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Two Hospitals Pay $8.37M to Settle Case About Psych Certifications, Treatment Plans

By Nina Youngstrom

In separate settlements with the HHS Office of Inspector General (OIG), two Massachusetts hospitals in the same family have agreed to pay a total of about $8.37 million to settle allegations that their inpatient psychiatric units didn't comply with Medicare requirements for certifications and treatment plans. The units were managed by a third-party contractor, according to the civil monetary penalty settlements, which were obtained through the Freedom of Information Act.

Steward Holy Family Hospital in Methuen agreed to pay $6.952 million and Nashoba Valley Medical Center, which is described in the settlement as "a Steward Family Hospital," agreed to pay $1.424 million. The settlements are otherwise virtually the same. OIG alleged the hospitals billed Medicare for services that were not provided as claimed or were false or fraudulent. Specifically, the hospitals "failed to maintain physician certifications, recertifications, and treatment plans for inpatient psychiatry services in violation of Medicare billing requirements," OIG alleged.

The covered conduct at Steward Holy Family lasted from April 1, 2011, to Aug. 24, 2016, and at Nashoba Valley Medical Center from Dec. 4, 2013, through Aug. 24, 2016. During that time, a third-party contractor managed the inpatient psych units and was responsible for maintaining medical records for patients on the units, the settlement said.

The settlements stemmed from their self-disclosures to OIG. The hospitals were admitted into OIG's Self-Disclosure Protocol in the spring of 2019. Their attorney, Damien Powell, and the hospitals didn't respond to *RMC*'s requests for comment. Neither hospital admitted liability in the settlement.

Certification and treatment plans seem to be the Achilles' heel of psychiatric hospitals,[1] said Georgia Rackley, senior clinical specialist with SunStone Consulting in Harrisburg, Pennsylvania. Inpatient psych is the mental health version of the intensive care unit, and psychiatrists, nurses and social workers should convey in their documentation specifically why the patient needs to stay, Rackley said.

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; physicians must recertify 30 days later and again 30 days after that, according to the conditions for Medicare payment (42 C.F.R. § 424.14(a)–(d)).[2]

Rackley said the Medicare language is at the heart of compliance, although it's a bit outdated because inpatient psychiatric stays typically don't continue longer than seven to 10 days. An exception: Some psychiatric facilities with specialized units are able to keep severely mentally ill patients for 30, 60 or 90 days, but typically Medicaid is the funding source, with somewhat different documentation requirements.

However long patients are there, documentation must explain why. "Medicare is looking for a certification statement that's supporting what's in the psychiatric evaluation; it could be part of the evaluation," she said. "A

weakness we often find in the physician daily progress notes is a lack of support for continuing the inpatient stay, and the physicians rely on broad terms such as the patient's need for 'stabilization' without elaboration."

Even when the nursing and psychiatrist notes are in the record, there may be a failure to connect the dots. "There's a huge disconnect when you look at the totality of the records," Rackley said. The psychiatrist may not pick up on the content of the nursing notes, which often are detailed and support the reason for the patient's stay.

Here's an example of a progress note that supports ongoing certification: "In view of poor judgment, insight and poor higher cognitive functioning, along with overtones of agitation and mood lability, with a risk of self-harm or harm to others if untreated, I am continuing the current level of inpatient treatment for further stabilization and management."

Certifications and recertifications were a factor in the False Claims Act case against Universal Health Services Inc. and UHS of Delaware Inc., which they settled in July for $117 million.[3] The Department of Justice alleged one hospital left certifications blank during patient stays and filled them out after discharge.

Treatment Plans Must Describe Goals

Treatment plans also are a sore spot at inpatient psych hospitals, Rackley said. Medicare regulations are very clear: "they have to be a road map: how we will spend our time with the patient and how we will know when discharge is possible," she said.

According to the *Medicare Benefit Policy Manual*:

> In accordance with [42 C.F.R. § 412.27(c)(3) and 42 C.F.R. § 482.61(c)], each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities. The written plan must include—
>
> 1. A substantiated diagnosis;
> 2. Short-term and long-range goals;
> 3. The specific treatment modalities utilized;
> 4. The responsibilities of each member of the treatment team; and
> 5. Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.[4]

Treatment goals should be measurable, with the treatment plan explaining how they will be measured and what modalities will be used, Rackley said. "How will you know the patient is less depressed, less psychotic, less violent? All inpatient notes should refer back to the treatment plan, but often you find no reference," she said. Medicare acknowledges some patients may not improve, including elderly people with dementia who may be a "handful" behaviorally, Rackley said. CMS gives psych hospitals wiggle room even when patients are deteriorating overall, as long as there are signs of active treatment that can bring symptoms under control.

Rackley said progress notes that paint a picture of stability day after day without providing some specifics put coverage of hospital days at risk. Psychiatrists should describe their patients' response to medication and other

therapies and elaborate on why they are no longer suicidal, for example.

Psychiatrists also may fail to document comorbidities (e.g., diabetes) and how they affect the patient's behavioral health condition, Rackley said. The social determinants of health are another area to highlight. Many patients with psychiatric conditions are compromised socioeconomically, she noted. They often have been exposed to violence and may be homeless, for example. That's long been a fact of life, but now it can be captured with the Z codes introduced in ICD-10. "They will need a safe and secure housing situation with oversight and supervision of meds," Rackley noted.

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1 Nina Youngstrom, "Checklist to Help Ensure Compliant Certifications for Inpatient Psychiatric Hospitalizations," *Report on Medicare Compliance* 29, no. 45 (December 21, 2020).
2 CMS, "Chapter 2 - Inpatient Psychiatric Hospital Services," *Medicare Benefit Policy Manual*, Pub. 100-02, revised December 14, 2018, https://go.cms.gov/3gWFg9k.
3 Nina Youngstrom, "Hospital Chain Pays $117M to Settle FCA Case About Medical Necessity, Therapy," *Report on Medicare Compliance* 29, no. 26 (July 20, 2020), http://bit.ly/3msnX16.
4 CMS, "Chapter 2 - Inpatient Psychiatric Hospital Services," *Medicare Benefit Policy Manual*, 13.