for each submitted claim using the International Classification of Diseases 9th Revision (ICD-9).[6] In general, diagnoses of mental health disorders fall under ICD-9 codes 290 to 319.

Types of Mental Health Services

Under Medicare Part B, beneficiaries can receive a variety of mental health services to diagnose, treat, or manage mental health disorders. Medicare Part B allowed mental health services include psychiatric diagnosis, psychotherapy, and psychiatric treatments other than psychotherapy.

Psychiatric diagnosis. Diagnostic services used to identify mental health disorders allow providers to plan for a patient's treatment of care. Psychiatric diagnostic services may include psychological and neuropsychological testing. During psychological testing, providers assess the emotionality, intellectual abilities, personality, or psychopathology of the patient. Additionally, providers may perform neuropsychological testing to assess the presence of aphasias,[7] developmental disorders, or other neuropsychological disorders.

Psychotherapy. Subsequent to identifying mental health disorders, treatments of care may include psychotherapy, a therapeutic procedure covered by Medicare, involving therapeutic communication between the provider of service and the patient. Providers attempt to alleviate emotional disturbances in the patient's life and relationships by identifying and resolving problems needed to achieve optimal functioning and reversing or changing maladaptive behavior patterns.

Psychiatric treatments other than psychotherapy. Other treatments covered by Part B include biofeedback training, family consultations, pharmacologic management, electroconvulsive therapy,

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[3] This total includes all claims, including those for beneficiaries residing in or out of nursing homes, with psychiatric codes (Current Procedural Terminology (CPT) codes 90801–90899) in addition to claims for evaluation, management, and central nervous system tests that are supported by a mental disorder diagnosis. The estimate is based on Office of Inspector General (OIG) analysis of a 1-percent sample of the 2006 Medicare National Claims History.

[4] Ibid. The figure is based on OIG analysis of the 2008 Medicare National Claims History (NCH).

[5] Centers for Medicare & Medicaid Services (CMS), *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 7, § 20. All CMS manuals referenced in this report can be accessed at http://www.cms.gov/Manuals/IOM/list.asp?intNumPerPage=all&submit=Go.

[6] In addition to the ICD-9, CMS and its contractors use the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which covers all mental health disorders for both children and adults. The DSM lists known causes of a disorder, gender statistics, age at onset, and prognosis, as well as research concerning the optimal treatment approaches. Together, the ICD-9 and the DSM provide the diagnostic codes used for mental health conditions.

[7] Aphasias involve disorders of expressive and receptive speech and language function.

environmental intervention, hypnotherapy, psychoanalysis, and other services not directly related to psychotherapy.

During non-Part A nursing home stays, Medicare generally pays providers 80 percent of the allowed amount for Part B services. However, for mental health services provided in outpatient settings, Medicare first limits its incurred expenses to 62.5 percent of the allowed amount, and then pays 80 percent of the reduced amount. As a result, Medicare may pay only 50 percent for mental health services. This payment policy is called the "outpatient mental health treatment limitation."[8]

Mental Health Coverage Guidance

In 2003, CMS issued guidance to its payment contractors in the form of a program memorandum specifically focusing on Part B mental health services. The program memorandum summarized a number of existing guidelines for coverage as follows:[9]

> (1) "Section 1862(a)(1)(A) of the Social Security Act states that all Medicare Part B services, including mental health services, must be 'reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.'"
> (2) "For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service."
> (3) "CPT and ICD-9-CM codes reported on health insurance claim form should be supported by documentation in the medical record."
> (4) "Providers should follow the documentation guidance for psychiatric diagnostic or evaluative interview procedures and psychiatric therapeutic procedures (CPT codes 90801 – 98002, 90804 – 90899 under the Psychiatric Section) … as described in the Physicians' Current Procedural Terminology …."

CMS instructed its payment contractors to include the memorandum in bulletins to providers and to post it on the contractors' Web sites.

Mandate for Office of Inspector General To Monitor Part B Payments

With the repeal of the Balanced Budget Act of 1997's (BBA)[10] consolidated billing provisions for non-Part A stays,[11] section 313(d) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)[12] directed OIG to conduct monitoring of Medicare Part B payments during non-Part A stays to ensure that there are no excessive services provided.[13]

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[8] Certain mental health services are exempt from the outpatient mental health treatment limitation (e.g., diagnostic services, such as psychological testing). See 42 CFR § 410.155.

[9] CMS, Program Memorandum Change Request 2520, Transmittal AB-03-037, March 28, 2003.

[10] P.L. 105-33.

[11] Section 4432 of the BBA established a prospective payment system for Part A stays and required nursing homes to arrange for and consolidate into a single Medicare bill the Part B services that a resident needs during his or her nursing home stay.

[12] P.L. 106-554.

[13] Section 313 of the BIPA maintained consolidated billing for Part A stays and therapy services (regardless of Part A coverage), but repealed consolidated billing requirements for non-Part A stays. Therefore, claims for beneficiaries during non-Part A stays continue to be individually submitted by suppliers and providers, except for therapy services.

As part of this monitoring, OIG recently completed evaluations of durable medical equipment use[14] and enteral nutrient pricing.[15] Two ongoing evaluations include a medical record review of enteral nutrition therapy claims and an overview of Part B services during non-Part A nursing home stays.

Related Work

Over the last decade, OIG has performed several reviews of mental health services provided to Medicare beneficiaries.[16] In a 2001 review, OIG focused on mental health services in nursing homes and found that over one-third of the mental health services were not medically necessary, were not documented, or were questionable.[17] In another review, OIG found that approximately 31 percent of outpatient Part B mental health services allowed in 1998 were paid in error resulting in $185 million in inappropriate payments.[18]

More recently, OIG issued a report in 2007 on payments for Part B mental health services provided to beneficiaries in 2003.[19] The study included all settings, not just nursing homes. The report found that 47 percent[20] of the mental health services allowed by Part B did not meet program requirements, resulting in approximately $718 million in inappropriate payments. Of the sampled services, OIG found that miscoded and undocumented services accounted for 26 percent and 19 percent, respectively, of identified errors. Further, medically unnecessary services and services that violated the "incident to" rule[21] each accounted for 4 percent of identified errors. OIG recommended that CMS revise, expand, and reissue its 2003 program memorandum on Part B mental health services with an increased emphasis on proper documentation and coding and emphasis on the requirements of the "incident to" rule. In its response, CMS agreed "that additional focused provider education on mental health services may be warranted," but noted that significant information on medical documentation requirements and on the "incident to" rule was available on its Web site. To date, CMS has not reissued the 2003 program memorandum. However, in July 2008, CMS issued a special edition article to explain and consolidate Medicare's guidelines for payment of Part B mental health services.[22]

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[14] OIG, *Part B Services During Non-Part A Nursing Home Stays: Durable Medical Equipment* (OEI-06-07-00100), July 2009.

[15] OIG, *Medicare Part B Services During Non-Part A Nursing Home Stays: Enteral Nutrient Pricing* (OEI-06-07-00590), January 2010.

[16] OIG, *Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers* (A-04-98-02145), October 1998; *Review of Outpatient Psychiatric Services at Psychiatric Hospitals for Calendar Year 1998* (A-01-99-00530), November 2000; and *Medicare Part B Payments for Mental Health Services* (OEI-03-99-00130), May 2001.

[17] OIG, *Medicare Payments for Psychiatric Services in Nursing Homes: A Follow-up* (OEI-02-99-00140), January 2001.

[18] OIG, *Medicare Part B Payments for Mental Health Services* (OEI-03-99-00130), May 2001.

[19] OIG, *Medicare Payments for 2003 Part B Mental Health Services: Medical Necessity, Documentation, and Coding* (OEI-09-04-00220), April 2007.

[20] This is the percentage of identified unduplicated errors.

[21] Section 1861(s)(2)(A) of the Social Security Act, 42 CFR § 410.26.

[22] CMS, *Medicare Payments for Part B Mental Health Services*, July 2008.

Payment Errors Identified and Reviewed by CMS

In 2002, CMS established the Comprehensive Error Rate Testing (CERT) program to review approximately 100,000 randomly selected claims for payment accuracy. The CERT reviews result in annually published reports by CMS, and identify the degree to which sampled claims complied with Medicare coverage, coding, and billing regulations.

According to the 2006 CERT report, psychotherapy (HCPCS code 90806: 45–50 minute session of individual insight-oriented psychotherapy furnished in an office or outpatient facility) was among the top 20 services with documentation errors.[23] This psychotherapy service had a documentation error rate of 5.1 percent and a projected improper payment amount of nearly $13 million. These CERT results, however, are not comparable with our study's results because of methodological differences between the two reviews. For example, the CERT focuses on a random sample of all claims submitted to Medicare's fee-for-service program, whereas this review focused solely on a random sample of Part B mental health claims submitted during non-Part A nursing home stays.

METHODOLOGY

Scope

For this study, we identified all Part B mental health claims associated with beneficiaries during non-Part A nursing home stays in 2006. We conducted a medical necessity, documentation, and coding review of mental health services provided to a random sample of nursing home residents during these stays.

Identification of Mental Health Claims During Non-Part A Nursing Home Stays

We utilized several databases obtained from CMS to identify Part B payments allowed for mental health services during non-Part A nursing home stays. These databases included the MDS, the Online Survey Certification and Reporting system (OSCAR), the Enrollment Database (EDB), and the NCH.

Minimum Data Set. The MDS is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid.[24] It includes information about each resident's health, physical functioning, mental status, and general well-being, as well as nursing home admission and discharge dates. Each nursing home reports these individual assessments electronically to the State upon admission and updates them at least quarterly.[25] The States subsequently transmit MDS data to CMS. We used the MDS (version 2.0) to identify all assessed nursing home residents in 2006 and their Social Security numbers (SSN), related nursing homes, and nursing home stay dates. To determine resident stay dates between January 1 and December 31, 2006, we extracted all nursing home

[23] CMS, *Long Report – Improper Medicare Fee-For-Service Payments Report*, November 2006.

[24] CMS, *Resident Assessment Instrument Version 2.0 Manual*, December 2002, ch. 1, p. 4.

[25] More assessments are required for stays paid under the Part A SNF benefit.

admission and discharge dates for each resident. We used assessment dates as proxies for missing admission or discharge dates according to the following assumptions:

- *Missing Admission Date*. If the resident was in the nursing home on January 1, 2006 (determined from subsequent assessments that the nursing homes conducted), we used the date of the first assessment conducted in 2005 as the admission date.
- *Missing Discharge Date*. We defined the date of the last assessment (received through March 2007) as the discharge date.

Online Survey Certification and Reporting system. The OSCAR database contains nursing home facility demographic information, as well as survey results from nursing home certification and complaint surveys. To obtain information about nursing homes (e.g., facility name; address; number of beds; and SNF, NF, or dual SNF/NF certification), we linked the MDS facility identification numbers with the facility numbers maintained in OSCAR.

Enrollment Database. The EDB includes beneficiary-level data (e.g., name, SSN, and Medicare Health Insurance Claim Number (HICN)). Using this database, we matched SSNs contained in the MDS file to SSNs in the EDB to identify Medicare beneficiaries and their associated HICNs. We excluded beneficiaries having no matching SSN from further analysis.

National Claims History. The NCH is a data reporting system that includes both Part A and Part B claims. We used the NCH to identify mental health claims allowed by Part B during non-Part A nursing home stays. To identify mental health claims associated with Medicare beneficiaries with nursing home stays (identified earlier), we first matched their HICNs to claims with mental health service HCPCS. This match identified mental health claims allowed for Medicare beneficiaries during all nursing home stays. To identify claims only during non-Part A stays, we then removed all claims for Part A paid SNF stays[26] and inpatient hospital stays by matching the stay dates from the MDS to the SNF and inpatient hospital claims in the NCH. The resulting dataset comprised all mental health claims for which billing was allowed under Part B during non-Part A nursing home stays in 2006.

Sample Design

The matches with the MDS, the OSCAR, the EDB, and the NCH resulted in a population of all beneficiaries who had allowed Part B mental health claims during non-Part A nursing home stays in 2006. A random sample of 400 claims out of 2,963,572 claims was reviewed for medical necessity, sufficiency of documentation, and appropriateness of billing codes. Medical reviews could not be done for 24 of the sampled claims for the following reasons: the facility identification was unavailable, the facility moved and could not be reached by telephone or mail, or the facility indicated that the beneficiary had never been in its facility. Therefore, the resulting sample comprised 376 claims.

[26] OIG routinely conducts audits related to the issue of inappropriate Part B payments occurring during Part A stays. As such, we excluded all Part A stays from our review.

Medical Review

To conduct a medical review of the sample of Part B mental health claims, we obtained medical records and documentation from the providers of service and nursing homes where the beneficiaries were residing in 2006. To allow for records relating to an entire episode of care, we requested resident records for 6 months prior to the date of the sampled claim(s) to 1 month following the date; this provided more context and detail for the medical reviewers. When a provider did not respond to our initial request for documentation, we sent up to two followup request letters and conducted followup telephone calls for more information. See Appendix B for a list of medical documents requested from nursing homes and providers.

Identifying medically unnecessary, inadequately documented, and miscoded claims. We contracted with licensed psychiatrists and professional coders to conduct a review of medical records for beneficiaries associated with the sampled claims. The psychiatrists and coders reviewed beneficiaries' nursing home medical records and provider services records, and compared them against coverage guidelines, definitions from the ICD-9, the DSM, and the CPT.

We calculated inappropriately paid amounts for claims with medically unnecessary services, inadequately documented services, and miscoded services.[27] Some of the sampled claims had more than one type of error. However, in calculating the total claims inappropriately paid, we adjusted for overlapping errors by counting claims with multiple errors only once.

Standards

This study was conducted in accordance with the *Quality Standards for Inspections* approved by the Council of Inspectors General on Integrity and Efficiency.

RESULTS

Thirty-nine Percent of Mental Health Claims Allowed by Medicare Part B During Non-Part A Nursing Home Stays in 2006 Did Not Meet Program Requirements for Coverage, Resulting in $74 Million in Inappropriate Payments

Medicare allowed approximately $211 million for Part B mental health claims during non-Part A nursing home stays in 2006. Thirty-nine percent of these claims did not meet the program requirements for coverage. As a result, Medicare allowed inappropriate payments of $74 million for these mental health claims. For example, we found that 25 percent of claims were undocumented or lacked adequate documentation to determine whether they were medically necessary or whether they supported the services billed. Other errors involved claims that were medically unnecessary or miscoded. Table 1 groups these sampled claims by type of error and displays statistical projections of these errors to the population of Medicare Part B payments during non-Part A nursing home stays in 2006. Related confidence intervals are provided in Appendix C.

[27] Miscoded services can be upcoded (billed for higher procedure codes than were actually performed), downcoded (billed for lower procedure codes than were actually performed), or inaccurately coded (the correct service is completely different from the service billed).

Table 1. Medicare Part B Allowed Mental Health Claims That Did Not Meet Program Requirements for Coverage During Non-Part A Nursing Home Stays in 2006

Type of Error	Sample (376 Total Claims)		Projected	
	Number of Claims	Inappropriately Allowed Amount	Percentage of Services	Inappropriately Allowed Amount
Medically Unnecessary	**37**	**$2,870**	**9.8**	**$21,264,592**
Undocumented/Inadequately Documented*	**95**	**$7,158**	**25.3**	**$53,034,825**
To Determine Medical Necessity	46	$3,525	12.2	$26,114,330
To Support Services Billed	84	$6,313	22.3	$46,774,798
Miscoded	**29**	**$534**	**7.7**	**$3,953,850**
(Total Overlapping Errors)	(14)	($587)	(3.7)	($4,351,857)
Total Errors	***147***	***$9,975***	***39.1***	***$73,901,410***

***** We adjusted for claims that had both of these documentation errors by counting them only once.

Source: OIG medical review of Part B mental health services provided to beneficiaries during non-Part A nursing home stays in 2006.

Medicare Part B allowed inappropriate payments of $21 million for medically unnecessary mental health claims. Based on the psychiatrists' medical review, we estimate that 10 percent (37 of 376 claims) of Part B mental health claims allowed during non-Part A nursing home stays in 2006 were medically unnecessary. For example, a medically unnecessary service involved a patient who was given full sessions of psychotherapy twice a week. Given the patient's memory problems and dementia, the psychiatrist reviewer determined that the intensity and level of treatment were unnecessary and inappropriate, especially after 3 years of treatment.[28]

Medicare Part B allowed inappropriate payments of $53 million for mental health claims lacking adequate documentation. We estimate that 25 percent (95 of 376 claims) of Part B mental health claims allowed during non-Part A nursing home stays in 2006 were undocumented, lacked adequate documentation to determine whether they were medically necessary, or lacked adequate documentation to support the services billed.[29] Of the 376 sampled mental health claims, 9 percent (33 of 376 claims) were completely undocumented, 3 percent (13 of 376 claims) lacked adequate documentation to determine whether services were reasonable and medically necessary,[30] and 22 percent (84 of 376 claims) lacked adequate documentation to substantiate either the appropriateness of the service billed or the date of service. These errors resulted in $18 million, $8 million, and $47 million in inappropriate payments by Part B, respectively. Because we

[28] Payment contractor coverage guidelines (i.e., local coverage determinations) do not cover psychotherapy services when documentation indicates that dementia has produced a severe enough cognitive defect to prevent establishment of a relationship with the therapist which allows insight-oriented, behavior-modifying, or supportive therapy to be effective.

[29] Under section 1833(e) of the Social Security Act, "[n]o payment shall be made to any provider of services … unless there has been furnished such information as may be necessary in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid or for any prior period."

[30] For the majority of these claims, there were no records for the correct date of service.

adjusted for claims that had two or more of these documentation errors by counting them only once, total inappropriate payment due to lack of documentation was $53 million.

Medicare Part B allowed inappropriate payments of $4 million for miscoded mental health claims. We estimated that 8 percent of mental health claims allowed by Medicare Part B were miscoded, resulting in $4 million in overpayments. Of the 376 sampled Part B mental health claims, reviewers identified 29 claims that contained HCPCS billing codes that did not accurately reflect the services provided. We found that 17 of these 29 miscoded claims were upcoded, meaning that providers billed for higher procedure codes than were actually performed. For example, a provider billed for a longer length of service than indicated by the medical records, resulting in an overpayment. The provider billed for psychotherapy treatment that lasted 45 to 50 minutes (90818) while medical reviewers determined that only a 20- to 30-minute (90816) session was provided. The remaining 12 miscoded claims contained inaccurate services codes, in which the correct service is completely different from the service billed.[31] For example, one provider billed for psychotherapy treatment that lasted 20 to 30 minutes (90816), while medical reviewers determined that the provider actually furnished medication management (90862). Accounting for sample claims with both overpayments and underpayments, we estimate that Medicare Part B allowed net overpayments of $4 million.

Psychotherapy Services Comprised the Vast Majority of Errors Related to Medical Necessity, Documentation, and Miscoding

Consistent with the 2006 CERT report, which found that a psychotherapy service was among the top 20 services with documentation errors, we found that psychotherapy services were associated with the most number of errors related to medical necessity, documentation, and miscoding. Individual insight-oriented psychotherapy services, specifically, accounted for the majority of claims across all error types. For example, individual insight-oriented psychotherapy services comprised 30 (of 37) claims and 24 (of 29) claims that had medical necessity errors and miscoding errors, respectively. See Table 2 for the distribution of errors by types of mental health services. Other services associated with errors include group psychotherapy, family psychotherapy, drug management, psychiatric examination, and electroconvulsive therapy.

[31] Five of these twelve inaccurate services resulted in underpayments by Medicare Part B.

Table 2. Distribution of Error Types by Types of Mental Health Service*

Service Type (As Billed)	Medically Unnecessary	Inadequate Documentation To Determine Medical Necessity	Inadequately Documented To Support Services Billed	Miscoded	Total Claims (Unduplicated Count)
Individual Insight-Oriented Psychotherapy	30	31	49	24	100
Group Psychotherapy	4	4	12	1	18
Pharmacologic Management With No Psychotherapy	2	9	16	2	20
Psychiatric Diagnostic Interview Examination	1	2	6	1	7
Family Psychotherapy	0	0	0	1	1
Electroconvulsive Therapy	0	0	1	0	1
Total Number of Claims	**37**	**46**	**84**	**29**	**147**

*Sample size=376

Source: OIG medical review of Part B mental health services provided to beneficiaries during non-Part A nursing home stays in 2006.

Although Diagnosis Codes Did Not Directly Affect Reimbursement, 71 Percent of Part B Mental Health Claims Contained Inaccurate Diagnosis Codes or Lacked Adequate Documentation To Support the Diagnosis Code

Based on the psychiatrists' medical review, we found that 268 of the 376 (71 percent)[32] sampled Part B mental health claims contained errors related to the ICD-9 codes listed on the claims.[33] These inaccurate ICD-9 codes did not have a direct impact on the reimbursement of the sampled Part B mental health claims.[34] In most cases, the medical record supported the need for mental health services. However, including an inaccurate or undocumented diagnosis is inconsistent with the 2003 program memorandum and possibly could affect quality of care if it prevented a patient from receiving the proper treatment to address his or her illness. Furthermore, other providers who become involved in the patient's care might mistakenly rely on an inaccurately coded diagnosis when planning further treatments for the patient.

Of the 268 sampled Part B mental health claims that contained errors related to the ICD-9 codes, 174 contained inaccurate ICD-9 codes. For example, one patient had been diagnosed with senile dementia with depressive features (ICD-9 code 290.21), but medical reviewers determined that the patient should have been diagnosed with Alzheimer's disease[35] (ICD-9 code 331.0) based on

[32] We adjusted for claims that had both of these diagnostic errors by counting them only once.

[33] Forty-five percent (120 of 268) of these claims also did not meet 1 or more of the program requirements previously discussed.

[34] CMS's CERT contractors do not consider ICD-9 diagnostic codes when identifying errors in their reviews, as long as the condition indicated in the medical record supports the medical necessity of the service.

[35] Alzheimer's disease is a neurodegenerative disorder of the central nervous system resulting in progressive loss of memory and intellectual functions; begins in the middle or later years; characterized by brain lesions, such as neurofibrillary tangles and neuritic plaques.

medical record documentation. For the remaining 94 claims, reviewers could not make a determination about the appropriateness of the diagnosis due to the lack of documentation.[36]

CONCLUSION

Medicare Part B payments for mental health services during non-Part A nursing home stays continue to be an area of concern. Our results are consistent with prior OIG reports that have identified inappropriately paid mental health services. Thirty-nine percent of Part B mental health claims allowed during non-Part A nursing home stays in 2006 were paid inappropriately because of claims that were medically unnecessary, undocumented or inadequately documented, or miscoded. These errors resulted in an estimated $74 million in inappropriate Part B payments.

To address issues related to Part B payments for mental health services, CMS promoted provider awareness by posting guidance material online and issued a special edition article in 2008 to explain and consolidate Medicare's guidelines for payment of Part B mental health services.[37] Although the article may have improved provider compliance since issuance, we cannot determine its impact because CMS issued the guidance material after the service dates for the claims examined during this evaluation.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-06-06-00580 in all correspondence.

[36] Based on CMS's program memorandum, ICD-9 codes reported on claim forms should be supported by documentation in the medical record.

[37] CMS, *Medicare Payments for Part B Mental Health Services*, July 2008.

APPENDIX A

Table A-1: Healthcare Common Procedure Coding System Mental Health Codes

Description		Current Procedural Terminology Code
Psychiatric Diagnosis		
Evaluation of patient self-assessment for depression		S3005
Interview		90801–90802
Evaluation of records or reports		90885
Report preparation		90889
Psychological testing		96101–96103
Neuropsychological testing		96118–96120
Psychotherapy		
Individual		
Insight-oriented	Hospital or residential care Office or outpatient	90816–90819, 90821–90822 90804–90809
Interactive	Hospital or residential care Office or outpatient	90823–90824, 90826–90829 90810–90815
Family		90846–90847, 90849
Group		90853, 90857
Pharmacologic management with minimal psychotherapy		90862
Psychiatric Services Other Than Psychotherapy		
Pharmacologic management with no psychotherapy		M0064
Partial hospitalization services		S0201
Intensive outpatient psychiatric services		S9480
Family stabilization services		S9482
Crisis intervention mental health services		S9484–S9485
Psychoanalysis		90845
Narcosynthesis analysis		90865
Electroconvulsive therapy		90870
Biofeedback training		90875–90876
Hypnotherapy		90880
Environmental intervention		90882
Consultation with family		90887
Any unlisted mental health service and procedure		90899

Note: A medical evaluation and management service conducted on the same day as a psychotherapy service must not be reported separately when billing codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, and 90829.

Source: Centers for Medicare & Medicaid Services, and American Medical Association's *Physicians' Current Procedural Terminology*.

APPENDIX B

Table B-1: Medical Record Documents Requested From Nursing Homes and Providers

The following documents for a period of 6 months prior to identified service to 1 month following service:
Physician orders to include telephone and verbal orders
Physician progress notes
History and physical notes
Medication records
Nurse progress notes
Other progress notes
Discharge summaries for any inpatient stays during 2006
Psychiatric, psychological, or other related notes/records/procedures/tests
All MDS resident assessments conducted during 2005 through 2007
Any mental health assessments conducted during 2005 through 2007
Any other information concerning medical necessity

Source: Office of Inspector General evaluation of 376 sample Part B mental health claims for non-Part A nursing home stays during 2006.

APPENDIX C

Table C-1: Confidence Intervals for Mental Health Claims That Did Not Meet Program Requirements for Coverage During Non-Part A Nursing Home Stays in 2006*

Statistic	N	Estimated Inappropriately Allowed Amount/ Percentage of Claims	95-Percent Confidence Interval
Medically Unnecessary	37	$21,264,592 9.8 %	$18,578,943–$23,950,242 6.8–12.9 %
Undocumented/Inadequately Documented**	95	$53,034,825 25.3 %	$48,636,041–$57,433,609 20.9–29.7 %
To Determine Medical Necessity	46	$26,114,330 12.2 %	$23,273,569–$28,955,090 8.9–15.6 %
To Support Services Billed	84	$46,774,798 22.3 %	$42,543,041–$51,006,555 18.1–26.6%
Miscoded	29	$3,953,850 7.7 %	$1,722,334–$6,185,365 5.0–10.4%
(Total Overlapping Errors)	(14)	($4,351,857) (3.7 %)	($1,961,476–$6,742,239) (1.8–5.6 %)
Total Errors	**147**	**$73,901,410** **39.1 %**	**$67,495,681–$80,307,138** **34.1–44.1 %**

*Sample size=376; N=number in sample

****** We adjusted for claims that had two or more of these documentation errors by counting them only once.

Source: Office of Inspector General analysis and projections of 376 sample Part B mental health claims and payments for non-Part A nursing home stays during 2006.