

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PSYCHOTHERAPY SERVICES
BILLED BY A NEW YORK CITY
PROVIDER DID NOT COMPLY
WITH MEDICARE REQUIREMENTS**

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Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: March 2022

Report No. A-02-21-01006

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



Why OIG Did This Audit

Medicare paid approximately \$1 billion for psychotherapy services provided to Medicare beneficiaries nationwide during calendar year 2019. Prior OIG audits and reviews found that Medicare had made millions of dollars in improper payments for mental health services, including psychotherapy services. After analyzing Medicare claims data for Part B psychotherapy services provided during 2019, we identified a New York City provider that was among the highest reimbursed individual providers in the Nation.

Our objective was to determine whether a New York City provider complied with Medicare requirements when billing for psychotherapy services.

How OIG Did This Audit

Our audit covered 15,559 beneficiary days for psychotherapy services for which a New York City provider received Medicare reimbursement totaling \$1.1 million during the period April 1, 2018, through August 31, 2020 (audit period). We reviewed a simple random sample of 100 beneficiary days. We did not determine whether the services were medically necessary.

Psychotherapy Services Billed by a New York City Provider Did Not Comply With Medicare Requirements

What OIG Found

The New York City provider did not comply with Medicare requirements when billing for psychotherapy services for all 100 sampled beneficiary days. Specifically, beneficiaries' treatment plans associated with these services were not provided or did not contain required elements (e.g., frequency or duration of services). This heightens the risk that treatments were inappropriate or unnecessary and could have a significant effect on the beneficiaries' quality of care received. We also found that services billed to Medicare did not meet incident-to requirements or were conducted by a therapist that was not licensed or registered in New York State. Also, time spent on psychotherapy services was not documented and treatment notes were not maintained to support the services billed. In addition, for psychotherapy services provided during 96 sampled beneficiary days, there was no evidence that beneficiaries' treatment plans were signed by the treating physician.

On the basis of our sample results, we estimated that the New York City provider received \$1.1 million in Medicare overpayments for psychotherapy services. These deficiencies occurred because the provider did not develop policies and procedures or provide training to its therapists to ensure that psychotherapy services were appropriately billed to Medicare.

What OIG Recommends and New York City Provider Comments

We recommend that the New York City provider (1) refund to the Medicare program the estimated \$1.1 million overpayment and (2) based upon the results of this audit, 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. We also recommended that the provider develop policies and procedures and provide training to its therapists to ensure that psychotherapy services comply with Medicare requirements.

In written comments on our draft report, the New York City provider disagreed with our first recommendation, agreed with the legal basis of our second recommendation but described the extrapolated sum as grossly overbroad, and agreed with our remaining recommendations. After reviewing the New York City provider's comments, we reduced the number of deficiencies for one finding and maintain that our findings and associated recommendations, as revised, are valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare paid approximately \$1 billion for psychotherapy services provided to Medicare beneficiaries nationwide during calendar year 2019. Prior Office of Inspector General (OIG) audits and reviews found that Medicare had made millions of dollars 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 After analyzing Medicare claims data for Part B psychotherapy services provided during 2019, we identified a New York City provider that was among the highest reimbursed individual providers in the Nation.

OBJECTIVE

Our objective was to determine whether a New York City provider 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 the period April 1, 2018, through August 31, 2020 (audit period), National Government Services (NGS) was the MAC that processed and paid the New York City provider's Medicare claims.

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.

¹ *On-Site Psychological Services, P.C.: Audit of Medicare Payments for Psychotherapy Services* ([A-02-19-01012](#)), issued July 21, 2020; *Grand Desert Psychiatric Services: Audit of Medicare Payments for Psychotherapy Services* ([A-09-19-03018](#)), issued Apr. 20, 2020; and *Oceanside Medical Group Received Unallowable Medicare Payments for Psychotherapy Services* ([A-09-18-03004](#)), issued Aug. 28, 2019.

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, and clinical social workers).² 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.³ Medicare also pays for services billed incident to the service of a physician or certain other practitioners.⁴

Medicare beneficiaries 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 healthcare professional.⁵ For a provider to receive Medicare payment for both the E&M and psychotherapy services, the two services must be significant and separately identifiable.⁶

² The Social Security Act (the Act) §§ 1832(a)(1) and 1861(s); 42 CFR §§ 410.20, 410.71, and 410.73–410.75.

³ 42 CFR §§ 410.20, 410.71, and 410.73–410.75.

⁴ 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 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)).

⁵ 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 (CMS *Medicare Benefit Policy Manual*, chapter 15, § § 190(B)(3), 200(C)(1), and 210(B)(2)).

⁶ American Medical Association (AMA), *CPT [Current Procedural Terminology] 2018–2020*.

Medicare requires that psychotherapy services be reasonable and necessary for the diagnosis or treatment of a beneficiary's illness.⁷ 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 performed alone or in conjunction with an E&M service.⁸ 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.)⁹ 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.¹⁰ (Figure 1 shows the psychotherapy CPT codes and their descriptions.)

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.¹¹ Medical records supporting psychotherapy services provided to Medicare beneficiaries must indicate the time spent on the psychotherapy encounter. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record.¹² Further, treatment

⁷ The Act § 1862(a)(1)(A).

⁸ **The five-character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2017–2019 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.**

⁹ AMA, CPT 2018–2020.

¹⁰ AMA, CPT 2018–2020. “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.

¹¹ The Act § 1833(e).

¹² Local Coverage Determination (LCD) for Psychiatry and Psychology Services (L33632) established by NGS. This LCD states that a treatment plan is not required if only a few brief services are provided. Services provided to the beneficiaries associated with all of our sampled claims were part of extended psychotherapy services.

plans must contain certain required elements and indicate the beneficiary's diagnosis and anticipated treatment goals. Medicare guidance states that services must be authenticated, via handwritten or electronic signatures, by the individual responsible for the care of the beneficiary to support services provided.¹³

New York City Provider

The New York City provider we audited, located in Queens, New York, provides a wide range of treatment options for mental health patients, including behavioral therapy and psychiatry consultations. During our audit period, Medicare reimbursed the New York City provider more than \$1.1 million for a variety of psychotherapy services provided by its owner (a licensed physician), four licensed master social workers, one registered professional nurse, and one social worker.

Medicare Requirements for Providers to Identify and Return Overpayments

OIG believes that this audit report 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 overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.¹⁴

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.¹⁵

HOW WE CONDUCTED THIS AUDIT

Our audit covered 15,559 beneficiary days for psychotherapy services for which a New York City provider received Medicare Part B reimbursement totaling more than \$1.1 million during our

¹³ CMS Internet-Only Manual (IOM) Publication 100-08; *Medicare Program Integrity Manual* (PIM), Chapter 3 § 3.3.2.4.

¹⁴ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

¹⁵ 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 Fed. Reg. at 7670.

audit period.¹⁶ We reviewed a simple random sample of 100 beneficiary days with payments totaling \$7,286:¹⁷

- 88 services for 45 minutes of psychotherapy,
- 10 services for 30 minutes of psychotherapy with an E&M service, and
- 2 services for 45 minutes of psychotherapy with an E&M service.

For each psychotherapy service in our sample, we requested medicals records from the New York City provider and reviewed the documentation to determine whether the New York City provider complied with Medicare requirements for billing psychotherapy services. However, we did not determine whether the services were medically necessary.

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, Appendix C contains our sample results and estimates, and Appendix D details the types of deficiencies for each sample item.

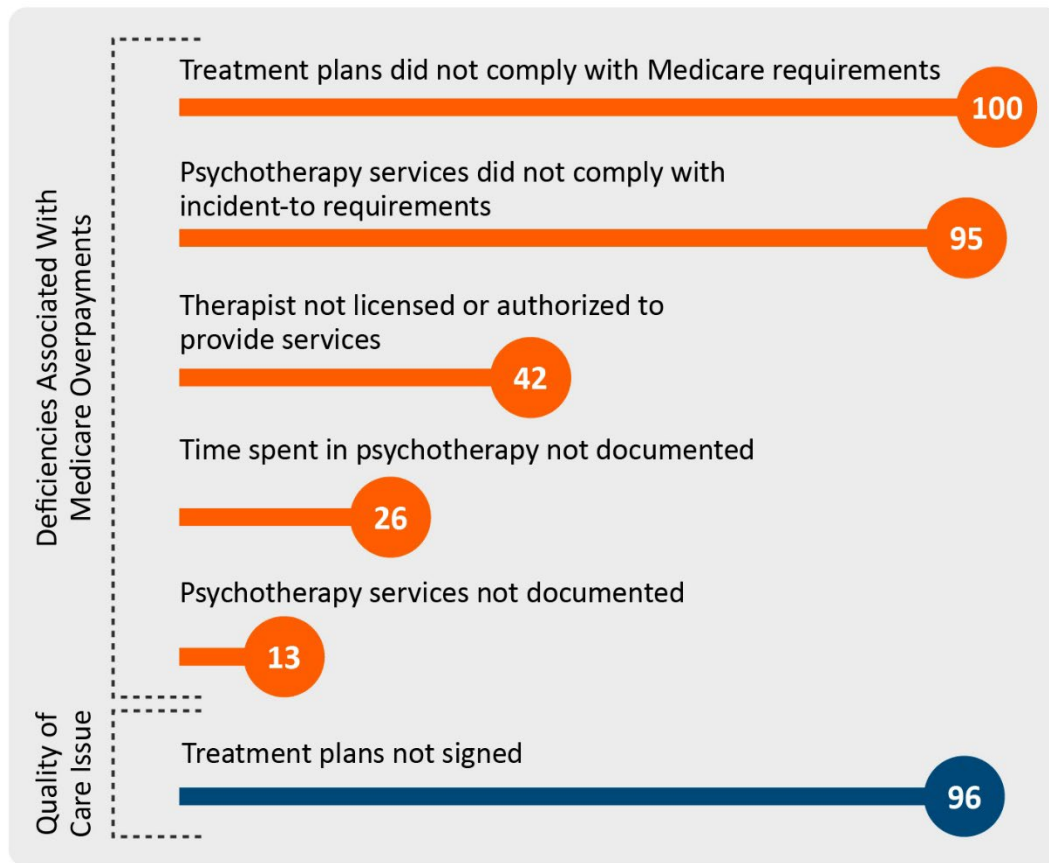
FINDINGS

The New York City provider did not comply with Medicare requirements when billing for psychotherapy services for all 100 sampled beneficiary days. Figure 2 (next page) shows the number of services for each type of deficiency we found.

¹⁶ Our sampling frame totaled \$1,126,836. A beneficiary day consisted of all psychotherapy services claimed on a specific date of service for a specific beneficiary for which the New York City provider received a payment from Medicare.

¹⁷ Some beneficiary days include more than one service.

Figure 2: Unallowable Services in Our Sample by Type of Deficiency¹⁸



As a result, the New York City provider received \$7,286 in unallowable Medicare payments. On the basis of our sample results, we estimated that the New York City provider received at least \$1,118,789 in Medicare overpayments for psychotherapy services. These deficiencies occurred because the New York City provider did not have policies and procedures in place or provide training to ensure that treatment plans covering psychotherapy services were maintained and contained all required elements prior to providing the services.

In addition, the New York City provider did not ensure that psychotherapy services billed to Medicare complied with incident-to requirements or that services were conducted by therapists that met Medicare qualification requirements. Also, the New York City provider did not have policies and procedures or provide training to its therapists to ensure that psychotherapy services billed to Medicare were adequately documented, actually provided, and supported by treatment notes.

¹⁸ The total number of deficiencies is greater than 100 because all 100 beneficiary days had more than 1 deficiency, for a total of 375 deficiencies.

TREATMENT PLANS DID NOT COMPLY WITH MEDICARE REQUIREMENTS

Treatment plans must be documented, updated, and included in beneficiaries' medical records (LCD L33632(C), Section III). The treatment plans must contain the type, amount, frequency, and duration of the psychotherapy services to be furnished, and indicate beneficiaries' diagnoses and anticipated goals. Further, when a beneficiary's psychotherapy treatment does not indicate improvement and there is no reasonable expectation of improvement, the services are no longer considered reasonable or medically necessary (LCD L33632(B)).

For all 100 sampled beneficiary days, the New York City provider claimed Medicare reimbursement for psychotherapy services for which the associated beneficiary's treatment plan did not comply with Medicare requirements. Specifically:

- For 95 beneficiary days, the treatment plan did not contain required elements (e.g., frequency or duration of services).
- For 4 beneficiary days, the New York City provider did not maintain a treatment plan.
- For 1 beneficiary day, services were provided before the treatment plan was established.

These deficiencies occurred because the New York City provider did not have policies and procedures in place to ensure that treatment plans covering psychotherapy services were maintained and contained all required elements prior to providing the services. Additionally, the New York City provider did not provide training to its therapists on how to properly develop and maintain treatment plans. For example, one beneficiary received psychotherapy services two times per week. However, the beneficiary's treatment plan did not specify the frequency of the services to be performed; therefore, we were unable to verify whether the beneficiary was receiving the appropriate number of services (e.g., whether services should have been provided only one time per week).

Additionally, we identified potential quality-of-care issues related to services provided to beneficiaries with missing or inadequate treatment plans. The New York City provider did not document if a beneficiary's condition improved or had a reasonable expectation of improvement because the provider did not ensure that beneficiaries' treatment plans complied with Medicare requirements. Without a periodic summary of goals, progress towards goals, and an updated treatment plan that described any improvement in the beneficiary's condition, the clinician would not be able to determine whether the services provided were necessary, had a reasonable expectation to improve the beneficiary's mental health, or made progress towards goals. This could have a significant effect on the quality of care the New York City provider provided to Medicare beneficiaries and may have resulted in inappropriate or unnecessary treatments.

PSYCHOTHERAPY SERVICES DID NOT COMPLY WITH 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 if certain requirements are met, including the following:

- 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)).
- The incident-to services must be provided under the direct supervision of a physician. This 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); 42 CFR § 410.32(b)(3)(ii)).
- During the COVID-19 pandemic, CMS allowed telehealth services performed by a nonphysician practitioner incident-to a physician's service to be supervised using real-time interactive audio and video technology (42 CFR § 410.26(b) and 42 CFR § 410.32(b)(3)(ii)).

For 95 of the 100 sampled beneficiary days, the New York City provider was unable to provide evidence to show that the therapist was under the direct supervision of a physician. Specifically:

- For 82 beneficiary days, the New York City provider was unable to provide evidence to show that the services were provided under the direct supervision of a physician in an office setting.

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.

- For 13 beneficiary days, the New York City provider was unable to provide evidence that telehealth services were provided under supervision (i.e., documentation did not indicate that the supervising physician was available to provide assistance using real-time interactive audio and video technology).

These deficiencies occurred because the New York City provider did not have policies and procedures in place to document evidence that services performed by a nonphysician practitioner were provided under the direct supervision of a physician. Specifically, the New York City provider stated that it did not maintain sign-in logs to document when therapists and the physician were on site or document how the supervising physician was available to provide assistance using real-time interactive audio and video technology during telehealth services. Additionally, the New York City provider did not provide training to its staff on documenting information related to incident-to requirements in beneficiaries' treatment notes. Due to the lack of sign-in logs, we could not verify whether these incident-to services were performed under the direct supervision of a physician.

THERAPIST NOT LICENSED OR AUTHORIZED TO PROVIDE SERVICES

The specific Medicare Part B services that clinical social workers are legally authorized to perform, as they pertain to the diagnosis and treatment of mental illness, are set by the State in which they perform such services. The services must be of a type that would be covered if they were furnished by a physician or as an incident-to a physician's professional service (42 CFR § 410.73 (b)(1)). Psychiatric services provided incident-to a physician's service must be rendered by individuals licensed or otherwise authorized by the State and qualified by their training to perform these services (LCD 33632(B)).

For 42 of the 100 sampled beneficiary days, the New York City provider claimed Medicare reimbursement for psychotherapy services provided by a therapist that was not licensed or registered in New York State.

These deficiencies occurred because the New York City provider did not have policies and procedures in place to ensure that psychotherapy services were conducted by therapists who met Medicare qualification requirements. Specifically, the New York City provider incorrectly determined that a New York State waiver of social worker license was applicable to one of the therapists it employed.¹⁹ The waiver applies only to psychotherapy services provided to beneficiaries through programs administered by State and local government agencies—not to programs administered by the Federal government, including Medicare Part B psychotherapy

¹⁹ N.Y. Education Law §7706(8) (providing exemptions for social workers who are employees of a program or service operated, regulated, funded, and approved by the certain New York State and local government agencies).

services provided by individual therapists or group practices.²⁰ As a result, beneficiaries may have received inadequate services since these services were provided by an unlicensed therapist that was not enrolled in the Medicare program. This could have a significant effect on the quality of care provided to Medicare beneficiaries.

TIME SPENT IN PSYCHOTHERAPY NOT DOCUMENTED

Medicare 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)). Psychotherapy times are for face-to-face services with the beneficiary. Providers must bill the CPT code with a time range closest to the actual time spent on psychotherapy (e.g., CPT code 90832 for 16 to 37 minutes of psychotherapy). Providers must not bill for psychotherapy of less than 16 minutes (AMA, CPT 2017–2018).

For 26 of the 100 sampled beneficiary days, the New York City provider claimed Medicare reimbursement for psychotherapy services for which the treatment notes did not document the time spent on psychotherapy. The treatment notes did not specify either the start and stop times of the session (e.g., “10:00 a.m. to 10:45 a.m.”) or the total time spent on psychotherapy during the session (e.g., “45 minutes”).

This occurred because the New York City provider did not have policies and procedures in place to ensure that the time spent on psychotherapy services was documented in beneficiaries’ treatment notes. Additionally, the New York City provider did not provide training to its therapists on how to properly document the time spent on psychotherapy services in the associated treatment notes.

PSYCHOTHERAPY SERVICES NOT DOCUMENTED

Payment must not be made to a Medicare 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)). When documenting both E&M and psychotherapy services, the two services must be significant and separately identifiable.²¹

²⁰ Current exemptions in the licensed social work, mental health, and psychology professions are applicable to employees of a program or service operated, regulated, funded, and approved by the following New York State and local government agencies: Department of Mental Hygiene, Office of Children and Family Services, Office of Temporary and Disability Assistance, Department of Corrections and Community Supervision, Office for the Aging, Department of Health, local governmental units, and social services districts.

²¹ The medical and psychotherapeutic components of the services may be separately identified as follows: (1) the type and level of E&M service is selected first by the provider based on the key components of history, examination, and medical decision-making; (2) the time associated with activities used to meet criteria for the E&M service is not included in the time used for reporting the psychotherapy service; and (3) a separate diagnosis is not required for the reporting of E&M and psychotherapy on the same date of service (AMA, CPT 2018–2020).

For 13 of the 100 sampled beneficiary days, the New York City provider claimed Medicare reimbursement for some psychotherapy services that were not documented. Specifically, the New York City provider did not provide treatment notes associated with psychotherapy sessions for the services billed. For 11 of the 13 sampled beneficiary days, psychotherapy sessions were billed in conjunction with an E&M session with the physician. Although the New York City provider provided the associated beneficiaries' medical records, the medical records did not document that psychotherapy services were provided. Specifically, for each of the sampled beneficiary days, the New York City provider provided a treatment note for an E&M session—not a subsequent psychotherapy session.

This occurred because the New York City provider did not have policies and procedures in place to ensure that psychotherapy services billed to Medicare were actually provided or supported by treatment notes. The New York City provider stated that clerical errors in its Medicare billing resulted in overpayments. Additionally, the New York City provider stated that it did not provide training to its therapists on how to properly document and maintain treatment notes.

TREATMENT PLANS NOT SIGNED

Medicare guidance states that services provided be authenticated by the individual responsible for the care of the beneficiary. Medicare will accept handwritten or electronic signatures to support services provided.²²

For 96 of the 100 sampled beneficiary days, the New York City provider did not maintain signature pages for the associated beneficiary's treatment plans.²³ Therefore, we could not verify that the beneficiaries' treatment plans were signed by the treating physician, which may have resulted in inappropriate or unnecessary treatments. A valid physician's signature on a treatment plan confirms that the contents of the treatment plan are accurate and that the appropriate plan of care and treatment is provided or supervised by the physician that signed the plan. Since we used Medicare guidance as the basis for our findings on the use of signatures, we are not questioning the associated Medicare reimbursement claimed for these services based solely upon the lack of signatures.

²² PIM, Chapter 3 § 3.3.2.4.

²³ The provider did not provide the associated beneficiary's treatment plan for the remaining four sampled beneficiary days.

RECOMMENDATIONS

We recommend that the New York City provider:

- refund to the Medicare program the estimated \$1,118,789 overpayment;²⁴
- based upon the results of this audit, 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;²⁵
- develop policies and procedures to ensure that:
 - treatment plans contain all required elements, are maintained and are signed by the treating physician,
 - the performing therapists and supervising physicians comply with the requirements related to incident-to services,
 - psychotherapy services are conducted by therapists that meet Medicare qualification requirements,
 - time spent on psychotherapy services is documented, and
 - treatment notes are signed and maintained to support the services billed; and
- provide training to its therapists on how to properly:
 - develop and maintain treatment plans,
 - document that incident-to services were performed under the direct supervision of a physician,

²⁴ OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

²⁵ This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

- document time spent on psychotherapy services, and
- document and maintain treatment notes to support the services billed.

NEW YORK CITY PROVIDER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the New York City provider disagreed with our first recommendation to refund overpayments to the Medicare program, agreed with the legal basis of our second recommendation but described the extrapolated sum as grossly overbroad, and agreed with our third and fourth recommendations.²⁶ Specifically, the New York City provider stated that our estimate of overpayments is “inaccurate, unwarranted or at the very least, grossly overestimated” and that a majority of our sampled claims complied with Medicare requirements. Also, the New York City provider stated that it is committed to implementing policies and procedures to help ensure that psychotherapy services billed to Medicare are actually and appropriately provided, adequately documented, and correctly billed.

After reviewing the New York City provider’s comments and for the reasons detailed below, we reduced the number of deficiencies for one finding and maintain that our remaining findings and associated recommendations are valid.²⁷ We also maintain that our estimated value of overpayments in the sampling frame is valid based on the findings identified in our report.²⁸ A summary of the New York City provider’s comments and our responses follows. The New York City provider’s comments are included as Appendix E.²⁹

²⁶ Contrary to the New York City provider’s comments, there is no estimated overpayment associated with our second recommendation since it does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in our first recommendation.

²⁷ We revised one finding associated with psychotherapy services that did not comply with incident-to requirements. However, the three sampled beneficiary days associated with this finding contained other deficiencies that did not meet Medicare requirements. Therefore, the total overpayment amount and our overall recommended recovery did not change.

²⁸ To calculate the value of overpayments in the sampling frame, we properly executed our statistical sampling methodology and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation. Appendix B provides further details regarding our statistical sampling methodology.

²⁹ We did not include attachments to the New York City provider’s comments because they contain personally identifiable information; however, they will be provided separately in their entirety to CMS. The New York City provider subsequently submitted a corrective action plan that we will also provide to CMS.

TREATMENT PLANS DID NOT COMPLY WITH MEDICARE REQUIREMENTS

New York City Provider Comments

The New York City provider stated that treatment plans associated with our sampled beneficiary days complied with Medicare requirements regarding frequency and duration of services. Specifically, the provider stated that the frequency of treatments are indicated in the patients' medical notes, and the duration of services can be "readily gleaned" by a review of beneficiaries' progress notes. According to the provider, the physician determines and documents the frequency of services in her progress notes, and the therapists maintain the frequency as ordered by the physician. According to the provider, the duration of services can "be observed" in beneficiaries' treatment plans and as determined by the beneficiaries' ongoing treatment sessions. The New York City provider also described three examples in which, according to the provider, beneficiaries' progress toward their goals and any associated improvement are documented in the beneficiaries' progress notes. The provider also stated that the components of the treatment plan are well documented within the beneficiary's entire medical record, and the beneficiary's progress is documented in the treatment plans as well as in the doctor's medical notes and the psychotherapy progress notes.

Office of Inspector General Response

Treatment plans—not therapists' progress notes—must contain the type, amount, frequency, and duration of the psychotherapy services to be furnished, and indicate beneficiaries' diagnoses and anticipated goals. Although progress notes may indicate statements made by beneficiaries indicating how the beneficiaries are reportedly feeling, such notes are no substitute for treatment plans. As we indicated in the report, without a periodic summary of goals, progress towards goals, and an updated treatment plan describing any improvement in a beneficiary's condition, the clinician would not be able to determine whether the services provided were necessary, had a reasonable expectation to improve the beneficiary's mental health, or made progress towards goals.

PSYCHOTHERAPY SERVICES DID NOT COMPLY WITH INCIDENT-TO REQUIREMENTS

New York City Provider Comments

Regarding sampled beneficiary days for which the New York City provider was unable to provide evidence that the therapist was under the direct supervision of a physician while in an office setting, the provider stated that the physician met with the associated beneficiaries during intake visits and subsequent visits. According to the provider, this established a link between the two professionals (i.e., therapist and physician). The provider also stated that patient sign-in sheets for the sampled beneficiary days indicate the names of therapists that provided services to the associated beneficiaries on the same day the physician signed into the office to treat other patients. The provider submitted additional documentation with its comments that included sign-in sheets covering three of our sampled beneficiary days.

Office of Inspector General Response

After reviewing the New York City provider's comments and additional documentation included with its comments, we revised our determinations for the three sampled beneficiary days.³⁰ For these sampled beneficiary days, the provider submitted patient sign-in sheets that indicated the physician was present in the same office suite as the therapists providing services. However, for the remaining 95 sampled beneficiary days, we maintain that incident-to services must be provided under the direct supervision of a physician. This means that the physician must be physically present in the same office suite as the nonphysician practitioner providing the incident-to service or use real-time interactive audio and video technology for telehealth services and be immediately available to provide assistance if that becomes necessary.

THERAPIST NOT LICENSED OR AUTHORIZED TO PROVIDE SERVICES

New York City Provider Comments

The New York City provider reiterated its position that a New York State waiver of social worker license was applicable to the therapist associated with 42 sampled beneficiary days. According to the provider, had the therapist applied for a limited permit to practice clinical work as authorized by New York State law, he would have been authorized to provide Medicare psychotherapy services.

Office of Inspector General Response

We maintain that the waiver referenced by the New York City provider applies only to social workers who are employees of a program or service operated, regulated, funded, or approved by certain New York State and local government agencies—not to programs administered by the Federal Government, including Medicare Part B psychotherapy services provided by individual therapists or group practices. Regardless of what the New York City provider believed to be allowable, the therapist associated with the 42 sampled beneficiary days was not licensed to practice clinical work in New York State during our audit period.

TIME SPENT IN PSYCHOTHERAPY AND PSYCHOTHERAPY SERVICES NOT DOCUMENTED

New York City Provider Comments

The New York City provider agreed that, for 26 sampled beneficiary days, treatment notes did not document the time spent on psychotherapy; however, the provider stated that it can provide affidavits from relevant therapists affirming their time spent providing psychotherapy services to the associated beneficiaries. For 13 other sampled beneficiary days, the provider conceded that psychotherapy services were not adequately documented.

³⁰ The three sampled beneficiary days contained other deficiencies that did not meet Medicare requirements. Therefore, the overpayment amount for these sampled beneficiary days did not change.

Office of Inspector General Response

We maintain that time spent on psychotherapy services was not documented for each of the 26 sampled beneficiary days. Additionally, without contemporaneous records to support its position, we cannot accept attestations that were made as a result of our audit findings and more than 2 years after these services were performed as documentation of the reported time spent on the services.

TREATMENT PLANS NOT SIGNED

New York City Provider Comments

The New York City provider cited a *Medicare Program Integrity Manual* provision indicating that providers “will sometimes include an attestation statement” in documentation submitted for medical review and attached over 300 attestations to support the treatment plans that were not initially signed.

Office of Inspector General Response

As noted in the report, we are not questioning the associated Medicare reimbursement claimed for services based solely upon the lack of signatures because we used Medicare guidance as the basis for our findings on the use of signatures. However, we maintain that the Medicare guidance cited by the New York City states that providers will *sometimes* include attestations in lieu of required documents (*emphasis added*). For our audit, the New York City provider did not initially maintain signatures for the associated beneficiary’s treatment plans associated with 96 of the 100 sampled beneficiary days and created the attestations described in its comments only as a result of our audit.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicare Part B claims for psychotherapy services for which a New York City provider received Medicare reimbursement from April 1, 2018, through August 31, 2020 (audit period). Our sampling frame consisted of 15,559 beneficiary days that included 15,566 lines of service, totaling \$1,126,836. We reviewed a simple random sample of 100 beneficiary days with payments totaling \$7,286.

We reviewed supporting documentation to determine whether the New York City provider complied with Medicare requirements for billing psychotherapy services. We did not determine whether the services were medically necessary.

We did not review the New York City provider's overall internal control structure. Rather, we limited our review of internal controls to those that were significant to our objective. This includes reviewing the New York City provider's established policies and procedures, management oversight structure, segregation of duties, and trainings provided to its staff.

We performed audit work from December 2020 to August 2021.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- interviewed officials from the New York City provider to gain an understanding of their policies and procedures for providing, documenting, and billing Medicare Part B psychotherapy services;
- obtained from CMS's National Claims History (NCH) file the New York City provider's paid Medicare Part B claims for psychotherapy services claimed during our audit period;³¹
- created a sampling frame of 15,559 beneficiary days for psychotherapy services and selected a statistically valid simple random sample of 100 psychotherapy beneficiary days for review (Appendix B);

³¹ Our audit 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.

- 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 from the New York City provider for each sampled beneficiary day;
- reviewed the supporting documentation to determine whether the New York City provider complied with Medicare requirements;
- estimated the total Medicare overpayments for psychotherapy services that the New York City provider provided (Appendix C); and
- discussed the results of our audit with the New York City provider officials.

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

SAMPLING FRAME

The sampling frame consisted of 15,559 beneficiary days, for psychotherapy services provided by a New York City provider, totaling \$1,126,836. The sampling frame included psychotherapy services for which a New York City provider received Medicare reimbursement during our audit period that had not been previously reviewed by a CMS contractor.

SAMPLE UNIT

The sample unit was a beneficiary day. A beneficiary day consisted of all psychotherapy services claimed on a specific date of service for a specific beneficiary for which the New York City provider 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 sorted the sample units in the sampling frame first by the beneficiary's health insurance claim number and then by the date the psychotherapy service was performed. We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of Medicare overpayments for psychotherapy services in our sampling frame. 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 Details and Results

No. of Beneficiary Days in Sampling Frame	Value of Beneficiary Days in Sampling Frame	Sample Size	Value of Sample	No. of Beneficiary Days with Overpayments	Value of Beneficiary Days with Overpayments
15,559	\$1,126,836	100	\$7,286	100	\$7,286

Table 2: Estimated Value of Overpayments in the Sampling Frame³²
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$1,126,836
Lower limit	\$1,118,789
Upper limit	\$1,126,836

³² The point estimate and upper limit we calculated using the OIG/OAS statistical software for the total overpayment amount were \$1,133,630 and \$1,148,471, respectively. We adjusted these estimates downward to reflect the known value of the sampling frame.

APPENDIX D: TYPES OF DEFICIENCIES BY SAMPLE ITEM

DESCRIPTION OF DEFICIENCIES	
A	Treatment Plans Did Not Comply with Medicare Requirements
B	Psychotherapy Services Did Not Comply with Incident-To Requirements
C	Therapist Not Licensed or Authorized to Provide Services
D	Time Spent in Psychotherapy Not Documented
E	Psychotherapy Services Not Documented
F	Treatment Plans Not Signed³³

Sample Number	A	B	C	D	E	F	Overpayment
1	X	X				X	\$72
2	X	X				X	75
3	X	X			X		56
4	X	X				X	71
5	X	X			X	X	59
6	X	X				X	75
7	X	X				X	71
8	X	X			X		56
9	X	X	X	X		X	71
10	X	X	X	X		X	75
11	X	X	X			X	79
12	X	X			X	X	61
13	X	X	X	X		X	71
14	X	X	X			X	75
15	X	X	X	X		X	75
16	X	X	X			X	79
17	X	X				X	71
18	X				X		70
19	X	X	X	X		X	75
20	X	X			X	X	75
21	X		X	X		X	75
22	X	X	X			X	75

³³ Each of the sampled beneficiary days under this deficiency contained at least one other deficiency. Since we used Medicare guidance as the basis for our findings on the use of signatures, we are not questioning the associated Medicare reimbursement claimed for these services based solely upon lack of signatures.

Sample Number	A	B	C	D	E	F	Overpayment
23	X	X	X			X	79
24	X				X	X	75
25	X	X				X	75
26	X	X	X	X		X	71
27	X	X	X			X	75
28	X	X				X	75
29	X	X				X	75
30	X	X	X			X	75
31	X	X			X		59
32	X	X				X	75
33	X	X				X	72
34	X	X				X	75
35	X	X				X	75
36	X	X	X	X		X	72
37	X	X	X			X	75
38	X	X			X	X	55
39	X	X	X	X		X	72
40	X	X	X			X	75
41	X	X	X	X		X	71
42	X	X				X	71
43	X	X				X	71
44	X	X				X	75
45	X	X				X	75
46	X	X				X	79
47	X	X				X	71
48	X	X				X	71
49	X	X				X	75
50	X	X			X	X	57
51	X	X				X	72
52	X	X				X	79
53	X	X	X			X	75
54	X	X	X			X	79
55	X	X	X			X	79
56	X	X	X	X		X	72

Sample Number	A	B	C	D	E	F	Overpayment
57	X	X				X	75
58	X	X				X	75
59	X	X				X	75
60	X	X				X	75
61	X	X				X	75
62	X	X				X	75
63	X	X	X	X		X	75
64	X	X	X			X	79
65	X	X	X	X		X	71
66	X	X	X	X		X	75
67	X	X			X	X	57
68	X	X		X		X	79
69	X	X	X	X		X	75
70	X	X			X	X	56
71	X	X	X	X		X	72
72	X	X		X		X	75
73	X	X	X			X	75
74	X	X	X	X		X	71
75	X	X	X			X	75
76	X	X	X			X	75
77	X	X	X	X		X	72
78	X	X		X		X	75
79	X	X	X	X		X	71
80	X	X				X	75
81	X	X				X	75
82	X	X	X	X		X	71
83	X	X	X	X		X	71
84	X	X	X	X		X	75
85	X	X				X	71
86	X	X				X	75
87	X				X	X	59
88	X	X	X			X	75
89	X	X	X			X	75
90	X	X	X			X	75

Sample Number	A	B	C	D	E	F	Overpayment
91	X	X				X	75
92	X	X				X	71
93	X	X				X	79
94	X	X	X			X	79
95	X	X				X	71
96	X	X				X	75
97	X	X				X	75
98	X			X		X	79
99	X	X				X	75
100	X	X				X	75
Totals:	100	95	42	26	13	96	\$7,286*

*Amounts do not add up exactly due to rounding.

APPENDIX E: NEW YORK CITY PROVIDER COMMENTS

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December 6, 2021

VIA ELECTRONIC MAIL (Michael.Guarnieri@hhs.oig.gov)

Office of Audit Service, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278
c/o Brenda M. Tierney
Regional Inspector General for Audit Services

Re: Comments to OIG Draft Report
Draft Report Number: A-02-21-01006

Dear Ms. Tierney:

* [REDACTED] M.D. Psychiatry, P.C. ([REDACTED] Psychiatry" or "The Practice") hereby presents to the Office of Inspector General ("OIG") its response and comments to OIG's Draft Report# A-02-21-01006, dated October 5, 2021 (the "Draft Report").

As set forth herein, while [REDACTED] Psychiatry appreciates any opportunity to continue to improve its policies and procedures surrounding the billing and documentation of its psychotherapy services, we submit that the OIG's determination of overpayment in the amount of \$1,118,789.00 is inaccurate, unwarranted or at the very least, grossly overestimated.

About [REDACTED] Psychiatry and its Patient Population

The Practice is located in Queens, New York and is presently comprised of one psychiatrist ([REDACTED] M.D.), four therapists, one receptionist, one office manager, and two billers. Roughly 40% of the Practice's patients are Jewish immigrants from the former Soviet Union (Russia, Ukraine, and Central Asian Republics). They reside in the neighborhood with their families. Most of the pathology observed and treated at the Practice consists of Depressive Disorder, Adjustment Disorder, Anxiety Disorder, Panic Disorder, Cognitive Disorder, and Psychotic Disorder. Patients are first seen by Dr. [REDACTED] who decides the treatment. She conducts medication management and supportive therapy monthly once the patient is stabilized on medication. Therapists provide individual therapy sessions as so indicated by the psychiatrist.

* **OIG Note:** The deleted text throughout Appendix E has been redacted because it is personally identifiable information.

Psychiatry's Response to the Draft Report

Relevant Law and Coverage Policy

The Social Security Act states that "[p]ayment 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."¹ The CMS Coverage Policy recommends the following components in all psychiatric medical records documentation.

1. Name of beneficiary and date of service;
2. The type of service (individual, group, family, interactive, etc.)
3. Time element, where duration of the face-to-face contact is the determining factor for coding the service rendered;
4. Modalities and frequency of treatment furnished;
5. A clinical note for each encounter, where in the aggregate, summarizes the following items:
 - a. Diagnosis;
 - b. Symptoms;
 - c. Functional status;
 - d. Focused mental status examination;
 - e. Treatment plan;
 - f. Prognosis; and
 - g. Progress to date.

Elements such as treatment plans, functional status and prognostic assessment are expected to be documented, updated and available for review, but do not need to be delineated for each individual date of service.

6. Identity and professional credentials of the person performing service.

Based upon the Practice's preliminary review ² the Practice's patient records exhibit compliance with the foregoing requirements for a majority of submitted claims. Several examples described and analyzed below demonstrate that Dr. [REDACTED] and her therapists complied with Medicare requirements, while also providing complete and compassionate care to the Practice's patients and moreover complied with Medicare record requirements.

¹ Social Security Act § 1833(e).

² [REDACTED] Psychiatry has been given only a relatively short time frame to review and respond to the Draft Report, and thus has not yet had the opportunity to complete its review of relevant documents and verify the statistical validity of OIG's data, sampling protocol, and the overall approach used in connection with the audit. Accordingly, the Practice hereby expressly reserves its rights to further dispute the validity of the OIG's statistical analysis and its resulting findings, conclusions, extrapolations, and estimates, including the specific protocols and sampling methods chosen, and representativeness of individual services that were purportedly randomly selected from the sampling frame. The Practice further reserves the right to amend, correct, or further respond as necessary or applicable.

I. PATIENT TREATMENT PLANS COMPLY WITH MEDICARE REQUIREMENTS

The Draft Report identified treatment plans for ninety-five (95) beneficiaries which it determined did not contain required elements such as frequency or duration of services (Draft Report, Page 7). However, the Practice indicates the frequency of treatment in its patients' medical notes and the duration can be readily gleaned by a review of patients' progress notes, which details the patients' progress from one session to the next.

It is important to note the Medicare Local Coverage Determinations ("LCD") states the following, *"Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning."*³

With regards to the frequency and duration of the services, the Medicare LCD states that, *"[t]here are no specific limits on the length of time that services may be covered. **There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response.** As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued."*⁴

The frequency of the psychotherapy services, as demonstrated in the examples set forth below, are determined and documented by Dr. [REDACTED] in her progress notes. The therapists maintain the frequency of therapy sessions with the patients as ordered by Dr. [REDACTED] and the duration of services can be observed in the treatment plans as the patient attains his/her goals and as determined by the patient's ongoing session. This is demonstrated in the following three examples.

Furthermore, it is [REDACTED] Psychiatry's position that, regardless of the varying level of specificity used when charting the particular psychotherapy encounters, the psychotherapy services were actually and appropriately provided to each of the patients as necessary and appropriate for their care and treatment. It would thus be unjust for it to be required to refund for services it actually provided and attempted to sufficiently document.

Mr. [REDACTED] (*Exhibit 1*)

Mr. [REDACTED] was first seen by Dr. [REDACTED] on 2/20/2020. Based on the doctor's evaluation, she determined the patient was to start therapy sessions twice a week. Patient psychotherapy progress notes document the patient is to continue the therapy twice a week. The patient's goals and target dates are documented on the treatment plan.

As noted in the LCD, there are many factors that affect the outcome of the treatment. In the case of Mr. [REDACTED] the patient was depressed and concerned about the state of his health. This is a crucial factor since the patient was seen during the high point of the Covid pandemic. Improvement is documented in

³ CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 70.1 (emphasis supplied).

⁴ *Id.*

the psychotherapy note dated 4/22/2020 as the documentation states, “*Pt reports that he follows therapist’s recommendations thinking positive, keep his thoughts under control, focused what he is doing today without think about far future, that help to be become less anxious.*” This improvement was achieved and observed on 4/22/2020, well before the target date on the treatment plan dated 5/15/2020.

Ms. [REDACTED] (*Exhibit 2*)

Ms. [REDACTED] was initially seen by Dr. [REDACTED] on 1/22/2020. Based on Dr. [REDACTED]’s evaluation, she determined the patient should start therapy sessions once a week. Patient psychotherapy progress notes document the patient is to continue the therapy once a week. Ms. [REDACTED] goals and target dates are documented on her treatment plan.

Improvement is documented in the psychotherapy note dated 2/17/2020 as the documentation states, “*Patient arrived for therapy session. Reported she told family she started therapy and felt good afterwards.*” Ms. [REDACTED] was again seen by Dr. [REDACTED] on 2/20/2020. Documentation for that session notes that Ms. [REDACTED] “*feels less anxious and says therapy helps her control her sx [symptoms].*” These improvements were achieved well before the target date on the treatment plan dated 5/14/2020.

Mr. [REDACTED] (*Exhibit 3*)

Mr. [REDACTED] was first seen by Dr. [REDACTED] on 8/18/2018. Based on Dr. [REDACTED]’s evaluation, she determined the patient should start therapy sessions twice a week. However, the 8/19/2019 progress note documents the patient “*has difficulties to remember appointments and scheduled events*”. The patient continues to come to therapy once a week or earlier if needed. The patient’s goals and target dates are documented on the treatment plan.

Improvement is documented in the progress note with Dr. [REDACTED] dated 9/4/2019 as the documentation states, “*Pt feels less irritable, less depressed, less nervous. Sleep improved.*” Progress continues on the psychotherapy notes with comments on 9/9/19 that “*patient discussed his view on his current life health and future*”. On 9/11/19, the patient’s progress note indicated that “*patient reported some improvement of his symptoms.*” On 9/18/19 the progress note indicated that “*patient discussed his plans to socialize more with peers and family members*”. On 9/23/19, the therapist indicated that “*patient reported improvement of the symptoms, feels less depressed. Better sleep.*” On 9/25/19 the provider noted that, “*patient discussed his plans for upcoming holidays.*” These improvements were achieved well before the target date on the treatment plan dated 11/15/2019.

The Draft Report states that:

“*[T]he documentation did not document if a beneficiary’s condition improved or had reasonable expectation of improvement*” and “*without a periodic summary of goals, progress towards goals, and an update treatment plan that described any improvement in the beneficiary’s condition the clinician would not be able to determine whether the services provided were necessary.*” (Draft Report, Page 7).

However, the foregoing examples demonstrate that this assessment is not accurate. There is no requirement that patients’ treatment plans be restricted to just one page. The components of the treatment plan are well documented within the patient’s entire medical record. The treatment plan does

include the patient's progress towards goals, as each of the goals include target dates which are updated as the patient progresses through the course of therapy. The patient's progress is documented in the treatment plans as well as in Dr. [REDACTED] medical notes and psychotherapy progress notes.

Annexed hereto as Exhibit 4 is a fully copy of all medical records requested for purposes of the Draft Audit and have been organized to include the initial intake, where applicable the follow-up notes by Dr. [REDACTED] the patient's treatment plan and progress notes.

II. PSYCHOTHERAPY SERVICES COMPLY WITH INCIDENT TO REQUIREMENTS

Medicare denied eighty-five (85) beneficiary days for services billed as incident to for "failure to provide evidence to show that the services were provided under the direct supervision of a physician in an office setting" (Draft Report, Pages 8-9).

As per the National Government Services (NGS) "Incident to" Office Guidelines:

Documentation must support evidence that a supervising physician was present and available. The documentation submitted to support billing "incident to" services must clearly link the services of the NPP staff to the services of the supervising physician(s). Evidence of the link may include:

1. While cosignature of the supervising physician is not required, it is suggested as a means of verifying the physician's availability for oversight;
2. The NPP performing the service may include entry in the note of the identity and credentials of the supervising physician who was available during the visit; or
3. *Documentation from other dates of service, both initial and subsequent, should clearly establish a link between the two providers.*⁵

In the cases billed by Dr. [REDACTED] as incident to, the patient records include the intake visit by Dr. [REDACTED] as well as subsequent visits notes as applicable, which supports the incident to services. Further, patient sign-in sheets, which indicate the names of the therapists' providing services on the same day as Dr. [REDACTED] the supervising provider, are collectively annexed hereto as *Exhibit 5*.

III. THERAPIST BELIEVED TO BE AUTHORIZED TO PROVIDE SERVICES

The Draft Report identifies 42 beneficiary days where psychotherapy services were provided by a therapist who not licensed or authorized by New York State. (Draft Report at p. 9).

As [REDACTED] Psychiatry has previously advised the OIG, it relied on several releases, one of which was issued by the New York State Department of Education, Office of the Professions, in concluding that an unlicensed Social Worker could provide therapy serves for the Practice under supervision. Copies of the aforementioned publications are annexed hereto as *Exhibit 6*. As the practice has also previously

⁵ National Government Services (NGS) Website, "Incident to" Office Guidelines (emphasis added).

advised, the therapist in question, [REDACTED] MSW ("Mr. [REDACTED]") was supervised at all times by Dr. [REDACTED] a psychiatrist) and [REDACTED] a Licensed Master Social Worker. (See **Exhibit 7** annexed hereto).

Had Mr. [REDACTED] applied for a limited permit to practice clinical social work as authorized by Section 7705 of New York's Education Law, he would have been authorized to provide the psychotherapy services under relevant New York Law, and thus under applicable Medicare determination. See 8 N.Y.C.R.R. § 74.6, LCD 33632. Again, [REDACTED] Psychiatry respectfully submits that the record indicates that the relevant psychotherapy encounters took place – under the supervision of both a psychiatrist and Licensed Master Social Worker. It would be unjust for it to be required to refund for services it actually provided, and which it believed it was providing appropriately, due to the fact that Mr. [REDACTED] failed to apply for a permit.

IV. TIME SPENT IN PSYCHOTHERAPY

The Draft Report identifies 26 beneficiary days where the treatment notes did not document the time spent on psychotherapy. (Draft Report at p. 10). The Practice concedes time spent in Psychotherapy is not contained in treatment notes; however, the Practice can provide affidavits from relevant therapists affirming their time spent providing psychotherapy services to the relevant patients (examples of which are annexed hereto as **Exhibit 8**) for the OIG's review.

V. PSYCHOTHERAPY SERVICES NOT DOCUMENTED

The Draft Report identifies 13 beneficiary days where psychotherapy services were not adequately documented. (Draft Report pp. 10-11). The Practice concedes this point.

VI. TREATMENT PLANS NOT INITIALLY SIGNED SUPPORTED BY SIGNATURE ATTESTATIONS

A majority of Medicare's denials were based upon unsigned treatment plans. The Medicare Program Integrity Manual, Section 3.3.2.4.C provides that, "*Providers will sometimes include an attestation statement in the documentation they submit. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.*"⁶

CMS also instructs, "*Reviewers shall consider all attestations that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature. However, such attestation cannot be used to "backdate" the plan of care.*"⁷

Additionally, the Medicare Learning Network (MLN) Fact Sheet, "Complying with Medicare Signature Requirements," ICN 905364 October 2016 provides the following sample question:

⁶ Medicare Program Integrity Manual Chapter 3, Section 3.3.2.4.C (emphasis added).

⁷ Id (emphasis added).

*"Am I able to attest to my signature?" The MLN Fact Sheet provides the answer as, "Yes, you may attest that a signature is yours. A signature attestation is a statement that must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary."*⁸

MLN further provides, "We accept a signature attestation for medical documentation, except orders. The attestation must be associated with a medical record and created by the author. Attestations may be considered, regardless of their creation date, unless the regulation or policy indicates the signature must be in place before a given event or date."⁹

It is important to note that treatment plans are not orders. The treatment plan is created to ensure the goals are connected to areas of focus that relate specifically to the client. Treatment planning allows for the client to be able to see the progress or lack thereof that has been made in their treatment.

The orders for the psychotherapy services are documented in Dr. [REDACTED] intake and subsequent visit notes.

Please refer to Exhibit 9 which includes sample signature attestations for patient treatment plans determined to be absent signatures.

[REDACTED] Psychiatry's Specific Response to OIG's Recommendations

Recommendation No. 1: *refund to the Medicare program the estimated \$1,118,789 overpayment.*

[REDACTED] Psychiatry disagrees with this recommendation because, as discussed above, the Practice largely disagrees with the OIG's findings and submits that the overpayments identified by OIG within the reopening period are greatly exaggerated.

Recommendation No. 2: *based upon the results of this audit, 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.*

[REDACTED] Psychiatry agrees that this correctly states its obligation under CMS rules, but disputes the extrapolated sum as grossly overbroad for the reasons stated above.

Recommendation No. 3: *develop policies and procedures to ensure that: (i) treatment plans contain all required elements, are maintained and are signed by the treating physician; (ii) the performing therapists and supervising physicians comply with the requirements related to incident-to services; (iii) psychotherapy services are conducted by therapists that meet Medicare qualification requirements; (iv) time spent on psychotherapy services is documented; and (v) treatment notes are signed and maintained to support the services billed.*

[REDACTED] Psychiatry agrees with these recommendations and will commit to implementing policies

⁸ Medicare Learning Network Fact Sheet: "Complying With Medicare Signature Requirements", 03.2021 (emphasis added).

⁹ Medicare Program Integrity Manual Chapter 3, Section 3.3.2.4.C.

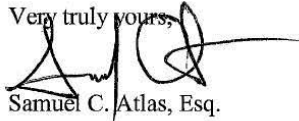
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and procedures to strengthen management oversight and provider training to help ensure that psychotherapy services billed to Medicare are actually and appropriately provided, adequately documented, and correctly billed. We will be shortly forwarding a corrective action plan.

Recommendation No. 4: *provide training to its therapists on how to properly: (i) develop and maintain treatment plans; (ii) document that incident to services were performed under the direct supervision of a physician; (iii) document time spent on psychotherapy services; and (iv) document and maintain treatment notes to support the services billed.*

See Response to Recommendation No. 3, *supra*.

On behalf of [REDACTED] Psychiatry, we appreciate the opportunity to respond to OIG's Draft Report. Please do not hesitate to contact me at (516) 747-6700 Ext. 311 with any questions regarding this response and [REDACTED] Psychiatry's review of this matter to date.

Very truly yours,

Samuel C. Atlas, Esq.