

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OCEANSIDE MEDICAL GROUP RECEIVED
UNALLOWABLE MEDICARE PAYMENTS
FOR PSYCHOTHERAPY SERVICES**

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Office of Inspector General

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Report in Brief

Date: August 2019

Report No. A-09-18-03004

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



Why OIG Did This Review

Medicare paid about \$1.9 billion for psychotherapy services provided to beneficiaries nation-wide from July 1, 2015, through June 30, 2017 (audit period). Prior OIG reviews found that Medicare had made millions in improper payments for mental health services, including psychotherapy services. After analyzing Medicare claim data, we selected for review Oceanside Medical Group (Oceanside). Our analysis indicated that providers from Oceanside billed Medicare an average of 33 individual services per day. In addition, two providers each billed for services on all but 5 days during our audit period.

Our objective was to determine whether Oceanside complied with Medicare requirements when billing for psychotherapy services.

How OIG Did This Review

Our review covered Oceanside's Medicare Part B claims for psychotherapy services provided during our audit period. Our sampling frame consisted of 52,608 beneficiary days, totaling \$2.8 million. (A beneficiary day consisted of all psychotherapy services provided on a specific date of service for a specific beneficiary for which Oceanside received a Medicare payment.) We reviewed a random sample of 100 beneficiary days, which included 103 individual psychotherapy services. We did not determine whether the services were medically necessary.

Oceanside Medical Group Received Unallowable Medicare Payments for Psychotherapy Services

What OIG Found

Oceanside did not comply with Medicare requirements when billing for psychotherapy services. Specifically, none of the 100 sampled beneficiary days, consisting of 103 psychotherapy services, complied with Medicare requirements: psychotherapy was not provided (52 services), psychotherapy time was not documented (49 services), and adequate supporting documentation was not provided (2 services).

As a result, Oceanside received \$5,317 in unallowable Medicare payments. On the basis of our sample results, we estimated that Oceanside received at least \$2.6 million in unallowable Medicare payments for psychotherapy services. These overpayments occurred because Oceanside did not have policies and procedures or effective management oversight to ensure that psychotherapy services billed to Medicare were actually provided, adequately documented, and correctly billed.

What OIG Recommends and Oceanside Comments

We recommend that Oceanside (1) refund to the Medicare program the portion of the estimated \$2.6 million overpayment for claims that are within the reopening period; (2) for the remaining portion of the estimated \$2.6 million overpayment for claims that are outside of the reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and (4) implement policies and procedures and strengthen management oversight to ensure that psychotherapy services billed to Medicare are actually provided, adequately documented, and correctly billed.

Oceanside disagreed with our findings and our first recommendation. Oceanside agreed that our second and third recommendations correctly stated Oceanside's obligations under the 60-day rule but disputed that it was "in violation of any overpayment." Oceanside agreed with our fourth recommendation and provided information on actions that it had taken or planned to take to address our recommendation.

After reviewing Oceanside's comments, we maintain that our findings and recommendations remain valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicare paid approximately \$1.9 billion for psychotherapy services provided to Medicare beneficiaries nation-wide from July 1, 2015, through June 30, 2017 (audit period). Prior Office of Inspector General (OIG) reviews found that Medicare had made millions in improper payments for mental health services (including psychotherapy services) that were billed incorrectly, provided by unqualified providers, undocumented, inadequately documented, or medically unnecessary.¹ The report issued in 2001 stated that psychotherapy services were particularly problematic.

After analyzing Medicare claim data, we selected several providers for review, including Oceanside Medical Group (Oceanside), which is located in Santa Monica, California.² Our analysis indicated that individual providers from Oceanside billed Medicare an average of 33 individual services per day.³ On some days, 4 providers each billed for more than 90 individual services. In addition, two providers each billed for services on all but 5 days during our 2-year audit period.

OBJECTIVE

Our objective was to determine whether Oceanside complied with Medicare requirements when billing for psychotherapy services.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Part B provides supplementary medical insurance for medical and other health services. CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Part B claims. During our audit period, Noridian Healthcare Solutions, LLC (Noridian), was the MAC that processed and paid Oceanside's Medicare claims.

¹ *Medicare Payments for 2003 Part B Mental Health Services: Medical Necessity, Documentation, and Coding* ([OEI-09-04-00220](#)), issued April 2007; and *Medicare Part B Payments for Mental Health Services* ([OEI-03-99-00130](#)), issued May 2001.

² We plan to issue separate reports on the results of our reviews of the other providers.

³ The average of 33 individual services includes individual psychotherapy and other services, such as evaluation and management (E&M) services and psychiatric diagnostic evaluations.

Psychotherapy

Psychotherapy treats mental illness and behavioral disturbances. A physician or other qualified healthcare 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.

Psychotherapy can help eliminate or control troubling symptoms so that a person can function better. It can also increase well-being and healing. 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 Coverage of Psychotherapy Services

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.⁴ 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.⁵

Medicare beneficiaries may receive a medical E&M service on the same day as a psychotherapy service by the same physician, psychiatrist, or other qualified healthcare professional.⁶ For a provider to receive Medicare payment for both the E&M and psychotherapy services, the two services must be significant and separately identifiable.⁷

Medicare requires that psychotherapy services be reasonable and necessary for the diagnosis or treatment of a beneficiary's illness.⁸ Providers bill Medicare for individual psychotherapy

⁴ The Social Security Act (the Act) §§ 1832(a)(1) and 1861(s); 42 CFR §§ 410.20, 410.71, and 410.73–410.75; CMS's *Medicare Benefit Policy Manual*, Pub. No. 100-02 (the Manual), chapter 6, § 70.1(C)(1); and CMS's *Mental Health Services* booklet (ICN 903195), issued January 2015.

⁵ The Manual, chapter 15, §§ 30, 160, 170, 190, and 200.

⁶ Other qualified healthcare professionals that 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 (the Manual, chapter 15, §§ 190(B)(3), 200(C)(1), and 210(B)(2)).

⁷ American Medical Association (AMA), *CPT [Current Procedural Terminology] 2015–2017*, and Medicare Learning Network (MLN) Matters Special Edition Article SE1407, reissued on March 18, 2014.

⁸ The Act § 1862(a)(1)(A).

services using one of six psychotherapy CPT⁹ codes, depending on the time spent on psychotherapy and whether the service was performed alone or in conjunction with an E&M service. (Figure 1 shows the psychotherapy CPT codes and their descriptions.) Providers must bill the appropriate CPT code based on the actual time spent on psychotherapy. Each code has a range of time associated with it. 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.)¹⁰ There is also a CPT code for group psychotherapy and another for interactive complexity, which is an add-on code that can be billed with a psychotherapy service.¹¹

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

To be paid for an individual psychotherapy service, the provider must furnish information necessary to determine the amount due to the provider.¹² CMS guidance states: “Because time is indicated in the code descriptor for the psychotherapy CPT codes, it is important for providers to clearly document in the patient’s medical record the time spent providing the psychotherapy service.”¹³

⁹ The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2014–2016 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.

¹⁰ AMA, CPT 2015–2017, and MLN Matters Special Edition Article SE1407, reissued on March 18, 2014.

¹¹ AMA, CPT 2015–2017. “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 code may be used in conjunction with CPT codes for psychotherapy.

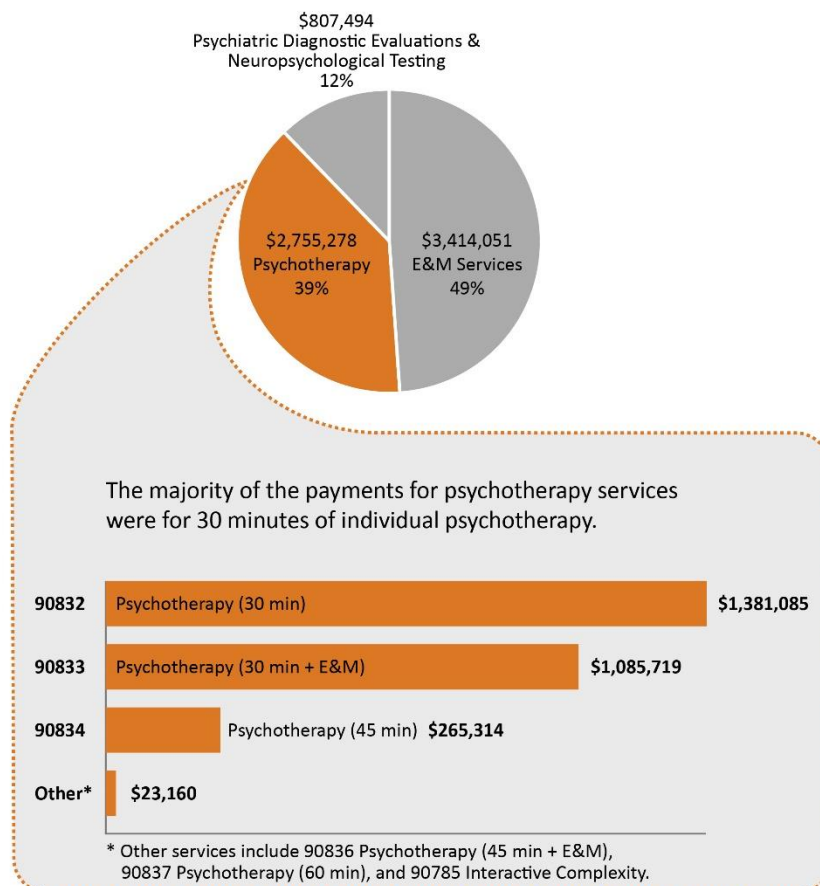
¹² The Act § 1833(e).

¹³ MLN Matters Special Edition Article SE1407, reissued on March 18, 2014.

Oceanside Medical Group

Oceanside was established in 2011 and provides services at various facilities, such as hospitals, skilled nursing facilities, and residential care facilities. For our audit period, Medicare paid Oceanside nearly \$7 million for a variety of services, such as E&M services, psychotherapy, and psychiatric diagnostic evaluations provided by its owner (a licensed psychiatrist) and seven independent contractors: three clinical psychologists, three nurse practitioners, and one physician assistant. Our analysis of Medicare claim data showed that 39 percent of the Medicare payments that Oceanside received were for psychotherapy. The majority of these payments were for the two CPT codes representing 30 minutes of time spent on psychotherapy (with and without E&M). Figure 2 shows all the Medicare payments that Oceanside received during our audit period and the amount paid by Medicare for psychotherapy services, with a breakdown of the CPT codes billed for psychotherapy services.

Figure 2: Thirty-nine Percent of the Medicare Payments to Oceanside Were for Psychotherapy



Medicare Requirements for Providers To Identify and Return Overpayments

OIG believes that this audit report constitutes credible information of potential overpayments. Providers that receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).¹⁴

HOW WE CONDUCTED THIS REVIEW

Our review covered Oceanside's Medicare Part B claims for psychotherapy services provided during our audit period. Our sampling frame consisted of 52,608 beneficiary days, totaling \$2.8 million.¹⁵ We reviewed a random sample of 100 beneficiary days, which included 103 individual psychotherapy services (for 3 beneficiary days, the beneficiaries received 2 psychotherapy services):

- 51 services for 30 minutes of psychotherapy with an E&M service,
- 43 services for 30 minutes of psychotherapy, and
- 9 services for 45 minutes of psychotherapy.

We requested medical records from both Oceanside and the facilities where the services were provided. Oceanside provided us with supporting documentation for 100 of the 103 psychotherapy services in our sample.¹⁶ The facilities provided medical records for 98 psychotherapy services.¹⁷ We reviewed the documentation to determine whether Oceanside complied with Medicare requirements for billing psychotherapy services. However, we did not determine whether the services were medically necessary.

¹⁴ The Act § 1128J(d); 42 CFR part 401, subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

¹⁵ Our sampling frame totaled \$2,752,119. A beneficiary day consisted of all psychotherapy services provided on a specific date of service for a specific beneficiary for which Oceanside received a payment from Medicare. We excluded (1) beneficiary days with payment amounts less than \$25 and (2) lines of service that had been reviewed, were currently under review, or were excluded from review by the Recovery Audit Contractor (RAC). (Each line of service represented a billed service on a claim.)

¹⁶ Oceanside did not provide supporting documentation for two services because the services had not been provided. Because no psychotherapy services were provided, we considered these services to have been billed in error. For one service, Oceanside was unable to obtain the medical record from the facility; however, the facility provided the medical record to us for review.

¹⁷ We requested the medical records from the facilities to supplement and corroborate the supporting documentation that we obtained from Oceanside. The facilities did not provide medical records for five services because they were unable to locate the records, they did not maintain beneficiary medical records, or the services were not provided (which included the two services that Oceanside did not provide and were billed in error).

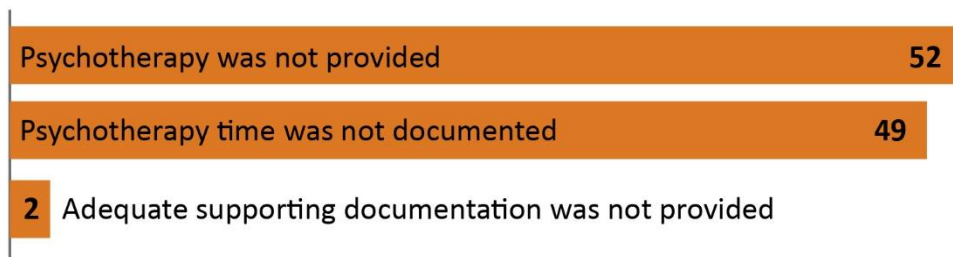
We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. 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, Appendix B describes our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

Oceanside did not comply with Medicare requirements when billing for psychotherapy services. Specifically, none of the 100 sampled beneficiary days, consisting of 103 psychotherapy services, complied with the requirements. Figure 3 shows the number of services for each type of deficiency we found.

Figure 3: Unallowable Services in Our Sample by Type of Deficiency



As a result, Oceanside received \$5,317 in unallowable Medicare payments. On the basis of our sample results, we estimated that Oceanside received at least \$2.6 million¹⁸ in unallowable Medicare payments for psychotherapy services. These overpayments occurred because Oceanside did not have policies and procedures or effective management oversight to ensure that psychotherapy services billed to Medicare were actually provided, adequately documented, and correctly billed.

¹⁸ The estimated lower limit for the unallowable Medicare payments was \$2,694,446.

OCEANSIDE DID NOT COMPLY WITH MEDICARE REQUIREMENTS WHEN BILLING FOR PSYCHOTHERAPY SERVICES

Psychotherapy Was Not Provided

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)). To report both E&M and psychotherapy, the two services must be significant and separately identifiable (AMA, *CPT* 2015–2017).

For 52 services, Oceanside did not provide psychotherapy. For 50 of these services, Oceanside or the facilities or both provided medical records, but the medical records did not indicate that psychotherapy had been provided. For the remaining two services, Oceanside stated that the services were not provided and had been billed in error.¹⁹

Psychotherapy Services Billed With E&M Services Were Particularly Problematic

Our sample included 51 psychotherapy services that were billed with E&M services. We found that 49 of these psychotherapy services were not provided.

Examples of Psychotherapy Services That Were Not Provided

On August 14, 2015, Oceanside billed Medicare for a 30-minute psychotherapy service in conjunction with an E&M service. Medicare paid Oceanside \$53 for the psychotherapy service and \$32 for the E&M service. However, the medical record for the date of service did not indicate that psychotherapy had been provided. The medical record stated that the beneficiary had a urinary tract infection and would be treated with psychotropic medications to prevent any further decline in the beneficiary’s cognition. (Psychotropic medication is a type of drug used to treat clinical psychiatric symptoms or mental disorders.)

In another instance, on September 20, 2016, Oceanside billed Medicare for a 30-minute psychotherapy service in conjunction with an E&M service. Medicare paid Oceanside \$53 for the psychotherapy service and \$33 for the E&M service. The medical record provided by the facility where the service was furnished indicated that the psychiatrist from Oceanside signed an order for a “MRSA [methicillin-resistant *Staphylococcus aureus*] culture,” which is a laboratory test unrelated to psychotherapy. The medical record also showed that on the same date a psychotherapy service was furnished by a provider who was not working for Oceanside. (This service was not part of our sample.)

¹⁹ Oceanside refunded the Medicare payment for one of these services; however, the refund occurred after we requested the medical records for our audit.

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 Act § 1833(e)). Providers must bill the CPT code based on the actual time spent on psychotherapy (i.e., CPT codes 90832 and 90833 for 16 to 37 minutes, CPT codes 90834 and 90836 for 38 to 52 minutes, and CPT codes 90837 and 90838 for 53 or more minutes). Providers must not bill for psychotherapy of less than 16 minutes (AMA, *CPT 2015–2017*).

For 49 services, the medical records indicated that psychotherapy was provided but Oceanside did not document the time spent on psychotherapy.

Example of Psychotherapy Time That Was Not Documented

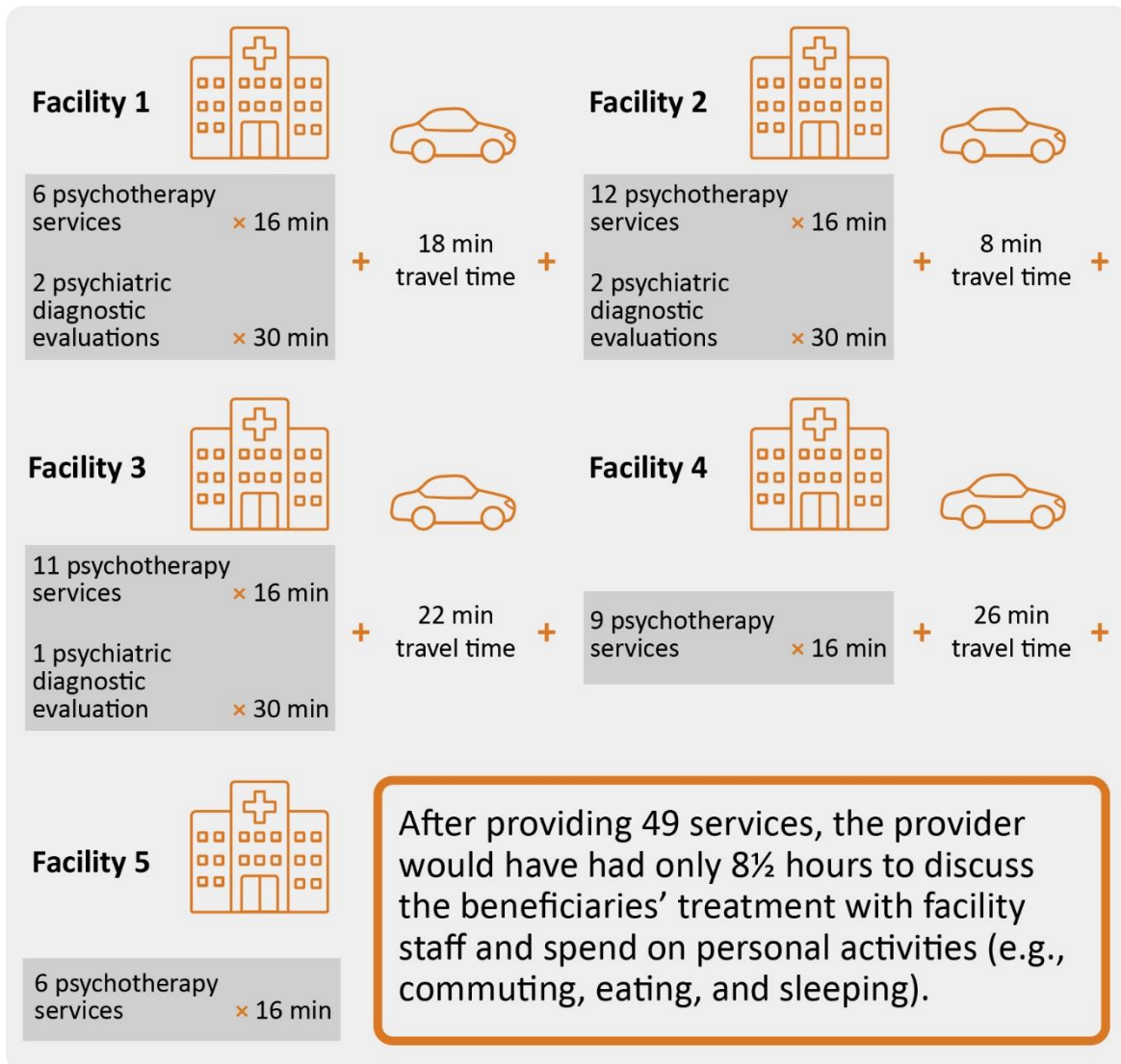
On April 30, 2016, Oceanside billed Medicare for a 30-minute psychotherapy service for which Medicare paid Oceanside \$53. For this service, the medical record did not include the time spent with the beneficiary to support that the provider had spent 16 to 37 minutes with the beneficiary.

Medicare claim data indicated that many of the providers at Oceanside often billed for a high number of services in 1 day,²⁰ which made us question the providers’ ability to spend 16 minutes or more with the beneficiaries for whom psychotherapy was billed. The claim data showed that on the date of service for the example above, Oceanside billed Medicare for 49 services (44 psychotherapy services and 5 psychiatric diagnostic evaluations) furnished by the same provider to beneficiaries at 5 different facilities. Figure 4 on the following page illustrates the number of services that Oceanside billed that day for this provider and the minimum amount of time it would have taken to provide the services.

Considering that our estimate did not include a meal period, breaks, or the time it would have taken the provider to travel to the first facility or discuss the beneficiaries’ treatment with facility staff, our data analysis suggests that it would have been unlikely for the provider to have spent 16 minutes or more furnishing each of the psychotherapy services billed to Medicare.

²⁰ Oceanside stated that it provided services to patients at various facilities regardless of whether patients had Medicare coverage. However, our analysis was limited to the services that were billed to Medicare.

Figure 4: It Would Have Taken at Least 15½ Hours for the Provider To Complete the 49 Individual Services That She Billed to Medicare for 1 Day²¹



Adequate Supporting Documentation Was Not Provided

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)).

²¹ To be conservative, our calculation was based on 16 minutes for psychotherapy (the minimum amount of time for a billable individual psychotherapy service) and 30 minutes for a psychiatric diagnostic evaluation. (Oceanside stated that it takes 30 to 45 minutes to complete a psychiatric diagnostic evaluation). The travel time to each facility was based on the fastest route by car.

According to CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08 (Program Integrity Manual): "All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service (chapter 3, § 3.3.2.5.A)." In addition, documents containing amendments, corrections, or addenda must (1) clearly and permanently identify any amendment, correction, or delayed entry²² as such; (2) clearly indicate the date and author of any amendment, correction, or delayed entry; and (3) clearly identify all original content, without deletion (Program Integrity Manual, chapter 3, § 3.3.2.5.B.).

For two services, neither Oceanside nor the facilities had adequate supporting documentation. For these services, Oceanside did not provide documentation that was created when the services were provided. Rather, Oceanside created the medical record entries after we requested supporting documentation for our audit. The medical records did not include any entries or original content that was documented on the date of service. Therefore, these entries were not considered to be amendments, corrections, or delayed entries.

Example of Inadequate Supporting Documentation

On October 15, 2016, Oceanside billed Medicare for a 30-minute psychotherapy service in conjunction with an E&M service. Medicare paid Oceanside \$45 for the psychotherapy service and \$28 for the E&M service. Oceanside could not provide us with the medical record for the service. However, we obtained the medical record from the facility where the psychotherapy service was furnished and found that the nurse practitioner from Oceanside had created the medical record entry for the service on February 6, 2018. This medical record entry was created after we had requested the medical record from Oceanside and nearly 16 months after the date of service.

OCEANSIDE RECEIVED UNALLOWABLE MEDICARE PAYMENTS

Oceanside received \$5,317 in Medicare payments for the 103 services that did not meet Medicare requirements. On the basis of our sample results, we estimated that at least \$2.6 million paid to Oceanside for psychotherapy services was unallowable for Medicare reimbursement.

²² Noridian's guidance states: "A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry." (Emphasis in original.) (Noridian, "Documentation Guidelines for Amended Medical Records," available at <https://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-amended-records>. Accessed on Aug. 22, 2018.)

OCEANSIDE DID NOT HAVE POLICIES AND PROCEDURES OR EFFECTIVE MANAGEMENT OVERSIGHT TO ENSURE THAT IT COMPLIED WITH MEDICARE REQUIREMENTS

Oceanside did not have policies and procedures or effective management oversight to ensure that psychotherapy services billed to Medicare were actually provided, adequately documented, and correctly billed.

Oceanside did not have written policies and procedures for documenting psychotherapy services. According to Oceanside's owner, Oceanside did not document some psychotherapy services or the time spent on psychotherapy because it was not aware of the Medicare requirements for billing psychotherapy services. Oceanside stated that it provided services at various facilities and followed the facilities' documentation requirements. Oceanside also stated that providers generally documented their services using the facilities' dictation systems, which prompted them for specific information that was needed to document the services. According to Oceanside, the dictation systems did not include a prompt for the time spent providing psychotherapy.

According to the biller at the billing company that Oceanside used to submit Medicare claims, each of Oceanside's providers gave her a list of beneficiaries for whom psychotherapy services were provided and included a symbol next to the beneficiaries' names to indicate the type of service that was provided. For example, for one provider, a plus sign indicated that a 45-minute psychotherapy service was provided. The biller stated that providers used different symbols in their billing lists, and she submitted Medicare claims on the basis of information contained in these lists. However, according to the biller and Oceanside's owner, no one at Oceanside reviewed these lists before submitting them to the biller or compared these lists with the beneficiaries' medical records to ensure that the psychotherapy services were actually provided, adequately documented, and correctly billed. In addition, Oceanside's owner stated that he reviewed selected medical records at random to ensure that psychotherapy services were properly documented.

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

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's 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's factsheet *Medicaid Documentation for Behavioral Health Practitioners*, December 2015.)

However, it was unclear how often he conducted these reviews because there was no specific review schedule or documentation of his reviews.

For the two services for which Oceanside did not provide adequate documentation, Oceanside stated that it re-created the medical records because it provided the services and the facilities misplaced the original medical records.

RECOMMENDATIONS

We recommend that Oceanside Medical Group:

- refund to the Medicare program the portion of the estimated \$2,694,446 overpayment for claims that are within the reopening period;²³
- for the remaining portion of the estimated \$2,694,446 overpayment for claims that are outside of the reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation;
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and
- implement policies and procedures and strengthen management oversight to ensure that psychotherapy services billed to Medicare are actually provided, adequately documented, and correctly billed.

OCEANSIDE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Oceanside disagreed with our findings and our first recommendation. For our second and third recommendations, Oceanside agreed that the recommendations correctly stated Oceanside's obligations under CMS's rules but disputed that it was "in violation of any overpayment." Oceanside agreed with our fourth recommendation

²³ OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to Department of Health and Human Services action officials. Action officials at CMS, acting through a MAC or other contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with CMS's policies and procedures. If a disallowance is taken, a provider has the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Part A/B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a decision by the Office of Medicare Hearings and Appeals. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

and provided information on actions that it had taken or planned to take to address our recommendation. Oceanside's comments are included in their entirety as Appendix D.

After reviewing Oceanside's comments, we maintain that our findings and recommendations remain valid.

COMMENTS AND RESPONSES ON FINDINGS

Oceanside provided specific comments on our findings that psychotherapy was not provided, psychotherapy time was not documented, and adequate supporting documentation was not provided, as well as on our cause that Oceanside did not have policies and procedures or effective management oversight to ensure that it complied with Medicare requirements (detailed in the following sections).²⁴

Psychotherapy Was Not Provided

Oceanside Comments

Regarding our finding that Oceanside did not provide psychotherapy for 52 services, Oceanside's position is that the documentation supporting the 52 individual services does describe the specifics for a discrete psychotherapy service. Oceanside stated that in several cases, psychotherapy assessments were performed using a psychiatric followup template and that those records reflect a dialogue between the patient and the clinician. Oceanside stated that while the records did vary in their specificity, they generally documented therapeutic techniques, including psychotherapeutic interventions, in a manner such that, even where E&M services were also provided, psychotherapy services could be discerned. According to Oceanside, the provision of psychotherapy is also evidenced in the records by the context of the discussions documented in them.

Regarding the examples in our report, Oceanside stated that the records for those examples indicate only that, in those two cases, the charting of the psychotherapy service was merged with the E&M service. Oceanside also stated that these two examples are not representative of all 52 services reviewed. In addition, Oceanside stated that "[w]hile that merging in the record is the subject of internal correction and training at Oceanside, Oceanside disagrees that it would automatically render the claim non-payable."

Oceanside cited two other examples (not cited in our report but included in our sample) that, according to Oceanside, sufficiently document valid psychotherapy encounters. Oceanside stated that "regardless of the varying level of specificity used when charting the particular

²⁴ Oceanside stated that it did not have the opportunity to verify the statistical validity of our data, sampling protocol, and the overall approach used in our audit. Oceanside stated that it "expressly reserves its rights and disputes the validity of OIG's statistical analysis and its resulting findings, conclusions, extrapolations, and estimates, including the specific protocols and sampling methods chosen, and the representativeness of individual services that were purportedly randomly-selected from the sampling frame."

psychotherapy encounter, the psychotherapy services were actually and appropriately provided to each of the patients as necessary and appropriate for their care and treatment.” Oceanside stated that “it would be unjust for it to be required to refund for services it actually provided and attempted to sufficiently document.”

Office of Inspector General Response

We maintain that our finding is valid. 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)). To report both E&M and psychotherapy, the two services must be significant and separately identifiable (AMA, CPT 2015–2017).

For 48 services, the psychotherapy services were billed in conjunction with E&M services; however, the documentation for these services did not show that the psychotherapy services were separately identifiable from the E&M services. The medical records for these services indicated that the beneficiaries were seen and that many of them had their medications reviewed or adjusted; however, the medical records did not document discernable psychotherapy services showing the therapeutic techniques used to address the beneficiaries’ conditions or the time associated with the psychotherapy services. In addition, for 15 of these services, Oceanside used a psychiatric followup template to document the E&M services and the psychotherapy services. The template contained sections such as the beneficiary’s current medications, a checklist for a mental status examination, and a checklist for the treatment plan. However, the template did not reflect a dialogue between the beneficiaries and the clinicians. Instead, the clinicians made brief notations, such as “patient was seen” and “case was reviewed.”

For two services that were billed without E&M services, the medical records indicated that the beneficiaries were seen, but the medical records did not document discernable psychotherapy services showing the therapeutic techniques used to address the beneficiaries’ conditions. For the remaining two services, Oceanside stated that the services were not provided and had been billed in error.

Regarding the examples in our report, the medical records for these services did not document discernable psychotherapy services showing therapeutic techniques indicative of psychotherapy services. Rather, the records provided by the facilities where the services were provided indicated that the beneficiaries were seen only for conditions unrelated to psychotherapy (e.g., a urinary tract infection and MRSA culture).

Regarding the two examples that Oceanside cited, the documentation that we obtained from the facilities where the services were provided indicated that psychotherapy was not provided on the sampled dates of service:

- For the first example, the Oceanside provider amended the date of service on the medical record for October 28, 2016, to reflect the sampled date of service of October 18, 2016; however, the medical record was amended after we requested documentation for our audit.²⁵ In addition, the facility provided a visitation log that indicated that the provider did not see the beneficiary on the sampled date of service.²⁶ Further, a representative from the facility informed us that Oceanside did not provide psychotherapy services to patients of that facility because it had its own psychotherapy providers on staff.
- For the second example, Oceanside provided a medical record for the sampled date of service (May 10, 2017). However, the facility informed us that psychotherapy was not provided on that date and that the beneficiary was discharged on that day. The facility provided the medical record for May 9, 2017, which included documentation for the most recent psychotherapy service provided before the beneficiary was discharged. We compared the information from the two records and determined that the record provided by Oceanside was a verbatim copy of the May 9, 2017, medical record provided by the facility. The only difference was the date of service.²⁷ Subsequently, Oceanside confirmed that the medical record it provided was not for the sampled date of service and that the psychotherapy service was not provided. We gave Oceanside the opportunity to provide the medical record for the sampled date of service; however, Oceanside did not provide the medical record.

Psychotherapy Time Was Not Documented

Oceanside Comments

Regarding our finding that Oceanside did not document the time spent on psychotherapy for 49 services, Oceanside stated that we disallowed the services because the start and stop times were not specifically documented and that it disagrees that this is a legitimate basis to assert overpayments. Oceanside stated that “documenting the starting and stopping face-to-face time with the patient is a good practice” that it currently employs, but “disagrees that the failure to document such time is ground to deny a service when the record describes a psychotherapy encounter which one can determine would meet the minimum time requirements to bill the code.” According to Oceanside, the psychotherapy encounters were documented sufficiently to determine that they would meet the minimum time required to bill these encounters, notwithstanding the lack of a documented stop and start time.

²⁵ In its comments, Oceanside stated that the example was for sample number six. However, it was actually for sample number 46.

²⁶ The claim data showed that Oceanside billed for services on both October 18 and October 28, 2016. Because Oceanside amended the date of service on the medical record to reflect our sampled date of service, the facility no longer had the medical record to support the other service billed by Oceanside.

²⁷ The claim data showed that Oceanside billed for services on both dates.

According to Oceanside, the clinicians that provided the 49 services are confident that at least 16 minutes of psychotherapy were provided to these beneficiaries. Oceanside stated that this is consistent with Oceanside’s policy and the training that these clinicians received, “which was to provide psychotherapy services whereby session[s] generally last at least 20 minutes.”

Oceanside also commented on the information in Figure 4 in our report and stated that the graphic “fails to support OIG’s speculative stance.” Oceanside stated that we presumed that a “15+ hour day is so excessive as to be unbelievable on its face” and that this conflicts with the reality that Oceanside’s clinicians have in many cases worked 12- to 15-hour workdays.

Office of Inspector General Response

We disallowed these 49 services because Oceanside did not document the time spent on psychotherapy, not because the start and stop times were not specifically documented.²⁸ 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)). The AMA, *CPT 2015–2017*, states that providers must bill the CPT code based on the actual time spent on psychotherapy and providers must not bill for psychotherapy of less than 16 minutes. CMS guidance states: “Because time is indicated in the code descriptor for the psychotherapy CPT codes, it is important for providers to clearly document in the patient’s medical record the time spent providing the psychotherapy service.”²⁹ Oceanside’s documentation did not show that at least 16 minutes of psychotherapy had been provided to the beneficiaries and that the services were properly billed.

During our fieldwork, Oceanside told us that during our audit period it did not have policies and procedures for providing psychotherapy services and that the owner of Oceanside provided training to the clinicians that worked for Oceanside. The owner also told us that he was not aware of the time requirements for psychotherapy services. We also interviewed the Oceanside provider who provided the majority of the psychotherapy services for which the time spent was not documented, and she was not aware of the time requirement for psychotherapy CPT codes. During our interviews, when we showed her medical records for the psychotherapy services that she had provided, she could not recall the amount of time spent providing the services. She stated that the billed psychotherapy code was based on whether the service was an initial or followup visit.

Regarding the information in Figure 4, our analysis indicates only the *minimum* amount of time that it would have taken to provide the services that were billed that day. Our analysis did not account for other activities that would make up a regular workday (e.g., walking from one beneficiary to the other within the same facility or taking breaks). According to Oceanside, its

²⁸ The time spent on psychotherapy could be documented by showing the start and stop times or by indicating the number of minutes spent providing the psychotherapy service.

²⁹ MLN Matters Special Edition Article SE1407, reissued on March 18, 2014.

providers spend at least 20 minutes on psychotherapy services; if that were the case, for the example in Figure 4, it would have taken the provider nearly 18½ hours to complete the services that the provider billed to Medicare. That would have left the provider with only 5½ hours to discuss the beneficiaries' treatment with facility staff and to spend on personal activities (e.g., commuting, eating, and sleeping). In addition, that would have exceeded the 12- to 15-hour workday that Oceanside said its providers worked in many cases.

Adequate Supporting Documentation Was Not Provided

Oceanside Comments

Regarding our finding that Oceanside did not provide adequate supporting documentation for two services, Oceanside stated that the missing records were a result of a simple error. According to Oceanside, one of the services was documented contemporaneously at the time the service was provided; however, Oceanside stated that, when the dictated note was requested from the facility, the facility was unable to provide it and apparently did not enter the note or had misplaced it. Oceanside explained that the note was rewritten by the provider because he felt that it was important to have a rewritten note in the record, rather than having no note at all. Oceanside stated that it has undertaken corrective measures and proposes additional measures to address any similar errors in the future.

Office of Inspector General Response

CMS's Program Integrity Manual states: "All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered." Documentation that is amended, corrected, or entered after the services have been provided must comply with certain recordkeeping principles to be considered when making review determinations.³⁰ Oceanside's rewritten note, which was created in response to our audit nearly 2 years after the date of service, failed to meet those requirements. In addition, because the date on the rewritten note was the date of service, not the date it was rewritten, we did not discover that it was a rewritten note until we questioned its origin. According to Noridian, creating new records when records are requested is considered falsifying records.³¹

Policies, Procedures, and Management Oversight

Oceanside Comments

Oceanside stated that it "has developed and is continuing to develop better policies and procedures and more extensive oversight management." Oceanside also stated that since the

³⁰ Program Integrity Manual, chapter 3, § 3.3.2.5.

³¹ Noridian, "Documentation Guidelines for Amended Medical Records," available at <https://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-amended-records>. Accessed on August 22, 2018.

audit it has implemented better recordkeeping protocols regarding billing for E&M services and psychotherapy. Oceanside noted that it underwent a prepayment audit by a CMS contractor that covered 4,000 claims from November 2017 through June 2018, and its documentation was deemed sufficient because nearly all of the claims reviewed during the audit were approved for payment. Oceanside stated that the results of the audit bolster its position that its documentation practices have been sufficient to justify the reimbursement it has received for psychotherapy services.

Oceanside stated that although it recognizes that its previous policies and procedures left significant opportunities for improvement, Oceanside disagrees that it failed to meet standards under Medicare for billing and receiving payment for psychotherapy services.

Office of Inspector General Response

The CMS contractor's audit was for claims submitted after our audit period, and the results of that audit do not change our findings and recommendations based on our sample selection.

COMMENTS AND RESPONSES ON RECOMMENDATIONS

Oceanside's comments on our recommendations were as follows:

- Regarding our first recommendation, Oceanside disagreed with the recommendation because it disagreed with our findings and that overpayments were identified within the reopening period that would justify a refund.
- Regarding our second and third recommendations, Oceanside stated that it agreed that the recommendations correctly state "its obligation under CMS rules, but disputes that it is in violation of any overpayment" because Oceanside disagreed with our findings.
- Regarding our fourth recommendation, Oceanside agreed with our recommendation and stated that it will commit to implementing policies and procedures to strengthen management oversight. Oceanside stated that, since our audit, it has already improved its policies and procedures through better recordkeeping practices and improved documentation of E&M services so that they can be discerned from psychotherapy encounters more clearly, separately, and identifiably. Oceanside also stated that it will (1) create an internal compliance manual, (2) send the owner and potentially other clinicians to a recordkeeping course and a seminar on coding and billing, (3) conduct an internal audit by an outside consultant on a quarterly basis for at least 1 year to identify any billing or recordkeeping issues, (4) deploy a system to track all medical record dictation, and (5) purchase and implement a hospital tracking program to aid Oceanside clinicians with their busy schedule and help them more easily to track each patient seen at each location.

We maintain that our recommendations are valid because of the reasons outlined in our responses to Oceanside's comments on our findings. Oceanside should implement our first and second recommendations related to the estimated \$2,694,446 overpayment for claims that are within our audit period and return the overpayments. In addition, Oceanside should investigate and repay any similar overpayments that may exist outside of the audit period (our third recommendation).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered Oceanside's Medicare Part B claims for psychotherapy services provided from July 1, 2015, through June 30, 2017. Our sampling frame consisted of 52,608 beneficiary days, totaling \$2,752,119.³² We reviewed a random sample of 100 beneficiary days, which included 103 individual psychotherapy services:

- 51 services for 30 minutes of psychotherapy with an E&M service,
- 43 services for 30 minutes of psychotherapy, and
- 9 services for 45 minutes of psychotherapy.

We requested medical records from both Oceanside and the facilities where the services were provided. Oceanside provided us with supporting documentation for 100 of the 103 psychotherapy services in our sample.³³ The facilities provided medical records for 98 psychotherapy services.³⁴ We reviewed the documentation to determine whether Oceanside complied with Medicare requirements for billing psychotherapy services. However, we did not determine whether the services were medically necessary.

We did not review Oceanside's overall internal control structure. Rather, we limited our review of internal controls to those that were significant to our objective.

We conducted our audit from November 2017 to October 2018, which included fieldwork performed at Oceanside's office in Santa Monica, California.

³² A beneficiary day consisted of all psychotherapy services provided on a specific date of service for a specific beneficiary for which Oceanside received a payment from Medicare. We excluded (1) beneficiary days with payment amounts less than \$25 and (2) lines of service that had been reviewed, were currently under review, or were excluded from review by the RAC.

³³ Oceanside did not provide supporting documentation for two services because the services had not been provided. Because no psychotherapy services were provided, we considered these services to have been billed in error. For one service, Oceanside was unable to obtain the medical record from the facility; however, the facility provided the medical record to us for review.

³⁴ We requested the medical records from the facilities to supplement and corroborate the supporting documentation that we obtained from Oceanside. The facilities did not provide medical records for five services because they were unable to locate the records, they did not maintain beneficiary medical records, or the services were not provided (which included the two services that Oceanside did not provide and were billed in error).

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed Noridian officials to obtain an understanding of Medicare reimbursement requirements for psychotherapy services;
- interviewed Oceanside officials to obtain an understanding of Oceanside’s policies and procedures for providing and documenting psychotherapy services;
- interviewed Oceanside’s biller to obtain an understanding of the procedures for billing Medicare for psychotherapy services;
- obtained from CMS’s National Claims History (NCH) file the paid Medicare Part B claims for psychotherapy services that Oceanside provided to Medicare beneficiaries for our audit period;³⁵
- created a sampling frame of 52,608 beneficiary days for psychotherapy services and randomly selected a sample of 100 beneficiary days (Appendix B);
- reviewed data from CMS’s Common Working File and other available data for the services for the sampled beneficiary days to determine whether the claim lines for the services had been canceled or adjusted;
- obtained supporting documentation for the sampled beneficiary days from Oceanside and from the facilities where the services were provided;
- reviewed the supporting documentation to determine whether Oceanside complied with Medicare requirements;³⁶
- estimated the amount of the unallowable payments for psychotherapy services that Oceanside provided (Appendix C); and
- shared the results of our review with Oceanside officials.

³⁵ 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.

³⁶ Neither Oceanside nor the facilities provided medical records for two services because the services had not been provided. We considered these services to have been billed in error.

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: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of all Medicare Part B psychotherapy services provided to beneficiaries during our audit period and for which Oceanside received Medicare payments.

SAMPLING FRAME

We obtained claim data from CMS's NCH file, representing 53,547 lines of service totaling \$2,755,278. (Each line of service represented a billed service on a claim.) We grouped these lines of service by beneficiary Health Insurance Claim Number and date of service to identify the beneficiary days. We excluded (1) beneficiary days with payment amounts less than \$25 and (2) lines of service that had been reviewed, were currently under review, or were excluded from review by the RAC. As a result, the sampling frame consisted of 52,608 beneficiary days that included 53,373 lines of service, totaling \$2,752,119.³⁷

SAMPLE UNIT

The sample unit was a beneficiary day. A beneficiary day consisted of all psychotherapy services provided on a specific date of service for a specific beneficiary for which Oceanside received a payment from Medicare.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiary days.

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 consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

³⁷ Of the 52,608 beneficiary days, 51,843 beneficiary days had 1 line of service and 765 beneficiary days had 2 lines of service.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of unallowable payments for psychotherapy services. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

No. of Beneficiary Days in Sampling Frame	Value of Beneficiary Days in Sampling Frame	Sample Size	Value of Sample	No. of Unallowable Beneficiary Days	Value of Unallowable Beneficiary Days
52,608	\$2,752,119	100	\$5,317	100	\$5,317

Table 2: Estimated Value of Unallowable Payments³⁸
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$2,752,119
Lower limit	2,694,446
Upper limit	2,752,119

³⁸ The upper limit calculated using the OIG/OAS statistical software for the total overpayment amount was \$2,899,731, and the point estimate was \$2,797,088. We adjusted these estimates downward to reflect the known value of the sampling frame.

APPENDIX D: OCEANSIDE COMMENTS³⁸



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FILE No.: 5525-002

June 24, 2019

VIA FEDERAL EXPRESS

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90-7th Street, Suite 3-650
San Francisco, CA 94103

VIA SECURED UPLOAD

Attn: Monica Mejia

Re: *Oceanside Medical Group Response to Draft Report Number A-09-18-03004*

Dear Ms. Ahlstrand and Ms. Mejia:

Oceanside Medical Group (“Oceanside”) hereby presents to the Office of Inspector General (“OIG”) its response and comments to OIG’s Draft Report, entitled *Oceanside Medical Group Received Unallowable Medical Payments for Psychotherapy Services* (the “Draft Report”).

As set forth herein, while Oceanside appreciates any opportunity to continue to improve its policies and procedures surrounding the billing and documentation of its psychotherapy services, Oceanside disagrees that any overpayments have been identified in the Draft Report that would require any refund.

About Oceanside and its Patient Population

Oceanside is a psychiatric medical group which provides psychiatric and psychotherapy treatment to patients who have been admitted into various acute care hospitals, skilled nursing facilities, and residential care facilities.

Oceanside treats patients with moderate to severe mental health disorders requiring admission into an acute care hospitals or skilled nursing facilities. The psychiatric services provided by Oceanside include evaluation, diagnoses, and development of a treatment plan to stabilize the mental health patient which includes medication management and psychotherapy services to promote, restore, and maintain social or emotional functioning. These are difficult patients who are often a danger to themselves and others. Many also have a substance abuse disorder. These patients are often combative, confused, disorganized, delusional, display poor insight and judgment, and demonstrate poor concentration. In broad terms, the mental health

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³⁸ We redacted personally identifiable information.

patient population served by Oceanside, many of which are homeless, have a high likelihood of a relapse.¹

Oceanside's Response to OIG's Findings

The Draft Report concluded that all 103 of the individual services comprising OIG's sample of 100 "beneficiary days" from a "sampling frame" of 52,608 beneficiary days² were not allowable because the billed psychotherapy services reviewed either (1) were not provided based on the documentation; (2) did not include start/stop times; (3) were unsupported by adequate documentation; and (4) Oceanside did not have policies and procedures or effective management oversight to ensure that it complied with Medicare requirements. As discussed below and based on its preliminary review, Oceanside respectfully disagrees with each of these findings for the following reasons.

1. Psychotherapy Not Documented

OIG determined that 52 of the 103 individual services were "not provided" because "[f]or 50 of these services...the medical records did not indicate that psychotherapy had been provided."³ In other words, OIG appears to have assumed that all 52 individual services were not provided because it believed the documentation did not reflect that any psychotherapy service had been rendered. Oceanside disagrees with this conclusion.

Based on Oceanside's preliminary review of the records sampled by OIG,⁴ in general, Oceanside's position is that the documentation supporting the 52 individual services does describe the specifics for a discrete psychotherapy service, including a summary of diagnosis, functional status, and treatment plan. In several cases, psychotherapy assessments were

¹ The mental health issues for which the Medicare beneficiaries in the sample were treated include major depressive disorder both acute and chronic, schizophrenia, schizophrenia paranoid type, schizoaffective disorder, suicidal ideation (both passive and active), bipolar disorder, delusions, and substance abuse.

² Oceanside has been given only a relatively short time to review and respond to the OIG Draft Report and has not yet had the opportunity to complete its documentary review and verify the statistical validity of OIG's data, sampling protocol, and the overall approach used in connection with the audit. Accordingly, Oceanside hereby expressly reserves its rights and disputes the validity of OIG's statistical analysis and its resulting findings, conclusions, extrapolations, and estimates, including the specific protocols and sampling methods chosen, and the representativeness of individual services that were purportedly randomly-selected from the sampling frame.

³ For the remaining two services, Oceanside informed OIG that they were billed in error.

⁴ Oceanside has had a relatively limited time to review and respond to OIG's audit and therefore has not had the opportunity to undertake a full review of all records. Oceanside therefore reserves the right to amend, correct or further respond as necessary or applicable.

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performed using a psychiatric follow-up template and the records reflect a dialog between the patient and the clinician about the patient's depression, anxiety, and feeling of being overwhelmed, for example. While the records did vary in their specificity, they generally documented therapeutic techniques including psychotherapeutic interventions in a manner such that, even where E&M services were also provided, psychotherapy service could be discerned. Further, the provision of psychotherapy is also evidenced in the records by the context of the discussions documented in them, including those describing an ongoing assessment and adjustment of treatment interventions.

The Draft Report casts a characterization of insufficient documentation across the board by purporting to identify two "examples" of instances where psychotherapy services allegedly were not provided on August 14, 2015 and September 20, 2016. Oceanside believes these two "cherry picked" records indicate only that, in those two cases, the charting of the psychotherapy service was merged with the E&M service, and that OIG's careful selection of these two examples is not representative of all 52 services reviewed. While that merging in the record is the subject of internal correction and training at Oceanside, Oceanside disagrees that it would automatically render the claim non-payable.

For example, although not cited in the Draft Report, OIG concluded that the following progress note for sample patient number 6 did not support the provision of psychotherapy:

SUBJECTIVE The patient is a [redacted]-year-old [redacted] with a history of schizoaffective disorder, currently on the partial hospitalization program. Awake and alert. Mood is euthymic. Affect is constricted. Continues to experience anxiety throughout the day. Feels overwhelmed sometimes. Continues to have depression; however, states that medications are helping [redacted] not sinking into a deep depression. Stated that [redacted] likes coming to the program because it is helping cope with some of the stressors outside. [Redacted] likes socialize with others. At this point, the patient will continue to be monitored and [redacted] will be continued to being treated in the partial hospitalization program.

PLAN OF CARE Continue to monitor behavior. Maintain safety precautions. Continue to provide group and individual psychotherapy. Continue with psychotropic medication regimen. Case was discussed with [redacted] and he agrees with the current treatment plan.

From any reasonable perspective, the above note sufficiently documents a valid psychotherapy encounter. During this visit there is a dialog between the patient and the clinician about his depression, anxiety, feeling of being overwhelmed sometimes. The patient and clinician spoke about how the patient's medications are helping him, and the patient stated that he likes attending the program because it is helping cope with some outside stressors. It is also obvious from the

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note that the mental health provider assessed the patient and psychotherapy intervention is apparent and evidenced by the context of their discussions.

The same is true for sample patient number 70, also disallowed by OIG:

The patient has been very confused, agitated, irritable, and disorganized. Has been forgetful. Has had poor attention and concentration. Poor insight, judgment, and impulse control. The patient is a [redacted]-year old [redacted] patient with a diagnosis of paranoid schizophrenia. The patient is alert and oriented x2, to person and place. [Redacted] mood is anxious. Affect is congruent. Thought process is disorganized. The patient has poor attention and concentration. Poor insight, judgment and impulse control. This clinician assessed the patient, and provided the patient with supportive psychotherapy, reality orientation, and coping skills. Encouraging the patient to participate in treatment milieu, processing thoughts and feelings in session, and redirect the patient. Continue with medication management and behavioral management. The clinician has reviewed the patient's chart, and discussed the treatment with Nursing staff.

Again, the above record sufficiently documents that a psychotherapy encounter took place. The note documents the clinician's assessment of the patient and also records that the patient was provided with supportive psychotherapy, reality orientation, and coping skills. The patient was encouraged to participate in treatment and processing thoughts and feelings in session. The provider therefore adequately documented a psychotherapy service including an ongoing assessment, adjustment of treatment, and interventions with the patient. And although the time spent with the patient was not documented on the progress note, this service is allowable even without documenting the time, particularly since the psychotherapy was the only service billed to Medicare and it was billed at the lowest psychotherapy service level, requiring only 16 minutes spent with the patient. In fact, the documented description of the visit describes a psychotherapy encounter between the clinician and the patient which could not have reasonably taken any less than 16 minutes.

Furthermore, it is Oceanside's position that, regardless of the varying level of specificity used when charting the particular psychotherapy encounter, the psychotherapy services were actually and appropriately provided to each of the patients as necessary and appropriate for their care and treatment. While Oceanside recognizes that its documentation during this period left room for improvement, Oceanside insists that services were in fact rendered and that, despite the merging of psychotherapy and E&M into single notes in some cases, it would be unjust for it to be required to refund for services it actually provided and attempted to sufficiently document.

2. Psychotherapy Time Not Documented

OIG determined that 49 psychotherapy services were not allowable because the start/stop times were not specifically documented. Oceanside disagrees that this is a legitimate basis to assert overpayments.

While documenting the starting and stopping face-to-face time with the patient is a good practice that Oceanside currently employs, Oceanside disagrees that the failure to document such time is ground to deny a service when the record describes a psychotherapy encounter which one can determine would meet the minimum time requirements to bill the code. Based on Oceanside's preliminary review of the records, the psychotherapy encounters were documented sufficiently to determine that they would meet the minimum time required to bill the psychotherapy encounters, notwithstanding the lack of a documented stop/start time.

Take for example the progress notes for sample patient number 1 disallowed by OIG:

The patient is a [redacted]-year-old [redacted] treated for schizoaffective disorder under the care of [redacted]. [Redacted] remains paranoid, delusional, agitated, unpredictable, aggressive, hostile, impulsive and agitated with poor insight, poor capacity to formulate a logical plan for [redacted] safety and requires acute inpatient treatment.

Received patient sitting in a wheelchair and waiting for outdoor smoke break. Alert and oriented x 2 with confusion. Redirectable. Cooperative with care. No episodes of agitation noted. Isolative and withdrawn. Depressed mood. Denies having SI/HI Episodes of talking to self. Denies having pain. No signs of acute distress.

Approached patient calmly, scheduled medications given per MD order. Reoriented and redirected as needed. Encouraged to express feelings and concerns. Monitored for safety and behavior. Assisted with toileting needs promptly. Kept clean and dry. Provided a safe and therapeutic environment.

PLAN:
Monitor behavior. Stabilize mood with psychotropic medications by [redacted]. Continue to provide group and individual psychotherapy support by writer. Encourage pt. to participate in treatment. Motivate pt to stay optimistic about treatment.

The above note easily describes an encounter equal to the minimum 16 minutes of time needed to bill the service. The note documented an ongoing assessment and adjustment of treatment

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interventions. The patient was reoriented and redirected during the intervention as needed. The patient was encouraged to express feelings and concerns, monitored for safety and behavior, assisted with toilet needs promptly, kept clean and dry, and provided with a safe a therapeutic environment. This note therefore illustrates a psychotherapy encounter lasting more than the minimum 16-minute time to bill the service, making the lack of a documented start/stop time by itself an insufficient ground to deny the service.

In addition, the Oceanside clinicians who provided the 49 services reviewed the records and are confident that at least 16 minutes of psychotherapy were provided to these beneficiaries. This is consistent with Oceanside's policy and, according to Oceanside's clinicians whose services are at issue, the training these clinicians received, which was to provide psychotherapy services whereby session generally last at least 20 minutes. Unfortunately, they were not aware during the relevant time period that CMS apparently had issued an article stating the importance of providers documenting in the patient's medical record the time spent providing the psychotherapy services.

In an attempt to bolster its conclusion that the 49 services should be disallowed merely because they did not include face-to-face start/stop times, OIG openly speculates in the Draft Report that the volume of reported encounters by Oceanside makes OIG "question" whether the minimum 16-minutes could have been provided at all. OIG's speculation in this regard is not only unpersuasive, it reveals OIG's underappreciation for Oceanside's busy practice and work ethic of its clinicians, and the extremely high demand for psychiatric services in this state, particularly in the acute settings in which Oceanside focuses its care.

OIG's own data analysis indicates that individual Oceanside providers billed Medicare an average of 33 individual services per day. This is not excessive. In fact, based on 16 minutes spent face to face with the patient, on average the individual clinicians at Oceanside worked 8.8 hours daily, which is several hours less than the 12 -15 hour workday which is typical for many of its providers.⁵

In addition, OIG mentions that two providers each billed for services all but 5 days during the 2-year audit period, as if this were too incredible to be believed. Oceanside has not seen the data to confirm this; but, even if true, Oceanside's position is that hospital-based medical practices work longer hours and more days per week, in part because the clinician is required to make rounds daily until the patient is discharged. Moreover, it is well known that

⁵ OIG also reports that, on some days, four Oceanside providers each billed more than 90 individual services. Oceanside questions the accuracy of this finding, which appears to be erroneous. Unfortunately, it does not appear to us that OIG provided the names of these providers or the patient names and dates of service so that Oceanside could verify this contention.

there is a shortage of psychiatric beds in California. It is therefore commonplace for a mental health practice to discharge one patient and immediately have another take their place.

Finally, OIG infographic (Figure 4) purports to show psychotherapy services rendered by an unnamed provider for whom OIG “calculated” the time spent with the patient and travel times between each facility. This graphic also fails to support OIG’s speculative stance. In concluding that it would have taken 15.5 hours for the provider to have completed the 49 individual services which Oceanside billed to Medicare for one day, OIG necessarily presumes that a 15+ hour day is so excessive as to be unbelievable on its face. Yet this opinion evidently held by the OIG reviewers, who were admittedly not mental health clinicians, conflicts with the reality that, according to Oceanside’s clinicians, they have in many cases worked 12 to 15 hour workdays; something that is not necessarily unusual among psychiatric providers, especially given the high demand for psychiatric treatment.⁶ Accordingly, OIG’s speculative basis for “questioning” the face-to-face time spent by Oceanside psychiatric providers frequently work extended hours only demonstrates that OIG staff do not have first-hand knowledge of the long work days of Oceanside’s clinicians and many other psychiatric providers in this state.

3. Adequate Supporting Documentation Not Provided

OIG identified two instances where Oceanside allegedly failed to provide adequate supporting documentation because Oceanside supposedly “created the medical record entries after [OIG] requested supporting documentation for our audit.”

Based on Oceanside’s preliminary review, these missing records appear to be the result of a simple error. For example, according to [REDACTED], who provided one of the two services, the service was documented contemporaneously at the time the service was rendered through dictation; however, when the dictated note was requested from the facility, the facility was unable to provide it and apparently did not enter the note or had misplaced it. The note was only rewritten by [REDACTED] because [REDACTED] felt it was important to have a re-written note in the record, rather than having no note at all. Oceanside has since undertaken corrective measures and proposes additional measures herein to address any similar errors in the future.

⁶ The need for mental health services has continued to climb dramatically. Readmission rates and emergency department visits for mental health and substance abuse conditions are high. An article in Clinical Psychiatry News reported that in San Diego between 2009 and 2015 the number of emergency visits related to mental health increased 56% for children and 41% among adult putting a strain on emergency departments (ED) resources as many of these patients wait in the ED for an inpatient bed. California Health Care Almanac reports that spending on mental health in the United States is projected to increase by more than 60%, from \$147 billion in 2009 to \$238 billion in 2020. From past projections it is reported that the total US mental health expenditures in 2015 were projected to be \$186 billion, or 6% of the total health care expenditures. Medicaid and other public programs were projected to pay 53% with Medicare projected to pay 15%. All of these statistical facts point to longer workdays for mental health providers.

4. Oceanside did not have policies and procedures or effective management oversight to ensure that it complied with Medicare requirements

Oceanside has developed and is continuing to develop better policies and procedures and more extensive oversight management, including documenting the time spent on psychotherapy going forward. Oceanside has also implemented better record keeping protocols regarding billing for evaluation and management services and psychotherapy since the audit.

Record keeping problems are commonplace among providers; however, it should be emphasized that Oceanside underwent a Safeguard prepayment audit which covered 4,000 claims during the period November 2017 through June 2018, and its documentation was deemed sufficient because nearly all of the claims reviewed during the audit by Safeguard were approved for payment. Indeed, the fact that Oceanside did so well in the Safeguard review, which began relatively soon after the audit period ended, further bolsters Oceanside's position that its documentation practices have been sufficient enough to justify the reimbursement it has received for psychotherapy services.

In any event, although Oceanside recognizes that its previous policies and procedures left significant opportunities for improvement, Oceanside disagrees that it failed to meet standards under Medicare for billing and receiving payment for psychotherapy services. Based on its preliminary review, Oceanside found that OIG largely mischaracterized Oceanside's relatively minimal record keeping problems as noncompliance, which is unsupported and conflicts with the recent Safeguard audit that concluded with most of the reviewed claims being deemed payable.

Oceanside's Specific Response to OIG's Recommendations

1. Recommendation No. 1: *refund to the Medicare program the portion of the estimated \$2,694,446 overpayment for claims that are within the reopening period*

Oceanside disagrees with this recommendation and that any refund is due because, as discussed above, Oceanside disagrees with OIG's findings and that overpayments were identified by OIG within the reopening period that would justify refund.

2. Recommendation No. 2: *for the remaining portion of the estimated \$2,694,446 overpayment for claims that are outside of the reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation*

Oceanside agrees that this correctly states its obligation under CMS rules, but disputes that it is in violation of any overpayment for the reasons stated above.

3. Recommendation No. 3: *exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation*

Oceanside agrees that this correctly states its obligation under CMS rules, but disputes that it is in violation of any overpayment for the reasons stated above.

4. Recommendation No. 3: *implement policies and procedures and strengthen management oversight to ensure that psychotherapy services billed to Medicare are actually provided, adequately documented, and correctly billed*

Oceanside agrees with this recommendation and will commit to implementing policies and procedures to strengthen management oversight to help ensure that psychotherapy services billed to Medicare are actually provided, adequately documented, and correctly billed.

Oceanside has already improved its policies and procedures since the audit; these include better record keeping practices and improved documentation of E&M services so they can be discerned from the psychotherapy encounters more clearly, separately and identifiably. Again, such improvement is readily evidenced by the outcome of the Safeguard review of Oceanside's claim.

In addition, to further guard against documentation issues in the future, Oceanside is willing to undertake the additional following measures:

- The creation of an internal compliance manual with a section regarding policies and procedures and a subsection dealing with record keeping practices;
- Sending [REDACTED] and potentially other Oceanside clinicians to a record keeping course and a coding and billing seminar with emphasis on Medicare's requirements to bill psychotherapy services with and without an E&M service;
- Conducting an internal audit by an outside consultant on a quarterly basis for at least one year to identify any billing or record keeping issues and compliance with the newly established Oceanside policies and procedures; this would include a review of, at minimum, 15 charts, per provider, along with the billing records;
- The deployment of a system to track all medical record dictation; and

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- The purchase and implementation of a hospital tracking program to aid Oceanside clinicians with their busy schedule and help them more easily to track each patient seen at each location.

* * *

On behalf of Oceanside, we appreciate the opportunity to respond to OIG's Draft Report. Please do not hesitate to contact me with any questions regarding this response and Oceanside's review of this matter to date.

Sincerely,

NELSON HARDIMAN, LLP

/s/

By: John A. Mills

JAM:sjz