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Hospital Pays $2.33M in CMP Case on Psych Certifications, Recerts

By Nina Youngstrom

UMass Memorial HealthAlliance-Clinton Hospital in Massachusetts agreed to pay $2.33 million to settle a civil monetary penalty case about questionable documentation for Medicare inpatient psychiatric services. Certifications and recertifications, which support the medical necessity of treatment for the patient's condition, weren't consistently found in the medical records at its Geriatric Medical Psychiatric Unit. Although the hospital fixed that problem, another one surfaced when the hospital was monitoring the corrective action plan, and it subsequently self-disclosed to the HHS Office of Inspector General, according to the settlement and an OIG memo.

During due diligence conducted for a merger of HealthAlliance and Clinton Hospital, there was a risk assessment of inpatient psychiatric services at Clinton Hospital's Geriatric Medical Psychiatric Unit. The hospital did two back-to-back internal reviews covering Jan. 1, 2011, through Jan. 20, 2017. During the first review, which covered the six-year look back period required by the Medicare 60-day overpayment return rule, the hospital allegedly "determined that the medical records did not consistently contain the appropriate documentation to satisfy Medicare requirements. While monitoring corrective measures implemented to address this issue, the hospital discovered that one of the newly implemented documentation processes resulted in the inappropriate manipulation of dates on certain forms," OIG said. That's when the second review was conducted, which covered the last six months.

The hospital was accepted into the OIG Self-Disclosure Protocol in June 2018. OIG contends the hospital submitted claims to Medicare that it knew or should have known were false or fraudulent. It didn't admit liability in the settlement.

Boston attorney Larry Vernaglia, who represented UMass, suggests that all inpatient psychiatric facilities conduct voluntary reviews of certifications and recertifications. "The industry hasn't focused on this as a compliance objective," he says. They're vulnerable, however, with inpatient psychiatric facilities facing reviews by recovery audit contractors (*RMC 10/30/17, p. 1*) and Medicare administrative contractors in targeted probe and educate (*RMC 10/29/18, p. 1*). Certifications and recertifications specifically are under scrutiny. "It's easy to let a form slip through the cracks, but it's also an easy one to fix with training, education and some auditing."

More Leeway With Diagnostic Tests

Medicare Part A covers inpatient psychiatric admissions with a valid admission order before discharge when physicians certify the need for services at admission and day 12 of hospitalization and recertification every 30 days after. Hospitals often get claim denials for inpatient psychiatric stays because physicians don't meet the certification deadlines or auditors contend there isn't proof of certification in the medical records. CMS says that a certification form isn't required, although some hospitals have adopted forms to make themselves audit proof (*RMC 11/19/18, p. 4*).

Hospitals got a little leeway from CMS in January with a revision to the *Medicare Benefit Policy Manual* (Chap. 2, Inpatient Psychiatric Hospital Services), which now gives them more grounds to recertify patients. CMS has

added diagnostic study as a reason for extending the patient's inpatient psychiatric stay. "In addition, the hospital records should show that services furnished were intensive treatment services, admission or related services *necessary for diagnostic study*, or equivalent services," the manual now states. Vernaglia said CMS included similar flexibility in earlier *Federal Register* issuances, and recommended that all inpatient psych facilities become familiar with them.

That's very helpful because sometimes patients require more time in the hospital to evaluate their response to a medication adjustment, says Wanda Cidor, a specialist master with Deloitte & Touche. Therapy sessions may have tapered off so the psychiatrist wouldn't recertify the hospital stay for that reason. But it may be necessary to check blood levels to ensure Lithium, for example, is in the appropriate range, says Hari Pillai, a senior consultant with Deloitte & Touche. "I believe now if it's an extra four to five days, the recertification may be covered," he says. "That's more in line with the standard of practice we're seeing."

Certifications and recertifications can be challenging because the requirements are "very prescriptive," Cidor says. Although inpatient psychiatric units are free to skip cert/recert forms, it's risky. "If their clinicians are documenting their thought processes and plans of care, you will probably find all the elements required," Cidor says. "But a lot of documentation is not that good."

She also sometimes sees inconsistency in the charts. The physician may document that the patient requires intensive treatment, but there's no evidence that therapy was provided. "It all has to align," Cidor explains.

Less Internal Oversight of Psychiatric Units

The slew of audits and recent settlements may be CMS abhorring a vacuum. There seems to be less internal compliance oversight of inpatient psychiatric units, says Kelly Sauders, a partner at Deloitte & Touche. "These units are treated very separately," she says. "Where you would have case managers or utilization reviewers in a regular acute-care hospital, we don't always see that with inpatient psychiatric units. That contributes to some of the challenges a lot of hospitals are facing with these units." Adding utilization reviewers and case managers can improve compliance with Medicare requirements "by having trained professionals monitoring documentation and patient readiness for discharge."

Sauders says another best practice is building certifications and recertifications into the electronic medical record systems. "I can't say we've seen a lot of providers do that yet" except as part of a corrective action plan after they identify a problem.

There are also challenges around the medical necessity of stays, particularly toward the end of an inpatient psychiatric stay. Sometimes hospitals face a difficult choice between keeping a patient safe and getting paid. They won't discharge patients who aren't safe to go home or require more intensive oversight and therapy than a group home provides, Pillai says. The other option is transferring patients to a state hospital, but the waiting lists often can be months long, he says. At some point, hospitals may be providing custodial care, which isn't covered by Medicare. "There's no other compliant option," Sauders says. "Once they know the patient doesn't meet the Part A requirement as far as an expectation for improvement, then subsequent days should not be billed to Medicare."

'Clean Up Problems Before the Transaction'

It's not uncommon for actual or potential violations to come up during due diligence in anticipation of a merger or acquisition. "When I represent the buyer, I say, 'Let's clean up problems before the transaction so you don't have to leave a large escrow that exceeds the anticipated loss,'" Vernaglia says. Also, buyers want to manage any refunding or self-disclosure to be sure they know their exposure. From the seller's perspective, he recommends

resolving a violation before the transaction closes (if possible) because sellers also know what their exposure is, and they can also participate in the self-disclosure, if one is necessary. But some transactions must close for tax or other reasons on an expedited basis. It is common for the investigation and resolution of compliance or billing concerns to extend beyond the closing. Remember that many liabilities follow provider agreements and surviving corporate entities (in stock transactions). So getting a handle on potential risks early in a transaction is extremely helpful. "Everybody is better off if it's done before the closing," Vernaglia says.

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