

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE CRITICAL CARE SERVICES
PROVIDER COMPLIANCE AUDIT:
CLINICAL PRACTICES OF THE
UNIVERSITY OF PENNSYLVANIA**

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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: October 2020

Report No. A-03-18-00003

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



Why OIG Did This Audit

Medicare paid approximately \$1.6 billion for critical care services provided to Medicare beneficiaries nationwide from October 2016 through March 2018 (audit period). A previous OIG review of critical care services found that few problems existed and concluded that those problems could be corrected by Medicare contractors. However, that review did not utilize medical review to determine whether the critical care services were appropriate and medically necessary. We selected for audit Clinical Practices of the University of Pennsylvania (Clinical Practices) because it was one of the 10 highest-paid providers of critical care services during our audit period.

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

How OIG Did This Audit

Our audit covered \$5.1 million in Medicare Part B payments for 28,085 critical care services provided during our audit period. We selected for review a random sample of 150 critical care services totaling \$27,053. Clinical Practices provided us with supporting documentation for the sampled claims. We submitted the 150 critical care services to an independent medical review contractor to determine whether the services were medically necessary and properly coded.

Medicare Critical Care Services Provider Compliance Audit: Clinical Practices of the University of Pennsylvania

What OIG Found

Clinical Practices complied with Medicare billing requirements for 136 of the 150 critical care services that we reviewed. However, Clinical Practices did not comply with Medicare billing requirements for the remaining 14 critical care services, and these errors resulted in Clinical Practices receiving \$1,399 in unallowable Medicare payments. These errors occurred because Clinical Practices incorrectly identified and billed critical care services for physician services that did not meet Medicare requirements.

On the basis of our sample results, we estimated that Clinical Practices received overpayments of at least \$151,588 for the audit period.

What OIG Recommends and Clinical Practices Comments

We recommend that Clinical Practices: (1) refund to the Medicare administrative contractor \$151,588 in estimated overpayments for critical care services; (2) based upon 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 of those returned overpayments as having been made in accordance with this recommendation; and (3) strengthen policies and procedures to ensure that critical care services billed to Medicare are adequately documented and correctly billed.

In written comments on our draft report, Clinical Practices did not indicate concurrence or nonconcurrence with our finding and recommendations. However, it did state that it is taking corrective action to improve provider documentation to reflect the severity of illness and the treatment provided to critically ill patients and to correct inadvertent errors made by its professional fee coding staff. In another correspondence, Clinical Practices indicated that it was planning to refund the \$151,588 in estimated overpayments to the Medicare administrative contractor. Clinical Practices did not address our recommendation to identify, report, and return overpayments in accordance with the 60-day rule.

We commend Clinical Practices for the actions it has taken and plans to take to address the deficiencies identified in our draft report related to its compliance with Medicare requirements when billing for critical care services. We maintain that our recommendation to identify, report, and return overpayments in accordance with the 60-day rule is valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare paid approximately \$1.6 billion for critical care services provided to Medicare beneficiaries nationwide from October 1, 2016, through March 31, 2018 (audit period). A previous Office of Inspector General (OIG) review of critical care services¹ found that few problems existed and concluded that those problems could be corrected by the responsible Medicare contractors. However, that review did not utilize medical review to determine whether the critical care services were appropriate and medically necessary. 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. We selected for audit Clinical Practices of the University of Pennsylvania (Clinical Practices) because it was one of the 10 highest-paid providers of critical care services during our audit period.

OBJECTIVE

Our objective was to determine whether Clinical Practices complied with Medicare requirements when billing for critical care services (Current Procedural Terminology² (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. The Centers for Medicare & Medicaid Services (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 practitioner³ 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

¹ *Medicare Reimbursement for Critical Care Services* (OEI-05-00-00420), issued February 2001.

² **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2016–2018 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.**

³ When we refer to physicians in this report, we include qualified non-physician practitioners.

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 (*HCPCS [Healthcare Common Procedure Coding System] and CPT Codebook 2016–2018*, and CMS, Medicare Claims Processing Manual, Pub. No. 100-04, Chapter 12, § 30.6.12.A (the Manual)).⁴

The time that can be reported as critical care is the physician time spent engaged in working 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 2016–2018*, and the Manual, Chapter 12, § 30.6.12.C).

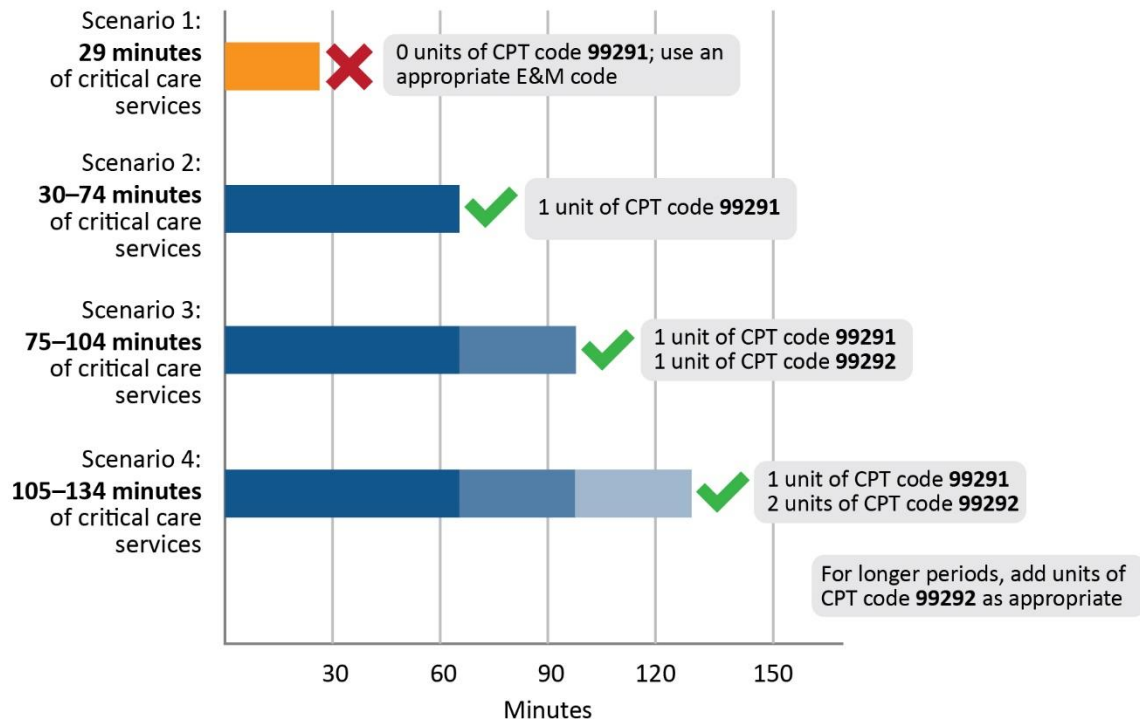
Critical care is a time-based service. CPT code 99291 is used to bill for the first 30 to 74 minutes of critical care on a given date of service by a physician or physician group of the same specialty.⁵ CPT code 99292 is used to bill for additional blocks of time of up to 30 minutes each beyond the first 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 (*HCPCS and CPT Codebook 2016–2018*, 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.

⁴ 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 2016–2018*.

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.

Figure: Critical Care Minutes and Corresponding CPT Codes and Units⁷



Medicare Requirements for Identifying and Returning Overpayments

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.⁸

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.⁹

⁷ HCPCS and CPT Codebook 2016–2018, and the Manual, Chapter 12, § 30.6.12(G).

⁸ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

⁹ 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. 7670.

Clinical Practices of the University of Pennsylvania

Clinical Practices is the faculty practice group for the University of Pennsylvania Perelman School of Medicine's clinical departments. Clinical Practices has locations throughout the Philadelphia, Pennsylvania, metropolitan area and includes physicians in 59 different medical specialties and sub-specialties. Clinical Practices operates as a University of Pennsylvania division and is responsible for operating the Perelman School of Medicine faculty's clinical practices, as well as other University of Pennsylvania Health System clinical practices.¹⁰ During our audit period, Novitas Solutions was the MAC that processed and paid Clinical Practices' claims.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$5.1 million in Medicare Part B payments for 28,085 critical care services provided during our audit period. We selected for review a random sample of 150 critical care services totaling \$27,053. The critical care services selected for review were provided at three Penn Medicine hospitals (the Hospital of the University of Pennsylvania, Penn Presbyterian Medical Center, and Pennsylvania Hospital) and at the Good Shepherd Penn Partners Specialty Hospital at Rittenhouse.¹¹ All four hospitals are located in Philadelphia, Pennsylvania.

We submitted the 150 critical care services to an independent medical review contractor to determine whether the services were medically necessary and properly coded.

Clinical Practices provided us with supporting documentation for the sampled claims. 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 admission period that included the sampled critical care service.

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.

¹⁰ The Perelman School of Medicine and University of Pennsylvania Health System are collectively known as "Penn Medicine."

¹¹ Good Shepherd Penn Partners Specialty Hospital at Rittenhouse is a long-term acute care hospital operated by Good Shepherd Penn Partners, a joint venture between Good Shepherd Rehabilitation Network in Allentown, Pennsylvania, and Penn Medicine.

FINDING

Clinical Practices complied with Medicare billing requirements for 136 of the 150 critical care services that we reviewed. However, Clinical Practices did not comply with Medicare billing requirements for the remaining 14 critical care services. Specifically, Clinical Practices billed for 14 critical care services for patients whose conditions did not indicate that the critical care services were medically necessary.

These billing errors resulted in Clinical Practices receiving \$1,399 in unallowable Medicare payments. These errors occurred because Clinical Practices incorrectly identified and billed critical care services for physician services that did not meet Medicare requirements.

On the basis of our sample results, we estimated that Clinical Practices received overpayments of at least \$151,588 for the audit period.¹²

See Appendix B for our statistical sampling methodology and Appendix C for our sample results and estimates.

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

Clinical Practices billed for critical care services (CPT codes 99291 and 99292) that were not medically necessary and therefore did not meet Medicare requirements for billing for critical care services performed by its physicians.

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

¹² To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total at least 95 percent of the time.

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 2016–2018*, 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 2016–2018*, 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. (*HCPCS and CPT Codebook 2016–2018*, and the Manual, Chapter 12, § 30.6.12.E).

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

Critical Care Services Were Not Medically Necessary

For 14 sampled services, Clinical Practices billed for critical care services that were not medically necessary. Specifically, the independent medical review contractor found that the information in the beneficiaries' medical records did not meet medical necessity requirements for critical care services, and the services should have instead been billed using a CPT code for subsequent hospital care.¹³

See the next page for examples of medically unnecessary critical care services.

¹³ For 1 of the 14 sampled services, the independent medical review contractor also found that the physician did not directly provide critical care services, and the physician did not devote his or her full attention to the patient during the period when critical care services were provided.

Medically Unnecessary Critical Care Services

Example 1

A patient was admitted to the hospital for a heart attack, underwent a cardiac catheterization, and was placed in the intensive care unit. The patient's medical history included chronic heart failure, nonischemic cardiomyopathy,¹⁴ and end-stage renal disease, and the patient also had a defibrillator implanted.

Medicare paid Clinical Practices \$186 for one unit of CPT code 99291 (30-74 minutes critical care) provided to the patient 4 days after admission. The medical records showed that, on this date, the patient was recovering well, was stable, had no chest pain or pulmonary concerns, and was undergoing dialysis for end-stage renal disease. The patient did not appear to have a critical illness or injury that acutely impaired vital organ systems, and there was no apparent high probability of imminent death or life-threatening deterioration of 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 \$86, a \$100 difference.

Example 2

A patient was taken to an emergency room due to a change in mental status that lasted for several days and resulted in loss of interest in work, increased fatigue, and confusion. The patient's medical history included diabetes mellitus type II, hypertension, and high blood cholesterol. The emergency room physician determined that the patient had a brain tumor, and the patient was transferred to another hospital for further treatment. Following the transfer, the patient had surgery and was admitted to the neuro intensive care unit.

Medicare paid Clinical Practices \$187 for one unit of CPT code 99291 (30-74 minutes critical care) provided to the patient 6 days after admission. The patient's medical records for this date did not indicate the presence of a critical illness or injury that acutely impaired vital organ systems, and there was no apparent high probability of imminent or life-threatening deterioration of 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 \$87, a \$100 difference.

¹⁴ Nonischemic cardiomyopathy is a general term for causes of decreased heart function other than heart attacks and arterial blockages.

EFFECT AND CAUSE OF IMPROPER BILLING OF CRITICAL CARE SERVICES

On the basis of our sample results, we estimated that Clinical Practices received at least \$151,588 in unallowable Medicare payments for critical care services. These unallowable payments occurred because Clinical Practices incorrectly identified and billed critical care services for physician services that did not meet Medicare requirements.

RECOMMENDATIONS

We recommend that Clinical Practices of the University of Pennsylvania:

- refund to the MAC \$151,588 in estimated overpayments for critical care services;¹⁵
- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule¹⁶ and identify any of those returned overpayments as having been made in accordance with this recommendation; and
- strengthen policies and procedures to ensure that critical care services billed to Medicare are adequately documented and correctly billed.

CLINICAL PRACTICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Clinical Practices did not indicate concurrence or nonconcurrence with our finding and recommendations. However, it did state that it is taking corrective action to improve provider documentation to reflect the severity of illness and the treatment provided to critically ill patients and to correct inadvertent errors made by its professional fee coding staff. Clinical Practices also stated that it believes the critical care services were medically necessary and clinically justified for the sample items but acknowledged that clinical documentation did not always demonstrate patient severity of illness. In another correspondence, Clinical Practices indicated that it was planning to refund the \$151,588 in estimated overpayments to the MAC. Clinical Practices did not address our recommendation to identify, report, and return overpayments in accordance with the 60-day rule.

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. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

¹⁶ This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

Specifically, Clinical Practices' corrective actions included conducting special education sessions for all intensive care unit physicians to emphasize core documentation requirements to support the delivery of critical care services. These special education sessions were in addition to ongoing annual billing compliance training provided to all physicians who manage patients in intensive care units and the emergency medicine department.

Clinical Practices also stated that it took actions to address coding errors by its certified professional fee coding staff. These actions included:

- providing focused education to professional fee coding staff to specifically address critical care documentation requirements for showing direct physician delivery of medical care for a critically ill or injured patient with the education emphasizing a critical illness or injury acutely impairing one or more vital organ systems;
- developing and implementing focused quality assurance audits for critical care services to enhance the quality assurance program for certified coders with a focus on critical care; and
- developing and distributing informational reports intended to improve medical record documentation and to accurately reflect the severity of illness and the complex clinical care provided.

In addition, Clinical Practices stated that it is negotiating a contract with an external vendor to install audit software to enhance the quality assurance audits for professional fee coding services.

We commend Clinical Practices for the actions it has taken and plans to take to address the deficiencies identified in our draft report related to its compliance with Medicare requirements when billing for critical care services. We maintain that our recommendation to identify, report, and return overpayments in accordance with the 60-day rule is valid.

Clinical Practices' comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$5,051,519 in Medicare Part B payments for 28,085 critical care services provided during the period October 1, 2016, through March 31, 2018. We selected for review a simple random sample of 150 critical care services totaling \$27,053. The critical care services selected for review were provided at three Penn Medicine hospitals (the Hospital of the University of Pennsylvania, Penn Presbyterian Medical Center, and Pennsylvania Hospital) and the Good Shepherd Penn Partners Specialty Hospital at Rittenhouse. All four of these hospitals are located in Philadelphia, Pennsylvania.

We submitted the 150 critical care services to an independent medical review contractor to determine whether the services were medically necessary and properly coded.

We did not review Clinical Practices' overall internal control structure. Rather, we limited our review of internal controls to those that were significant to our objective.

We conducted our fieldwork from September 2018 through May 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed Clinical Practices' policies and procedures for billing critical care services;
- interviewed Clinical Practices representatives to obtain an understanding of Clinical Practices' procedures for (1) providing critical care services to beneficiaries, (2) documenting the critical care services provided, and (3) billing Medicare for critical care services;
- obtained from CMS's National Claims History (NCH) file the paid Medicare Part B claims for critical care services that Clinical Practices billed to Medicare for our audit period;¹⁷
- removed any critical care services that were previously reviewed by a Recovery Audit Contractor (RAC);¹⁸

¹⁷ 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.

¹⁸ 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 Clinical Practices twice for the same claim.

- created a sampling frame of 28,085 critical care services totaling approximately \$5,051,519 for our audit period;
- selected a simple random sample of 150 critical care services from the sampling frame;
- reviewed data from CMS’s Common Working File for the sampled critical care services to determine whether critical care services had been canceled or adjusted;
- obtained documentation from Clinical Practices for the sampled critical care services and provided the documentation to an independent medical review contractor, which determined 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;
- used the results of the sample to estimate the Medicare overpayment amount Clinical Practices received for critical care services during our audit period; and
- discussed the results of our review with Clinical Practices officials.

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: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame contained 28,085 critical care service line items totaling \$5,051,519 that were billed by Clinical Practices during our audit period.

SAMPLE UNIT

The sample unit was a paid critical care service line item.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

The sample size was 150 critical care service line items.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the frame from 1 to 28,085. After generating 150 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to calculate our estimates. We estimated the total improper Medicare reimbursement paid to Clinical Practices during our audit period at the lower limit of a two-sided 90-percent confidence interval. We also used the software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Services With Improper Payments	Value of Improper Payments
28,085	\$5,051,519	150	\$27,053	14	\$1,399

ESTIMATES

Table 2: Estimated Overpayments for the Audit Period

(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	\$262,031
Lower Limit	\$151,588
Upper Limit	\$372,474

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 Healthcare Common Procedure Coding System (HCPCS) and CPT as the standard medical data code sets for physician services and other health care services.

HCPCS AND CPT CODEBOOK 2016-2018¹⁹

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 2016–2018 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 patient²⁰ during any period when critical care services are provided and, therefore, cannot provide services to any other patient during the same period.

§ 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 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.

APPENDIX E: CLINICAL PRACTICES COMMENTS



University of Pennsylvania Health System

Office of Billing Compliance

Robert F. Bacon, MHA
Vice President and Billing Compliance Officer

July 29, 2020

VIA UPS

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

RE: Penn Medicine
Clinical Practices of the University of Pennsylvania
Report Number A-03-18-00003

Dear Ms. Freda:

I am writing on behalf of Clinical Practices of the University of Pennsylvania ("CPUP") in response to your draft report dated June 17, 2020.

Penn Medicine is strongly committed to compliance with all applicable regulations. We understand the Office of the Inspector General's ("OIG") important role in ensuring compliance with billing regulations, and greatly appreciate the opportunity to respond to your draft report. We want to express our appreciation for extending the timeframe for responding to the audit report until July 31, 2020.

We also want to take this opportunity to provide some important context related to CPUP's provision of critical care services. The selected sample population included extremely complex clinical cases consisting of 140 patients representing 150 billed units of critical care services. In fact, 124 or 80% of the sample population required post-acute care services to include hospice, inpatient rehabilitation units, skilled nursing facilities or home health care following inpatient hospitalization. The mortality rates associated with the sample population illustrates the clinical severity associated with the patient's conditions. Specifically, 28 or 20% of the patient sample population expired during the inpatient hospital stay. Moreover, 14 or 10% of the patient sample expired within 30 days of hospital discharge. Therefore, critical care services were medically necessary and clinically justified for the sample population. However, we acknowledge that clinical documentation did not always demonstrate patient severity of illness.

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The Centers for Medicare and Medicaid Services (“CMS”) implemented the Comprehensive Error Rate Testing (“CERT”) program to measure improper payments in the Medicare Fee-for-Service (“FFS”) program. The CMS website states that the “CERT selects a stratified random sample of approximately 50,000 claims submitted to Part A/B Medicare Administrative Contractors (“MACs”) and Durable Medical Equipment MACs (“DMACs”) during each reporting period. This sample size allows CMS to calculate a national improper payment rate and contractor and service specific improper payment rates. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample is considered to reflect all claims processed by the Medicare FFS program during the report period.”¹

Under the auspices of the CERT program, CMS reported that Part B providers have an aggregate 8.64% error rate for Fiscal Year (“FY”) 2019². As referenced in the *2019 Medicare Fee-for-Service Supplemental Improper Payment Data* report, Table K1: E&M Service Types by Improper Payments illustrates that the CERT found that providers billing the Critical Care Evaluation and Management (“E&M”) code (99291) reflects an 18.3% error rate. By way of comparison, the aggregate audit results for CPUP reported an error rate of \$1,399 of \$27,053 representing an error rate of 5%, which is substantially lower than the nationally recognized CERT error rate.

The errors identified within the 14 cases were principally attributable to human error consisting of insufficient documentation by providers and inadvertent coding errors by certified professional fee coding staff. Provider documentation did not reflect the full severity of illness and related treatment for the critically ill patients.

Based upon information shared by the OIG Auditors during the course of the field audit, Penn Medicine initiated the following corrective action:

1. Documentation requirements with respect to critical care services are an ongoing component part of the annual Billing Compliance training program for all specialties managing the intensive care units and Emergency Medicine department. However, Penn Medicine developed and delivered special education sessions for all providers within the intensive care units re-emphasizing core documentation requirements to support the delivery of critical care services.
2. Provided focused education to professional fee coding staff emphasizing documentation requirements for critical care. Specifically, core documentation concepts addressing

¹ Centers for Medicare and Medicaid Services. (2018, November 30). CERT Background. Retrieved July 16, 2020, from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Background>

² U.S. Department of Health and Human Services. (2019, December 19). *2019 Medicare Fee-for-Service Supplemental Improper Payment Data (Rep.)*. Last accessed, July 15, 2020 from <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-program/cert/2019-medicare-fee-service-supplemental-improper-payment-data>

Nicole Freda
July 29, 2020
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critical care showing the direct delivery by a physician(s) of medical care for a critically ill or injured patient. Emphasis was placed upon a critical illness or injury acutely impairing one (1) or more vital organ systems. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. These concepts are consistent with both the *HCPCS* (Healthcare Common Procedure Coding System) and *CPTCodebook* 2016–2018, and CMS, Medicare Claims Processing Manual, Pub. No. 100-04, Chapter 12, § 30.6.12.A³.

3. Professional fee coding program management enhanced the quality assurance program for certified coders with focus on critical care. Specifically, management developed and implemented focused quality assurance audits in dedicated work queues with sample population exclusive to critical care services (CPT 99291/99292).
4. Professional fee coding management expanded documentation improvement initiative with enhanced feedback to clinical departments by developing and distributing informational reports. These reports are intended to improve medical record documentation, accurately reflect severity of illness, and complex clinical care provided.
5. Negotiating contract with external vendor to install audit software that will enhance the quality assurance audits for professional fee coding services. Anticipate implementation within the next six (6) months.

We appreciate the opportunity to respond to the draft audit report from the OIG, and believe that our subsequent remediation efforts will greatly reduce the likelihood of similar problems in the future.

If you have any questions or require additional information, please do not hesitate to contact me.

Respectfully submitted,

Robert F. Bacon Digitally signed by Robert F. Bacon
Date: 2020.07.29 09:08:59 -0400

Robert F. Bacon

Pc: Deborah A. Driscoll, MD
Keith Kasper
Kevin B. Mahoney
Thomas McCormick, Jr.
James Rush
John Sestito

³ The Act §§ 1173(a) and (c)(1) and 1848(b)(1), 42 CFR §§ 414.40(a) and 424.32(s)(1), and 45 CFR §§ 162.1002(a)(5) and (c)(1) provide the legal authority for using the *HCPCS* and *CPT Codebook* 2016–2018.