Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE IMPROPERLY PAID PROVIDERS FOR SOME PSYCHOTHERAPY SERVICES, INCLUDING THOSE PROVIDED VIA TELEHEALTH, DURING THE FIRST YEAR OF THE COVID-19 PUBLIC HEALTH EMERGENCY

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Inspector General

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Office of Inspector General

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Report in Brief
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Improperly Paid Providers for Some Psychotherapy Services, Including Those Provided via Telehealth, During the First Year of the COVID-19 Public Health Emergency

Why OIG Did This Audit

In response to the COVID-19 public health emergency (PHE), CMS temporarily expanded access to health services provided via telehealth. From March 2020 through February 2021 (audit period), Medicare Part B paid $1 billion for psychotherapy services, including telehealth services, provided to Medicare enrollees nationwide. Prior OIG audits of four psychotherapy providers identified high improper payment rates for psychotherapy services furnished before the PHE. We conducted this nationwide audit to determine whether compliance issues identified in the prior audits occurred during our audit period. To understand the challenges that providers faced when furnishing telehealth services, we also surveyed providers on their experience with providing those services to people enrolled in Medicare.

Our objective was to determine whether providers met Medicare requirements and guidance when billing for psychotherapy services, including services provided via telehealth.

How OIG Did This Audit

Our audit covered approximately $1 billion in Part B payments for more than 13.5 million psychotherapy services provided during our audit period. We selected two stratified random samples of psychotherapy services: one sample consisted of 111 enrollee days for telehealth services, and the other consisted of 105 enrollee days for non-telehealth services (i.e., provided in person).

What OIG Found

Providers did not meet Medicare requirements and guidance when billing for some psychotherapy services, including services provided via telehealth. For 84 of the 216 sampled enrollee days, providers met Medicare requirements. However, for 128 sampled enrollee days, providers did not meet these requirements (e.g., psychotherapy time was not documented). In addition, for 54 sampled enrollee days, providers did not meet Medicare guidance (e.g., providers' signatures were missing). (We did not review 4 sampled enrollee days and treated them as non-errors because they were already part of other OIG reviews.) Based on our sample results, we estimated that of the $1 billion that Medicare paid for psychotherapy services, providers received $580 million in improper payments for services that did not comply with Medicare requirements, consisting of $348 million for telehealth services and $232 million for non-telehealth services.

We also present the information we obtained on providers' experience with providing telehealth services during the PHE for the sampled enrollee days. CMS may be able to use this information when making decisions about how telehealth can be best used to meet the needs of Medicare enrollees in the future. We found that some providers reported challenges in furnishing telehealth services and most providers used approved communication technology to provide those services.

What OIG Recommends and CMS Comments

We recommend that CMS: (1) work with Medicare contractors to recover $35,560 in improper payments for the sampled enrollee days, (2) implement system edits for psychotherapy services to prevent payments for incorrectly billed services, and (3) strengthen educational efforts to make providers aware of educational materials on meeting requirements and guidance for psychotherapy services. The report contains three other recommendations.

CMS concurred with four of six recommendations and described its corrective actions to address those recommendations. CMS did not state its concurrence or nonconcurrence with the remaining two recommendations; however, CMS recommended that we remove one recommendation and described actions that it planned to take to address the other recommendation. After reviewing CMS's comments, we maintain that our recommendations are valid.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/92103021.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

The COVID-19 pandemic caused unprecedented challenges for providing and receiving in-person health care as well as significant health and safety concerns. In response to the COVID-19 public health emergency (PHE), in March 2020, Congress and the Secretary of Health and Human Services (HHS) authorized the Centers for Medicare & Medicaid Services (CMS) to temporarily implement waivers and modifications to Medicare program requirements. These changes expanded access during the PHE to health services provided via telehealth (using remote communications technologies) by temporarily eliminating or revising some of the requirements for these services.[1] The waivers and modifications provided more options for people enrolled in Medicare to receive services provided via telehealth, such as psychotherapy services, in the face of the PHE's challenges.

From March 1, 2020, through February 28, 2021 (audit period), Medicare Part B paid approximately $1 billion for psychotherapy services, including services provided via telehealth (also called telehealth services in this report), for Medicare enrollees nationwide. Our preliminary analysis determined that 57 percent of the total amount that Medicare paid for psychotherapy services provided during our audit period was for telehealth services (compared with less than 1 percent in calendar year 2019).[2]

Prior Office of Inspector General (OIG) audits of four psychotherapy providers, which reviewed services performed before the PHE, identified high improper payment rates and found that the providers did not comply with Medicare requirements when billing for psychotherapy services. For example, providers did not document or furnish psychotherapy services, inadequately documented psychotherapy services, and provided incomplete treatment plans. (See Appendix B for a list of related OIG reports, including several reports that focused on telehealth services provided during the PHE.)

Because of the significant increase in psychotherapy services billed as telehealth services during the PHE and the high improper payment rates we identified in our prior audits, we conducted this nationwide audit of psychotherapy services to determine whether the compliance issues identified in the prior audits occurred during our audit period. To understand the challenges

[1] In response to changes in legislation, CMS has already made some of these temporary waivers and modifications permanent and has extended flexibilities for Medicare coverage of payment for telehealth services through December 31, 2024.

[2] A prior Office of Inspector General (OIG) study found that 43 percent of Medicare beneficiaries used a telehealth service during the first year of the PHE and that beneficiaries used 88 times more telehealth services, compared with the year before the PHE. This study also found that beneficiaries used telehealth for 43 percent of all behavioral health services (including psychotherapy) they received during the first year of the PHE. (*Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic* (OEI-02-20-00520), March 15, 2022.)

that providers faced when furnishing telehealth services, we also surveyed providers on their experience with providing those services to Medicare enrollees.

OBJECTIVE

Our objective was to determine whether providers met Medicare requirements and guidance when billing for psychotherapy services, including services provided via telehealth.

BACKGROUND

COVID-19 Public Health Emergency and Expansion of Access to Telehealth

The COVID-19 pandemic created unprecedented challenges in Medicare enrollees' access to health care services.[3] In response to the PHE, HHS and CMS took a number of actions to temporarily expand access to telehealth for Medicare enrollees.[4] Telehealth (also known as telemedicine) uses electronic information and telecommunications technologies to provide care when a health care provider and enrollee are not in the same physical location. CMS expanded access, allowing enrollees to use telehealth for a wide range of services and in a wider array of locations, including urban areas.

Telehealth services may be provided through live video or audio-only visits.[5] To provide telehealth via live video, health care providers must use video communication products that are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[6]

[3] On March 11, 2020, the World Health Organization characterized COVID-19 as a pandemic. A pandemic is an epidemic that has spread over several countries or continents, usually affecting many people. An epidemic is an increase, often sudden, in the number of cases of a disease above what is normally expected in a population in a specific area. (See Centers for Disease Control and Prevention, "Lesson 1: Introduction to Epidemiology." Available online at https://www.cdc.gov/csels/dsepd/ss1978/lesson1/section11.html. Accessed on November 9, 2022.)

[4] HHS and CMS were able to temporarily expand access to telehealth because the declaration of the PHE and national emergency allowed the HHS Secretary to use the waiver authority under section 1135 of the Social Security Act (the Act). On March 13, 2020, then-President Trump declared the COVID-19 outbreak a national emergency. The Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 and the Coronavirus Aid, Relief, and Economic Security Act allowed CMS to waive telehealth-related restrictions with a PHE declaration in place.

[5] A live-video visit, also referred to as a "real-time" visit, is two-way, face-to-face interaction between a patient and provider using audiovisual communications technology. An audio-only visit is the use of a telephone without video.

[6] HHS, "Guidance on How the HIPAA Rules Permit Covered Health Care Providers and Health Plans To Use Remote Communication Technologies for Audio-Only Telehealth." Available online at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audio-telehealth/index.html. Accessed on October 13, 2022.

However, HHS issued a temporary notice to allow providers during the PHE to use any non-public-facing remote communication product that is available to communicate with patients.[7]

The Medicare Program and the Role of Medicare Administrative Contractors

The Medicare program provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. CMS administers the program.

Medicare Part B provides supplementary medical insurance for medical and other health services, such as outpatient services, which include psychotherapy. CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Part B claims for a defined geographic area (jurisdiction). During our audit period, seven MACs processed and paid Medicare Part B claims: CGS Administrators, LLC (CGS); First Coast Service Options, Inc. (FCSO); National Government Services, Inc. (NGS); Noridian Healthcare Solutions, LLC (Noridian); Novitas Solutions, Inc. (Novitas); Palmetto GBA, LLC (Palmetto); and WPS Government Health Administrators (WPS). Regardless of whether a service was provided via telehealth or in person, a provider must submit claims to the MAC that serves the jurisdiction in which the provider is physically located, even if the enrollee is located in a different MAC jurisdiction from the provider.

The MACs help CMS to implement Medicare program integrity measures (e.g., preventing and detecting improper payments and promoting Medicare compliance). MAC responsibilities include receiving Medicare Part B claims from providers within their jurisdictions; performing edits on these claims to determine whether they are complete and reimbursable;[8] calculating Medicare payment amounts and remitting payments to the appropriate parties;[9] educating providers on Medicare requirements and billing procedures; and performing medical reviews, which include collecting information for a selection of claims and reviewing enrollee medical records to ensure that Medicare pays only for services that meet all Medicare coverage, documentation, coding, and medical necessity requirements. For example, the MACs perform medical reviews as part of CMS's Targeted Probe and Educate (TPE) program. These medical

[7] 85 FR 22024, 22025 (Apr. 21, 2020). HHS, "Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency." Available online at https://public3.pagefreezer.com/content/HHS.gov/31-12-2020T08:51/https:/www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html. Accessed on July 20, 2022.

[8] An edit is programming within the standard claims processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

[9] The amount allowed for payment is equal to the lesser of the Medicare fee schedule amount or the amount charged by a provider. Medicare pays the provider the amount allowed for payment, less the enrollee share (i.e., deductibles and coinsurance). Not all enrollees pay out of pocket for coinsurance. Some enrollees have secondary insurance coverage (e.g., Medicaid) that will pay the coinsurance.

reviews focus on specific providers that bill a particular item or service, evaluate 20 to 40 claims per provider for an item or a service, and provide individualized education to providers based on the results of the reviews.

The MACs also develop local coverage determinations (LCDs) for their individual jurisdictions. LCDs are determinations by a MAC on whether a particular item or service is reasonable and necessary and therefore covered by Medicare within the specific jurisdiction that the MAC oversees.

Psychotherapy and Medicare Coverage of Psychotherapy Services

Psychotherapy treats mental illness and behavioral disturbances. A physician or other qualified health care professional establishes professional contact with the patient and, through therapeutic communication and techniques, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. Problems helped by psychotherapy include difficulties in coping with daily life; the impact of trauma, medical illness, or loss; and specific mental disorders, such as depression or anxiety. Psychotherapy may be used in combination with medication or other therapies.

Medicare Part B covers mental health services, such as individual and group psychotherapy, provided by qualified professionals (e.g., physicians, psychiatrists, clinical psychologists, clinical social workers, nurse practitioners, and physician assistants).[10] To provide such services, a provider must be licensed or legally authorized to perform the services by the State in which the services are provided.[11] Medicare also pays for services billed incident to the service of a physician or certain other practitioners.[12]

[10] The Act §§ 1832(a)(1) and 1861(s); 42 CFR §§ 410.20, 410.71, and 410.73–410.75.

[11] 42 CFR §§ 410.20, 410.71, and 410.73–410.75.

[12] 42 CFR § 410.26(b); the Act §§ 1861(s)(2)(A) (incident to physician's services), 1861(s)(2)(K)(i) (incident to physician assistant's services), 1861(s)(2)(K)(ii) (incident to nurse practitioner's or clinical nurse specialist's services), 1861(gg)(1) (incident to nurse-midwife's services), and 1861(ii) (incident to qualified psychologist's services). The incident-to provisions allow physicians and certain other practitioners to bill Medicare under their National Provider Identifier numbers for services furnished incident to their professional services by auxiliary personnel (e.g., a nurse practitioner employed by the same entity). To be covered as incident-to services, the services must meet certain conditions, including being an integral, although incidental, part of the physician's or other practitioner's personal professional services in the course of diagnosis or treatment of an injury or illness (42 CFR § 410.26(b)(2)).

Medicare enrollees may receive an evaluation and management (E&M) service on the same day as a psychotherapy service provided by the same physician, psychiatrist, or other qualified health care professional.[13] For a provider to receive Medicare payment for both the E&M and psychotherapy services, the services must be significant and separately identifiable.[14]

Medicare requires that psychotherapy services be reasonable and necessary for the diagnosis or treatment of an enrollee's illness.[15] Providers bill Medicare for individual psychotherapy services using one of six psychotherapy Current Procedural Terminology (CPT) codes, depending on the time spent on psychotherapy and whether the service was provided alone or in conjunction with an E&M service.[16]

Providers must bill the appropriate CPT code based on the actual time spent on psychotherapy whether provided via telehealth or in person, such as in an office. (Figure 1 shows the psychotherapy CPT codes and their descriptions.) Each code has an associated time range. For example, CPT codes 90832 and 90833 are billed for 16 to 37 minutes of psychotherapy. (Medicare does not cover psychotherapy services lasting less than 16 minutes.[17]) There is also a CPT code for group psychotherapy and another for interactive complexity, which is an

Figure 1: Psychotherapy CPT Codes and Descriptions

CPT Code	Description
90832	Psychotherapy (30 min)
90833	Psychotherapy (30 min + E&M)
90834	Psychotherapy (45 min)
90836	Psychotherapy (45 min + E&M)
90837	Psychotherapy (60 min)
90838	Psychotherapy (60 min + E&M)
90853	Group Psychotherapy
90785	Interactive Complexity

[13] Physicians and other qualified health care professionals perform E&M services to assess and manage the health of a person enrolled in Medicare. Other qualified health care professionals who may provide E&M services include nurse practitioners, clinical nurse specialists, and physician assistants who practice in collaboration with a physician or under the supervision of a physician.

[14] American Medical Association (AMA), CPT [Current Procedural Terminology] 2020–2021. An E&M service is significant and separately identifiable from a psychotherapy service performed at the same encounter if there is no overlap in the work associated with the E&M and the work associated with the psychotherapy service.

[15] The Act § 1862(a)(1)(A).

[16] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2019–2020 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply**.

[17] AMA, CPT 2020–2021.

add-on code that can be billed with a psychotherapy service.[18]

To be paid for an individual psychotherapy service, a provider must furnish information necessary to determine the amount due to the provider.[19] The provider must also comply with the documentation requirements included in the LCD for its jurisdiction. Five of the seven MACs (CGS, FCSO, NGS, Novitas, and WPS) had LCDs that included documentation requirements for psychotherapy services, but these requirements varied among the five MACs. Of these five MACs, two (CGS and NGS) had LCDs that required a written treatment plan that included the anticipated goals of the psychotherapy. Another MAC (WPS) also required the treatment goals to be documented in the medical record but not necessarily in the treatment plan. In addition, two MACs (WPS and CGS) required an updated treatment plan as well as documentation of progress toward the goals established by the provider.[20] Two of the seven MACs (Noridian and Palmetto) did not have any LCDs related to psychotherapy services.

Appendix C shows the differences in documentation requirements for the five MACs that had LCDs related to psychotherapy services. CMS and the MACs did not impose any new documentation requirements specific to telehealth services during the audit period; however, providers had to comply with existing Medicare documentation requirements for psychotherapy services.

Medicare Coverage of Psychotherapy Services Provided via Telehealth

Before the beginning of the PHE, Medicare enrollees were able to receive certain telehealth services, including psychotherapy services, if the following requirements were met:

- the service was from a provider with whom they had an established relationship;
- the enrollee received the service in a designated rural area;
- the enrollee traveled to, or was located in, a certain type of originating site (e.g., a physician's office, a skilled nursing facility, or a hospital) for the visit; and

[18] AMA, CPT 2020–2021. "Interactive complexity" refers to specific communication factors that complicate the delivery of psychiatric procedures, including more difficult communication with discordant or emotional family members. The interactive complexity CPT code (90785) may be used in conjunction with CPT codes for psychotherapy.

[19] The Act § 1833(e).

[20] WPS and CGS require providers to update treatment plans; however, these MACs' LCDs did not specify how frequently the treatment plans must be updated.

- the telehealth service was provided by live video only.[21]

To address the unprecedented challenges caused by the PHE, CMS broadened access to telehealth services by implementing temporary waivers and modifications to these Medicare requirements.[22]

Waivers and Modifications to Medicare Program Requirements for Telehealth Services During the Public Health Emergency

Retroactive to March 1, 2020, Congress and the Secretary of HHS authorized CMS to temporarily implement waivers and modifications to Medicare program requirements and conditions of participation for telehealth services during the PHE. The waivers provided more options for Medicare enrollees to receive psychotherapy services through telehealth in the face of the challenging conditions of the PHE. Specifically, CMS broadened Medicare coverage for telehealth services beyond rural areas and paid for telehealth services (including psychotherapy services) furnished to enrollees in any health care facility or in their homes.[23] Medicare also started paying for telehealth psychotherapy services provided through audio-only communications technology.[24] In addition, HHS announced that during the PHE, it would not enforce the requirement that a Medicare enrollee have an established relationship with a provider before receiving telehealth services. These changes helped to ensure that Medicare enrollees could continue receiving medical care safely from home, without having to visit an office or a hospital, which could put them and others at risk of contracting COVID-19.

The waivers and modifications that CMS implemented also affected the reimbursement of telehealth services. Before the PHE, a provider received a lower payment for services provided via telehealth. During the PHE, telehealth services are considered the same as in-person services and are paid at the same rate as in-person services. In addition, HHS-OIG informed

[21] 42 CFR § 410.78; CMS, "Medicare Telemedicine Health Care Provider Fact Sheet" (Mar. 17, 2020). Available online at https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet. Accessed on September 1, 2022.

[22] The Consolidated Appropriations Act of 2022 extended most telehealth flexibilities for 151 days after the end of the emergency period. An emergency period is the period in which an emergency or a disaster declared by the President exists or a PHE declared by the HHS Secretary exists (42 U.S.C. § 300ff-83(b)(2)).

[23] On November 19, 2021, CMS expanded access to telehealth services to treat mental health conditions for beneficiaries in Medicare fee-for-service. This expansion allows enrollees in urban areas and those seeking care from home to access telehealth services that treat mental health conditions (86 FR 64996, 65055, 65059 (Nov. 19, 2021)).

[24] Effective January 1, 2022, CMS amended the definition of interactive telecommunications system for telehealth services to include audio-only communications technology for diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes under certain circumstances (86 FR 64996, 65055, 65059 (Nov. 19, 2021); see also, CMS, Transmittal No. 11146, Change Request 12519 (dated Dec. 2, 2021, and effective Jan. 1, 2022)).

providers that they will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations for telehealth services provided during the PHE.[25]

Billing Medicare for Telehealth Psychotherapy Services

Although telehealth services are paid at the same rate as in-person services during the PHE, CMS revised the Medicare billing guidance for telehealth services. To bill Medicare for a telehealth psychotherapy service provided before March 1, 2020, a provider should have included place of service (POS) code 02 on a claim to indicate that the service was provided through telecommunication technology.[26] To bill Medicare for a telehealth psychotherapy service with a date of service on or after March 1, 2020, and for the duration of the PHE, a provider should submit a claim that includes the POS code that would have been billed if the service had been provided in person and add modifier 95 to indicate that the service was provided via telehealth.[27, 28]

Providers may also use the following modifiers to bill for telehealth services (used before and during the PHE):

- Modifier GT indicates that a critical access hospital method II service was provided via telehealth.[29]

- Modifier GQ indicates that a service was provided via asynchronous (store and forward) telecommunications systems.[30]

[25] HHS-OIG, "OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak," March 17, 2020. Available online at https://oig.hhs.gov/documents/special-advisory-bulletins/960/policy-telehealth-2020.pdf. Accessed on September 16, 2022.

[26] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 12, § 190.6.1.

[27] CMS, MLN Matters No. SE20011 (Sept. 8, 2021).

[28] A modifier is a two-character code reported with a CPT code and is used to give Medicare additional information needed to process a claim (*National Correct Coding Initiative Policy Manual for Medicare Services*, chapter I, § E(1)).

[29] A critical access hospital is a hospital certified under a specific set of Medicare conditions of participation, which are structured differently than the acute-care hospital conditions of participation. A critical access hospital may elect the method II payment option for outpatient professional services, which allows the hospital to be paid 115 percent of what it would otherwise be paid under the Medicare fee schedule.

[30] For Federal telemedicine demonstration programs conducted in Alaska or Hawaii, asynchronous store-and-forward technologies may be used as a substitute for an interactive telecommunications system (42 CFR § 410.78(d)). These technologies transmit a patient's medical information from an originating site to a provider at a distant site (42 CFR § 410.78(a)(1)).

- Modifier G0 indicates that a service was a telehealth service provided for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

Prior Office of Inspector General Work

Prior OIG audits of four psychotherapy providers, which did not focus on telehealth services, found that the providers did not comply with Medicare requirements when billing for psychotherapy services.[31] These audits identified improper payment rates that ranged from 88 percent to 99 percent and an estimated $7.6 million in total Medicare overpayments. Specifically, providers did not document or provide psychotherapy services, inadequately documented psychotherapy services, did not comply with incident-to requirements, or provided incomplete treatment plans. For example, three audits found that the providers did not always document the time spent providing psychotherapy services. In addition, two audits identified potential quality-of-care issues related to services provided to Medicare enrollees with missing or inadequate treatment plans.

OIG has issued several reports on telehealth services provided during the PHE. For example, for one study, we developed 7 billing measures (e.g., billing a high average number of hours of telehealth services per visit) and identified more than 1,700 health care providers whose billing for telehealth services during the first year of the COVID-19 pandemic posed a high risk to Medicare.[32] These providers billed for telehealth services (e.g., office visits, behavioral health services, and nursing home visits) for about half a million Medicare enrollees and received a total of $127.7 million in Medicare fee-for-service payments. Another study found that more than 2 in 5 Medicare enrollees used telehealth services during the COVID-19 pandemic, and enrollees used 88 times more telehealth services during the first year of the pandemic (March 2020 through February 2021) than they used in the prior year.[33]

Medicare Requirements for Providers To Identify and Return Overpayments

OIG believes that this audit report on psychotherapy services constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of: (1) 60 days after identifying those

[31] *Oceanside Medical Group Received Unallowable Medicare Payments for Psychotherapy Services* (A-09-18-03004), August 28, 2019; *Grand Desert Psychiatric Services: Audit of Medicare Payments for Psychotherapy Services* (A-09-19-03018), April 20, 2020; *On-Site Psychological Services, P.C.: Audit of Medicare Payments for Psychotherapy Services* (A-02-19-01012), July 21, 2020; and *Psychotherapy Services Billed by a New York City Provider Did Not Comply With Medicare Requirements* (A-02-21-01006), March 29, 2022.

[32] *Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks* (OEI-02-20-00720), September 7, 2022.

[33] *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic* (OEI-02-20-00520), March 15, 2022.

overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[34]

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.[35]

HOW WE CONDUCTED THIS AUDIT

Our audit covered approximately $1 billion in Medicare Part B payments for more than 13.5 million psychotherapy services provided during our audit period.[36] We selected two stratified random samples of psychotherapy services provided during this period: one sample consisted of psychotherapy services billed as telehealth services (telehealth sample), and the other sample consisted of psychotherapy services that were not billed as telehealth services (non-telehealth sample).[37] The telehealth sample consisted of 111 enrollee days, and the non-telehealth sample consisted of 105 enrollee days.[38] In total, we sampled 216 enrollee days, consisting of 216 psychotherapy services and 5 interactive complexity add-on services, with a total paid amount of $43,136:[39]

- 94 services for 60 minutes of psychotherapy (CPT code 90837),
- 61 services for 45 minutes of psychotherapy (CPT code 90834),
- 29 services for 30 minutes of psychotherapy (CPT code 90832),
- 22 services for 30 minutes of psychotherapy with an E&M service (CPT code 90833),
- 7 services for 45 minutes of psychotherapy with an E&M service (CPT code 90836),
- 3 services for 60 minutes of psychotherapy with an E&M service (CPT code 90838), and

[34] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 FR 7654 (Feb. 12, 2016).

[35] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; 81 FR at 7670.

[36] Of the $1 billion in Medicare Part B payments, approximately $591 million was for psychotherapy services that were billed as telehealth services, and approximately $439 million was for psychotherapy services that were not billed as telehealth services (i.e., provided in person).

[37] To identify psychotherapy services that were billed as telehealth services, we identified claim lines that included telehealth indicators (i.e., POS code 02 or modifiers 95, GT, GQ, or G0). Our analysis was based on the indicators used on each claim line. The analysis did not include an assessment of whether the providers furnished services only via telehealth or if they also furnished services in person.

[38] For the purpose of this audit, an "enrollee day" included all claim lines for Medicare Part B psychotherapy services with the same service start date for a specific enrollee.

[39] An add-on service is a service that, with rare exception, is performed in conjunction with another primary service by the same practitioner. An add-on service is rarely eligible for payment if it is the only procedure reported by a practitioner.

- 5 interactive complexity add-on services (CPT code 90785).

We requested supporting documentation from the providers of the services in the telehealth and non-telehealth samples.[40] We reviewed the supporting documentation to determine whether the providers met Medicare requirements and guidance when billing for psychotherapy services.[41] However, we did not determine whether the services were medically necessary or assess the quality of care provided to enrollees. We also requested that the providers respond to a questionnaire that contained questions related to the psychotherapy services (e.g., whether the psychotherapy service was provided via telehealth or in person and whether the psychotherapy service was provided under direct supervision of another provider).[42]

We summarized the information obtained from the questionnaires about providers' experiences furnishing services via telehealth during the PHE. This included information about challenges providers encountered, which types of communication products providers used, whether Medicare enrollees consented to receiving telehealth services, and whether providers collected coinsurance from enrollees for psychotherapy services.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology, and Appendix E describes our statistical sampling methodology. Appendices F and G contain our sample results and estimates for psychotherapy services billed with and without a telehealth indicator, respectively.

[40] For 4 of the 216 enrollee days, we did not request the supporting documentation because the providers were included in other ongoing OIG reviews.

[41] Because our audit focused on psychotherapy services, we did not review E&M services provided in conjunction with those services.

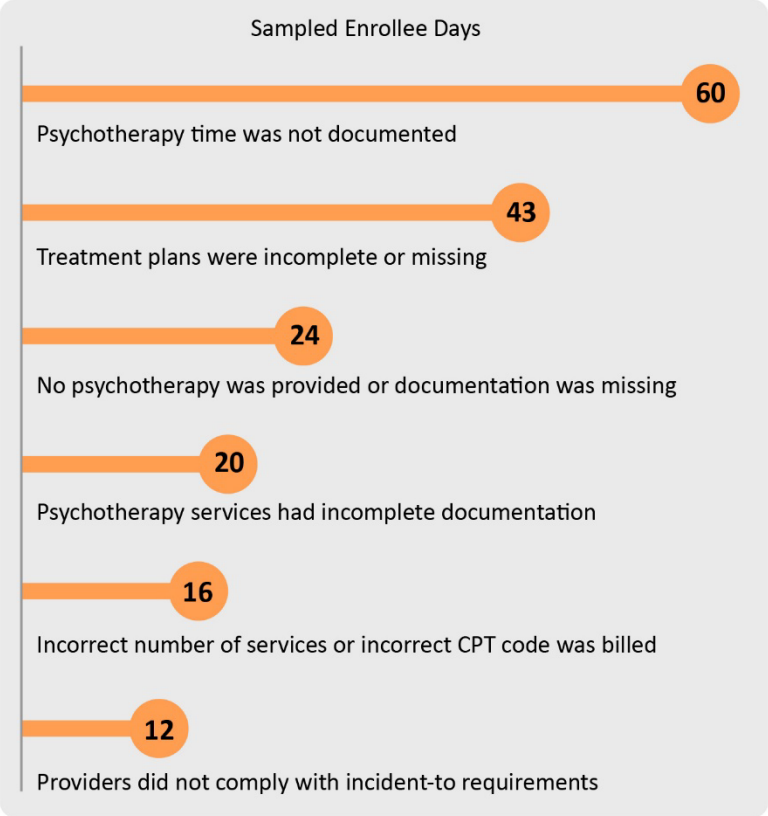
[42] We received questionnaire responses for 187 of the 216 sampled enrollee days. The 187 enrollee days consisted of 96 enrollee days from the telehealth sample and 91 enrollee days from the non-telehealth sample. Appendix D shows the questions that were included in the questionnaire.

FINDINGS

Providers did not meet Medicare requirements and guidance when billing for some psychotherapy services, including services provided via telehealth. For 84 of the 216 sampled enrollee days, providers met Medicare requirements. However, for 128 sampled enrollee days, providers did not meet these requirements.[43, 44] In addition, for 54 sampled enrollee days, providers did not meet Medicare documentation and billing guidance.

Figure 2 shows the total number of enrollee days in our two samples (i.e., telehealth and non-telehealth) for which providers did not meet Medicare requirements, by type of deficiency.[45] See Appendix H for a breakdown of the number of deficiencies in each sample.

Figure 2: The Total Number of Sampled Enrollee Days for Which Providers Did Not Meet Medicare Requirements, by Type of Deficiency



[43] We did not review 4 sampled enrollee days and treated them as non-errors because we determined they were already part of other OIG reviews after we had selected our samples.

[44] For each sampled enrollee day, only the amounts paid for the psychotherapy services that did not meet Medicare requirements were unallowable.

[45] The total number of deficiencies is greater than 128 because 43 enrollee days had more than 1 deficiency.

Medicare paid $35,560 for the 128 sampled enrollee days for which providers did not meet Medicare requirements. Based on our sample results, we estimated that of the $1 billion that Medicare paid for psychotherapy services, providers received $580 million in improper payments.[46] This improper payment amount consisted of $348 million for telehealth services and $232 million for non-telehealth services.[47]

Additionally, for 54 sampled enrollee days, providers did not meet Medicare documentation and billing guidance. Specifically, for 31 sampled enrollee dates, providers' signatures were missing, and for 29 sampled enrollee days, the claims did not accurately identify whether the psychotherapy services were provided via telehealth or in person.[48] These findings did not have associated improper payments because they did not reflect noncompliance with Medicare requirements. However, this information may be beneficial to CMS when considering future oversight mechanisms or policy changes related to providers' signatures and billing for telehealth services.

The deficiencies we identified in our audit occurred because CMS's oversight was not adequate to prevent or detect payments for psychotherapy services, including telehealth services, that did not meet Medicare requirements and guidance. CMS's oversight was partially affected by the unprecedented challenges of the PHE because CMS's focus was to ensure that Medicare enrollees had access to health care.

We are also presenting the information we obtained on providers' experience with providing telehealth services during the PHE for 118 sampled enrollee days.[49] CMS may be able to use this information when making decisions about how telehealth can be best used to meet the needs of Medicare enrollees in the future. Specifically, for 59 enrollee days, providers reported challenges in providing telehealth services, and for 80 enrollee days, providers reported using audiovisual communication technology products that were either HIPAA compliant or temporarily allowed during the PHE to provide telehealth services.

[46] We estimated that for our audit period Medicare improperly paid providers $579,667,510. We did not estimate the amount of coinsurance that Medicare enrollees were responsible for because providers are able to reduce or waive enrollees' cost-sharing for telehealth services provided during the PHE.

[47] We estimated that for our audit period Medicare improperly paid providers $347,699,561 for telehealth psychotherapy services and $231,967,949 for non-telehealth psychotherapy services.

[48] The total number of deficiencies is greater than 54 because 6 services had more than 1 deficiency.

[49] A total of 134 enrollee days had services that were provided via telehealth, consisting of 108 enrollee days in the telehealth sample and 26 enrollee days in the non-telehealth sample. As a result of our audit, we found that 26 enrollee days in the non-telehealth sample were provided via telehealth and 3 enrollee days in the telehealth sample were provided in person. The providers for 16 enrollee days with services that were furnished via telehealth did not provide responses to our questionnaire.

PROVIDERS DID NOT MEET MEDICARE REQUIREMENTS WHEN BILLING FOR PSYCHOTHERAPY SERVICES

For 128 sampled enrollee days, providers did not meet Medicare requirements, resulting in $35,560 of improper payments. Based on our sample results, we estimated that of the $1 billion paid by Medicare for psychotherapy services, providers received $580 million in improper payments.

Psychotherapy Time Was Not Documented

Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Social Security Act (the Act) § 1833(e)). Providers are required to use CPT codes when billing Medicare (45 CFR §§ 162.1002(c)(1) and (a)(5)).

Providers must bill the CPT code with the number of minutes closest to the actual time that was spent on psychotherapy:

- CPT codes 90832 and 90833 for 16 to 37 minutes of psychotherapy,
- CPT codes 90834 and 90836 for 38 to 52 minutes of psychotherapy, and
- CPT codes 90837 and 90838 for 53 or more minutes of psychotherapy (American Medical Association (AMA), CPT 2020–2021).

Providers must not bill for psychotherapy of less than 16 minutes (AMA, CPT 2020–2021).

Some patients receive an E&M service on the same day as a psychotherapy service provided by the same physician or other qualified health care professional. To report both E&M and psychotherapy, the two services must be significant and separately identifiable (AMA, CPT 2020–2021). Time associated with activities used to meet criteria for the E&M service is not included in the time spent on the psychotherapy service (i.e., the time spent by the psychotherapist on the patient's medical history, examination, and medical decision making when used for the E&M service is not part of the time spent on psychotherapy (AMA, CPT 2020–2021).

For 60 of the 216 sampled enrollee days, providers did not document the time spent on psychotherapy, including services provided via telehealth:

- For 54 enrollee days, the medical record entries for the psychotherapy services did not specify the start and stop times of the session (e.g., "10:00 a.m. to 10:45 a.m.") or specify the total time spent (e.g., "45 minutes") on psychotherapy during the session.

- For 6 enrollee days, the providers billed psychotherapy in conjunction with an E&M service. For these services, the supporting documentation showed the total amount of time spent on the encounter with the enrollee; however, the documentation did not specifically show how much of that time was spent providing the psychotherapy service.

Example of Psychotherapy Time That Was Not Documented

On June 25, 2020, a provider billed Medicare for a 60-minute psychotherapy service in conjunction with an E&M service provided in the office. Medicare paid $99 for the psychotherapy service and $172 for the E&M service. The enrollee's medical record stated that the provider spent a total of 60 minutes with the enrollee. The provider did not document how much of that time was spent specifically on the psychotherapy service or if the psychotherapy service was at least 16 minutes long (the minimum amount of time to bill any psychotherapy CPT code). Therefore, the $99 for the psychotherapy service was unallowable. The associated enrollee coinsurance for this service was $25.

Treatment Plans Were Incomplete or Missing

The individualized treatment plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses of a mental disorder or disease (e.g., generalized anxiety disorder) and anticipated goals of the psychotherapy treatment (e.g., to reduce symptoms) (CGS's LCD L34353 and NGS's LCD L33632). A periodic summary of treatment goals, progress toward those goals, and an updated treatment plan must be included in the medical record (WPS's LCD L34616 and CGS's LCD L34353).[50]

For 43 of the 216 sampled enrollee days, providers furnished treatment plans that did not include all the required elements or did not furnish any treatment plans:

- For 35 enrollee days, the treatment plans did not include the type, amount, frequency, or duration of services to be furnished, or did not indicate the enrollees' diagnoses or anticipated goals.

- For 6 enrollee days, the providers did not have treatment plans.

- For 2 enrollee days, the medical records included initial treatment plans that were established 6 and 8 years before the sampled enrollee days; however, updated treatment plans were not included in the medical records.

[50] For this finding, we applied the LCD requirements only to sampled enrollee days with claims that were processed and paid by the corresponding MACs.

Example of an Incomplete Treatment Plan

On December 18, 2020, a provider billed Medicare for a 60-minute psychotherapy service provided via telehealth, for which Medicare paid $125. The provider furnished a medical record that included an entry for the sampled enrollee day and the treatment plan dated September 14, 2020. The treatment plan included the type of service (e.g., individual psychotherapy), the anticipated goals (e.g., to facilitate adjustment to current cognitive changes and decrease anxiety), and the diagnosis (e.g., adjustment disorder with anxiety). However, the treatment plan did not include the amount, frequency, or duration of the services to be furnished. As a result, the $125 for the psychotherapy service was unallowable. The associated enrollee coinsurance for this service was $31.

For an additional 35 sampled enrollee days, the treatment plans were missing, but the MACs in those jurisdictions did not require treatment plans. As a result, the 35 enrollee days were allowable. Of the seven MACs, only three (CGS, NGS, and WPS) had LCDs that required a treatment plan or an updated treatment plan. Although the remaining four MACs (FCSO, Noridian, Novitas, and Palmetto) did not have LCDs that required treatment plans to be documented in the medical records, three of those MACs told us that they expected treatment plans to be documented, and the other MAC indicated on its website that psychotherapy documentation should include a treatment plan.

No Psychotherapy Was Provided or Documentation Was Missing

Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Act § 1833(e)).

For 24 of the 216 sampled enrollee days, providers did not document that psychotherapy was provided, did not furnish contemporaneous records to support the psychotherapy services, or did not furnish documentation for the psychotherapy services:[51]

- For 11 enrollee days, the providers furnished documentation for the sampled items; however, the documentation did not show that psychotherapy was provided.

- For 8 enrollee days, the providers did not furnish any documentation to support the psychotherapy services.[52]

[51] The total number of deficiencies is greater than 24 because 2 enrollee days had more than 1 deficiency.

[52] We made numerous attempts to contact the providers to request medical records, but they did not respond.

- For 7 enrollee days, the providers furnished documentation for the sampled items; however, they created the documentation after we had requested the medical records, which was more than 8 months after the sampled enrollee days.[53]

Example of a Psychotherapy Service for Which Documentation Was Created After Our Request

On June 30, 2020, a provider billed Medicare for a 60-minute psychotherapy service provided in the office, for which Medicare paid $118. The provider's lawyer provided a letter signed on November 8, 2021, stating that the medical records we had requested "are non-existent since it is not [the provider's] practice to create or maintain records of that sort in the course of his practice of psychotherapy." The lawyer also provided a treatment summary for the sampled enrollee that showed that the enrollee received 26 hourly psychotherapy services from March 1, 2020, through February 28, 2021. In addition, the lawyer provided a declaration signed on October 19, 2021, from the enrollee that included a list of dates when psychotherapy was furnished. The letter, treatment summary, and enrollee-signed declaration were created after our request for medical records. The provider did not furnish a medical record that was created close to the time of the sampled date of service to support that the psychotherapy service had been provided. As a result, the $118 for the psychotherapy service provided on June 30, 2020, was unallowable. The associated enrollee coinsurance for this service was $30.

Psychotherapy Services Had Incomplete Documentation

The medical record must indicate the therapeutic maneuvers (such as behavior modification (e.g., cognitive behavioral therapy), supportive interactions, or interpretive interactions) that were applied to produce a therapeutic change (WPS's LCD L34616, CGS's LCD L34353, and Novitas's LCD L35101).[54, 55]

[53] For 2 of the 7 sampled enrollee days, the providers explained that they had summarized the information for the psychotherapy services but stated that they did not have contemporaneous records for the services. For the remaining 5 enrollee days, the providers did not respond to our followup inquiries. For the 7 enrollee days, the documentation furnished by the providers also did not comply with Medicare requirements related to amendments, corrections, or delayed entries or with Medicare guidance for psychotherapy notes (CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, §§ 3.3.2.5 and 3.3.2.6).

[54] Cognitive behavioral therapy is a form of psychological treatment that has been demonstrated to be effective for a range of problems (including depression, anxiety disorders, and severe mental illness) and usually involves efforts to change thinking patterns.

[55] For this finding, we applied the LCD requirements only to sampled enrollee days with claims that were processed and paid by the corresponding MACs.

Providers must document that there was a reasonable expectation of improvement in the patient's disorder or condition, or maintenance of level of functioning (Novitas's LCD L35101, NGS's LCD L33632, and FCSO's LCD L33252). A periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record (WPS's LCD L34616 and CGS's LCD L34353).

The medical record documentation maintained by the provider must include a detailed summary of the session, including descriptive documentation of therapeutic interventions, such as examples of attempted behavior modification and supportive interaction (FCSO's LCD L33252). Medical records must document the patient's capacity to participate in psychotherapy if psychotherapy is the chosen treatment (WPS's LCD L34616 and Novitas's LCD L35101).

For 20 of the 216 sampled enrollee days, providers furnished incomplete documentation for the psychotherapy services, including services provided via telehealth:[56]

- For 11 enrollee days, the providers did not document the therapeutic maneuvers (e.g., cognitive behavioral therapy) that were applied to produce a therapeutic change.

- For 6 enrollee days, the providers did not document that the psychotherapy services were expected to improve the enrollees' condition or maintain the mental health status or function of the enrollees.[57]

- For 4 enrollee days, the providers did not include in the medical records a periodic summary of goals or progress toward goals.

Can Improper Documentation Affect the Quality of Care Provided to Medicare Enrollees?

Proper documentation promotes patient safety and quality of care. According to CMS, documentation is an important aspect of patient care and is used to coordinate services among medical professionals, furnish sufficient services, and improve patient care. (CMS presentation *Your Medical Documentation Matters*, Dec. 9, 2015.)

CMS also stated: "Behavioral health practitioners are in the business of helping their patients. Patients are their priority. Meeting ongoing patient needs, such as furnishing and coordinating necessary services, is impossible without documenting each patient encounter completely, accurately, and in a timely manner. Documentation is often the communication tool used by and between professionals. Records not properly documented with all relevant and important facts can prevent the next practitioner from furnishing sufficient services. The outcome can cause unintended complications." (CMS factsheet *Medicaid Documentation for Behavioral Health Practitioners*, December 2015.)

[56] The total number of deficiencies is greater than 20 because 2 enrollee days had more than 1 deficiency.

[57] We considered this requirement to be met if there was a statement in the supporting documentation for an enrollee that showed that the psychotherapy service was expected to improve the enrollee's condition or maintain the mental health status or function of the enrollee, or if there was documentation of the goals of treatment (e.g., a treatment plan).

- For 1 enrollee day, the provider did not include in the medical record a detailed summary of the session (i.e., the medical record did not include descriptive documentation of therapeutic interventions).

- For 1 enrollee day, the provider did not document the enrollee's capacity to participate in the psychotherapy.[58]

Example of Incomplete Documentation for a Psychotherapy Service

On March 31, 2020, a provider billed Medicare for a 60-minute psychotherapy service provided in the office, for which Medicare paid $84. The provider furnished a medical record entry for the sampled enrollee day and documented the enrollee's concerns related to COVID-19. However, this entry did not include any therapeutic maneuvers (e.g., cognitive behavioral therapy) that were applied to produce a therapeutic change. As a result, the $84 for the psychotherapy service was unallowable. The associated enrollee coinsurance for this service was $21.

The Incorrect Number of Services or the Incorrect CPT Code Was Billed

Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Act § 1833(e)). Providers must bill the CPT code with the number of minutes closest to the actual time that was spent on psychotherapy: CPT codes 90832 and 90833 for 16 to 37 minutes of psychotherapy, CPT codes 90834 and 90836 for 38 to 52 minutes of psychotherapy, and 90837 and 90838 for 53 or more minutes of psychotherapy (AMA, CPT 2020–2021). Providers must not bill for psychotherapy of less than 16 minutes (AMA, CPT 2020–2021).

For 16 of the 216 sampled enrollee days, providers billed the incorrect number of services or the incorrect CPT code:

- For 12 enrollee days, the providers billed for more than one psychotherapy service per enrollee day, but the medical records showed that only one service was provided for each enrollee day. The providers for all 12 sampled enrollee days stated that they had unintentionally billed the incorrect number of services.

- For 4 enrollee days, the providers billed the incorrect CPT code for the psychotherapy services.

[58] We considered this requirement to be met if there was a statement in the supporting documentation that showed that the enrollee interacted with the provider.

Examples of Providers That Billed the Incorrect Number of Services and Billed the Incorrect CPT Code

On May 28, 2020, a provider billed for 30 psychotherapy services provided via telehealth on one date of service for a single enrollee. Each service was for CPT code 90832 (for 30 minutes of psychotherapy), and Medicare paid the provider $1,202. However, according to the supporting documentation, only one psychotherapy service was provided. Therefore, we determined that the remaining 29 services were billed in error. (Based on our review of the documentation, the service that was provided complied with Medicare requirements.) As a result, the $1,138 for the 29 psychotherapy services that were not provided was unallowable. The associated enrollee coinsurance for the 29 services was $285. The provider stated that its billing system incorrectly billed the time spent on the psychotherapy service as the number of units.

On February 1, 2021, another provider billed CPT code 90834 for 45 minutes of psychotherapy provided in the office, for which Medicare paid $67. However, the medical record entry showed that 55 minutes of psychotherapy time had been provided. Therefore, the provider should have billed CPT code 90837 for 60 minutes of psychotherapy and should have been paid $98. As a result, an additional $31 for the psychotherapy service was allowable.

Providers Did Not Meet Incident-To Requirements

Medicare Part B pays for services and supplies incident to the service of a physician (or certain other practitioners) (42 § CFR 410.26(b)). Services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness (42 CFR § 410.26(b)(2)).

Certain nonphysician practitioners have the option to provide services incident to the services of a physician and may bill under the physician's National Provider Identifier (NPI) number if certain requirements are met. One of those requirements is that the services must be provided as an integral, though incidental, part of the service of a physician in the course of diagnosis or treatment of an injury or illness (42 CFR § 410.26(b)(2)). Another requirement is that the incident-to services must be provided under the direct supervision of a physician, which means that the physician must be physically present in the same office suite as the nonphysician practitioner providing the incident-to service and be immediately available to provide assistance if that becomes necessary (42 CFR §§ 410.26(a)(2) and (b)(5).[59] During a PHE, the presence of the supervising physician includes virtual presence through audio and video real-time communications technology (excluding audio-only) (42 CFR § 410.32(b)(3)(ii)).

[59] Direct supervision in the office setting means that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed. (42 CFR § 410.32(b)(3)(ii).)

For 12 of the 216 sampled enrollee days, providers billed for incident-to psychotherapy services (including services provided via telehealth) that were not an integral part of the physician's personal in-office services or were not adequately supervised:[60]

- For all 12 enrollee days, the psychotherapy services were not an integral part of services that the physician (e.g., the psychiatrist) provided in the course of diagnosis or treatment of an injury or illness. For each of these services, the billing providers did not diagnose the enrollees or establish the course of treatment.

- For 2 enrollee days, the providers did not provide information to show that the services were provided under the direct supervision of a psychiatrist (e.g., that the psychiatrist was present in the office suite).[61]

How Much Are Nonphysician Practitioners Paid for Psychotherapy Services?

For psychotherapy services billed by psychiatrists and psychologists, Medicare allows for payment of 100 percent of the amount shown in the Medicare Physician Fee Schedule; however, other types of providers receive lower payments. For psychotherapy services billed by nurse practitioners and clinical social workers, Medicare allows for payments of 85 percent and 75 percent, respectively, of the Physician Fee Schedule amount. However, services provided by nonphysicians can be reimbursed at the physician rate if they are billed as incident to the services of a physician, psychiatrist, or psychologist.

Example of a Psychotherapy Service That Did Not Meet Incident-To Requirements

On August 21, 2020, a provider billed Medicare for a 30-minute psychotherapy service in conjunction with an E&M service provided in the office. Medicare paid $56 for the psychotherapy service and $56 for the E&M service. The services were billed under the NPI number of a psychiatrist; however, the medical record for the sampled enrollee day showed that a nurse practitioner provided the services. The provider's response on the questionnaire stated that the psychotherapy service was not provided under the direct supervision of another provider. As a result, the $56 for the psychotherapy service was unallowable. The associated enrollee coinsurance for this service was $15.

PROVIDERS DID NOT MEET MEDICARE GUIDANCE WHEN BILLING FOR PSYCHOTHERAPY SERVICES

For 54 sampled enrollee days, providers did not meet Medicare documentation and billing guidance. Specifically, providers' signatures were missing, or providers did not accurately identify on claims whether the services were provided via telehealth or in person. These

[60] The total number of deficiencies is greater than 12 because 2 enrollee days had more than 1 deficiency.

[61] We accepted the providers' responses to the questionnaires as support that the services were provided under direct supervision.

findings did not have associated overpayments because they did not reflect noncompliance with Medicare requirements. However, this information may be beneficial to CMS when considering future oversight mechanisms or policy changes related to providers' signatures and billing for telehealth services.

Providers' Signatures Were Missing

CMS guidance states: "Medicare requires that services provided . . . be authenticated by the persons responsible for the care of the [enrollee]." Medicare will accept handwritten or electronic signatures to support services provided. The furnishing provider's signature on a note (e.g., a medical record entry) indicates that the provider affirms that the note adequately documents the care provided. (CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.3.2.4.)

Why Are Provider's Signatures Important?

According to the American Academy of Professional Coders (AAPC), the purpose of a physician's signature in a medical record is to clearly identify who ordered and provided supplies or services for the patient. It also serves as a testament that the services provided were accurately and fully documented, reviewed, and authenticated. (AAPC, "Authenticate Services with Proper Physicians' Signatures," Mar. 1, 2014. Available at Authenticate Services with Proper Physicians' Signatures—AAPC Knowledge Center. Accessed on Aug. 3, 2022.)

For 31 of the 216 sampled enrollee days, providers furnished medical records to support the psychotherapy services, including services provided via telehealth. However, the medical record entries were missing the signatures of the providers that furnished the services.[62]

Example of a Medical Record That Was Missing the Provider's Signature

On December 10, 2020, a provider billed Medicare for a 60-minute psychotherapy service provided via telehealth. Medicare paid $123 for the psychotherapy service. The provider provided a handwritten medical record entry for the sampled enrollee day; however, the medical record entry did not include the provider's signature.

Providers Did Not Accurately Identify on Claims Whether Services Were Provided via Telehealth or in Person

To bill Medicare for telehealth psychotherapy services with dates of service on or after March 1, 2020, and for the duration of the PHE, providers should submit claims that include the POS code that would have been billed if the service had been provided in person and modifier 95 to indicate that the service was provided via telehealth (CMS, Medicare Learning Network (MLN) Matters No. SE20011).

[62] Of the 31 sampled enrollee days, 24 contained at least 1 other deficiency (e.g., psychotherapy time was not documented). We are not questioning the associated Medicare reimbursement for the remaining 7 sampled enrollee days because the only deficiency was based on guidance for lack of signatures.

To bill Medicare for services that were part of a Federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, providers should submit claims with modifier GQ. To bill Medicare for services provided for diagnosis and treatment of an acute stroke, provider should submit claims using modifier G0. To bill Medicare for critical access hospital method II claims, the claims should be submitted with modifier GT. (CMS, MLN Matters No. SE20011.)

For 29 of the 216 sampled enrollee days, providers did not correctly bill telehealth psychotherapy services. The responses to the provider questionnaires and the medical records showed that the providers for these services did not accurately identify on the claims whether the services were provided via telehealth or in person:[63]

- For 26 sampled enrollee days, the providers did not include telehealth indicators (i.e., POS code 02 or modifiers 95, GT, GQ, or G0) on the claims to identify the services as telehealth services. However, the responses to the provider questionnaires and the medical records showed that the services were provided via telehealth, not in person.

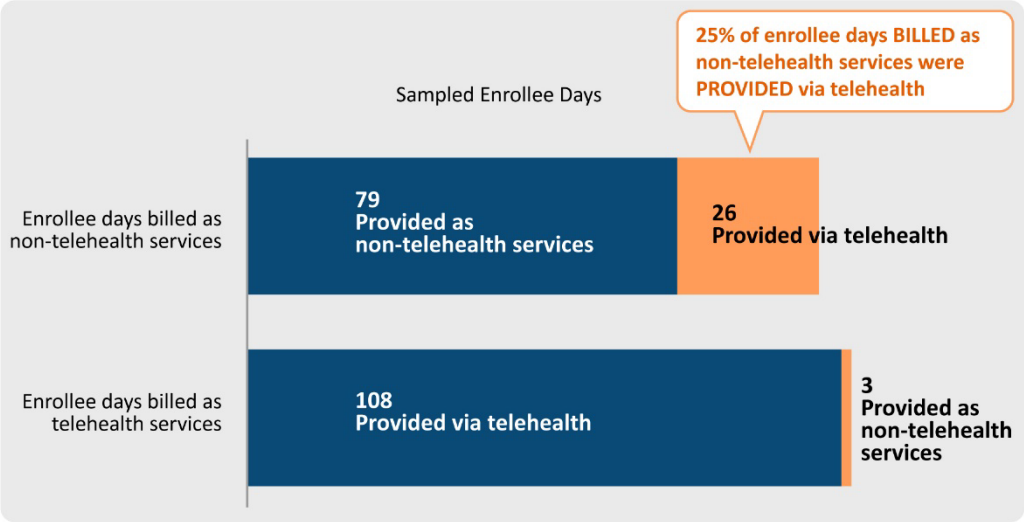
- For 3 sampled enrollee days, the providers included either modifier 95 or modifier GT on the claims to identify the services as telehealth services. However, the responses to the provider questionnaires showed that the services were furnished in the providers' offices (as non-telehealth services).

Although the payments for these services were not affected by the incorrect modifiers, providers' inaccurate identification of these services as telehealth or in person services may affect CMS's and the MACs' ability to rely on the claims data for these services and may impact future policy changes.

Figure 3 shows the number of sampled enrollee days that were provided via telehealth in each sample.

[63] The providers for 187 of the 216 sampled enrollee days responded to the questionnaires.

Figure 3: Twenty-Five Percent of the Enrollee Days Billed as Non-Telehealth Services Were Provided via Telehealth



Example of a Claim That Did Not Accurately Identify Telehealth Services With a Modifier

On March 31, 2020, a provider billed Medicare for a 60-minute psychotherapy service provided in the office. Medicare paid $109 for the psychotherapy service. The provider did not bill the service with a telehealth indicator (i.e., POS code 02 or modifiers 95, GT, GQ, or G0). However, the provider's response to the questionnaire showed that the service was provided via telehealth through audiovisual technology.

CMS OVERSIGHT WAS NOT ADEQUATE TO PREVENT OR DETECT PAYMENTS FOR PSYCHOTHERAPY SERVICES THAT DID NOT MEET MEDICARE REQUIREMENTS AND GUIDANCE

The deficiencies we identified in our audit occurred because CMS's oversight mechanisms were not adequate to prevent or detect payments for psychotherapy services, including telehealth services, that did not meet Medicare requirements and guidance. Oversight mechanisms included conducting medical reviews and implementing system edits, educating providers on Medicare requirements, and establishing or updating documentation requirements. The PHE has caused unprecedented challenges for Medicare enrollees' access to health care. In response to these challenges, CMS and the MACs eliminated or revised some of these oversight mechanisms and focused their efforts on ensuring that Medicare enrollees had access to health care.

CMS Suspended Medical Reviews and Disabled Edits

On March 30, 2020, CMS suspended most Medicare Part B medical reviews in an effort to reduce provider burden and ensure that Medicare enrollees have access to medically necessary

services during the PHE.[64] As a result, the MACs did not conduct any medical reviews of psychotherapy services, including services provided via telehealth.[65] By reviewing providers' supporting documentation, for example, the MACs could have detected or prevented some of the deficiencies that our audit identified.

In addition, CMS informed us that at the beginning of the PHE it disabled or revised edits that were in place for psychotherapy services, including prepayment edits that limited the number of services that could be billed per Medicare enrollee per day.[66] These system edits could have prevented Medicare from paying for some psychotherapy services that were improperly billed (e.g., billing for more than one service per enrollee day).

CMS's Educational Efforts Were Not Effective in Ensuring Provider Compliance With Medicare Requirements and Guidance for Psychotherapy Services

During our audit period, CMS and providers were operating in challenging times, and requirements and guidance for telehealth services changed rapidly. To educate providers on these changes, CMS and the MACs published guidance documents (e.g., MLN Booklet, *Medicare Mental Health*; MLN Booklet, *Telehealth Services*; and *Telehealth for Providers: What You Need To Know*) and updated their websites with information on telehealth flexibilities during the PHE and ongoing changes affecting telehealth services. The websites also included educational materials on Medicare requirements and guidance for psychotherapy services. Some MACs also provided webinars on these topics. However, the results of our audit showed that many providers are not adequately documenting psychotherapy services, including telehealth services. The findings indicate that additional educational efforts are needed to improve provider compliance with Medicare requirements and guidance for psychotherapy services. By using the TPE program, for example, the MACs could help ensure that providers are aware of the Medicare requirements for psychotherapy services and aware of the educational resources available to them.[67]

[64] CMS prohibited the MACs from reviewing claims with dates of service on or after March 1, 2020. According to CMS, other contractors were available to review the claims when necessary.

[65] In May 2021, CMS stated that MACs were permitted to resume postpayment reviews of items and services with dates of service after March 1, 2020. However, the MACs confirmed that they did not conduct any medical reviews of psychotherapy services provided during our audit period.

[66] According to CMS, the system edits were reimplemented. However, our data analysis showed that after reimplementation, Medicare paid for claims billed for psychotherapy services in excess of the established limit per day.

[67] Beginning in September 2021 (after our audit period), the MACs were permitted to resume the TPE reviews. The TPE program's process typically includes up to three rounds of pre- or postpayment probe reviews, each of which may be followed by one-on-one education for providers that are found to be noncompliant. (CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.5.)

CMS Has Not Established National Documentation Requirements for Psychotherapy Services, and Medicare Administrative Contractor Requirements Varied

Our audit showed that not all providers documented treatment plans for psychotherapy services they provided, which occurred because not all providers were required to have documented treatment plans. CMS has not established national Medicare documentation requirements that apply to all MAC jurisdictions for psychotherapy services. In addition, the documentation requirements that the seven MACs established in their LCDs varied based on the MAC jurisdiction:

- Two MACs (Noridian and Palmetto) did not have an LCDs for psychotherapy services. Therefore, they did not have any specific psychotherapy documentation requirements for their jurisdictions.

- The remaining five MACs had LCDs that included documentation requirements for psychotherapy services, but those requirements varied. For example, only three MACs (WPS, CGS, and NGS) had LCDs that required a treatment plan or an updated treatment plan, and only the LCDs for WPS and CGS required documentation of progress toward goals established by the provider.

Although MACs are not required to have the same provisions in their LCDs, requiring providers in all jurisdictions to document treatment plans and progress toward established goals may help ensure that Medicare enrollees receive adequate care because treatment plans enable providers to track enrollees' treatment and progress. In contrast to what is required for outpatient psychotherapy services, written treatment plans are required for inpatient psychiatric services and outpatient psychiatric hospital services.[68] In addition, the MACs informed us that they either require treatment plans or expect providers to have documented treatment plans. However, there is no treatment plan requirement for outpatient psychotherapy services that is applicable in all jurisdictions.

PROVIDERS' EXPERIENCE WITH PROVIDING TELEHEALTH SERVICES

Providers' use of telehealth was critical for providing psychotherapy services to Medicare enrollees during the first year of the PHE.[69] The increased use of telehealth for these services

[68] 42 CFR § 412.27(c)(3) and CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 6, § 70.1. Outpatient psychiatric hospital services are services provided by a hospital to outpatients who need psychiatric care.

[69] *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic* (OEI-02-20-00520), March 15, 2022.

during the PHE shows that Medicare enrollees were able to overcome the unprecedented challenges caused by the PHE for accessing health care.[70]

Using providers' responses to our questionnaire about the psychotherapy services included in our two statistical samples, we found that some providers reported challenges in furnishing telehealth services and most providers used approved communication technology to provide those services.[71] (For 118 of the 134 sampled enrollee days for which psychotherapy services were furnished via telehealth, providers responded to our questionnaires.[72, 73]) The information we obtained from the questionnaires may help CMS make decisions about how telehealth can be best used to meet the needs of Medicare enrollees in the future.

Some Providers Reported Challenges in Furnishing Telehealth Services

For 59 of the 118 sampled enrollee days, providers did not report challenges in furnishing telehealth services. However, for the remaining 59 enrollee days, providers reported that they encountered challenges related to providing telehealth services, which included problems with Medicare enrollees accessing services. Specifically, they reported the following challenges:

- technology issues (e.g., providers and enrollees had unreliable internet connections),
- lack of education on the use of technology (e.g., enrollees did not know how to use telehealth communication technology),
- privacy concerns (e.g., enrollees had to try to distance themselves from others in the household to keep psychotherapy sessions private), and

[70] Our preliminary analysis determined that 57 percent of the total amount that Medicare paid for psychotherapy services provided during our audit period was for services provided via telehealth (compared with less than 1 percent in calendar year 2019).

[71] Providers for 187 of 216 sampled enrollee days responded to our questionnaire. The 187 enrollee days consisted of 96 enrollee days from the telehealth sample and 91 enrollee days from the non-telehealth sample. The same questionnaire was sent to providers in both samples because some of the questions (e.g., who provided the psychotherapy service) were pertinent to both telehealth and non-telehealth services.

[72] A total of 116 providers were associated with the 118 enrollee days.

[73] A total of 134 enrollee days had services that were provided via telehealth, consisting of 108 enrollee days in the telehealth sample and 26 enrollee days in the non-telehealth sample. Our audit found that 26 enrollee days in the non-telehealth sample were provided via telehealth, and 3 enrollee days in the telehealth sample were provided in person.

- lack of access to audio-only or audiovisual communications technology (e.g., enrollees did not have access to a telephone or a device that would display video).[74]

In addition, one provider that furnished a psychotherapy service in the office reported that it was "difficult to feel therapeutic presence" when providing psychotherapy via telehealth and that enrollees are not as comfortable with telehealth.[75]

Most Providers Used Audiovisual Communication Technology To Provide Telehealth Services, and All of Those Providers Used Products That Were HIPAA Compliant or Temporarily Allowed During the Public Health Emergency

Effective March 1, 2020, and through the duration of the PHE, Medicare will pay for telehealth psychotherapy services provided through both audiovisual and audio-only communication systems (CMS's *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, October 2022).

To provide telehealth via live video, health care providers must use video communication products that are HIPAA compliant. However, HHS issued a temporary notice to allow providers to use other popular communications products to deliver telehealth during the PHE (HHS, *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*).

For 80 of the 118 sampled enrollee days, providers reported that they furnished telehealth services using audiovisual technology. For 37 enrollee days, providers reported using audio-only technology. For the remaining enrollee day, the provider did not report whether they furnished the telehealth service using audiovisual or audio-only technology.

What Other Information Did Providers Report on the Questionnaires?

Providers furnished information on whether Medicare enrollees consented to telehealth psychotherapy services, whether the initial services were provided in person, and whether coinsurance was collected:

- ✓ For all 118 sampled enrollee days, providers reported that enrollees consented to receiving telehealth services.
- ✓ For 92 sampled enrollee days, providers reported that the enrollees' initial services were provided in person.
- ✓ For 63 sampled enrollee days, providers reported that coinsurance was collected for the psychotherapy services. The majority of the coinsurance was collected from secondary insurance providers.

[74] This information was obtained from the providers' responses to our questionnaire. Most providers did not elaborate on their responses and did not provide detailed information on the challenges they or their Medicare enrollees encountered using telehealth services.

[75] Therapeutic presence is "the state of having one's whole self in the encounter with a client by being completely in the moment on a multiplicity of levels—physically, emotionally, cognitively, and spiritually" (Shari M. Geller and Leslie S. Greenberg, *Therapeutic Presence: A Mindful Approach to Effective Therapy,* American Psychological Association).

Of the 80 sampled enrollee days for which providers reported that services were provided using audiovisual technology, for 39 enrollee days, providers reported that they used HIPAA-compliant products to provide telehealth services. For 34 enrollee days, providers reported that they used video communication products that are temporarily allowed during the PHE. For the 7 remaining enrollee days, providers reported that they used more than one platform for audiovisual technology, which included products that were HIPAA compliant and products that were temporarily allowed during the PHE.

CONCLUSION

The PHE has caused extraordinary challenges for the delivery of health care to the American people. As a result, CMS's priority during the PHE has been to ensure that Medicare enrollees have access to health care while also protecting Medicare enrollees and providers from infection with COVID-19. CMS was required to act quickly to address the PHE's challenges and to notify providers of changes to Medicare coverage requirements and billing guidance for telehealth services. We understand that CMS was operating in challenging times during the first year of the PHE. However, as CMS continues to reinstitute its program integrity measures and considers making other permanent changes to telehealth services, CMS should focus on implementing adequate oversight of providers to minimize the risk of paying for psychotherapy services, including those provided via telehealth, that do not meet Medicare requirements. When operating in a PHE, CMS should use the information and recommendations included in this report to determine additional ways to safeguard the Medicare trust fund and the quality of care furnished to enrollees while still ensuring that Medicare enrollees have access to health care during PHEs. Additionally, CMS could determine which program integrity measures were necessary during this PHE to help navigate a possible future PHE.

Why Is Documentation of Psychotherapy Services Important?

According to the American Psychological Association (APA), records that include documentation of treatment plans, psychotherapy services provided, and patients' progress document the provider's planning and implementation of an appropriate course of services, which allows a provider to monitor treatment. These records may be especially important when significant time elapses between contacts with the patient or when the patient seeks services from another provider. (APA, "Record Keeping Guidelines," available at https://www.apa.org/practice/guidelines/record-keeping. Accessed on Aug. 3, 2022.)

The APA stated: "Tracking treatment outcomes improves patients' health and quality of life because it enables a [provider] to see how a patient's treatment plan is working—and to adjust those therapies as needed." (APA, "Need help tracking patient outcomes?" available at https://www.apa.org/monitor/2019/02/patient-outcomes. Accessed on Aug. 3, 2022.)

Our audit found that most psychotherapy providers did not meet Medicare documentation requirements, which remained the same during our audit period (i.e., the first year of the PHE). Prior audits of individual providers' psychotherapy services had similar deficiencies, which is evidence that compliance with Medicare documentation requirements for psychotherapy services was problematic before the PHE. Now that CMS has reinstituted most program integrity measures, CMS and the MACs must take

action to establish adequate oversight mechanisms (e.g., conducting medical reviews of psychotherapy services and making providers aware of educational materials on billing and documentation for these services) to ensure that Medicare pays only for psychotherapy services that meet Medicare requirements.[76]

In addition, CMS should review MAC jurisdictions' LCD requirements for psychotherapy services to identify which provisions effectively promote program integrity and should consider additional steps that it could undertake to ensure appropriate coverage and payment for psychotherapy services across all jurisdictions.

CMS could have potentially saved Medicare $580 million in improper payments for our audit period by taking the necessary steps to implement adequate provider oversight mechanisms for psychotherapy services.

Our audit also found that most providers who responded to our questionnaire were able to use telehealth to overcome the unprecedented challenges caused by the PHE for accessing psychotherapy services. Although some providers in our samples reported that they encountered challenges when providing telehealth services, the majority of the providers did not report any challenges. In addition, most providers used approved communication technology to provide telehealth services. The information in this report may help CMS make decisions about how telehealth can be best used to meet the needs of Medicare enrollees in the future.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services work with the MACs to:

- recover $35,560 in improper payments made to providers for the 128 sampled enrollee days that did not meet Medicare requirements and

- based on the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

Now that CMS has reinstituted most program integrity measures, we also recommend that CMS take the following steps, which if in effect during the audit period could have saved Medicare an estimated $579,667,510 during that period:

[76] In May 2021, CMS stated that MACs were permitted to resume postpayment reviews of items and services with dates of service after March 1, 2020. In addition, CMS stated that it reinstated the system edits for psychotherapy services that were in place before the PHE.

- Conduct medical reviews of psychotherapy services, including services provided via telehealth, to verify that the services are documented and billed in accordance with Medicare requirements.

- Implement system edits for psychotherapy services, including services provided via telehealth, to prevent payments for services that were billed incorrectly.

- Strengthen educational efforts to make providers aware of educational materials on how to meet Medicare requirements and guidance for psychotherapy services, including services provided via telehealth.

- Review MAC jurisdictions' LCD requirements for psychotherapy services to identify which provisions effectively promote program integrity, and consider additional steps that CMS could undertake to ensure appropriate coverage and payment for psychotherapy services across all jurisdictions.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first, second, third, and fifth recommendations and described actions that it had taken or planned to take to address our recommendations. For the first, second, and third recommendations, respectively, CMS stated that it will: (1) direct the MACs to recover the identified overpayments consistent with relevant law and the agency's policies and procedures, (2) analyze OIG's data to identify appropriate suppliers to notify of potential overpayments and then instruct the MACs to notify those suppliers of the potential overpayments, and (3) work with the medical review contractors to evaluate the risk associated with psychotherapy services. For the fifth recommendation, CMS stated that it had taken action to prevent improper Medicare payments by educating health care providers and suppliers on proper billing.

CMS did not explicitly state its concurrence or nonconcurrence with our fourth recommendation (to implement system edits for psychotherapy services) and our sixth recommendation (to review MAC jurisdictions' LCD requirements for psychotherapy services to identify which provisions effectively promote program integrity). However, for our fourth recommendation, CMS stated that it continues to recommend that we remove this recommendation. For our sixth recommendation, CMS stated that it will consider our findings and recommendation and other available information to determine whether Medicare should update its documentation requirements.

Our summaries of CMS's comments on our fourth and sixth recommendations and our responses are in the sections that follow. After reviewing CMS's comments, we maintain that our recommendations are valid.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included in their entirety as Appendix I.

RECOMMENDATION TO IMPLEMENT SYSTEM EDITS FOR PSYCHOTHERAPY SERVICES

CMS Comments

CMS did not explicitly state its concurrence or nonconcurrence with our fourth recommendation. CMS stated that it temporarily suspended or temporarily deleted Medicare National Correct Coding Initiative edits for telehealth services allowed during the PHE. CMS stated that it has since reimplemented these edits in phases, an approach that gradually resumed oversight of providers' coding, and therefore has addressed our recommendation.

CMS also stated that OIG identified payments for services above the established limits after the edits were reimplemented, thus implying in this report that the edits are not functioning properly for claims above those limits. CMS stated that OIG believes that any claim with a unit of service in excess of the established limit (which CMS called the medically unlikely edit (MUE) value) was improper.[77] For these claims, CMS noted that if contractors have evidence (e.g., by conducting a medical review) that units of service in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the contractor may bypass the MUE. CMS stated that, given those considerations, CMS believes the edits are functioning as intended and continues to recommend that we remove our recommendation.

Office of Inspector General Response

We acknowledge that CMS reimplemented system edits during our audit period; however, our data analysis showed that Medicare paid for claims billed for psychotherapy services in excess of the established limit after the edits were reimplemented. Those claims were not included in our sample but were identified to provide CMS with additional information. We did not assess whether those claims were allowable and agree that services in excess of CMS's established limit may be allowable if they meet Medicare requirements. Therefore, we revised footnote 66 to avoid any implication that these services were unallowable.

Our audit found that for 12 sampled enrollee days the providers billed for more than one psychotherapy service per enrollee day, but the medical records showed that only one service was provided for each enrollee day. Accordingly, we recommended that CMS implement system edits for psychotherapy services, including services provided via telehealth, to prevent payments for services that were billed incorrectly. To address our recommendation, CMS should consider the information in this report, verify that its current edits are working, and determine whether additional edits need to be implemented.

[77] The MUE value for a CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

RECOMMENDATION TO REVIEW MEDICARE ADMINISTRATIVE CONTRACTOR JURISDICTIONS' LOCAL COVERAGE DETERMINATION REQUIREMENTS FOR PSYCHOTHERAPY SERVICES

CMS Comments

CMS did not explicitly state its concurrence or nonconcurrence with our sixth recommendation. CMS stated that section 1869(f)(2)(B) of the Act does not mandate that LCDs be uniform across all jurisdictions, as there are a number of valid reasons why variation at the local MAC level is appropriate, but that CMS will intervene if a given LCD conflicts with national coverage. CMS also stated that, based on the information in our report, it believes that the MACs' LCDs are consistent with their statutory authority and that the MACs have complied with the scope of their contracts. CMS stated that it will require the MACs to continue to follow the established LCD process. Finally, CMS stated that it will consider our findings and recommendation and other available information to determine whether Medicare should update its documentation requirements, which may require notice-and-comment rulemaking.

Office of Inspector General Response

We understand that LCDs are not required to be uniform across all jurisdictions but note that section 1862(l)(5)(A) of the Act encourages consistency of coverage determinations. We appreciate CMS's consideration of our findings and recommendation to determine whether Medicare documentation requirements for psychotherapy services should be updated. We encourage CMS to take appropriate action to implement the requirements for psychotherapy services that it deems necessary to effectively promote program integrity.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nationwide audit covered approximately $1 billion in Medicare Part B payments for more than 13.5 million psychotherapy services provided from March 1, 2020, through February 28, 2021.[78] We selected two stratified random samples of psychotherapy services provided during the audit period: one sample consisted of psychotherapy services billed as telehealth services, and the other sample consisted of psychotherapy services that were not billed as telehealth services.[79] The telehealth sample consisted of 111 enrollee days, and the non-telehealth sample consisted of 105 enrollee days.[80] In total, we sampled 216 enrollee days, consisting of 216 psychotherapy services and 5 interactive complexity add-on services, with a total paid amount of $43,136:

- 94 services for 60 minutes of psychotherapy (CPT code 90837),[81]
- 61 services for 45 minutes of psychotherapy (CPT code 90834),
- 29 services for 30 minutes of psychotherapy (CPT code 90832),
- 22 services for 30 minutes of psychotherapy with an E&M service (CPT code 90833),
- 7 services for 45 minutes of psychotherapy with an E&M service (CPT code 90836),
- 3 services for 60 minutes of psychotherapy with an E&M service (CPT code 90838), and
- 5 interactive complexity add-on services (CPT code 90785).

We requested supporting documentation from the providers for the services in the telehealth and non-telehealth samples.[82] We reviewed the supporting documentation to determine whether the providers met Medicare requirements and guidance when billing for

[78] Of the $1,030,320,255 in total Medicare Part B payments, $590,948,013 was for psychotherapy services billed as telehealth services, and $439,372,242 was for psychotherapy services that were not billed as telehealth services.

[79] To identify psychotherapy services that were billed as telehealth services, we identified claim lines that included telehealth indicators (i.e., POS code 02 or modifiers 95, GT, GQ, or G0). Our analysis was based on the indicators used on each claim line. The analysis did not include an assessment of whether the providers furnished services only via telehealth or if they also furnished services in person.

[80] For the purpose of this audit, an "enrollee day" included all claim lines for Medicare Part B psychotherapy services with the same service start date for a specific enrollee.

[81] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2019–2020 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply**.

[82] For 4 of the 216 enrollee days, we did not request the supporting documentation because the providers were included in other ongoing OIG reviews. These enrollee days were treated as non-errors for this audit.

psychotherapy services.[83] However, we did not determine whether the services were medically necessary or assess the quality of care provided to enrollees. We also requested that the providers respond to a questionnaire that contained questions related to the psychotherapy services.[84]

We summarized the information obtained from the questionnaires about providers' experiences furnishing services via telehealth during the PHE. This included information about challenges providers encountered, which types of communication products providers used, whether Medicare enrollees consented to receiving telehealth services, and whether providers collected coinsurance from enrollees for psychotherapy services.

We did not perform an overall assessment of the internal control structures of CMS or the MACs. Rather, we limited our review to those controls that were significant to our objectives. Specifically, we reviewed CMS's oversight mechanisms for processing and reviewing Medicare claims for psychotherapy and telehealth services, and for preventing improper payments for those services. For example, we obtained an understanding of CMS's and the MACs' system edits and their policies and procedures for documenting and billing psychotherapy and telehealth services.

We conducted our audit from July 2021 to December 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS and Medicare Part B MAC officials to obtain an understanding of Medicare reimbursement requirements for psychotherapy services, including services provided via telehealth;
- obtained from CMS's National Claims History (NCH) file the paid Medicare Part B claims for psychotherapy services provided to Medicare enrollees during our audit period;[85]

[83] Because our audit focused on psychotherapy services, we did not review E&M services provided in conjunction with those services.

[84] We received questionnaire responses for 187 of the 216 sampled enrollee days. The 187 enrollee days consisted of 96 enrollee days from the telehealth sample and 91 enrollee days from the non-telehealth sample. Appendix D shows the questions that were included in the questionnaire.

[85] Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's NCH file, but we did not assess the completeness of the file.

- created a sampling frame of 7,742,740 enrollee days for psychotherapy services billed with a telehealth indicator (totaling $590,948,013 in Medicare Part B payments) and another sampling frame of 5,828,328 enrollee days for psychotherapy services billed without a telehealth indicator (totaling $439,372,242 in Medicare Part B payments);

- analyzed the sampling frame to determine whether Medicare paid for claims billed for psychotherapy services in excess of the established limit after CMS's system edits were reimplemented;

- selected a stratified random sample of 111 enrollee days of psychotherapy services billed with a telehealth indicator and a stratified random sample of 105 enrollee days of psychotherapy services billed without a telehealth indicator;

- reviewed data from CMS's Common Working File and other available data for the services for the sampled enrollee days to determine whether the claim lines for the services had been canceled or adjusted;

- requested supporting documentation from the providers for 212 of the 216 enrollee days included in the 2 samples;[86]

- reviewed the supporting documentation to determine whether providers met Medicare requirements when billing for psychotherapy services;

- requested that the providers respond to a questionnaire that included questions related to the services included in our samples and analyzed the responses to obtain information on providers' experience with providing telehealth services during the PHE;

- reviewed the supporting documentation and the responses to the questionnaires to determine whether providers met Medicare guidance when billing for psychotherapy services;

- estimated the total amounts of unallowable Medicare payments made to providers that did not meet Medicare requirements when billing for psychotherapy services that were billed as telehealth services (Appendix F) and not billed as telehealth services (Appendix G); and

- discussed the results of our audit with CMS officials.

[86] We did not request supporting documentation for 4 enrollee days because we determined that they were already part of other OIG reviews after we had selected our samples. These enrollee days were treated as non-errors for this audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR OF GENERAL REPORTS

Report Title	Report Number	Date Issued
Illinois Generally Complied With Requirements for Claiming Medicaid Reimbursement for Telehealth Payments During COVID-19	A-05-21-00035	12/21/2022
Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic	OEI-02-22-00150	11/30/2022
The IHS Telehealth System Was Deployed Without Some Required Cybersecurity Controls	A-18-21-03100	9/7/2022
Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks	OEI-02-20-00720	9/2/2022
Psychotherapy Services Billed by a New York City Provider Did Not Comply With Medicare Requirements	A-02-21-01006	3/29/2022
Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic	OEI-02-20-00520	3/15/2022
Most Medicare Beneficiaries Received Telehealth Services Only From Providers With Whom They Had an Established Relationship	OEI-02-20-00521	10/18/2021
On-Site Psychological Services, P.C.: Audit of Medicare Payments for Psychotherapy Services	A-02-19-01012	7/21/2020
Grand Desert Psychiatric Services: Audit of Medicare Payments for Psychotherapy Services	A-09-19-03018	4/20/2020
Oceanside Medical Group Received Unallowable Medicare Payments for Psychotherapy Services	A-09-18-03004	8/28/2019

APPENDIX C: DIFFERENCES IN PSYCHOTHERAPY DOCUMENTATION REQUIREMENTS IN MEDICARE ADMINISTRATIVE CONTRACTORS' LOCAL COVERAGE DETERMINATIONS[87]

Documentation Requirements		WPS	CGS	NGS	FCSO	Novitas
Treatment Plan	Updated treatment plan	X	X			
	Treatment plan with the following elements:					
	Type of service to be furnished		X	X		
	Amount of service to be furnished		X	X		
	Frequency of services/sessions		X	X		
	Duration of treatment		X	X		
	Diagnosis		X	X		
	Anticipated goals		X	X		
Individual Psychotherapy	Periodic summary of goals	X	X			
	Progress toward goals	X	X			
	Time spent on psychotherapy	X	X			X
	Therapeutic maneuvers	X	X			X
	Patient's capacity to participate in psychotherapy	X				X
	Patient's capacity to benefit from psychotherapy	X				
	Reasonable expectation of improvement or maintenance of level of function			X	X	X
	Medical necessity, including: (1) presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to alter baseline functioning; (2) detailed summary of the session, including descriptive documentation of therapeutic interventions; (3) degree of patient participation and interaction with the therapist, the reaction of the patient to the therapy session, documentation toward goal-oriented outcomes, and the changes or lack of changes in patient symptoms and/or behavior as a result of the therapy session; and (4) rationale for any departure from the plan or extension of therapy should be documented in the medical record. The therapist must document patient-therapist interaction in addition to an assessment of the patient's problem(s).				X	

[87] An "X" in the table shows that the individual LCD requirement was in place at the MAC.

Documentation Requirements		WPS	CGS	NGS	FCSO	Novitas
Group Psychotherapy	Led by a person who is authorized by State statute to perform this service	X	X	X	X	
	Must not include socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy	X	X	X	X	
	Self-help groups or support groups without a qualified professional present are not covered	X				
	Group size of 12 people or fewer	X	X	X	X	
Interactive Complexity	The medical record for interactive complexity reported with the psychiatric procedures must indicate that the person being evaluated does not have the ability to interact through normal verbal communicative channels, include adaptations utilized in the session and the rationale for employing these interactive techniques, and recommendations for future care.	X	X		X	
Psychotherapy Limitations	Psychotherapy services do not include teaching grooming skills, monitoring activities of daily living (ADLs), recreational therapy (dance, art, play), or social interaction.	X	X	X	X	X
	Severe and profound mental retardation is never covered for psychotherapy services.	X	X			X
	Severe and profound mental intellectual disabilities are never covered for psychotherapy services.			X		
	Psychotherapy services are not covered when documentation indicates that senile dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.	X	X	X	X	X

APPENDIX D: PROVIDER QUESTIONNAIRE

Questions
1. How was the psychotherapy service provided (e.g., in office, telehealth)? If the service was provided via telehealth, provide a response to questions *a* through *e* below. a. Did you provide the service via audio-only technology? Or was the service provided using both audio and visual technology? b. If the service was provided via telehealth with audio and visual technology, what platform was used for the psychotherapy service (e.g., Zoom, FaceTime)? c. Did the enrollee provide consent for the service to be provided via telehealth? d. Where was the provider located during the service? e. Where was the enrollee located during the service?
2. Have you faced any challenges (e.g., technology, scheduling) with providing telehealth psychotherapy services to any patient?
3. Who provided the psychotherapy service to the enrollee? Please provide their name, title, and NPI number.
4. Was the psychotherapy service provided under the direct supervision of another provider? If so, please provide their name, title, and NPI number. a. Was the direct supervision provided in person or through virtual presence? b. If the direct supervision was provided virtually, what platform was used? c. If the direct supervision was provided virtually, was video real-time communication technology used? Or was audio-only technology used?
5. Was your first visit with this enrollee in person or via telehealth?
6. Did you collect the coinsurance for the psychotherapy service? If so, who paid the coinsurance (e.g., the enrollee, secondary insurance)?

APPENDIX E: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We created two sampling frames of Medicare Part B line items grouped by enrollee and service start date for psychotherapy services provided during our audit period. The first sampling frame comprised 7,742,740 enrollee days, which included 7,876,615 line items for psychotherapy services billed with a telehealth indicator, totaling $590,948,013 in Medicare Part B payments. The second sampling frame comprised 5,828,328 enrollee days, which included 6,090,430 line items for psychotherapy services billed without a telehealth indicator, totaling $439,372,242 in Medicare Part B payments. Both sampling frames contained enrollee days with payment amounts of $25 or greater that had not been previously reviewed by OIG, the Recovery Audit Contractor, or another Medicare contractor.

SAMPLE UNIT

The sample unit was an enrollee day, which consisted of all claim lines for Medicare Part B psychotherapy services with the same service start date for a specific enrollee.

SAMPLE DESIGN AND SAMPLE SIZE

We used two stratified random samples. To accomplish this, we separated each sampling frame into three strata. Tables 1 and 2 show the details of the strata for the enrollee days that contained claim lines billed with and without a telehealth indicator, respectively.

Table 1: Strata for Enrollee Days Billed With a Telehealth Indicator

Stratum	Payment Range for Enrollee Days	No. of Enrollee Days in Sampling Frame	Sample Size	Total Value of Enrollee Days in Sampling Frame
1	Enrollee days ($25.00–$79.99)	4,619,104	50	$281,231,018
2	Enrollee days ($80.00–$999.99)	3,123,625	50	309,697,407
3	Enrollee days (more than $999.99)	11	11	19,588
Total		**7,742,740**	**111**	**$590,948,013**

Table 2: Strata for Enrollee Days Billed Without a Telehealth Indicator

Stratum	Payment Range for Enrollee Days	No. of Enrollee Days in Sampling Frame	Sample Size	Total Value of Enrollee Days in Sampling Frame
1	Enrollee days ($25.00–$79.99)	3,312,137	50	$194,619,114
2	Enrollee days ($80.00–$999.99)	2,516,186	50	244,745,501
3	Enrollee days (more than $999.99)	5	5	7,627
Total		**5,828,328**	**105**	**$439,372,242**

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the enrollee days in each stratum by Health Insurance Claim number and date of service before we consecutively numbered the sample units in each stratum of each sampling frame. We then generated the random numbers for our samples according to our sample design, and we selected the corresponding items for review.

ESTIMATION METHODOLOGY

We used the OAS statistical software to separately estimate the total amounts that Medicare improperly paid providers for psychotherapy services in the sampling frame with a telehealth indicator and in the sampling frame without a telehealth indicator.

APPENDIX F: SAMPLE RESULTS AND ESTIMATES FOR PSYCHOTHERAPY SERVICES BILLED WITH A TELEHEALTH INDICATOR

Table 3: Sample Results

Stratum	No. of Enrollee Days in Sampling Frame	Value of Enrollee Days in Sampling Frame	Sample Size	Value of Sample	No. of Enrollee Days With Improper Payments	Value of Enrollee Days With Improper Payments
1	4,619,104	$281,231,018	50	$2,976	29	$1,839
2	3,123,625	309,697,407	50	5,179	28	2,846
3	11	19,588	11	19,588	11	19,114
Total	**7,742,740**	**$590,948,013**	**111**	**$27,743**	**68**	**$23,799**

Table 4: Estimated Value of Improper Payments in the Sampling Frame for Psychotherapy Services Billed With a Telehealth Indicator
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$347,699,561
Lower limit	296,619,364
Upper limit	398,779,759

APPENDIX G: SAMPLE RESULTS AND ESTIMATES FOR PSYCHOTHERAPY SERVICES BILLED WITHOUT A TELEHEALTH INDICATOR

Table 5: Sample Results

Stratum	No. of Enrollee Days in Sampling Frame	Value of Enrollee Days in Sampling Frame	Sample Size	Value of Sample	No. of Enrollee Days With Improper Payments	Value of Enrollee Days With Improper Payments
1	3,312,137	$194,619,114	50	$2,918	26	$1,328
2	2,516,186	244,745,501	50	4,848	29	2,861
3	5	7,627	5	7,627	5	7,572
Total	**5,828,328**	**$439,372,242**	**105**	**$15,393**	**60**	**$11,761**

Table 6: Estimated Value of Improper Payments in the Sampling Frame for Psychotherapy Services Billed Without a Telehealth Indicator

(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$231,967,949
Lower limit	193,320,897
Upper limit	270,615,052

APPENDIX H: SUMMARY OF DEFICIENCIES RELATED TO PSYCHOTHERAPY SERVICES IN THE TELEHEALTH AND NON-TELEHEALTH SAMPLES

Types of Deficiencies			No. of Deficiencies (Telehealth Sample)	No. of Deficiencies (Non-Telehealth Sample)	Total
Medicare Requirements	1	Psychotherapy time was not documented	24	36	**60**
	2	Treatment plans were incomplete or missing	29	14	**43**
	3	No psychotherapy was provided, or documentation was missing	11	13	**24**
	4	Psychotherapy services had incomplete documentation	11	9	**20**
	5	Incorrect number of services or incorrect CPT code was billed	12	4	**16**
	6	Providers did not meet incident-to requirements	5	7	**12**
Medicare Guidance	7	Providers' signatures were missing	20	11	**31**
	8	Providers did not include modifiers on claims to identify telehealth services	3	26	**29**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: February 15, 2023

TO: Juliet T. Hodgkins
Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Providers for Some Psychotherapy Services, Including Those Provided via Telehealth, During the First Year of the COVID-19 Public Health Emergency (A-09-21-03021)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

COVID-19 has exacerbated the nation's struggle with mental health and substance use disorders, collectively called behavioral health conditions, fueling a full-blown crisis. To ensure that every American gets the behavioral health care they deserve, President Biden announced a strategy to address the national mental health crisis as part of the Administration's Unity Agenda.[1] Additionally, CMS has issued a Behavioral Health Strategy, seeking to adopt a data-informed approach that removes barriers to care and promotes person-centered behavioral health care, including emotional and mental wellbeing.[2] With almost $1 trillion in claims and covering more than 63 million Americans, Medicare plays a critical role in implementing this strategy as evidenced by a series of new behavioral health policies in CMS' Calendar Year (CY) 2023 Physician Fee Schedule and Outpatient Prospective Payment System final rules. [3]

In the context of the COVID-19 public health emergency (PHE), CMS recognized that the use of telehealth could help address new challenges regarding potential exposure risks, for people with Medicare, health care providers, and the community at large. To facilitate the use of telecommunications technology as a safe substitute for in-person services, CMS, on a temporary

[1] Additional information is available in Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his Frist State of the Union. Accessed at: https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

[2] Additional information about how CMS is addressing and improving behavioral health is available on the CMS website at: https://www.cms.gov/about-cms/story-page/behaviorial-health?_sm_byp=iVV0tTRn1ZQNFskr

[3] Overviews of the new behavioral health policies are available in the final rule Fact Sheets available at: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule; https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2

interim final basis, added many services to the list of eligible Medicare telehealth services, eliminated frequency limitations and other requirements associated with particular services furnished via telehealth, and clarified several payment rules that apply to other services that are furnished using telecommunications technologies that can reduce exposure risks.[4]

Over the course of the COVID-19 PHE, CMS has learned a great deal from health care providers, facilities, insurers, and other stakeholders' experience and use of the various waivers and flexibilities. In many cases, these flexibilities have proven to be incredibly useful during the initial challenges of the pandemic. In fact, CMS has determined that some of these measures should remain in place, consistent with our statutory authority, even after the end of the COVID-19 PHE to promote innovation, improve quality, advance health equity, and expand access to care. For example, lessons learned from the beginning of the pandemic on mental and behavioral health services furnished via telehealth informed CMS' decision to make permanent a policy to allow mental and behavioral health services to be furnished via audio-only telecommunications technology in certain circumstances.[5]

Additionally, CMS has taken steps to implement policies consistent with changes in legislation that take effect after the COVID-19 PHE ends. For example, Section 123 of the Consolidated Appropriations Act, 2021 removed the geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of a mental health disorder. The amendments made by section 123 require for these services that there must be an in-person, non-telehealth service with the physician or practitioner within six months prior to the initial telehealth services and requires the Secretary to establish a frequency for subsequent in-person visits. CMS implemented these statutory amendments via the CY 2022 Physician Fee Schedule Final Rule, specifying that an in-person, non-telehealth visit must be furnished at least every 12 months for these services, and that exceptions to the in-person visit requirement may be made based on beneficiary circumstance (with the reason documented in the patient's medical record), while clarifying that more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.

CMS takes the health and safety of individuals with Medicare seriously, and is committed to providing them with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. As such, CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

CMS has also taken action to prevent improper Medicare payments by educating health care providers and suppliers on proper billing. CMS educates health care providers and suppliers on Medicare billing through various channels including the Medicare Learning Network (MLN), weekly electronic newsletters, and quarterly compliance newsletters. As stated in the OIG's report, CMS and the MACs published several guidance documents and updated their websites with

[4] The list of these eligible telehealth services is published on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

[5] Medicare Program; Calendar Year 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Final Rule (86 FR 64996) (11/19/2021). Accessed at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf

information related to telehealth flexibilities and psychotherapy services throughout the audit period.[6]

The OIG's recommendations and CMS's responses are below.

OIG Recommendation 1

The OIG recommends that the Centers for Medicare & Medicaid Services work with the MACs to recover $35,560 in improper payments made to providers for the 128 sampled enrollee days that did not meet Medicare requirements.

CMS Response

CMS concurs with this recommendation. CMS will direct the MACs to recover identified overpayments consistent with relevant law and the agency's policies and procedures.

OIG Recommendation 2

The OIG recommends that the Centers for Medicare & Medicaid Services work with the MACs to, based on the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

CMS Response

CMS concurs with this recommendation. CMS will analyze OIG's data to identify appropriate suppliers to notify of potential overpayments. CMS will then instruct the MACs to notify the identified suppliers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation 3

The OIG recommends that the Centers for Medicare & Medicaid Services conduct medical review of psychotherapy services, including services provided via telehealth, to verify that the services are documented and billed in accordance with Medicare requirements.

CMS Response

CMS concurs with this recommendation. CMS will work with the medical review contractors to evaluate the risk associated with psychotherapy services.

OIG Recommendation 4

The OIG recommends that the Centers for Medicare & Medicaid Services implement system edits for psychotherapy services, including services provided via telehealth, to prevent payments for services that were billed incorrectly.

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[6] Examples of the guidance documents that were published during the audit period include: MLN Booklet Medicare Mental Health available at: https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf; MLN Fact Sheet Telehealth Services available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf; FromCoverage to Care Telehealth For Providers: What You Need to Know available at: https://www.cms.gov/files/document/telehealth-toolkit-providers.pdf

CMS Response

CMS issued waivers to prevent gaps in access to care for patients affected by the COVID-19 PHE, including waivers for services furnished via telehealth. The changes to payment and coverage policies were intended to allow health care providers maximum flexibility to minimize the spread of COVID-19 among individuals with Medicare, health care personnel, and the community at large and increase capacity to address the needs of their patients. Subsequently, CMS temporarily suspended or temporarily deleted Medicare NCCI edits based on the list of all Covered Telehealth Services for the COVID-19 PHE to accommodate the changes. CMS has since reimplemented the NCCI edits in phases, an approach that gradually resumed oversight of providers' coding while facilitating access to care during the PHE, and therefore has already addressed the OIG's recommendation.

Although these edits have been reimplemented and CMS believes it has addressed the recommendation, OIG indicates that it identified payments for services above the established limits after the edits were reimplemented, thus implying the edits aren't functioning properly for claims above established limits. CMS would like to emphasize that the medically unlikely edits (MUEs) associated with the codes for this audit have an adjustment indicator of "3" which means that these are per day edits based on clinical benchmarks. OIG believes that any claim with a unit of service in excess of the MUE value was improper. However, CMS notes that for these claims, if contractors have evidence (e.g., conduct medical review) that units of service in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the contractor may bypass the MUE for a HCPCS code with an adjustment indicator of "3" during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher-level appeal. Given those considerations, CMS believes the edits are functioning as intended, and CMS continues to recommend that OIG remove this recommendation.

OIG Recommendation 5

The OIG recommends that the Centers for Medicare & Medicaid Services strengthen educational efforts to make providers aware of education materials on how to meet Medicare requirements and guidance for psychotherapy services, including services provided via telehealth.

CMS Response

CMS concurs with this recommendation. CMS has taken action to prevent improper Medicare payments by educating health care providers and suppliers on proper billing. CMS educates health care providers and suppliers on Medicare billing through various channels including the Medicare Learning Network (MLN), weekly electronic newsletters, and quarterly compliance newsletters. As stated in the OIG's report, CMS and the MACs published several guidance documents and updated their websites with information related to telehealth flexibilities and psychotherapy services throughout the audit period. CMS and the MACs will continue to educate providers regarding proper billing and Medicare requirements.

Additionally, as stated above, CMS will notify the MACs of this audit so that they may evaluate the vulnerabilities associated with psychotherapy services and conduct data analysis to determine if psychotherapy services should be a part of their medical review strategy.

OIG Recommendation 6

The OIG recommends that the Centers for Medicare & Medicaid Services review MAC jurisdictions' LCD requirements for psychotherapy service to identify which provisions

effectively promote program integrity, and consider additional steps that CMS could undertake to ensure appropriate coverage and payment for psychotherapy services across all jurisdictions.

CMS Response

Congress expressly delegated to MACs the function of developing LCDs, as defined in section 1869(f)(2)(B) of the Social Security Act. The statute does not mandate that LCDs be uniform across all jurisdictions, as there are a number of valid reasons why variation at the local MAC level is appropriate. However, CMS will intervene if a given LCD conflicts with national coverage or the MAC did not follow the LCD development process outlined in chapter 13 of the Medicare Program Integrity Manual.

Based on the information within this report, CMS believes that the MACs' LCDs are consistent with their statutory authority, and the MACs have complied with the scope of their contracts. CMS will require the MACs to continue to follow the established LCD process, including the reliance upon evidence of general acceptance by the medical community, for establishing any such determinations.

CMS takes the health and safety of individuals with Medicare seriously, and is committed to providing them with access to medically necessary services. As stated above, CMS has adopted a data-informed approach that removes barriers to care and promotes person-centered behavioral health care. As such, CMS has taken a number of actions to increase access to equitable and high-quality behavioral health services and improve outcomes for individuals with Medicare. CMS will consider the OIG's findings and recommendation and other available information to determine if Medicare should update its documentation requirements, which may require notice and comment rulemaking.