DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Ohio Department of Public Welfare
Docket No. 80-72-OH-HC
Decision No. 219

DATE: September 30, 1981

DECISION

The Ohio Department of Public Welfare (State) appealed from a penalty disallowance of $438,970.71 made by the Health Care Financing Administration (Agency) pursuant to Section 1903(g) of the Social Security Act (the Act) for the quarter ending June 30, 1979. The Agency determined that the State violated the recertification requirement of Section 1903(g)(1)(A) for four patients in two mental hospitals.

The Agency modified the amount of the disallowance twice during the course of the appeal. The Agency made the first reduction because the Agency's original calculation reflected State expenditures for services in addition to mental hospital services. The Agency accepted the figure submitted by the State as the correct amount representing mental hospital services only and reduced the penalty to $115,990.84. The Agency later determined that the calculation did not reflect the fact that the Section 1903(g) penalty is limited to long-term services, i.e., beyond 60 or 90 days, depending on the level of service. Therefore, the Agency recalculated the penalty again and reduced the amount further. We conclude that the disallowance in an amount to be agreed upon by the parties must be upheld.

This decision is based on the State's application for review, the Agency's response, the parties' responses to the Board's Order to Show Cause, a supplemental memorandum submitted by the Agency concerning modification of the penalty, and an informal conference in which the representatives of both parties, a Board staff attorney and the presiding Board member participated. We have determined that there are no material facts in dispute.

Pertinent Statutes, Regulations, and Policy

Section 1903(g) of the Act requires that the State agency responsible for the administration of the State's Medicaid plan under Title XIX of the Act show to the satisfaction of the Secretary that the State has an "effective program of control over utilization of" long-term inpatient services in certain facilities, including "hospitals for mental diseases." This showing must be made for each quarter that the Federal medical assistance percentage (FMAP) is requested with respect

to amounts paid for such services for patients who have received care for 90 days in "hospitals for mental diseases," or the FMAP will be decreased according to the formula set out in Section 1903(g)(5). The satisfactory showing must include evidence that "in each case for which payment is made under the State plan, a physician certifies at the time of admission, ... (and recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days ...) that such services are or were required to be given on an inpatient basis because the individual needs or needed such services" (Section 1903(g)(1)(A)).

This statutory requirement is implemented by 42 CFR 456.160, effective September 29, 1978. This regulation states:

> (a) A physician must certify and recertify for each applicant or recipient that inpatient services in a mental hospital are or were needed.
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> (c) Recertifications must be made at least every 60 days after certification.

An Agency Action Transmittal, SRS-AT-75-122, dated November 13, 1975, instructed the States about "what is required in order for States to be considered in adherence" with the statute and regulation. It defined recertification as "the process by which a physician attests to an individual's need for continued placement at a specific level of care." The Action Transmittal identified several conditions "which must be met in order for the recertification to be considered valid." The recertification must be in writing, it must be signed by a physician using his/her signature or initials, and the recertification must be dated at the time it is signed or initialed. Several types of documents may be acceptable as recertifications, e.g., a statement signed and dated by a physician that the patient needs a particular level of care, signed and dated physician orders or progress notes which indicate the need for continued care, or a medical evaluation signed and dated by a physician. The date of the signature must meet the Agency's requirements for a timely recertification, and the signature must be identifiable as that of a physician.

Discussion

In September 1979, Federal reviewers conducted an onsite survey, in accordance with Section 1903(g)(2), of ten mental hospitals in the State, to determine whether the requirements of Sections 1903(g)(1)(A) and (B) were met for the quarter ending June 30, 1979. The reviewers found that four recertifications were invalid. Thereafter, the Agency issued a notice of disallowance, from which this appeal was taken.

1) The Validity of the Recertifications for Two Patients

The Agency determined that there were no valid recertifications for two patients in one MH. The State submitted documentation, allegedly constituting valid recertifications, for the two patients. The Agency examined this documentation and responded that the documentation did not establish that the two patients were recertified in accordance with Federal requirements. The Agency stated that each document lacked some aspect of a valid recertification. The State focused on the physician orders (Doctor's Order Sheet and Patient Progress Note Sheet) submitted for the two patients and argued that they were valid recertifications (Response to the Order to Show Cause). The Agency had stated that these orders could not qualify as valid recertifications because they "do not indicate what level of care was under evaluation and therefore do not perform a proper recertification function" (Response to the Application for Review, page 14). At the informal conference, the Agency clarified this statement, saying that the physician orders, which contained only notes regarding drug prescriptions and brief descriptions of the patients' behavior, did not constitute statements that the patients continued to need inpatient mental hospital care; therefore, the physician orders did not meet the recertification requirements. The State had submitted written evaluations of the physician orders (Response to Order to Show Cause); the evaluations were prepared specifically for the appeal by two physicians who were, successively, the Medical Director and Acting Medical Director of the institution in which the two patients resided. The evaluations stated that the physician orders constituted a clear statement of the patients' need for "continuation at a hospital level of care." At the conference, the State emphasized the arguments made in its Response to the Order to Show Cause, and indicated that the evaluations were submitted as those of "expert witnesses." The Agency's written response to the State's submission of these evaluations was that the physician orders did not assess the patients' need for mental hospital services and that the evaluations did not constitute a timely assessment of that need and were, therefore, "irrelevant" (Response to Order to Show Cause and State Response, pages 5-7). At the conference, the Agency stated that its position is that the recertifications must clearly attest to a need for continued care at a specific level, without the reviewers' reference to a professional evaluation of the documents; the recertification must be obvious to a non-physician.

The Agency has provided the States with notice of a consistent set of requirements about what constitutes a valid recertification. The statute, regulation, and Action Transmittal require that a physician "recertify" (attest) to the continued need for care. Accordingly, there must be a periodic assessment of a patient's need for a level of care. We do not agree with the State that this required recertification can be implied here from brief notes about the patients'

physical and mental state. We cannot equate a description of a patient's behavior or physical condition, which may support a decision that continued treatment at the mental hospital level of care is medically necessary, with the actual determination that the mental hospital level of care is, in fact, medically necessary. While we do not conclude that any particular "magic" words are necessary, we do conclude that to recertify, the physician's comments must evidence an actual assessment of continued need. We agree with the Agency that it is impractical and unreasonable to expect Agency reviewers during a validation survey to make judgments about the patients' medical needs from brief statements about patient behavior and physical condition. We conclude that the physician orders do not indicate that a physician attested to the patients' need for continued mental hospital care.

This Board has previously concluded, on the basis of the statutory language and the statute's legislative history, that the Secretary does not have the discretion to waive or reduce the penalty once there is a finding that a violation of Section 1903(g) occurred (Tennessee Department of Public Health, Decision No. 167, April 30, 1981; Colorado Department of Social Services, Decision No. 169, April 30, 1981.) Therefore, we conclude that the portion of the disallowance based on the violation of the recertification requirement for the two patients must be sustained.

2) The Absence of Recertifications for Two Patients

The Agency determined that the State had not recertified two other patients' need for continuing inpatient mental hospital level of care. The State alleged, in its application for review, that the two patients were not eligible for mental hospital services during that quarter, but that FMAP was claimed for them because of an administrative error. The State asserted that because the patients were not eligible for the services, no recertifications were necessary. The Agency alleged that the patients received the services even though ineligible and that the State received Medicaid payments for those services. At the informal conference, the State clarified that its use of the term "ineligible" refers to the need for mental hospital level of care rather than to eligibility for Medicaid services in general. The State confirmed that a medical determination was made in May 1978 for both patients that they no longer needed inpatient mental hospital care. The State claimed that the patients remained in the institution, however, because of an alleged difficulty in finding alternative care for them. The State continued to claim Medicaid for the patients well into 1980. The State asserted that, because FMAP was claimed for the patients due to clerical error, the appropriate remedy is to disallow the FMAP claimed. The State asserted, in its Response to the Order to Show Cause (page 7), "the fact that the State of Ohio may choose to allow a patient to remain in one of its mental

hospitals, following the termination of a patient's eligibility for inpatient services ... should not be grounds for the imposition of a penalty under Section 1903(g) of the Act" (page 7).

The Agency argued that the "circumstances surrounding petitioner's failure to appropriately recertify the two cited recipients ... present a classic example of an ineffective utilization control program" (Response to Order to Show Cause, page 7). The Board concludes, and the Agency does not dispute, that if the patients had either continued to need mental hospital services but were ineligible for Medicaid, or had been discharged from the mental hospital during the period for which FMAP was paid, a simple disallowance of the claimed FMAP would be appropriate. Also, if the State had supported those patients in full, there would be no basis for Federal interference in State utilization of long-term inpatient services.

Section 1903(g) requires a reduction in FMAP "with respect to amounts paid for [any long-term inpatient care services] furnished under the State plan ... to such individual ... unless the State makes a showing ... that (A) in each case for which payment is made under the State plan, a physician ... recertifies ... that such services were required to be given on an inpatient basis because the individual needs ... such services." (Section 1903(g)(1)(A)). The purpose of the statute is to prevent "unnecessary and overutilization of costly institutional care under medicaid, accompanied by insufficient usage of less costly alternative out-of-institution health care ... [and to] place affirmative responsibility upon States to assure proper patient placement." (S. Rep. 92-1230, September 26, 1972, page 44). The Agency argued that the Section 1903(g) penalty would be nullified if "any State could avoid the penalty by merely admitting its error and refunding the Medicaid funds" (Response to Order to Show Cause, page 9).

We conclude on the basis of the statutory language and the purpose of the Section as articulated in the legislative history that, where Medicaid funds were paid for unnecessary utilization, the State may not avoid the assessment of a penalty by merely characterizing payments as in error during the administrative appeals process. We do not believe that the issue presented here is whether a penalty must be assessed where a State clearly demonstrates that there was a purely fiscal error. Although a medical judgment was made in May 1978 concerning the two individuals' need for inpatient mental hospital care, there is no evidence in the record that a determination was made prior to the quarter ending June 30, 1979, to cut off the availability of Medicaid payments for such individuals. Here, the State admits that, although the two patients did not need mental hospital level of care in May 1978, they continued to receive it from that date without the necessary recertification of the need for such care, and that Medicaid funds were paid for this care over a long period of time. Therefore, we conclude that the portion of the disallowance based on these patients should be upheld.

Conclusion

We conclude that the penalty disallowance should be upheld because the State did not recertify two patients according to Federal requirements, and because the State retained two patients in a mental hospital and was reimbursed under Medicaid for these services, after a medical determination that the patients no longer needed the level of care provided in the institution.

/s/ Donald F. Garrett

/s/ Norval D. (John) Settle

/s/ Cecilia Sparks Ford, Panel Chair