Audit Risk Alert

Alert No: #67

Inpatient Behavioral Health Services
Issued: November 2024

The purpose of this Audit Risk Alert is to share common issues identified during audits related to the Centers for Medicare & Medicaid (CMS) documentation requirements for inpatient psychiatric facilities (including distinct part units (DPU)) services, and patient monitoring and documentation in accordance with industry standards and HCA Healthcare guidelines.

NONCOMPLIANCE WITH THE REQUIREMENTS MAY RESULT IN INCREASED ORGANIZATIONAL RISK, PAYMENT DENIALS, AND REGULATORY CITATIONS.

Please share this alert with the appropriate physicians and staff within your divisions and facilities, specifically those responsible for management and oversight of inpatient behavioral health services and regulatory compliance.

Background

Acute inpatient mental health treatment represents the most intensive level of psychiatric care. Acute inpatient mental health treatment is a short-term program that provides specific treatment for patients who suffer from psychiatric issues. These patients require intensive, comprehensive, multimodal treatment including 24 hours per day of medical supervision and coordination because of a mental disorder.

CMS Regulatory Requirements

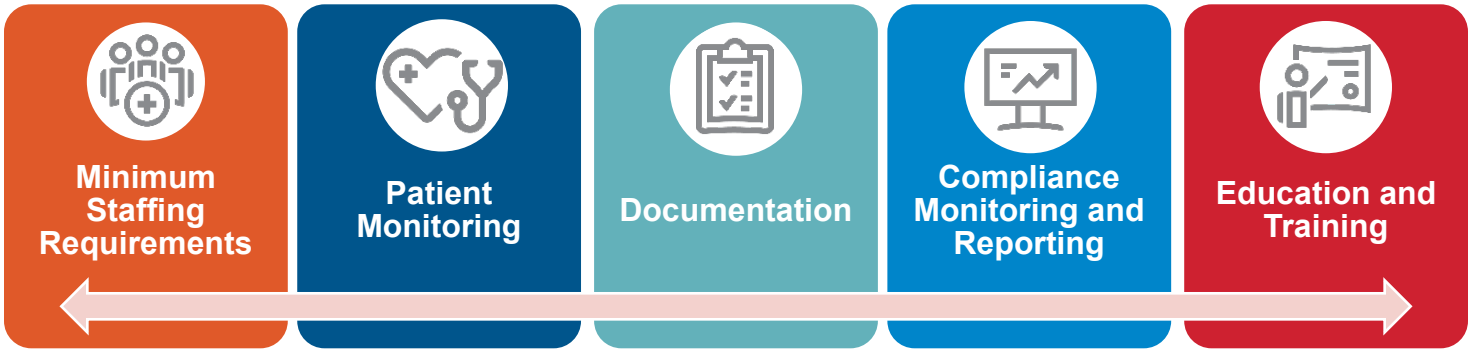
Medicare pays for inpatient psychiatric services to inpatient psychiatric facilities (IPFs) under a prospective payment system (PPS) when certain conditions of payment are met. If an IPF fails to comply fully with these conditions, CMS may withhold (in full or in part) or reduce Medicare payment to the IPF until the facility provides adequate assurances of compliance. The inpatient psychiatric facility maintains clinical records necessary to determine the degree and intensity of the treatment provided to the patient and provides the required services. Medical record documentation should support the patient's need for psychiatric services in accordance with the CMS regulations.

Patient Monitoring and Documentation, Staff Education and Training, Compliance Monitoring and Reporting Requirements

In accordance with industry standards and HCA Healthcare guidelines, all inpatient behavioral health patients should be monitored a minimum of once every fifteen minutes. A Registered Nurse (RN) should round with a Mental Health Tech (MHT) minimally every two hours to assess patient wellbeing and communicate with unit staff the status/condition changes for each patient. A minimum of two nursing staff are assigned on the inpatient unit at all times. One nurse should be a RN, and the second nursing staff may be an MHT. Staff are to record the location and behavior of the patient on the Patient Monitoring Form and the Charge RN should validate and attest that all rounds are completed and documented in a timely and accurate manner by signing off the monitoring form each shift. Staff should receive appropriate education and training, and patient monitoring performance should be monitored monthly and compliance results reported to the Quality Committee.

Key Findings Identified During Internal Audit Reviews

Internal Audit's review identified that **industry standards and HCA Healthcare guidance for patient monitoring, documentation, staff education and training, compliance monitoring and reporting** were not consistently followed. The common deficiencies are noted below.



Minimum Staffing Requirements

In accordance with HCA Healthcare guidance, *"Clinical Staffing"*, a minimum of two nursing staff are assigned on the inpatient unit at all times. One nursing staff should be a Registered Nurse (RN) and the second nursing staff may be a qualified mental health technician (MHT).

- **Audit findings included instances when the RNs and MHTs left the behavioral health unit together, leaving the patients unsupervised, and instances where only one nursing staff, either the MHT or RN, was present on the unit or in the gym with the patients.**

Patient Monitoring

In accordance with HCA Healthcare guidance, *"Standard and Special Observation"*, the requirements for patient monitoring include the following:

- All patients are monitored at a minimum of once every fifteen minutes.
- At least every 2 hours, an RN should round with a MHT to assess the wellbeing of the patients. The RN should use this time to communicate with the MHT regarding the status or any condition changes for each patient. The Patient Monitoring Form should be initialed by the RN at the time rounding occurred.
- While making rounds, staff members should observe the environment for unsafe conditions.
- If the patient is in their room, staff members should enter the room to observe the condition of the patient. When a patient appears to be sleeping or resting, staff should observe the rise and fall of the patient's chest.
- In low light conditions, flashlights or nightlights may be used to assist in adequate visualization of the patient.
- Staff on inpatient behavioral health units should visualize the hallways at all times, especially during sleeping hours (e.g., video monitoring, placement of staff in hallways, etc.).

- **Audit findings included instances when the 15-minute and 2-hour RN patient monitoring checks were not performed but were documented as being performed. During 15-minute and 2-hour RN monitoring checks, instances were observed when staff did not enter the patients' rooms to assess their safety or condition.**

Documentation Requirements

In accordance with HCA Healthcare guidance, *"Standard and Special Observation"*, the documentation requirements for patient monitoring include:

- From the time of a patient's admission to the behavioral health unit, a designated staff member should observe the behavior and location of the patient at a minimum of every 15-

minutes and document on the Patient Monitoring Form or the electronic record. Any untoward occurrences should be called to the attention of the Clinical Nurse Coordinator (CNC) or designee immediately and documented.

- Each shift, the CNC or designee is responsible for assigning the 15-minute patient monitoring and record the assignments on the Shift Assignment Form.
- Each patient should be personally located by the designated staff member(s) and the patient's location and safety should be documented on the Patient Monitoring form along with the staff member's initials and the time the patient monitoring round occurred. During joint rounds with the RN and MHT, both staff members should initial the Patient Monitoring Form. Initials and signatures of staff members should be legible.
- If a 15-minute or 2-hour RN patient monitoring round is missed, the staff member should make a notation on the back of the patient monitoring form explaining the reason for the missed round and escalate to the CNC or designee. The notation shall include date, time, reasons for missed round, and staff signature with initials that are legible.
- For patients on one-to-one (1:1) monitoring, the type of precaution should be noted on the patient monitoring form at the top of the form.
- If a patient's level of monitoring is ordered to change during a shift, the patient monitoring form or the electronic record should be updated to reflect the new level of monitoring as of the ordered start time.
- Each shift, the CNC or designee should sign-off each patient's monitoring form to validate that all rounds were completed and documented in a timely and accurate manner.

➢ **Audit findings included instances where the patient's level of monitoring changed from standard monitoring (every 15-minutes) to a one-to-one (1:1), but the change in level of monitoring was not documented on the monitoring form. We noted instances where the Charge Nurses failed to document their attestation that the checks were performed for the shift.**

Compliance Monitoring and Reporting

In accordance with HCA Healthcare guidance, *"Standard and Special Observation"*, the requirements for compliance monitoring and reporting include:

- Patient Monitoring Form Review and Rounding Requirements:
  - Behavioral Health Services (BHS) Leadership, House Supervisors, or any Hospital Executives rounding on the Behavioral Health Unit (BHU) should randomly review patient monitoring forms to identify accuracy and timeliness. When variations are found, these should be addressed immediately and reported to the BH executive, or appropriate nursing/quality leader as soon as possible for follow up. The number of patient monitoring forms reviewed per month is determined by the facility's leadership.
- Video Review Requirements:
  - Video reviews should occur at a minimum of once a month, for each shift, and on each unit. Staff should be monitored for performance of 15-minute patient monitoring and every 2-hour RN rounds. The review should capture a cross section of staff to assess accountability and competence, including weekends and holiday shifts.
  - A minimum of one hour of video review should be conducted. Video review may be competed by BHS Leadership, Hospital Leadership, CNC or designee.
- Compliance Reporting:
  - Monthly patient monitoring form audits and video review compliance results should be reported to the Quality Committee.

➢ **Audit findings included instances where monthly patient monitoring check sheets and video review were not completed and/or the compliance results were not reported to the Quality Committee.**

Staff Education and Training

In accordance with HCA Healthcare guidance, *"Behavioral Health Employee Orientation"*, completion of the orientation program is required of all staff in the mental health area regardless of employment status. The Program Director and Nurse Manager is responsible for development of a systematic means of orienting new employees to all aspects of their role, and care of the patients. All staff should successfully complete both hospital and unit specific orientation prior to assuming their assigned role independently. Minimal orientation topics are specific to each employee's role.

- **Audit findings included instances where employees were up to four years past due and/or were not assigned some or all of the mandatory HealthStream courses. Some employees were unable to verbalize that unit training and education was provided.**

CMS Regulatory Standards and Documentation Requirements for Inpatient Psychiatric Services

Internal Audit's documentation review identified that the **CMS regulatory standards for inpatient psychiatric services** were not consistently supported by documentation in the medical record, resulting in repayments to Medicare. The common deficiencies are noted below.

Treatment Plan

An individualized treatment plan must be developed by a physician in collaboration with other disciplines. The treatment plans must be signed by the physician and those mental health professionals contributing to the treatment plan.

- **Audit findings included treatment plans that the physician and/or the care team either failed to sign or signed late (after the patient's discharge).**

Psychiatric Evaluation

A psychiatric evaluation must be completed. If the evaluation is completed by a non-physician, a physician's signature is necessary. In those cases where the mental status portion of the psychiatric evaluation is performed by a non-physician, there should be evidence that the person is credentialed by the hospital, legally authorized by the state to perform that function, and a physician review and countersignature is present, where required by hospital policy or state law.

- **Audit findings included psychiatric evaluations that lacked a physician signature or a physician's countersignature for a non-physician provider. Additionally, findings included a lack of documentation that included a description of the patient's onset of illness, past medical history, attitude and behavior, intellectual and/or memory functioning.**

Certification/Recertification

Medicare pays for inpatient psychiatric services only if a physician certifies and recertifies the need for services. The certification must be documented upon inpatient admission. If the patient continues to require active inpatient psychiatric treatment, then a physician must recertify as of the 12th day of hospitalization.

- **Audit findings included a lack of documentation of a physician's certification or re-certification.**

History and Physical (H&P)

The patient must receive a thorough history and physical examination, which includes a neurological exam and gross testing of cranial nerves II through XII. Statements such as cranial nerves 'intact' or 'normal' are not sufficient.

- **Audit findings included H&P documentation stating that the gross testing of the cranial nerves were "normal" or "intact".**

Discharge Summary

Each medical record must have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge. CMS also requires medical records to be completed within 30 days following discharge.

- **Audit findings included discharge summary documentation that lacked a recapitulation of the patient's hospitalization and the patient's condition at discharge, or the discharge summary was completed greater than 30 days post discharge.**

Legal Admission Status

The medical record must include the patient's legal status. Legal status is defined in the state statutes and dictates the circumstances under which the patient was admitted and/or is being treated (i.e., voluntary, involuntary, or committed by court).

- **Audit findings included documentation of the patient's legal admission status was either lacking or documentation conflicted within the medical record.**

Admission or Point of Origin Code

The correct source of admission or point of origin admission codes must be included when submitting claims for services. A Point of Origin code indicates the point of origin for the admission or visit and defines where the patient came from before presenting to the facility. Point of Origin D must be reported when a patient is discharged from an acute care inpatient stay in a hospital and transferred to the same hospital's psychiatric DPU for admission. CMS does not make this payment if the beneficiary was discharged from an inpatient stay in an acute care section of a hospital and admitted to the same hospital's DPU for inpatient psychiatric services. In this case, the costs of emergency department services are covered by the Medicare payment that the hospital receives for the beneficiary's immediately preceding inpatient stay. Point of Origin code 'D' must be reported to prevent the IPF from receiving the qualifying ED adjustment as would be an overpayment.

- **Audit findings included admission point of origin documentation errors related to admissions from non-healthcare facilities, court or law enforcement, transfers from another hospital, and admissions from an acute inpatient stay from the same hospital.**

Key Takeaways

- Hospital administration and medical staff **should follow the CMS requirements and HCA Healthcare guidance** related to inpatient psychiatric facility services to ensure its success. **It is the responsibility of each facility's administration to ensure that the requirements and documentation expectations are applied** by all individuals involved in inpatient psychiatric services.

- Hospitals should disseminate and **provide education and training on key risks and compliance topics** to applicable physicians and staff.

- Hospitals should **monitor, assess, and mitigate key compliance risks related** to inpatient psychiatry facilities and services.

1. **Inpatient Psychiatric Facility (IPF) Self-Monitoring Requirements:**
    - The IPF program director (or designee) is responsible for conducting the self-review quarterly.
    - All completed self-review tools should be sent to the facility CFO, Ethics and Compliance Officer (ECO), Behavioral Health Services Regional Vice President (BHS RVP), and Behavioral Health Services Assistant Vice President of Nursing Operations (BHS AVP).
    - The facility ECO is to report monitoring results to the Facility Ethics and Compliance Committee (FECC).
    - All non-reconciled fall outs on the self-review are to be reported to Regulatory Compliance Support (Regs) via the Regs Helpline within 2 business days of the final review.
    - Self-Monitoring Tools and Resources:
        - Behavioral Health Services - Inpatient Psychiatry Facility Monitoring Overview
        - Behavioral Health Services - Quarterly Inpatient Psychiatric Facility Self-Review Process
        - Behavioral Health Services - Inpatient Psychiatric Facility Regulatory Compliance Self-Review Tool

2. **Patient Monitoring and Reporting Requirements:**
    - The IPF program director or designee is responsible for conducting a review of the patient monitoring sheets and video review monthly.
    - Compliance results are to be reported to the Quality Committee.
    - Patient Monitoring and Reporting Tools and Resources:
        - Guidance for Clinical Staffing
        - Guidance for Standard and Special Observation
        - Video Monitoring and Patient Monitoring Form and Observation Rounds Audit Tool
        - Video Monitoring and Rounding Audit Tool
        - Patient Monitoring Form - Every 15 Minute Checks without Times
        - Patient Monitoring Form - Every 15 Minute Checks with Time Blocks
        - Guidance for Behavioral Health Employee Orientation

Additional Resources

Regulations/Standards:

- CMS Pub 100-2 Chapter 2 - Inpatient Psychiatric Hospital Services
- CMS Pub 100-01 Chapter 4 - Physician Certification and Recertification of Services
- CMS Pub 100-01 Transmittal 39 - General Information, Eligibility, and Entitlement
- Federal register 42 CFR 412.22 - General Rules
- Federal register 42 CFR 412.23 - Classifications
- Federal register 42 CFR 412.25 - Common Requirements
- Federal register 42 CFR 412.27 - Exclusions
- Federal register 42 CFR 424.14 - Requirements
- Federal register 42 CFR 482.60 - Special Provisions
- Federal register 42 CFR 482.61 - Conditions of Participation
- Federal register 42 CFR 482.62 - Conditions of Participation
- Inpatient Psychiatric Facilities Prospective Payment System Update
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet
- CMS Form 437 Psychiatric Unit Criteria Worksheet
- SE 1401 Point of Origin for Admission or Visit Code (Formerly Source of Admission Code) for Inpatient Psychiatric Facilities (IPFs)
- SE 1020 Reminder to Inpatient Psychiatric Facilities (IPFs) to use Source of Admission Code D for Patient Transfers within the Same Facility

HCA Healthcare Resources:

- Atlas Connect Regulatory Compliance Support (Regs) – Inpatient Psychiatric Facilities Page
- Atlas Connect Behavioral Health Services – Behavioral Health Services Page
- Inpatient Psychiatric Facility Self-Monitoring Guidance and Self Review Tool
- HCA Healthcare Policy, REGS.APS.001 - Certification and Recertification for Post-Acute Services
- HCA Healthcare Inpatient Psychiatric Facility Physician Certification and Recertification Form
- Cranial Nerve Assessment Site
- Reporting Point of Origin for Admission or Visit Code D

Key Contacts

If you have any questions, please contact the following individuals:

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