



Inpatient Psychiatric Hospitals

Cypress Creek Hospital

Results in Brief

Why OIG Conducted This Audit

The Texas Health and Human Services Office of Inspector General (OIG) initiated this audit in response to a risk assessment after lawsuits and reports alleging that private inpatient psychiatric hospitals were committing and holding patients (a) that did not meet admission or commitment criteria or (b) without the person's consent. The OIG Audit and Inspections Division (OIG Audit) reviewed Cypress Creek Hospital's (Cypress Creek's) medical records, policies and procedures around (a) admissions, commitments, and discharges (b) specific consents, and (c) physician orders.

Summary of Review

The audit objective was to determine whether Cypress Creek completed admission, commitment, and specific consent requirements for STAR+PLUS members receiving inpatient psychiatric services in accordance with selected federal and state regulations, rules, and policies.

The audit examined STAR+PLUS claims processed by UnitedHealthcare of Texas, Inc. and United Behavioral Health, Inc. (United), and associated documentation with service dates from September 1, 2019, through February 28, 2021.

Conclusion

Cypress Creek Hospital (Cypress Creek) complied with selected federal and state regulations, rules, and policies related to physician licensing, required facility signage and patient access to outside communication. However, it should strengthen controls to comply with requirements related to physician orders, psychiatric evaluations, treatment plans, patient consent forms, and days billed.

Key Results

Based on the site visit on March 1, 2022, and additional testing, Cypress Creek complied with requirements related to inpatient facility requirements and physician licensing. However, Cypress Creek has the opportunity to improve the documentation and timing of its orders, consents, and evaluations. Specifically:

- Two voluntary patients who requested discharge were held beyond four hours without documentation of reasonable cause. If the treating physician has no concerns with a voluntary patient's request for discharge, the patient should be released within four hours. If the doctor questions the release, the doctor must evaluate the patient and determine whether to release or seek court approval by hour 24. While the patients who requested release were discharged within 24 hours, the physician should have documented reasonable cause to detain the patient more than the initial 4 hours.
- All 60 sampled records included an initial psychiatric evaluation. However, ten were not conducted timely, one was not performed by a physician, and auditors could not determine if one was timely. Cypress Creek could have patients in its care who were not evaluated by a physician or whose psychiatric evaluations were not completed timely.
- Most medication orders were prescribed and signed by a physician as required; however, some were either not signed at all or not signed timely. Of the 296 orders for psychoactive medication in the sample, 46 (15.5 percent) were not signed as required. Medication orders not signed by a physician may mean psychoactive medications were administered without verification from the treating physician.

Background

Cypress Creek is a 128-bed facility providing care for adolescents and adults in the Houston, Texas, area. It provides inpatient hospital psychiatric services to beneficiaries of the Texas STAR+PLUS program under contract with United, a Texas managed care organization (MCO). STAR+PLUS is a Texas Medicaid managed care program for people who have disabilities or are age 65 or older. Individuals in STAR+PLUS receive Medicaid basic services and long-term services and supports through a health plan they choose.

Through its provider contract with United, Cypress Creek received Texas Medicaid reimbursements of \$3.4 million for inpatient psychiatric hospitalization services delivered to 266 Medicaid beneficiaries during the audit scope, of which \$131,587 related to electroconvulsive therapy.

Management Response

OIG Audit presented preliminary audit results, issues, and recommendations to Cypress Creek in a draft report dated August 3, 2022. Cypress Creek agreed with the audit recommendations and asserted corrective actions had already been implemented or were underway. Cypress Creek's management responses are included in the report following each recommendation.

For more information, contact:
OIGAuditReports@hhs.texas.gov

- Cypress Creek obtained most of the required medication consent forms for psychoactive medication; however, most medication consent forms had errors. Of 137 required medication consent forms tested, 18 were not obtained at all. Of the 119 medication consent forms on file, 13 were obtained after administration and 60 were unable to determine when obtained.
- All 40 sampled records included a written and signed physician admission order, although not all were completed. Six were not signed timely, four did not include the date and time, and seven did not include the time. Cypress Creek could have patients in its care without admission authorization.
- Cypress Creek did not always retain protective custody and emergency detention orders in patients' medical records. Of the ten involuntarily admitted patients tested, eight records (80 percent) were missing the appropriate court order, which could result in patients being held without authority.
- Cypress Creek did not ensure all patients acknowledged their rights or their treatment team completed their treatment plans.
 - All 40 records tested contained the Patient's Bill of Rights form signed by staff who explained the patient's rights. However, of the 38 forms signed by the patient, all had errors.
 - Of 39 treatment plans tested, all were missing at least one team member's signature. Without these acknowledgments, the facility risks health, safety, and rights of patients in its care.
- Texas Administrative Code requires specific elements for voluntary admission and certain therapy consent. Cypress Creek created its own forms for these purposes, but the forms did not contain all the elements required.
- In three instances, Cypress Creek billed for a patient the day before admission because the patient arrived late at night but was not admitted until the next morning. This resulted in an overpayment of \$2,361.

Recommendations

Cypress Creek should:

- Document reasonable cause when voluntary patients are held longer than four hours after requesting discharge.
- Ensure psychiatric evaluations are completed by a physician within the required timeframe based on type of admission.
- Ensure medication consent forms are obtained and completed prior to medication administration.
- Ensure staff follows policies in place.
- Retain court orders.
- Update its forms to include all required information.
- Repay the \$2,361 overpayment.