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Hospital Chain Pays $117M to Settle FCA Case About Medical Necessity, Therapy

By Nina Youngstrom

Putting to rest 19 whistleblower lawsuits, Universal Health Services Inc. and UHS of Delaware Inc. have agreed to pay $117 million to settle false claims allegations that its hospitals billed Medicare, Medicaid and other federal programs for inpatient behavioral health care that wasn't medically necessary or adequate, the Department of Justice said July 10.[1] The allegations run the gamut, and include keeping patients in the hospital too long, billing for services not provided and using restraints improperly. Some patients allegedly didn't belong in a psychiatric hospital at all.

UHS, which is headquartered in King of Prussia, Pennsylvania, operates 354 acute-care hospitals and behavioral health facilities. Most of the whistleblower lawsuits were handled by the U.S. Attorney's Office for the Eastern District of Pennsylvania, although they were filed in various districts.

"This was sobering reading," said Georgia Rackley, senior clinical specialist with SunStone Consulting in Harrisburg, Pennsylvania. The settlement is a very expensive reminder for health systems with psychiatric services to look under their hood, she said. "Behavioral health units tend to be overlooked because they're not a big cash cow," Rackley said. "It is benign neglect. Compliance departments can't forget about these behavioral health units. Then you end up with a mess."

Universal Health Services didn't admit liability in the settlement. In a statement, the company said it disputes any wrongdoing and contends the settlement doesn't constitute "failure to provide appropriate care and treatment in accordance with governing rules and regulations. "

Medicare Part A covers inpatient psychiatric admissions with a valid admission order before discharge when physicians certify the need for services at admission and at day 12 of the patient's hospitalization and recertify 30 days later and again 30 days after that, according to the conditions for Medicare payment for inpatient psych services (42 C.F.R. § 424.14(a)–(d)).

One of the complaints was filed against Universal Health Services' Havenwyck Hospital in Auburn Hills, Michigan, by two whistleblowers employed there: Sandra McLauchlin, who worked in nursing management, and Christina Varner, a charge nurse. They alleged the hospital ran afoul of various Medicare requirements for inpatient psychiatric hospitals, including treatment plans, assessments and certifications.

Certifications Allegedly Were Filled Out After the Fact

Patients are supposed to have a psychiatric evaluation with a trained physician within 60 hours of admission, which is billed under an initial hospital inpatient care code like CPT 99222 and has been assigned by the American Medical Association an average time of 50 minutes. But that's not how it played out at the hospital, the complaint alleged. "The reality is that Havenwyck physicians spend very little time with patients in these assessments, much less than is actually billed," according to the whistleblowers, who gave six examples of patients whose initial psych evaluations lasted between four and 10 minutes.

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The complaint also describes certifications and recertifications that are more paperwork than patient care. "Havenwyck's Medicare certification/recertification paperwork is a blank, pink form. As a matter of policy and practice, this form typically remains blank throughout the patient's stay at Havenwyck," the complaint alleged. "After discharge, a staffer from utilization review or medical records backfills the 'correct' dates that certification or recertification *was supposed to have occurred* on the form, after the fact."

Except when surveyors showed up, interdisciplinary treatment plan meetings almost never took place, even though they're required for every patient within 72 hours of admission and then every seven days after, the whistleblowers alleged.

"It is common practice hospital-wide for representatives from each department to fraudulently sign off on participation in developing a treatment plan, when no such effort has been undertaken," the complaint alleged. "The actual process typically involves a passage of paperwork among treaters, after the fact."

Another complaint was filed against Forest View Psychiatric Hospital in Grand Rapids, Michigan, by case manager/therapist Heidi Parent-Leonard. She alleged that a psychiatrist there, Jahandar Saifollahi, billed almost every new inpatient visit as CPT code 99222 or 99223 and almost every established inpatient visit as a 99232. "Although he bills the visits under CPT code 99232, which typically requires 25 minutes per visit, he regularly sees 30-45 patients per day," the complaint alleged. According to the whistleblower, Saifollahi told nurses to line the patients up in the hallway outside a group room. "Relator estimates that he then spends on average approximately five minutes talking to each patient," the complaint alleged.

Majority of Patients Were Not Psychotic

In a third complaint, whistleblowers Kenneth Russell and Yvette Gates sued Anchor Hospital in Atlanta, Georgia. Russell was a mental health technician and Gates a licensed professional counselor. According to the complaint, the industry standard for performing a diagnostic psychiatric assessment is one to two hours. Around May 15, 2017, Gates was instructed by the head of Anchor's assessment referral services to limit assessments to 30 minutes. The hospital billed Medicare and Medicaid for the 30-minute assessments under CPT code 90791 for one hour of assessment per patient between March 15, 2017, and August 7, 2017, the complaint alleged. Because the assessments were rushed, many patients weren't properly diagnosed. For example, between February and May 2017, 130 Medicare and Medicaid patients were admitted and diagnosed with psychosis, but "the overwhelming majority of these patients were not experiencing psychosis and/or were not mentally ill when they were admitted," the whistleblowers alleged.

They also alleged that a common practice was to use "psychotropic drugs to sedate and chemically restrain patients at Anchor Hospital." Patients allegedly were routinely injected with powerful sedatives to restrain and discipline them.

Keep an Eye on Charges That Don't Add Up

Medical necessity is the theme of the case, Rackley said. "Psychiatric inpatient admissions are more like a story," she said. "The dots need to connect to support the medical necessity." Often something falls through the cracks in behavioral health. "Certification is a big one for Medicare patients. There needs to be an explicit statement of the need for inpatient hospitalization," Rackley said. "But certification is not a one and done statement. Medical necessity has to be supported in every progress note. We often find that's an area that's lacking." Statements may be too generic. For example, the physician may document the reasons for continued hospitalization as "stabilization."

"From an auditing standpoint, we're looking for something substantial. Why is this patient still in the hospital?"

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Treatment plans also require specificity, but the electronic medical records may have a cookie-cutter quality. “There needs to be individuation,” she said, with “measurable goals and a sense of active, dynamic treatment.” It’s not enough to say “the patient will no longer feel depressed” without explaining how that will be measured, such as: “Patient no longer verbalizes suicidal ideation. Social worker will have meeting with family to ensure there are no firearms in the house.”

Rackley said behavioral health providers also should be wary of charges that don’t add up. She would be skeptical if a psychiatrist billed for evaluation and management (E/M) codes for office visits plus psychotherapy codes and CPT 90785 for interactive complexity. “It’s potentially possible, but not likely, given the role of psychiatrists in many organizations,” she said. “Nowadays, psychiatrists are booked 15 minutes max” per visit.

If psychiatrists are going to bill for both medication management and psychotherapy, they must make the psychotherapy time of the E/M visit separate and distinct, Rackley said. “It’s an add-on code,” she explained. “The note has to reflect the time increments. It can say, ‘The total visit was 60 minutes, of which 30 minutes was spent in psychotherapy.’” The documentation must also have enough detail to support the psychotherapy. “We rarely see physicians get that right.”

In its statement, Universal Health Services said, “Since its founding in 1979, UHS and its affiliate hospitals have maintained a consistent policy to fully comply with all laws, government regulations and guidelines while prioritizing high quality, evidence-based patient care delivered by compassionate clinicians who determine appropriate treatment and care based on the individual needs of each patient.” The hospital chain noted that “many of the individual facilities identified as defendants in the qui tam cases and/or a focus of the government’s investigation were acquired by UHS from prior operators; and the allegations and investigations of those facilities in part pre-dated UHS’ acquisition and operational control. When UHS acquires a new facility, it rigorously assesses the operation and where needed, adjusts procedures to ensure compliance with proven protocols and high standards of care.”

Universal Health Services said it cooperated with the government and “repeatedly provided investigators with objective and documentary evidence and clinical data refuting the allegations of improper activity. UHS’ commitment to the highest standards of compliance and safety is a core belief and responsibility all of us take very seriously. Quality of care and patient satisfaction are our most important metrics. UHS is one of the few behavioral health providers voluntarily measuring clinical outcomes. We deliver industry-leading outcomes including: 91% feel better at discharge than when admitted; 90% of patients were satisfied with their treatment; and 86% would recommend the facility to someone needing treatment.”

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1 Department of Justice, “Universal Health Services, Inc. And Related Entities To Pay $122 Million To Settle False Claims Act Allegations Relating To Medically Unnecessary Inpatient Behavioral Health Services And Illegal Kickbacks,” news release, July 10, 2020, https://bit.ly/3948mzD.

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