

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ON-SITE PSYCHOLOGICAL
SERVICES, P.C.:
AUDIT OF MEDICARE PAYMENTS
FOR PSYCHOTHERAPY SERVICES**

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Office of Inspector General

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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: July 2020

Report No. A-02-19-01012

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



Why OIG Did This Audit

Medicare paid approximately \$2.2 billion for psychotherapy services provided to Medicare beneficiaries nationwide during calendar years 2017 and 2018. Prior OIG audits and reviews found that Medicare had made millions of dollars in improper payments for mental health services, including psychotherapy services. Using data analysis techniques, we identified On-Site Psychological Services, P.C. (On-Site), at risk for noncompliance with Medicare billing requirements.

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

How OIG Did This Audit

Our audit covered 23,947 claims for psychotherapy services for which On-Site received Medicare reimbursement totaling \$3.9 million during calendar years 2017 and 2018 (audit period). We reviewed a stratified random sample of 120 claims. We did not determine whether the services were medically necessary.

On-Site Psychological Services, P.C.: Audit of Medicare Payments for Psychotherapy Services

What OIG Found

On-Site did not comply with Medicare requirements when billing for most of its psychotherapy services. Of the 120 claims for psychotherapy services in our sample, 111 did not comply with Medicare billing requirements. Specifically, beneficiaries' treatment plans did not comply with Medicare requirements (111 claims), therapeutic maneuvers were not specified in beneficiaries' treatment notes (9 claims), and treatment notes did not support services billed (5 claims). We also identified potential quality-of-care issues related to all 120 claims for psychotherapy services: beneficiaries' treatment plans did not document if a beneficiary's condition improved or had a reasonable expectation of improvement (111 claims) and treatment notes were "signed" with digital images of clinicians' signatures (109 claims).

On the basis of our sample results, we estimated that On-Site received at least \$3.3 million in Medicare overpayments for psychotherapy services. These deficiencies occurred because On-Site's management oversight did not ensure that treatment plans were maintained or contained all required elements, therapeutic maneuvers utilized by clinicians were properly documented in treatment notes, and reliable treatment notes were maintained to support services billed. In addition, On-Site also did not have controls in its electronic recordkeeping system to allow for electronic signatures.

What OIG Recommends and On-Site Comments

We recommend that On-Site (1) refund to the Medicare program the estimated \$3.3 million overpayment; (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; (3) strengthen its management oversight to ensure that it properly maintains treatment plans that contain all required elements, therapeutic maneuvers utilized by clinicians are properly documented in treatment notes, and it properly maintains reliable treatment notes to support services billed; and (4) implement controls for authenticating signatures on treatment notes.

In written comments on our draft report, On-Site did not indicate concurrence or nonconcurrence with our findings or recommendations, but it did indicate that there are opportunities to improve some of the deficiencies identified in the report. On-Site also described a series of corrective actions that it has taken or plans to take to improve its compliance with Medicare requirements.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare paid approximately \$2.2 billion for psychotherapy services provided to Medicare beneficiaries nationwide during calendar years 2017 and 2018 (audit period). 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 Using data analysis techniques, we identified On-Site Psychological Services, P.C. (On-Site), at risk for noncompliance with Medicare billing requirements.

OBJECTIVE

Our objective was to determine whether On-Site 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, National Government Services (NGS), was the MAC that processed and paid On-Site'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 *Oceanside Medical Group Received Unallowable Medicare Payments for Psychotherapy Services* ([A-09-18-03004](#)), issued August 2019; *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.

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

Medicare requires that psychotherapy services be reasonable and necessary for the diagnosis or treatment of a beneficiary's illness.³ Providers bill Medicare for individual psychotherapy services using one of six psychotherapy Current Procedural Terminology (CPT)⁴ codes, depending on the time spent on psychotherapy and whether the service was performed alone or in conjunction with an evaluation and management (E & M) service. 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.)⁵ There is also a CPT code for group psychotherapy and another for interactive

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 The Act § 1862(a)(1)(A).

⁴ **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.**

⁵ AMA, CPT 2015–2017.

complexity, which is an add-on code that can be billed with a psychotherapy service.⁶ (The figure describes these codes as well as the six psychotherapy CPT codes.)

To be paid for an individual psychotherapy service, the provider must furnish information necessary to determine the amount due to the provider.⁷ Medical records supporting psychotherapy services provided to Medicare beneficiaries must indicate the time spent on the psychotherapy encounter and the therapeutic maneuvers⁸ that were applied.

Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record.⁹ Further, treatment plans must contain certain required elements and indicate the diagnosis and anticipated goals. CMS guidance states that Medicare will accept handwritten or electronic signatures to support services provided; however, stamp signatures are generally not acceptable on any medical record.¹⁰

Figure: 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

On-Site Psychological Services, P.C.

On-Site, headquartered in Nanuet, New York, provides psychotherapy services at various independent and assisted living facilities throughout New York. During our audit period, Medicare paid On-Site nearly \$3.9 million for a variety of psychotherapy services provided by its

⁶ 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.

⁷ The Act § 1833(e).

⁸ A therapeutic maneuver can be a behavior modification, supportive or interpretive interactions, that were applied to produce a therapeutic change.

⁹ 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; however, services that were provided to all of our sampled claims were part of extended psychotherapy services.

¹⁰ CMS Internet-Only Manual (IOM) Publication 100-08; Medicare Program Integrity Manual (PIM), Chapter 3 § 3.3.2.4.

owner (a licensed psychiatrist) and 39 independent contractors—22 licensed social workers and 17 clinical psychologists.

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.¹¹

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.¹²

HOW WE CONDUCTED THIS AUDIT

Our audit covered 23,947 claims for psychotherapy services for which On-site received Medicare reimbursement totaling \$3.9 million¹³ during our audit period. We reviewed a stratified random sample of 120 claims with payments totaling \$30,885.¹⁴ For each sample claim, we requested medicals records from On-Site and reviewed the documentation to determine whether On-Site 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, and Appendix C contains our sample results and estimates.

¹¹ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

¹² 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.

¹³ Our sampling frame totaled \$3,850,117. We excluded 186 claims that had been reviewed, were currently under review, or were excluded from review by the Recovery Audit Contractor (RAC) and 125 claims for which Medicare payment was less than \$15.

¹⁴ Each claim may include more than one service.

FINDINGS

On-Site did not comply with Medicare requirements when billing for most of its psychotherapy services. Of the 120 sampled claims for psychotherapy services, 9 complied with Medicare billing requirements, but the remaining 111, with overpayments totaling \$27,571, did not. Specifically:

- For all 111 sampled claims that did not comply with Medicare requirements, On-Site claimed Medicare reimbursement for psychotherapy services for which the associated beneficiary's treatment plan did not comply with Medicare requirements.
- For 9 of the 111 sampled claims that did not comply with Medicare requirements, On-Site claimed Medicare reimbursement for some psychotherapy services for which the required therapeutic maneuver was not specified in the treatment notes.
- For 5 of the 111 sampled claims that did not comply with Medicare requirements, On-Site claimed Medicare reimbursement for some psychotherapy services for which the associated treatment notes did not support the services billed.

On the basis of our sample results, we estimated that On-Site received at least \$3.3 million¹⁵ in Medicare overpayments for psychotherapy services. These deficiencies occurred because On-Site's management oversight did not ensure that treatment plans contained all required elements prior to providing psychotherapy services. Further, On-Site's electronic recordkeeping system did not maintain a history of beneficiaries' treatment plans. Specifically, the system overrode and discarded existing treatment plans when new treatment plans were created. Additionally, On-Site's management oversight did not ensure that therapeutic maneuvers were specified in beneficiaries' treatment notes and that treatment notes supported the services billed.

Additionally, we identified potential quality-of-care issues related to the 111 sampled claims for which the associated beneficiary's treatment plan did not comply with Medicare requirements. Beneficiaries receiving services with missing or inadequate treatment plans could have a significant effect on the quality of care On-Site provided to Medicare beneficiaries and may have resulted in inappropriate or unnecessary treatments.¹⁶ Further, for 109 sampled claims, beneficiary treatment notes maintained on On-Site's electronic recordkeeping system were "signed" with digital images of clinicians' signatures accessible to all On-Site employees that had access to its electronic recordkeeping system (e.g. On-Site's owner).¹⁷ On-Site's system did

¹⁵ Specifically, the estimated lower limit for the Medicare overpayments was \$3,373,440.

¹⁶ The claims associated with this quality-of-care issue were also included in our calculation of overpayments related to the 111 sampled claims for which the associated beneficiary's treatment plan did not comply with Medicare requirements.

¹⁷ The claims associated with this quality-of-care error were not included in our calculation of overpayments.

not have controls or edits to allow for electronic signatures (i.e., authenticated digital signatures). Therefore, we could not verify that the clinicians who performed psychotherapy services “signed” the treatment notes.

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 111 sampled claims, On-Site claimed Medicare reimbursement for psychotherapy services for which the associated beneficiary’s treatment plan did not comply with Medicare requirements. Specifically:

- For 92 sampled claims, the treatment plan did not contain required elements (e.g., frequency or duration of services not specified).
- For 13 sampled claims, the treatment plan provided by On-Site was in effect after our audit period. Specifically, On-Site’s electronic recordkeeping system only maintained the most recent treatment plans—not prior treatment plans in effect during our audit period.
- For six sampled claims, On-Site did not provide a treatment plan.

These deficiencies occurred because On-Site’s management oversight did not ensure that treatment plans contained all required elements prior to providing psychotherapy services. For example, one beneficiary received psychotherapy services two times per week; however, since the treatment plan did not specify the frequency of the services to be performed, 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). Further, On-Site’s electronic recordkeeping system did not maintain a history of beneficiaries’ treatment plans. Specifically, it would override and discard existing treatment plans when new treatment plans were created.

Additionally, we identified potential quality-of-care issues related to beneficiaries receiving services with missing or inadequate treatment plans. Without adequate treatment plans in place, On-Site was not able to document if a beneficiary’s condition improved or had a reasonable expectation of improvement. For one sampled claim, eight separate psychotherapy services were provided to the associated beneficiary; however, without 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 or had a reasonable

expectation to improve the beneficiary's mental health. This could have a significant effect on the quality of care On-Site provided to Medicare beneficiaries and may have resulted in inappropriate or unnecessary treatments.

THERAPEUTIC MANEUVERS 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)). For psychotherapy services, the medical record must indicate the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions, that were applied to produce a therapeutic change (LCD L33632(C), Section II).

For nine sampled claims, On-Site claimed Medicare reimbursement for some psychotherapy services for which the required therapeutic maneuver was not specified in the beneficiary's treatment notes. For example, treatment notes for one claim detailed that only leisure games were played at the beneficiary's residence (i.e., it did not identify the therapeutic maneuver performed).¹⁸ This occurred because On-Site's management oversight did not ensure that therapeutic maneuvers were specified in treatment notes. Rather, On-Site provided treatment note templates that instructed clinicians to document the therapeutic maneuvers that took place during therapy sessions; however, it did not ensure that treatment notes indicated the therapeutic maneuvers before submitting claims for Medicare reimbursement.

TREATMENT NOTES DID NOT SUPPORT SERVICES BILLED

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)). As described earlier, an add-on CPT code for interactive complexity is used when specific communication factors complicate the delivery of a psychiatric procedure. Medical records associated with claims with this add-on code must include adaptations utilized in the session and the rationale for employing interactive communication techniques (LCD L33632(C), Section II).

For five sampled claims, On-Site claimed Medicare reimbursement for some psychotherapy services for which the associated treatment notes did not support the services billed. Specifically:

- For three sampled claims, On-Site provided identical treatment notes to support services provided on multiple dates.¹⁹ For example, for one sampled claim, treatment

¹⁸ We noted that therapeutic maneuvers associated with 111 sampled claims were adequately documented. For example, one treatment note detailed that the therapist utilized an "object-oriented, supportive therapeutic approach to improve the beneficiary's communication skills" to support the services billed.

¹⁹ We questioned only the services associated with the duplicate treatment notes, not the entire claim.

notes for group psychotherapy services provided on three separate dates²⁰ were identical.

- For one sampled claim, On-Site billed for an individual therapy session; however, the treatment note indicated that the clinician met with the beneficiary's family without the beneficiary being present.²¹
- For one sampled claim, On-Site billed for an interactive complexity add-on related to a service that was not documented. Specifically, although the associated treatment note described the beneficiary as blind, the note did not describe adaptations utilized in the session to support claiming the enhanced payment associated with the add-on code.

These deficiencies occurred because On-Site's management oversight did not ensure that treatment notes supported services billed.

DIGITAL IMAGES OF CLINICIANS' SIGNATURES USED TO SIGN TREATMENT NOTES

Medicare will accept handwritten signatures or electronic signatures to support services provided. Stamp signatures are generally not acceptable on any medical record.²² Further, providers that use electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods.²³

For 109 sampled claims, On-Site used an electronic recordkeeping system to maintain medical records that contained digital images of clinicians' signatures (not digital signatures) to document treatment notes. We could not verify that clinicians who performed psychotherapy services signed the associated treatment notes because any individual with access to digital images of the clinicians' signatures, which were maintained in the same system, could have applied these images to treatment notes. A valid clinician's signature on a treatment note confirms that the contents of the treatment note are accurate and that the services were actually performed by the clinician that signed the note. Since Medicare guidance is the only source that clarifies the use of signatures, we are not questioning the associated Medicare reimbursement claimed for these services.

²⁰ The services were submitted for reimbursement on one claim.

²¹ A CPT code for family psychotherapy services without the beneficiary present (90846) may have been more appropriate to bill. For this sampled claim, we also determined that the beneficiary's treatment plan did not comply with Medicare requirements. Therefore, the Medicare payments associated with this claim were already included in our calculation of improper payments.

²² PIM, Chapter 3 § 3.3.2.4.

²³ PIM, Chapter 3 § 3.3.2.4(E). For example, providers need to design and implement a system that will prevent any unauthorized modifications to electronic signatures or authentications.

RECOMMENDATIONS

We recommend that On-Site Psychological Services, P.C.:

- refund to the Medicare program the estimated \$3,373,440 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 rule²⁵ and identify any of those returned overpayments as having been made in accordance with this recommendation;
- strengthen its management oversight to ensure that:
 - it properly maintains treatment plans that contain all required elements,
 - therapeutic maneuvers utilized by clinicians are properly documented in treatment notes,
 - it properly maintains reliable treatment notes to support services billed, and
- implement controls for authenticating signatures on treatment notes.

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.

ON-SITE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, On-Site did not indicate concurrence or nonconcurrence with our findings or recommendations, but it did indicate that there are opportunities to improve its medical record documentation that would address the deficiencies identified in the report. On-Site also described a series of corrective actions that it has taken or plans to take to improve compliance with Medicare requirements and assure consistency in its documentation practices.

Among its corrective actions, On-Site stated that it redesigned its electronic medical record (EMR) system to ensure that clinicians' documentation is properly maintained. According to On-Site, the EMR system now ensures that treatment plans contain all required elements and all treatment notes identify therapeutic maneuvers utilized by clinicians. The EMR system also contains edits that ensure clinicians document all services billed, including interactive complexity add-ons, and that electronic signatures comply with Medicare requirements.

We commend On-Site for their actions already taken prior to our audit and those it plans to take to address the deficiencies identified in our draft report related to its compliance with Medicare requirements when billing for psychotherapy services. On-Site's comments are included as Appendix D. We excluded the attachments to On-Site's comments because they contained personally identifiable information.²⁶

²⁶ On-Site attached examples of a treatment plan and treatment notes created under the EMR system and letters of support from providers it works with.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered On-Site's Medicare Part B claims for psychotherapy services provided from January 1, 2017, through December 31, 2018. Our sampling frame consisted of 23,947 claims, totaling \$3,850,117.²⁷ We reviewed a stratified random sample of 120 claims with payments totaling \$30,885.

We reviewed supporting documentation to determine whether On-Site complied with Medicare requirements for billing psychotherapy services. We did not determine whether the services were medically necessary.

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

We performed fieldwork from June 2019 to March 2020 at On-Site's corporate office in Suffern, New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal Medicare laws, regulations, and guidance;
- interviewed On-Site officials 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 paid Medicare Part B claims for psychotherapy services that On-Site provided to Medicare beneficiaries for our audit period;²⁸
- created a sampling frame of 23,947 claims for psychotherapy services and selected a statistically valid stratified sample of 120 psychotherapy claims for review (Appendix B);
- reviewed data from CMS's Common Working File and other available data for the services for the sampled claims to determine whether the claim lines for the services had been canceled or adjusted;

²⁷ We excluded 186 claims that had been reviewed, were currently under review, or were excluded from review by the RAC and 125 claims for which Medicare payment was less than \$15.

²⁸ 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.

- obtained supporting documentation from On-Site for each sampled claim;
- reviewed the supporting documentation to determine whether On-Site complied with Medicare requirements;
- estimated the total Medicare overpayments for psychotherapy services that On-Site provided (Appendix C); and
- discussed the results of our audit with On-Site 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

TARGET POPULATION

The target population consisted of all Medicare Part B psychotherapy services provided to beneficiaries during our audit period and for which On-Site received Medicare payments.²⁹

SAMPLING FRAME

The sampling frame consisted of an Access database 78,508 service line items from CMS' NCH file, for services provided by On-Site during calendar years 2017 or 2018. (Each line of service represented a billed service on a claim.) We grouped those service line items into 24,258 claims for which Medicare Part B paid a total of \$3,882,252. We excluded 186 claims that had been reviewed, were currently under review, or were excluded from review by the RAC and 125 claims for which Medicare payment was less than \$15. As a result, the sampling frame contained 23,947 claims, totaling \$3,850,117.

SAMPLE UNIT

The sample unit was a Medicare claim for psychotherapy services.

SAMPLE DESIGN

We used a stratified random sample as follows:

Stratum	Stratum Definition	Number of Frame Units	Sample Size	Dollar Value of Frame Units
1	Claims > \$15.00 and ≤ \$125.64	13,019	30	\$814,317
2	Claims > \$125.64 and ≤ \$322.86	8,172	50	1,809,998
3	Claims > \$322.86	2,756	40	1,225,802
TOTAL		23,947	120	\$3,850,117

SAMPLE SIZE

We selected a sample of 120 claims as described above in the sample design table.

SOURCE OF RANDOM NUMBERS

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

²⁹ The psychotherapy services in our target population contained the CPT codes 90832, 90833, 90834, 90836, 90837, 90838, 90853, and 90785.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each of the three strata. After generating random numbers for each stratum, 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 Results

Stratum	No. of Claims in Sampling Frame	Value of Claims in Sampling Frame	Sample Size	Value of Sample	No. of Claims with Overpayments	Value of Claims with Overpayments
1	13,019	\$814,317	30	\$2,058	27	\$1,797
2	8,172	1,809,998	50	10,985	50	10,985
3	2,756	1,225,802	40	17,842	34	14,789
Total	23,947	\$3,850,117	120	\$30,885	111	\$27,571

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

Point estimate	\$3,594,132
Lower limit	\$3,373,440
Upper limit	\$3,814,825

APPENDIX D: ON-SITE COMMENTS



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June 9, 2020

Report Number: A-02-19-01012

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

Dear Ms. Tierney:

Thank you for the opportunity to comment on the *Draft Report On-Site Psychological Services, P.C.: Audit of Medicare Payments for Psychotherapy Services* prepared by the U.S. Department of Health and Human Services Office of Inspector General ("OIG").

Position Statement: On-Site Psychological Services is serious about compliance and takes very seriously the findings in this Report. We strive every day to do the right thing while treating a vulnerable population in times when mental health services are so seriously in need. Although there are opportunities for improvement in On-Site's medical record documentation as identified in the Report, the psychotherapy services for which On-Site received reimbursement were actually provided. At no time did On-Site engage in any willful misconduct or other fraudulent billing activity. The corrective actions described in this Report were commenced before the commencement of this audit in an effort to improve compliance with federal and state requirements and assure consistency in On-Site's documentation practices.

Summary of Corrective Action

1. Electronic Health Record was re-designed with mandatory fields such that providers must complete all fields representing the elements of a treatment plan to comply with Medicare requirements.
2. Electronic Health Record was re-designed with mandatory fields such that providers must document the therapeutic maneuvers applied to achieve therapeutic change for each patient.
3. Electronic Health Record was re-designed to remind providers to document complexity (as applicable) to support services billed.
4. The Electronic Health Record was re-designed to assure electronic signatures of all providers is compliant with Medicare requirements to prevent misuse or abuse.
5. On-Site has designated a duly qualified Executive Clinical Director responsible for weekly monitoring of providers' documentation to assure compliance with Medicare requirements as part of its on-going Compliance Program.
6. On-Site will exercise due diligence to identify overpayments by engaging a duly qualified third-party auditor to review its billing practices for a period looking back to 2014 (6-year lookback period). On-Site will consult with said auditor to determine whether an annual external audit thereafter is indicated as part of its on-going Compliance Program.

My written comments to each of the findings contained in the Report are set forth below.

TREATMENT PLANS DID NOT COMPLY WITH MEDICARE REQUIREMENTS

On-Site employs NY State licensed clinical psychologists and clinical social workers, all of whom have education, training and clinical experience coming from a variety of different clinical backgrounds. As a result of the diversity within their backgrounds, documentation practices were not always consistent. In an attempt to bring uniformity to all of On-Site's documentation, in 2017 we began the process of creating our own EMR system. This proved to be a much more difficult task than

initially anticipated; however, over the past several years our EMR has developed into a system that ensures all of our clinicians' documentation meets CMS required standards and are uniformly executed. We designed the system with mandatory fields to assure that all required elements of a treatment plan are completed in compliance with Medicare. Appendix A is an example of a current treatment plan. Contrary to the findings in the Report, treatment plans are always archived and not overwritten. Whenever an individual psychotherapy session note is created following the session, the note is stored in our software as a PDF file with the current treatment plan *attached* as part of the document. When the treatment plan is updated in 6 months, the new version of the treatment plan is then attached to any new session notes. The older version of the treatment plan can never be discarded or overwritten because it remains attached to the prior session note and is stored as a PDF document in our system. Therefore, whenever a PDF session note is printed, the corresponding treatment plan will always be attached. At the end of the 6-month period, clinicians are reminded by the software that the treatment plan is about to expire, at which time they are prompted to *update* the treatment plan which creates a new version. The software is designed to prevent any new session notes from being written if the treatment plan has not been updated, ensuring that the update will take place timely.

THERAPEUTIC MANEUVERS NOT DOCUMENTED

Once again, due to the diverse backgrounds of our clinicians' documentation practices were not consistent. The software platform we have created *eliminates* the possibility that therapeutic maneuvers will be omitted because clinicians will not be permitted to sign the note until all such mandatory fields have been addressed. We specifically added a new mandatory field to the session notes to identify *the therapeutic maneuver* that was utilized by the clinician. Please see the session note attached to the treatment plan in Appendix A as a reference.

TREATMENT NOTES DID NOT SUPPORT SERVICES BILLED

Our new EMR system requires that each field is completed with data input at the time the note is created. It will not permit clinicians to cut and paste from prior

notes. Each field is extremely specific and ranges from the subjective Reporting of the patient, to the objective observations of the clinician, with a specific focus on detail and *measurable and quantifiable* characteristics. Prior to redesigning the EMR, some of the older clinicians were still handwriting their notes which made the identification of specific information difficult. The Report identifies one instance where the services provided by the clinician who met with the patient's family without the patient being present should have been billed as a 90846. In our new software, the CPT code for the specific type of session is chosen from a drop-down menu by the clinician and then appears in the EMR dashboard for the biller's benefit to avoid any mistakes in coding. To the extent interactive complexity is indicated, the EMR will prompt the clinician to address the adaptation and rationale (List Adaptations/List Rationale) in order to sign and submit the note. The reason why interactive complexity was necessary will therefore always be clearly stated when applicable. We have also created a number of software filters that act as a failsafe monitoring system. I will list some of them here:

- **Duplication of Services:** Once a service is provided on a given day (e.g. individual psychotherapy) and entered into the EMR, a second service (e.g. group psychotherapy) cannot be entered into the patient's EMR on the same day – so no duplication of services can occur.
- **Excessive Treatment:** A clinician may see a patient for one Long Psychotherapy Session CPT Code 90834 per week only. If the clinician attempts to enter a 2nd session, they must first contact me or Dr. Harris or one of the clinical directors and explain the medical necessity for the session. Similarly, the clinician may enter two Brief Psychotherapy Sessions CPT Code 90832, but if a 3rd is attempted, they must contact one of us to be granted the ability to enter that third session. During COVID, we had patients who had spouses die, close friends dies, etc., so we approved some extra sessions for bereavement and to prevent unnecessary hospitalizations.
- **Timely Documentation:** We request to each clinician that a session note be written the same day or the following day after the service takes place. The maximum amount of time the EMR allows to sign a session note is 72 hours. Signatures of all session notes are now time and date stamped. Also, a new

session note cannot be created if the previous session note was not signed and submitted.

- **Treatment Plans:** In order to ensure that treatment plans are updated every six months, the EMR sends reminders to the clinician that the current treatment plan will expire soon. The clinician is unable to write any session notes if the treatment plan expires, and therefore must update the document in order to create any further session notes.
- **Intakes:** The EMR will not allow an intake to be signed and submitted for billing until the clinician uploads the signed referral for treatment form, the signed confidentiality form, the signed insurance authorization, the completed MMSE, the patient's current medication regimen, and completes all sections of the psychosocial.
- **GPS Tracking:** Last year we began using a GPS monitored phone app with all our clinicians, that shows that they are physically at the facility during the hours that they are billing for services.
- **Monitoring Oversight:** We are also very fortunate to have Dr. Andiea Hedayat-Harris, Ph.D. as our Executive Clinical Director who has been doing documentation reviews of all On-Site clinicians for the past year. Dr. Harris has held academic positions as the Assistant Clinical Professor at Mount Sinai School of Medicine and as an Instructor of Psychology in Psychiatry at Cornell University Medical College. In 2006, Dr. Harris was appointed to the Deputy Director of Mental Health at Rikers Island, with over 4500 inmate patients and roughly 500 employees, mostly clinicians providing mental health services in 10 facilities under her supervision. Documentation review is one of her specialties, and her oversight and on-going monitoring of our documentation practices has been invaluable in ensuring that our clinicians follow all CMS policies and procedures for documentation. We are presently working with my IT department to create a ticket system that logs documentation findings by creating tickets that remain open until the clinician makes the subsequent corrective action/addendum, which then produces a closed ticket. Any patterns or trends identified during the

monitoring process will be included in education and training for the clinicians.

DIGITAL IMAGES OF CLINICIANS' SIGNATURES USED TO SIGN TREATMENT NOTES

We previously had a system whereby the clinician's signature was scanned into the EMR and appeared on the signature line when a note was signed. We have since moved to a "live signature" whereby a box appears, and the clinician signs the note using the mouse. In either case, when a clinician was initially granted access to our EMR, the first thing they were prompted to do is to change the password. Admins can view clinician's documents, but the option to *sign* a document is only given to the individual who logged in with their respective password. The programmer ensured me that when these passwords are changed, not even he has access to the new password which he said was in accordance with the specifications for a HIPAA audit trail. Furthermore, because the live signatures completed with the mouse look sloppy and are cumbersome to generate, we have been speaking to the programmer to create an E-signature, where the clinician's name appears on the signature line in a script font. Again, because only the clinician has the ability to sign a note, this E-signature follows the HIPAA format.

Ms. Tierney, I realize the findings in this audit repeatedly reference On-Site's management oversight, however, we have spent a great deal of effort over the past 3 years improving all aspects of this agency by adopting a comprehensive compliance plan, revising our policies and procedures, and educating our clinicians. We have designated an Executive Clinical Director with training, education, and experience in psychotherapy documentation to provide on-going monitoring and implementing rapid-cycle corrective action with individual clinicians when indicated.

On-Site is and has always been extremely focused on providing comprehensive treatment to our patient populations who are the most in need, as well as making sure that the facilities' needs were being met with in-services and program development. While deficiencies were identified in documentation, we

have taken those opportunities to improve our EMR, and I assure you there were no deficiencies in providing exceptional clinical care to the chronically ill psychiatric patients in the adult homes or the elderly clients we treat in the assisted living facilities. We have always prided ourselves on going that extra step to ensure that our services are superlative. I enclosed a few letters from homes where we have worked for decades (Appendix B), conveying sentiments of appreciation for the support we have given the homes over the years. Recently, an NGS inspector did a site visit of multiple facilities where On-Site practices, interviewing administrators, case managers, and even patients. He called me shortly after to say that in 12 years as an inspector, never had he heard so many amazing things about one agency from *everyone* he interviewed in these facilities. He joked and said that he couldn't get a single complaint out of anyone and that I should be very proud of my agency. I was exceptionally proud of my clinicians during this COVID crisis where we worked with the Polaris group of homes as well as the Amber Court group of homes on providing pro bono phone sessions for their employees who were feeling the stress of being on the front lines of resident care. We have always hired great clinicians who provide exceptional care to our patients and much needed support to the homes themselves. We have never engaged in any fraudulent practices and are constantly striving to reach 100% compliance in all aspects of our work. Please understand that patient care has always been our central focus, and that we have made great progress in ensuring that we are equally as strong in complying with CMS policy and procedure protocols for documentation as well. Last year we began doing in-services with our clinicians on CMS Policy and Procedure, medical necessity, and the importance of using assessments to substantiate clinical observations with quantifiable data. Dr. Harris and I are always working with my programmer on further developing the EMR to be as comprehensive as possible.



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I appreciate your taking the time to read this and the attached reference letters.

Sincerely,

STEPHEN W. BUCKLEY, PHD
President & CEO
ON-SITE PSYCHOLOGICAL SERVICES, PC



4835-3634-2976, v. 2