

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE CRITICAL CARE SERVICES
PROVIDER COMPLIANCE AUDIT:
LAHEY CLINIC, INC.**

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**July 2022
A-03-20-00002**

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: July 2022

Report No. A-03-20-00002

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Medicare paid approximately \$2.4 billion for critical care services provided to Medicare beneficiaries nationwide from January 1, 2017, through March 31, 2019 (audit period). The 2018 Medicare improper payment error rate for critical care services was 19.7 percent, or about \$198 million. Using computer matching, data mining, and data analysis techniques, we identified Lahey Clinic, Inc. as a provider that was at risk for noncompliance with Medicare billing requirements for critical care services.

Our objective was to determine whether Lahey complied with Medicare requirements when billing for critical care services performed by its physicians.

How OIG Did This Audit

Medicare Part B paid \$5.3 million to Lahey for 30,738 critical care services provided during 5,109 inpatient admissions in our audit period. We selected a stratified random sample of 100 inpatient admissions that included 1,410 critical care services totaling \$233,797. We submitted the medical records for 10 judgmentally selected inpatient admissions to an independent medical review contractor. The 10 selected admissions included 92 critical care services totaling \$14,966.

Medicare Critical Care Services Provider Compliance Audit: Lahey Clinic, Inc.

What OIG Found

Lahey complied with Medicare billing requirements for 36 of the 92 critical care services that we reviewed. However, Lahey did not comply with Medicare billing requirements for the remaining 56 critical care services. All 10 of the inpatient admissions reviewed included at least 1 critical care service that did not comply with Medicare billing requirements. Specifically, Lahey billed for 54 critical care services for patients whose conditions did not indicate that the critical care services were medically necessary or for which the physician did not directly provide services that were at the level of care required for critical care services. In addition, Lahey billed for two critical care services that were billed using an incorrect Current Procedural Terminology code for the critical care service provided.

These billing errors resulted in Lahey receiving \$6,015 in unallowable Medicare payments. These errors occurred because Lahey did not have adequate policies and procedures to ensure that: (1) physicians correctly documented in the patient's medical record and identified critical care services that met Medicare requirements and (2) coders made correct determinations for critical care services that met Medicare requirements.

What OIG Recommends and Lahey Comments

We recommend that Lahey refund to the Medicare administrative contractor \$6,015 in overpayments for critical care services, and we also made procedural recommendations for Lahey to strengthen its policies and procedures. The full recommendations are in the report.

In written comments on our draft report, Lahey indicated partial concurrence with our first recommendation and full concurrence with our procedural recommendations. Lahey concurred with our results for 16 of the 56 critical care services, agreed that \$1,461 should be refunded, and stated that it addressed or is in the process of addressing the procedural recommendations. Lahey did not concur with the remaining 40 critical care services. After review and consideration of Lahey's comments, and because Lahey did not provide any additional medical record documentation to support its rebuttal of these 40 services, we maintain that our original findings remain valid.

We commend Lahey for the actions it has taken and plans to take to address the procedural recommendations to strengthen its policies and procedures.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare paid approximately \$2.4 billion for critical care services provided to Medicare beneficiaries nationwide from January 1, 2017, through March 31, 2019 (audit period). The Centers for Medicare & Medicaid Services (CMS) determined through its Comprehensive Error Rate Testing program that the 2018 improper payment error rate for critical care services was 19.7 percent, or about \$198 million. Medicare pays for critical care services that meet certain requirements if the physician documents that the total time spent providing critical care services was 30 or more minutes on the date of service. Using computer matching, data mining, and data analysis techniques, we identified providers at risk for noncompliance with Medicare billing requirements for critical care services. Lahey Clinic, Inc. (Lahey) was one of the providers identified.

OBJECTIVE

Our objective was to determine whether Lahey complied with Medicare requirements when billing for critical care services (Current Procedural Terminology¹ (CPT) codes 99291 and 99292) performed by its physicians.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the Medicare program. Medicare Part B provides supplementary medical insurance for medical and other health services, including critical care services performed by physicians. CMS contracts with Medicare administrative contractors (MACs) to process and pay Part B claims.

Medicare Coverage of Critical Care Services

Critical care is defined as medical care delivered directly by a physician or a qualified non-physician practitioner² for a critically ill or critically injured patient. A critical illness or injury is one that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Critical care involves high

¹ The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2017–2019 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

² When we refer to physicians in this report, we include qualified non-physician practitioners.

complexity decision making to assess, manipulate, and support vital system functions to treat single or multiple vital organ system failure and prevent further life-threatening deterioration of the patient's condition. Providing medical care to a critically ill, critically injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet these requirements (*HCPCS [Healthcare Common Procedure Coding System] and CPT Codebook 2017–2019*, and CMS, Medicare Claims Processing Manual (the Manual), Pub. No. 100-04, Chapter 12, § 30.6.12.A).^{3,4}

The time that can be reported as critical care is the physician time spent engaged in work that is directly related to the individual patient's care. That time must be spent either at the patient's immediate bedside or elsewhere on the floor or unit as long as the physician is immediately available to the patient. When the physician is providing critical care services, he or she must devote his or her full attention to the patient and cannot provide services to any other patient during the same period (*HCPCS and CPT Codebook 2017–2019*, and the Manual, Chapter 12, § 30.6.12.C).

Critical care is a time-based service. CPT code 99291 is used to bill for the first 30 to 74 minutes of critical care on a given date of service by a physician or physician group of the same specialty.⁵ CPT code 99292 is used to bill for additional blocks of time of up to 30 minutes each beyond the first 74 minutes of critical care occurring on the same date. Critical care that is less than 30 minutes in total duration on a given date should be reported using another appropriate evaluation and management (E/M)⁶ code such as subsequent hospital care⁷ (*HCPCS and CPT Codebook 2017–2019*, and the Manual, Chapter 12, § 30.6.12.F). See the Figure on the following page for an explanation of how to code critical care services according to the amount of time spent providing critical care.

³ The Act §§ 1173(a) and (c)(1) and 1848(b)(1), 42 CFR §§ 414.40(a) and 424.32(a)(1), and 45 CFR §§ 162.1002(a)(5) and (c)(1) provide the legal authority for using the *HCPCS and CPT Codebook 2017–2019*.

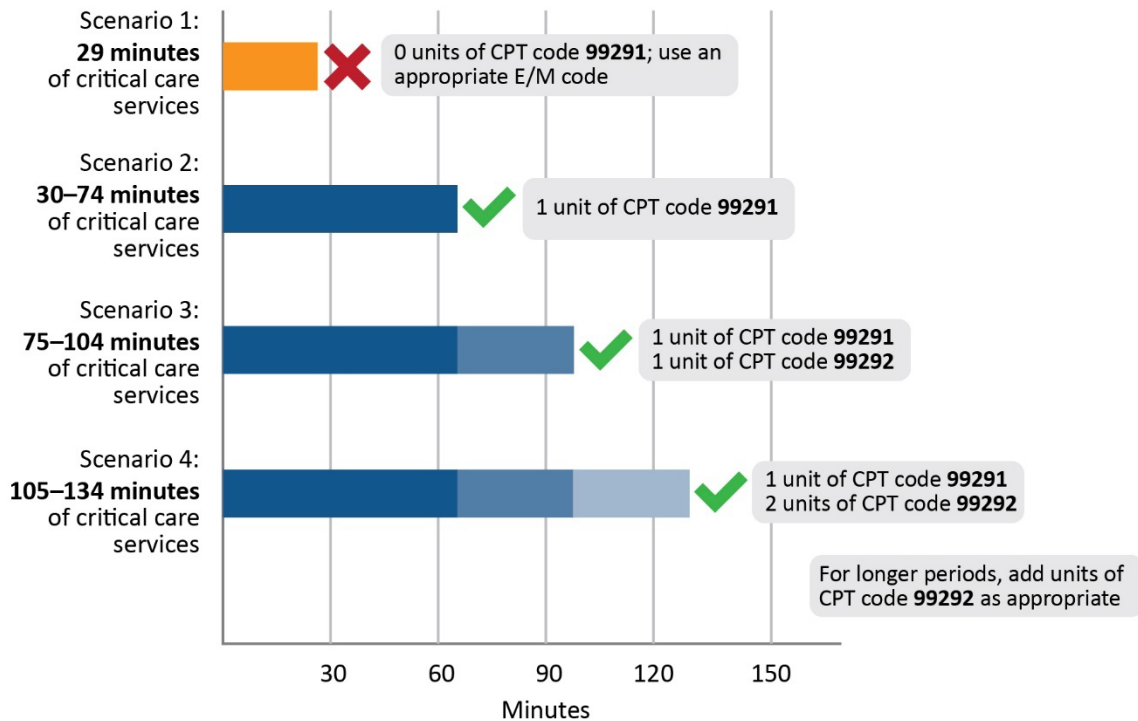
⁴ CMS withdrew § 30.6.12 of the Manual effective May 9, 2021, which was after our audit period (CMS, Medicare Claims Processing Manual Transmittal 10742 (Change Request 12275; May 3, 2021)). CMS issued a Final Rule for critical care services and companion manual revisions effective January 1, 2022 (86 Fed. Reg. 64996, 65159-65165 (Nov. 19, 2021); CMS, Medicare Claims Processing Manual Transmittal 11181 (Change Request 12543; Jan. 14, 2022)). This January 2022 Final Rule differs in some respects from the withdrawn Manual provision, and providers were advised to note the changes. However, these changes did not impact our findings and recommendations described in this report.

⁵ Reporting CPT code 99291 is a prerequisite to reporting CPT code 99292.

⁶ E/M services are patient care services furnished by qualified physicians and qualified non-physician practitioners. E/M CPT codes start at 99201 and end at 99499.

⁷ Subsequent hospital care includes reviewing the medical record and results of diagnostic studies, and changes in the patient's status (i.e., changes in history, physical condition, and response to management) since the last assessment. The CPT codes used to report subsequent hospital care are 99231 (typically 15 minutes of subsequent hospital care per day), 99232 (typically 25 minutes of subsequent hospital care per day), and 99233 (typically 35 minutes of subsequent hospital care per day).

Figure: Critical Care Minutes and Corresponding CPT Codes and Units⁸



Medicare Requirements for Identifying and Returning Overpayments

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of: (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.⁹

The 6-year lookback period is not limited by OIG’s audit period or restrictions on the Government’s ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.¹⁰

⁸ HCPCS and CPT Codebook 2017–2019, and the Manual, Chapter 12, § 30.6.12(G).

⁹ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

¹⁰ 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, Provider Reimbursement Manual—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

Lahey Clinic, Inc.

Lahey is a multi-specialty physician practice that employs over 1,400 physicians located in Burlington, Massachusetts, and a teaching affiliate of the Tufts University School of Medicine located in Boston, Massachusetts. The critical care services covered by our audit were provided by Lahey physicians at the following Lahey Health System, Inc. hospitals: Lahey Hospital and Medical Center in Burlington, Massachusetts; Winchester Hospital in Winchester, Massachusetts; and Beverley Hospital in Beverley, Massachusetts.¹¹ During our audit period, National Government Services was the MAC that processed and paid Lahey's claims.

HOW WE CONDUCTED THIS AUDIT

During our audit period, Medicare Part B paid \$5.3 million to Lahey for 30,738 critical care services provided during 5,109 inpatient admissions. We selected for review a stratified random sample of 100 inpatient admissions that included 1,410 critical care services totaling \$233,797.

From the 100 sampled inpatient admissions, we submitted the medical records for 10 judgmentally selected inpatient admissions to an independent medical review contractor to determine whether the services were medically necessary and properly coded. The 10 judgmentally selected inpatient admissions included 92 critical care services totaling \$14,966. We revised our methodology due to the resource-intensive effort required to perform a medical review of the 1,410 critical care services provided during the 100 sampled inpatient admissions. Therefore, we limited the medical review to the critical care services provided during these 10 inpatient admissions (92 critical care services). The results of this audit include only the actual overpayments for these 10 inpatient admissions and not a statistical estimate of overpayments.

Lahey provided us with supporting documentation for the 10 judgmentally selected inpatient admissions. The documentation included physician progress notes documenting critical care services and other physician services, admission and discharge summaries, diagnostic test results, and other medical record documentation supporting the inpatient admissions.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix A for the details of our audit scope and methodology.

¹¹ As of March 1, 2019, these three hospitals were owned by Beth Israel Lahey Health, Inc., which was formed through a merger of Lahey Health System, Inc., Care Group, Inc. and Seacoast Regional Health Systems, Inc.

FINDING

Lahey complied with Medicare billing requirements for 36 of the 92 critical care services that we reviewed. However, Lahey did not comply with Medicare billing requirements for the remaining 56 critical care services. All 10 of the inpatient admissions reviewed included at least 1 critical care service that did not comply with Medicare billing requirements. Specifically, Lahey billed for 54 critical care services for patients whose conditions did not indicate that the critical care services were medically necessary or for which the physician did not directly provide services that were at the level of care required for critical care services. Specifically, these 54 critical care services included:

- 41 services totaling \$4,289 that should have been billed using a CPT code for subsequent hospital care¹² and
- 13 services totaling \$1,646 that did not meet Medicare requirements for reimbursement as critical care or another E/M service.

In addition, Lahey billed for two critical care services totaling \$80 that were billed using an incorrect CPT code for the critical care service provided. Specifically, the critical care services were billed using CPT code 99291 (critical care, first 30 to 74 minutes) but should have been billed using CPT code 99292 (critical care, each additional 30 minutes).

Appendix C shows the breakdown of the allowable and unallowable critical care services and their related payments. Table 1 on the following page shows the unallowable critical care payments by category.

¹² The independent medical review contractor determined that the critical care services should have been billed as subsequent hospital care CPT codes 99232 (typically 25 minutes of subsequent hospital care per day) and 99233 (typically 35 minutes of subsequent hospital care per day).

Table 1: Categories of Unallowable Payments

Inpatient Admission	Medicare Part B Payments for Services Billed as Critical Care	Unallowable Payments	Categories of Unallowable Payments		
			Should Have Been Billed as Subsequent Hospital Care	Did Not Meet Requirements for Critical Care or Another E/M	Billed Incorrect CPT Code for the Critical Care Service Provided
1	\$380	\$255	\$255	\$0	\$0
2	518	442	85	357	0
3	1,462	349	349	0	0
4	184	98	98	0	0
5	530	275	275	0	0
6	181	95	95	0	0
7	4,493	1,020	1,020	0	0
8	1,490	811	315	416	80
9	2,089	683	683	0	0
10	3,639	1,987	1,114	873	0
Totals	\$14,966	\$6,015	\$4,289	\$1,646	\$80

These billing errors resulted in Lahey receiving \$6,015 in unallowable Medicare payments. These errors occurred because Lahey did not have adequate policies and procedures to ensure that: (1) physicians correctly documented in the patient’s medical record and identified critical care services that met Medicare requirements and (2) coders made correct determinations for critical care services that met Medicare requirements.

See Appendix B for our sampling methodology.

LAHEY DID NOT COMPLY WITH MEDICARE REQUIREMENTS WHEN BILLING FOR CRITICAL CARE SERVICES

Lahey did not comply with Medicare billing requirements for the 56 of the 92 (61 percent) critical care services reviewed. Specifically, Lahey billed for 54 critical care services for patients whose conditions did not indicate that the critical care services were medically necessary or for whom the physician did not directly provide services that were at the level of care required for critical care services. Lahey also billed for two critical care services that met the medical necessity and physician treatment requirements for critical care services but were billed using an incorrect CPT code for the critical care service provided.

Medicare Requirements

To be paid by Medicare, an item or a service must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (the Act § 1862(a)(1)(A)). Medicare payments may not be made to any provider of

services or other person without information necessary to determine the amount due to the provider (the Act § 1833(e)). In addition, providers must furnish sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

Critical care is defined as medical care delivered directly by a physician or a qualified non-physician practitioner for a critically ill or critically injured patient. A critical illness or injury is one that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Critical care involves high-complexity decision making to assess, manipulate, and support vital system functions to treat single or multiple vital organ system failure and prevent further life-threatening deterioration of the patient's condition. Providing medical care to a critically ill, critically injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet these requirements (*HCPCS and CPT Codebook 2017–2019*, and the Manual, Chapter 12, § 30.6.12.A).

The time that can be reported as critical care is the physician time spent engaged in work directly related to the individual patient's care. When the physician is providing critical care services, he or she must devote his or her full attention to the patient and cannot provide services to any other patient during the same period. The physician may be at the patient's immediate bedside or elsewhere on the floor or unit as long as he or she is immediately available to the patient. For example, the provider may bill critical care services for the time a physician spends reviewing a patient's test results or imaging studies or discussing a patient's care with other medical staff either in the unit or at the nursing station on the floor as long as the physician's full attention is on the patient during that time (*HCPCS and CPT Codebook 2017–2019*, and the Manual, Chapter 12, § 30.6.12.C).

Critical care is a time-based service, and the physician's progress notes should document the total time that critical care services were provided for each encounter on each date. Critical care CPT codes 99291 and 99292 are used to report the total time a physician spends providing critical care services to a critically ill or critically injured patient, even if the time the physician spends providing critical care services on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician (*HCPCS and CPT Codebook 2017–2019*, and the Manual, Chapter 12, § 30.6.12.E).

CPT code 99291 is used to bill for the first 30 to 74 minutes of critical care on a given date of service by a physician or physician group of the same specialty. CPT code 99292 is used to bill for additional blocks of time of up to 30 minutes each beyond the first 74 minutes of critical care occurring on the same date (*HCPCS and CPT Codebook 2017–2019*, and the Manual, Chapter 12, § 30.6.12.F).

A teaching physician can bill for critical care services that meet the requirements for critical care services if the teaching physician is present for the entire period covering the claim.¹³ A combination of the teaching physician's documentation and the resident's documentation may support critical care services. The teaching physician may refer to the resident's documentation for specific patient history, physical findings, and medical assessment. However, the teaching physician's medical record documentation must provide substantive information including: (1) the time the teaching physician spent providing critical care, (2) that the patient was critically ill during the time the teaching physician saw the patient, (3) what made the patient critically ill, and (4) the nature of the treatment and management provided by the teaching physician (the Manual, Chapter 12, § 30.6.12.M).

Appendix D contains details on the Medicare requirements related to critical care services.

Critical Care Services Did Not Meet Medical Necessity and Physician Level of Care Requirements

Lahey billed for 54 critical care services for patients whose conditions did not indicate that the critical care services were medically necessary or for whom the physician did not directly provide services that were at the level of care required for critical care services. Of these 54 critical care services, 41 should have been billed using a CPT code for subsequent hospital care. The remaining 13 critical care services did not meet Medicare requirements for reimbursement as critical care or another E/M service.

Critical Care Services Should Have Been Billed as Subsequent Hospital Care

Lahey incorrectly billed for 41 critical care services and should have billed these services using a CPT code for subsequent hospital care. Specifically, the independent medical review contractor found that the critical care services did not meet Medicare requirements because the patient's condition did not indicate that the critical care services were medically necessary, or the physician did not directly provide services that were at the level of care required for critical care services. These services should have instead been billed using a CPT code for subsequent hospital care. In addition, these 41 critical care services included 8 services that were billed with a -GC modifier¹⁴ and did not meet the requirements for critical care services provided by a teaching physician supervising a resident. These errors did not result in any additional overpayments for those eight services.

¹³ Only time spent by the resident and teaching physician together with the patient or the teaching physician alone with the patient can be counted toward critical care time. The teaching physician cannot bill critical care for time spent teaching residents and time spent by the resident in the absence of the teaching physician.

¹⁴ Modifiers are used to add information or change the description of service to improve accuracy or specificity. Modifiers can be alphabetic, numeric, or a combination of both, but will always be two digits. A -GC modifier indicates that the service was performed in part by a resident under the direction of a teaching physician.

The following are examples of critical care services that did not meet medical necessity and physician level of care requirements and that should have been billed as subsequent hospital care.

Critical Care Services Should Have Been Billed as Subsequent Hospital Care

Example 1

A patient was admitted to the hospital with a diagnosis of graft thrombosis of the left lower leg. The patient's medical history included hypertension, transient ischemic attack, Factor V Leiden mutation on coumadin, atrial fibrillation, chronic kidney disease, peripheral vascular disease, and a failed left femoral artery bypass. In the hospital, a left lower extremity bypass graft thrombectomy was performed with no complications. Postoperatively, the patient was admitted to the surgical intensive care unit.

Medicare paid Lahey \$380 for two units of CPT code 99291 (30-74 minutes of critical care), with one unit provided on each of the 2 days following surgery. Both critical care services were billed with modifier -GC indicating that the service was performed in part by a resident under the direction of a teaching physician.

Routine postoperative care was provided in the surgical intensive care unit, and there were no reported complications. The patient was noted to be in no acute distress with stable vital signs. The documentation does not support the presence of an illness or injury acutely impairing one or more vital organ systems such that there was a high probability of imminent or life-threatening deterioration in the patient's condition. In addition, the medical record did not indicate that the teaching physician was engaged in work directly related to the patient's care at the immediate bedside or immediately available to the patient elsewhere on the floor. The teaching physician documented that the patient was seen and evaluated during team rounds, and the physician reviewed the resident's notes and agreed with the findings and plan of care.

As a result, the independent medical review contractor found that the patient did not receive critical care services on these dates, the services did not meet the requirements for a service performed in part by a resident under the direction of a teaching physician (e.g., the teaching physician's progress note did not indicate the nature of the treatment and management provided), and the correct level of care provided for both services was subsequent hospital care, CPT code 99232. This correction reduced the Medicare payment to \$125, a \$255 difference.

Example 2

A patient presented to the hospital for a myocardial infarction. The patient's medical history included hypertension, hyperlipidemia, obstructive sleep apnea, and a prior stroke. Cardiac catheterization, heart bypass surgery, and coronary angioplasty were performed, and an intra-aortic balloon pump was placed. The patient was admitted to the intensive care unit. The patient went into cardiac arrest on day 6 and was revived in the intensive care unit, taken to the cardiac catheterization laboratory for evaluation, and returned to the intensive care unit on the same day. The patient was extubated two weeks after admission and the medical records showed the patient's condition to be stable with improved mental status.

Medicare paid Lahey \$193 for one unit of CPT code 99291 (30-74 minutes of critical care) provided to the patient on the date the patient was transferred out of the intensive care unit, 18 days after admission to the hospital. On this day, the patient's medical record showed that there had been no significant events, the patient's mental status was slowly improving as the patient was oriented to self and verbal, and no supplemental oxygen was being used. The documentation does not support the presence of an illness or injury acutely impairing a vital organ system such that there was a high probability of imminent or life-threatening deterioration in the patient's condition.

As a result, the independent medical review contractor found that the patient did not receive critical care services on this date, and the correct level of care provided was subsequent hospital care, CPT code 99233. This correction reduced the Medicare payment to \$90, a \$103 difference.

Critical Care Services Did Not Meet Requirements for Critical Care or Another E/M Service

Lahey billed for 13 critical care services that did not meet Medicare requirements for reimbursement as critical care or another E/M service. Specifically, the independent medical review contractor found that the critical care services did not meet the Medicare requirements because the patient's condition did not indicate that the critical care services were medically necessary or the physician did not directly provide services that were at the level of care required for critical care services, and the services did not meet the requirements for another E/M service.

The following is an example of services that did not meet critical care requirements or the requirements for another E/M service.

Services Did Not Meet Requirements for Critical Care or Another E/M Service

Example

A patient was admitted to the hospital through the emergency room for chronic obstructive pulmonary disease exacerbation. The patient's medical history included morbid obesity, bipolar disorder, schizophrenia, tobacco use, dry cough, and shortness of breath. The patient's respiratory system was positive for cough, shortness of breath, and dyspnea on exertion with wheezing. On day seven of the admission, the patient was intubated for increased shortness of breath and transferred to the intensive care unit in stable condition.

Medicare paid Lahey \$277 for one unit of CPT code 99291 (30-74 minutes of critical care) and one unit of CPT code 99292 (additional 30 minutes of critical care) for services provided 2 days after the patient was transferred to the intensive care unit. On this day, the patient's medical record showed that the patient's condition was serious but not critical, the treatment provided was standard for symptomatic relief, and the patient was responding well to treatment. The medical record did not contain evidence that the patient had a critical illness or injury that acutely impaired one or more vital organ systems such that there was a high probability of imminent or life-threatening deterioration in the patient's condition. As a result, the independent medical review contractor found that the patient did not receive critical care services on this date, and the correct level of care provided was subsequent hospital care, one unit of CPT code 99233. The one unit of CPT code 99233 replaced one unit of CPT code 99291. Since CPT code 99233 is a once per day service, the one unit of CPT code 99292 did not meet the requirements for another E/M service on the same day. This correction reduced the Medicare payment to \$87, a \$190 difference.

Critical Care Services Were Incorrectly Coded

Lahey billed for two critical care services that met Medicare requirements for reimbursement as critical care but coded these services with an incorrect CPT code. Specifically, the independent medical review contractor found that the two critical care services met the medical necessity requirements, and physicians provided the services at the level of care required for critical care services, but these critical care services were incorrectly billed using CPT code 99291 instead of CPT code 99292. In both cases, the physician provided a critical care service on the same day as another physician of the same specialty.

For one service, Lahey was paid \$161 for one unit of CPT code 99291 for 48 minutes of critical care services provided by Physician A. On the same date of service, Lahey was paid \$190 for one unit of CPT code 99291 and \$95 for one unit of 99292 for 85 minutes of critical care services provided by Physician B, a physician of the same specialty. Based on the 133 total minutes of critical care services provided by the two physicians of the same specialty on the

same date of service, Lahey correctly billed for one unit of CPT code 99291 and one unit of 99292 for Physician B and should have billed for one unit of CPT code 99292 for Physician A instead of one unit of CPT code 99291. This change to one unit of CPT Code 99292 resulted in a payment of \$81, an \$80 difference.

For the other service, Lahey was paid \$158 for one unit of CPT code 99291 for 63 minutes of critical care services provided by Physician A. On the same date of service, Lahey was paid \$186 for one unit of CPT code 99291 and \$280 for three units of CPT code 99292 for 145 minutes of critical care services provided by Physician B, a physician of the same specialty. Based on the total of 208 minutes of critical care services provided by the two physicians of the same specialty on the same date of service, Lahey correctly billed for one unit of CPT code 99291 and three units of 99292 for Physician B, and should have billed for two units of CPT code 99292 for Physician A instead of one unit of CPT code 99291. This change to two units of CPT Code 99292 resulted in a payment of \$158, a \$0 difference.

EFFECT AND CAUSE OF IMPROPER BILLING OF CRITICAL CARE SERVICES

These billing errors resulted in Lahey receiving \$6,015 in unallowable Medicare payments associated with the 10 inpatient admissions we reviewed. In total, 61 percent of the critical care services we reviewed did not comply with Medicare billing requirements.

These errors occurred because Lahey personnel did not follow Lahey's established policies and procedures for ensuring that: (1) physicians correctly documented in the patient's medical record and identified critical care services that met Medicare requirements and (2) coders made correct determinations for critical care services that met Medicare requirements. In addition, the errors resulted from Lahey not having an internal quality control process in place to determine the accuracy of its coders' work.

Lahey's process for billing Medicare for critical care starts when a physician treats a patient and documents the critical care service in the medical record. Lahey's instructions state that the medical record documentation should include the patient's medical condition, treatments rendered, and the physician's total critical care time spent treating the patient. The physician selects the critical care place holder code that routes the progress note to a coding work queue so that a coder can perform a documentation review. The coder reviews the medical record to determine whether the documentation meets requirements for critical care. Specifically, the coder's review includes assessing the patient's condition, the physician's interventions, the complexity of decision making to treat the patient's illness, and the documented time the physician spent providing critical care services. The coder assigns the appropriate CPT code based on this review, but there is no internal quality control process to determine whether the coding process is accurate. After the CPT code is assigned, the service is billed electronically to the MAC.

RECOMMENDATIONS

We recommend that Lahey Clinic, Inc.:

- refund to the MAC \$6,015 in overpayments for critical care services;¹⁵
- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen its policies and procedures to ensure that critical care services billed to Medicare are adequately documented and correctly billed by:
 - providing training to critical care physicians to ensure the services they identify for coding review meet Medicare requirements for critical care services,
 - providing training to coders to ensure they assign the appropriate CPT code for critical care or another E/M service based on their review of the medical record documentation, and
 - developing an internal quality control review process to determine the accuracy of coders who review services identified as critical care services.

LAHEY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Lahey indicated partial concurrence with our first recommendation and full concurrence with our second and third recommendations. For our first recommendation, Lahey concurred with the results for 16 of the 56 critical care services we questioned and agreed that \$1,461 should be refunded to the MAC. Lahey disagreed with the results for the remaining 40 critical care services, stating that the services were appropriately provided and supported in accordance with Medicare coverage criteria or that the documentation met CMS requirements.

In response to our second recommendation, Lahey stated that it is currently in the process of gathering information regarding claims submitted for critical care services during the applicable 6-year lookback period and would promptly refund any overpayments identified. Regarding our third recommendation, Lahey stated that it has developed and implemented a training and education program for both physicians and coders. Further, Lahey stated that all currently

¹⁵ OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal.

employed physicians providing critical care services and coders have been or are scheduled to receive training and education related specifically to the billing of critical care services. In addition, Lahey is currently in the process of developing and implementing an ongoing monitoring program for its coding staff.

Lahey provided two examples to support its position that the 40 questioned critical care services met Medicare requirements. In both examples, Lahey detailed the patient's condition, the services the physician provided to treat the patient, and its clinical opinion describing why the combination of the patient's condition and the services provided met critical care requirements.

We obtained an independent medical review contractor to determine the medical necessity for all claims in our sample, including the 40 services for which Lahey disagreed. We submitted the claims to our medical review contractor, which reviewed the medical records in their entirety to determine whether the services were provided in accordance with Medicare coverage and documentation requirements.

The independent medical review contractor's review of both cases that Lahey cited as examples concluded that the services provided did not meet critical care coverage criteria because the patient's medical record documentation did not contain evidence that the patient had a critical illness or injury that acutely impaired one or more vital organ systems such that there was a high probability of imminent or life-threatening deterioration in the patient's condition. Since neither patient had a critical illness or injury, the services provided to them should not have been billed to Medicare as critical care services.

For the first example, Lahey stated that, in its clinical opinion, the critical care services were medically necessary for unstable ventricular tachycardia and profound hypotension, which requires careful monitoring and treatment with titration of vasoactive medications and management of tachycardia postoperatively. The independent medical review contractor's review of the critical care service stated that the patient's condition was stabilized the day before the date of the denied critical care services, and, on the date of the denied critical care services, the patient was alert and pleasant but resistant to care.

For the second example, Lahey stated that, in its clinical opinion, the critical care service was medically necessary for severe hypoglycemia with seizures treated with continuous dextrose infusion and careful monitoring and treatment for glycemia. The independent medical review contractor's review of the critical care service stated that the patient received treatment in the emergency room, resulting in a stabilized condition. The patient was alert, oriented, and talking when the denied critical care service was provided and only required antihypertensive medicines for hypertension. In addition, the patient's laboratory work was normal and there were no electrocardiogram changes or evidence of pneumonia or respiratory failure.

After review and consideration of Lahey's comments, and because Lahey did not provide any additional medical record documentation to support its rebuttals, we maintain that our original findings and recommendations remain valid.

We commend Lahey for the actions it has taken and plans to take to address the other recommendations related to its compliance with Medicare requirements when billing for critical care services.

Lahey's comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For the period January 1, 2017, through March 31, 2019, Medicare Part B paid \$5,289,810 to Lahey for 30,738 critical care services provided during 5,109 inpatient admissions. The critical care services were provided during inpatient admissions at three Lahey Health System, Inc. hospitals: Lahey Hospital and Medical Center in Burlington, Massachusetts; Winchester Hospital in Winchester, Massachusetts; and Beverley Hospital in Beverley, Massachusetts. We selected for review a random sample of 100 inpatient admissions that included 1,410 critical care services totaling \$233,797.

From the 100 sampled inpatient admissions, we submitted the medical records for 10 judgmentally selected inpatient admissions to an independent medical review contractor to determine whether the services were medically necessary and properly coded. We judgmentally selected the first 10 inpatient admissions Lahey provided, which included 92 critical care services totaling \$14,966. Due to the resource-intensive effort required to perform a medical review of the 1,410 critical care services provided during the 100 sampled inpatient admissions, we limited the medical review to the critical care services provided during these 10 inpatient admissions. The results of this audit include only the actual overpayments for these 10 inpatient admissions and not a statistical estimate of overpayments.

We did not review Lahey's overall internal control structure. Rather, we limited our review of internal controls to those that were significant to our objective. Specifically, our review of internal controls focused on Lahey's control activities for documenting, coding, and billing for Medicare critical care services. We assessed whether Lahey designed the entity's control activities to achieve objectives and respond to risks.

To assess Lahey's control activities, we interviewed Lahey officials to obtain an understanding of Lahey's policies and procedures for documenting, coding, and billing critical care services. We also requested Lahey's written policies and procedures for documenting, coding, and billing for Medicare critical care services.

We conducted our audit from November 2019 through July 2021.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance, as well as the *HCPCS and CPT Codebook 2017-2019*;
- reviewed Lahey's policies and procedures for documenting, coding, and billing critical care services;

- interviewed Lahey representatives to obtain an understanding of Lahey’s procedures for: (1) providing critical care services to beneficiaries, (2) documenting the critical care services provided, and (3) coding and billing Medicare for critical care services;
- obtained from CMS’s National Claims History (NCH) file the paid Medicare Part A inpatient admissions and Medicare Part B claims for critical care services that Lahey billed to Medicare for our audit period;¹⁶
- removed inpatient admissions that were previously reviewed by a Recovery Audit Contractor (RAC) along with the critical care services that were provided during those admissions;¹⁷
- created a sampling frame of 5,109 inpatient admissions with 30,738 critical care services totaling \$5,289,810 for our audit period;
- selected a stratified random sample of 100 inpatient admissions from the sampling frame;¹⁸
- reviewed data from CMS’s Common Working File for the critical care services provided during the 10 inpatient admissions that we judgmentally selected from the 100 admissions in the stratified random sample to determine whether critical care services had been canceled or adjusted;
- obtained documentation from Lahey for the critical care services and provided the documentation for critical care services provided during the 10 inpatient admissions to an independent medical review contractor to determine whether the critical care services met medical necessity and coding requirements;
- reviewed the independent medical review contractor’s results and summarized the reasons it determined each claim with errors was improperly reimbursed;
- calculated the Medicare overpayment amount Lahey received for critical care services for the 10 inpatient admissions; and
- discussed the results of our review with Lahey officials.

¹⁶ Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS’s NCH file, but we did not assess the completeness of the file.

¹⁷ The RAC program was created through the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments paid to health care providers under fee-for-service Medicare plans. We removed services previously reviewed by a RAC to avoid the possibility of penalizing Lahey twice for the same claim.

¹⁸ After the stratified random sample was selected, we limited this audit to 10 of the 100 sampled inpatient admissions.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame contained 5,109 inpatient admissions not previously reviewed by a RAC contractor, with 30,738 critical care services totaling \$5,289,810 for our audit period.

SAMPLE UNIT

The sample unit was an inpatient admission that had at least one critical care service billed by a Lahey physician and paid by Medicare.

SAMPLE DESIGN

We used a judgmental sample selected from the 100 inpatient admissions in our original stratified random sample. (See Table 2.)

Table 2: Sample Design Strata

Stratum	Description	Number of Admissions	Number of Critical Care Services	Dollar Value of Critical Care Services	Sample Size
1	Admissions with 1 to 9 critical care services	4,285	13,883	\$2,377,655	40
2	Admissions with 10 or more critical care services	824	16,855	\$2,912,155	60
Totals		5,109	30,738	\$5,289,810	100

SAMPLE SIZE

The sample size of our judgmental sample was 10 inpatient admissions.

SOURCE OF RANDOM NUMBERS

No random numbers were used to select our judgmental sample. We generated the random numbers for the original stratified random sample using the OIG, Office of Audit Services statistical software.

METHOD FOR SELECTING SAMPLE UNITS

For our judgmental sample, we selected the first 10 inpatient admissions for which Lahey provided us documentation. For the original stratified random sample, we consecutively numbered the inpatient admissions within strata 1 and 2. After generating 40 random numbers

for stratum 1 and 60 random numbers for stratum 2, we selected the corresponding inpatient admissions in each stratum.

ESTIMATION METHODOLOGY

Due to the resource-intensive effort required to perform a medical review of the 1,410 critical care services provided during the 100 inpatient admissions selected for the original stratified random sample, we limited the medical review to the critical care services provided during the 10 judgmentally selected inpatient admissions. The results of this audit include only the actual overpayments for these 10 inpatient admissions and not a statistical estimate of overpayments.

APPENDIX C: ALLOWABLE AND UNALLOWABLE CRITICAL CARE SERVICES

Inpatient Admission	Number of Services Billed as Critical Care	Medicare Part B Payments for Services Billed as Critical Care	Number of Allowable Services Coded as Critical Care	Number of Unallowable Services Coded as Critical Care	Allowable Payments	Unallowable Payments
1	2	\$380	0	2	\$125	\$255
2	4	518	0	4	76	442
3	10	1,462	6	4	1,113	349
4	1	184	0	1	86	98
5	3	530	0	3	255	275
6	1	181	0	1	86	95
7	24	4,493	15	9	3,473	1,020
8	11	1,490	2	9	679	811
9	13	2,089	7	6	1,406	683
10	23	3,639	6	17	1,652	1,987
Totals	92	\$14,966	36	56	\$8,951	\$6,015

APPENDIX D: MEDICARE REQUIREMENTS RELATED TO CRITICAL CARE SERVICES

SOCIAL SECURITY ACT

§ 1862(a)(1)(A) This section states that notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

§ 1833(e) This section states that Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due to the provider.

§ 1173(a) This section is the Secretary's authority to adopt standards for electronic exchange for health care transactions.

§ 1173(c)(1) This section contains the Secretary's authority to establish code sets for health care transactions from those developed by private or public entities or establish code sets for elements if none were previously developed.

§ 1848(b)(1) This section contains the Secretary's authority to establish physician fee schedules and payment amounts for physician services and also contains the formula used for calculating payment for physician services.

CODE OF FEDERAL REGULATIONS

42 CFR § 424.5(a)(6) This section states that providers must furnish sufficient information to determine whether payment is due and the amount of the payment.

42 CFR § 414.40(a) This section states that CMS will establish uniform national definitions of services, codes to represent services, and payment modifiers to the codes.

42 CFR § 424.32(a)(1) This section states that a claim must be filed with the appropriate contractor on a form prescribed by CMS in accordance with CMS instructions.

45 CFR § 162.1002(a)(5) and (c)(1) These sections state that the Secretary will adopt HCPCS and CPT as the standard medical data code sets for physician services and other health care services.

HCPCS AND CPT CODEBOOK 2017-2019¹⁹

CPT Code 99291, Critical Care First Hour, and CPT Code 99292, Critical Care Additional 30 Minutes

This section states that:

Critical care is the direct delivery by a physician or other qualified health care professional of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system functions to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition. Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet these requirements. . . .

For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit. . . .

Time spent with the individual patient should be recorded in the patient's record. CPT Codes 99291 and 99292 are used to report the total duration of time spent in provision of critical care services to a critically ill or critically injured patient, even if the time spent providing care on that date is not continuous. . . .

CPT Code 99291 is used to report the first 30-74 minutes of critical care on a given date. It should be used only once per date even if the time spent by the individual is not continuous on the date of service. . . .

CPT Code 99292 is used to report additional blocks of time, of up to 30 minutes each beyond the first 74 minutes. . . .

¹⁹ The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2017–2019 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code CPT Code. . . .

Medicare Claims Processing Manual, CMS Pub. No. 100-04, Chapter 12

§ 30.6.12A This section states that critical care services are payable when all the criteria for critical care and critical care services are met. Critical care is defined as the direct delivery by a physician, or qualified non-physician practitioner, of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system functions to treat single or multiple vital organ system failure and prevent further life-threatening deterioration of the patient's condition. Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet these requirements.

§ 30.6.12C This section states that the duration of critical care services to be reported is the time the physician spent evaluating the patient, providing care to the patient, and managing the patient's care. The physician must devote his or her full attention to the patient during any period when critical care services are provided and, therefore, cannot provide services to any other patient during the same period.²⁰

§ 30.6.12E This section states that critical care is a time-based service, and for each date and encounter entry, the physician's progress notes must document the total time that he or she spent providing critical care services. Critical care CPT codes 99291 and 99292 are used to report the total time a physician spent providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date was not continuous. Non-continuous time for medically necessary critical care services may be aggregated. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician.

§ 30.6.12F This section states that CPT code 99291 is used to report the first 30 - 74 minutes of critical care on a given calendar date of service. It should only be used once per calendar date per patient by each physician or physician group of the same specialty. CPT code 99292 is used to report additional blocks of time of up to 30 minutes each beyond the first 74 minutes of critical care.²¹ Critical care of less than 30 minutes total duration on a given date is not reported separately using the critical care codes. This service should be reported using another appropriate E/M CPT code such as subsequent hospital care.

²⁰ The physician may be at the patient's immediate bedside or elsewhere on the floor or unit as long as the physician is immediately available to the patient.

²¹ Reporting CPT code 99291 is a prerequisite to reporting CPT code 99292.

§ 30.6.12M A teaching physician can bill for critical care services that meet the requirements for critical care services if the teaching physician is present for the entire period that the claim is covered by.²² A combination of the teaching physician's documentation and the resident's documentation may support critical care services. The teaching physician may refer to the resident's documentation for specific patient history, physical findings, and medical assessment. However, the teaching physician's medical record documentation must provide substantive information including: (1) the time the teaching physician spent providing critical care, (2) that the patient was critically ill during the time the teaching physician saw the patient, (3) what made the patient critically ill, and (4) the nature of the treatment and management provided by the teaching physician.

²² Only time spent by the resident and teaching physician together with the patient or teaching physician alone with the patient can be counted toward critical care time. The teaching physician cannot bill critical care for time spent teaching residents and time spent by the resident in the absence of the teaching physician.

APPENDIX E: LAHEY CLINIC, INC. COMMENTS



Beth Israel Lahey Health

Nicole Freda
Regional Inspector General for Audit Services
Office of Audit Services, Region III
801 Market Street, Suite 8500
Philadelphia, PA 19107-3134

RE: A-03-20-00002

Dear Ms. Freda:

The Lahey Clinic, Inc. (Lahey) submits this letter in response to the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General's ("OIG") draft audit report, A-03-20-00002 *Medicare Critical Care Services Provider Compliance Audit: Lahey Clinic, Inc.* (the "Draft Report"). After receiving the Draft Report dated March 2, 2022, Lahey has worked diligently with the assistance of our clinicians and certified coders to complete a thorough review of the services at issue. Lahey now submits this comprehensive written response, consistent with the extension OIG provided through May 2, 2022. In short, Lahey concurs with the conclusion of OIG's medical reviewer with respect to 16 of the 56 services questioned, but disagrees, for the reasons explained below, with the conclusions of the OIG's medical reviewer as to the remaining 40 services.

The Draft Report stated that Lahey billed for 56 critical care services for patients whose conditions did not indicate that the critical care services were medically necessary or for which the physician did not directly provide services that were at the level of care required for critical care services. In addition, Lahey allegedly billed for two critical care services that were billed using an incorrect Current Procedural Terminology code for the critical care service provided. These billing errors resulted in OIG's preliminary determination that Lahey received \$6,015 in unallowable Medicare payments.

Our review and analysis of these 56 services found that we concur with the OIG with respect to 16 of these services amounting to \$1,461.10 which we agree should be refunded to the Medicare program. However, we unequivocally disagree with the OIG's conclusion related to the remaining 40 services as summarized briefly below. Lahey would welcome an opportunity to engage with the OIG in more detail on the specific clinical presentations associated with these cases.

- In several of the 40 cases, the OIG alleged that critical care services did not meet Medicare coverage criteria. Our analysis of the medical records concluded that critical care services were appropriately provided and supported.

- For example, in one case an 82-year-old presented with a fractured hip and subsequently had surgery on 4/2. The patient had blood loss with Hgb of 5.6. On the evening of 4/3, the patient developed tachycardia, hypotension, hypoxia, confusion, and fever (102°). The patient was given two small doses of IV Lopressor with worsening of her hypotension, and was also started on a diltiazem drip. The first critical care service for this patient was provided by a physician on 4/4. The physician noted during his assessment that the patient's HR remained high (147) and patient was hypotensive (88/52). Temperature was noted at 102° with respiratory rate of 19; EKG was noted to have sinus tachycardia with premature atrial complexes at a rate of 150. Despite large volumes of colloid, the patient continued to have serious issues regarding heart rate control. The physician started a trial of IV diltiazem for rate control and asked that cardiology re-assess the patient. The physician assistant then saw the patient at 13:24 on 4/4. The patient continued with low hemoglobin and hematocrit, which requires close monitoring as well as a diltiazem drip for sinus tachycardia. In our clinical opinion, critical care services were medically necessary for unstable ventricular tachycardia and profound hypotension, which requires careful monitoring and treatment with titration of vasoactive medications and management of tachycardia postoperatively.

- In another case, the patient was a 44-year-old with end-stage-renal disease (ESRD) on hemodialysis (HD), an IV drug user as well as having chronic congestive heart failure (CHF) with severe tricuspid regurgitation (TR), and an insulin-dependent diabetic. The patient presented to the ED due to onset of seizures with severe hypoglycemia with a blood sugar of 11. The patient was also found to be hypothermic with a body temperature of 92.4° with uncontrolled hypertension (HTN). The critical care physician documented that the patient had diaphoresis, abdominal pain as well as nausea and vomiting. In addition, the patient had uncontrolled HTN (182/117) despite large doses of Labetalol 300 mg TID, hydralazine 25 mg every 8 hours, clonidine BID and nifedipine. In our clinical opinion, critical care services were medically necessary for severe hypoglycemia with seizures treated with continuous dextrose infusion and careful monitoring and treatment for glycemia.

- In some cases, the OIG questioned the documentation by the teaching physician for certain services. For example, in one case the OIG stated that:

...the teaching physician documented that the patient was seen and evaluated during team rounds, the physician had reviewed the resident's notes, and agreed with the findings and plan of care. It was not evident

from the record that the teaching physician was present and devoted his full attention to the patient for the entire period of time billed.

At the time the services that are the subject of this Draft Report were rendered, Chapter 12, Section 30.6.12(M) of the Centers for Medicare and Medicaid Services Claims Processing Manual (100-04) made clear that a teaching physician was able to combine his/her documentation with the resident's documentation to support the provision of critical care services.¹ As shown in the teaching physician's attestation below, the teaching physician's documentation expressly complied with the requirements in the CMS manual.

¹ Specifically, the CMS manual up until December 31, 2021 stated as follows: ***M. Teaching Physician Criteria***

2. *Documentation*

A combination of the teaching physician's documentation and the resident's documentation may support critical care services. Provided that all requirements for critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment. However, the teaching physician medical record documentation must provide substantive information including: (1) the time the teaching physician spent providing critical care, (2) that the patient was critically ill during the time the teaching physician saw the patient, (3) what made the patient critically ill, and (4) the nature of the treatment and management provided by the teaching physician. The medical review criteria are the same for the teaching physician as for all physicians. (See the Medicare Claims Processing, Pub. 100-04, Chapter 12, 000.1.1 for teaching physician documentation guidance.)

Unacceptable Example of Documentation:

"I came and saw (the patient) and agree with (the resident)".

Acceptable Example of Documentation:

"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

Teaching physician attestation:

I saw and evaluated the Patient with team during rounds. I reviewed the Resident/Fellow's notes and agree with the findings and plan of care. During this visit, Critical Care services were medically necessary for left bypass thrombosis, s/p thrombectomy, which requires careful monitoring and treatment with heparin drip, ASA, pain control, keeping leg warm. Duration of bedside critical care time over the past 24 hours, excluding procedures: 30 minutes.

The documentation completed by the teaching physician complied with the CMS requirements for critical care services.

Lahey is currently in the process of gathering information regarding claims submitted for critical care services during the applicable six-year lookback period. Any claims that merit refund will be promptly repaid.

Lahey has developed and implemented a robust training and education program for both providers and coders. All currently employed billing professionals providing critical care services and coders have been or are scheduled to receive training and education related specifically to the billing of critical care services. Lahey is currently in the process of developing and implementing an ongoing monitoring program for its coding staff.

Lahey is grateful for the opportunity to submit this response to OIG's Draft Report for inclusion in the final audit report. Lahey is confident that an objective and open-minded reconsideration of the OIG findings, in light of the comments and observations provided in this submission, will result in a favorable modification of the Draft Report.

Respectfully submitted,



Lori Dutcher
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