Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF LAHEY CLINIC FOR CALENDAR YEARS 2009 AND 2010

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

David Lamir
Acting Regional
Inspector General

April 2013
A-01-12-00502

Office of Inspector General

https://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

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.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for inpatient hospital services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Lahey Clinic (the Hospital) is a 317-bed teaching hospital of Tufts University School of Medicine, located in Burlington, Massachusetts. Medicare paid the Hospital approximately $351 million for 25,501 inpatient and 599,075 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

Our audit covered $2,411,614 in Medicare payments to the Hospital for 389 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in CYs 2009 and 2010 and consisted of 132 inpatient and 257 outpatient claims.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 95 of the 389 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 294 claims, resulting in net overpayments of $736,220 for CYs 2009 and 2010. Specifically, 87 inpatient claims had billing errors, resulting in net overpayments of $582,777, and 207 outpatient claims had billing errors, resulting in overpayments of $153,443. These overpayments occurred primarily because the Hospital's existing controls did not adequately prevent incorrect billing of these Medicare claims.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $736,220, consisting of $582,777 in overpayments for the incorrectly billed inpatient claims and $153,443 in overpayments for the incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

LAHEY CLINIC COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital concurred with most of our findings and recommendations but disagreed that it incorrectly billed 11 claims for inpatient short stays. For these claims, we maintain that the stays did not meet the medical necessity requirements for inpatient admissions.

The Hospital stated that it is committed to complying with all regulations and standards governing Federal health care programs, improving internal controls, and proactively auditing and monitoring to minimize the risk of errors. We acknowledge the Hospital's efforts to implement stronger controls.

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INTRODUCTION

BACKGROUND

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 A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.[1] The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.[2] All services and items within an APC group are comparable clinically and require comparable resources. In addition to the basic prospective payment, hospitals may be eligible for an additional payment, called an outlier payment, when the hospital's costs exceed certain thresholds.

Hospital Claims at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG

[1] In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

[2] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

identified these types of hospital claims using computer matching, data mining, and analysis techniques. Examples of these types of claims at risk for noncompliance included the following:

- inpatient short stays,
- inpatient same-day discharges and readmissions,
- inpatient transfers,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- inpatient claims billed with high severity level DRG codes,
- inpatient and outpatient claims paid in excess of charges,
- outpatient dental services,
- outpatient claims billed with services performed during the DRG payment window,
- outpatient claims billed with modifier -59,
- outpatient claims billed with evaluation and management (E&M) services,
- outpatient claims billed with observation services that resulted in outlier payments, and
- outpatient services billed during home health episodes.

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas."

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made 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." In addition, § 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment.

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, § 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them

correctly and promptly. Chapter 23, § 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

Lahey Clinic

Lahey Clinic (the Hospital) is a 317-bed teaching hospital of Tufts University School of Medicine, located in Burlington, Massachusetts. Medicare paid the Hospital approximately $351 million for 25,501 inpatient and 599,075 outpatient claims for services provided to beneficiaries during calendar years (CY) 2009 and 2010 based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

Scope

Our audit covered $2,411,614 in Medicare payments to the Hospital for 389 claims that we judgmentally selected as potentially at risk for billing errors. These 389 claims consisted of 132 inpatient and 257 outpatient with dates of service in CYs 2009 and 2010.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected 14 claims to focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork from November 2011 through August 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for CYs 2009 and 2010;

- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for CYs 2009 and 2010;

- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;

- judgmentally selected 389 claims (132 inpatient and 257 outpatient) for detailed review;

- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;

- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;

- used CMS's Medicare contractor medical review staff to determine whether 14 selected claims met medical necessity requirements;

- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;

- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;

- requested that the Medicare contractor provide an educational session in the form of a webinar to the Hospital addressing the Medicare requirements for inpatient and outpatient status, and observation services;

- calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our review with Hospital 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.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 95 of the 389 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 294 claims, resulting in net overpayments of $736,220 for

CYs 2009 and 2010. Specifically, 87 inpatient claims had billing errors, resulting in net overpayments of $582,777, and 207 outpatient claims had billing errors, resulting in overpayments of $153,443. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand the Medicare billing requirements within the selected risk areas that contained errors. For a detailed list of the risk areas that we reviewed and associated billing errors, see Appendix A.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 87 of the 132 selected inpatient claims that we reviewed. These errors resulted in net overpayments of $582,777.

Incorrectly Billed as Inpatient

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made 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."

For 59 of the 132 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital stated that this occurred due to a lack of clear physician documentation supporting inpatient care and the lack of an administrative workflow process to capture clerical errors. As a result of these errors, the Hospital received overpayments of $339,324.[3]

Incorrectly Billed as Separate Inpatient Stays

The Manual, chapter 3, § 40.2.5, states:

> When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

For 22 of the 132 selected claims, the Hospital billed Medicare separately for related discharges and readmissions within the same day. The Hospital stated that this occurred because it lacked an administrative workflow process to capture clerical errors. As a result of these errors, the Hospital received net overpayments of $199,977.

[3] The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

Incorrectly Billed Diagnosis-Related Group Codes

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made 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." In addition, the Manual, chapter 1, § 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately …."

For 5 of the 132 selected claims, the Hospital billed Medicare for incorrect DRG codes. The Hospital stated that this occurred because not all cases were reviewed and its coding staff misinterpreted the coding guidelines. As a result of these errors, the Hospital received overpayments of $42,676.

Manufacturer Credit for a Replaced Medical Device Not Reported

Federal regulations (42 CFR § 412.89) require reductions in the IPPS payments for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

The Manual, chapter 3, § 100.8, states that to correctly bill for a replacement device that was provided with a credit, hospitals must use the combination of condition code 49 or 50, along with value code "FD."

For 1 of the 132 selected claims, the Hospital received a reportable medical device credit from a manufacturer for a replaced device, but did not adjust its inpatient claim with the proper condition and value codes to reduce payment as required. The Hospital stated that this claim was the result of a "timing issue" and not an issue with its process to report medical device credits. As a result of this error, the Hospital received an overpayment of $800.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 207 of the 257 selected outpatient claims that we reviewed. These errors resulted in overpayments of $153,443.

Incorrectly Billed as Outpatient

The Manual, chapter 3, § 10.4, states that Part A covers certain items and nonphysician services furnished to inpatients and consequently the inpatient prospective payment rate covers these services.

For 172 of the 257 selected claims, the Hospital incorrectly billed Medicare Part B for outpatient services provided on the date of an inpatient admission that should have been included on the Hospital's inpatient (Part A) claims to Medicare. The Hospital stated that this occurred because it

did not fully implement its billing system to meet changes in Medicare requirements. As a result of these errors, the Hospital received overpayments of $69,365.

Incorrectly Billed Evaluation and Management Services, Number of Units, or Healthcare Common Procedure Coding System Codes

The Manual, chapter 12, § 30.6.6(B), states that a Medicare contractor pays for an E&M service that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedure.

The Manual, chapter 1, § 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately …." In addition, chapter 4, § 20.4, of the Manual states: "The definition of service units … is the number of times the service or procedure being reported was performed."

For 16 of the 257 selected claims, the Hospital incorrectly billed Medicare for E&M services that were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative work of the procedures (13 errors), an incorrect number of units (2 errors), or incorrect HCPCS code (1 error). The Hospital attributed this to human error or staff confusion about the interpretation of billing requirements. As a result of these errors, the Hospital received overpayments of $33,983.

Services Not Billable to Medicare

Section 1862(a)(12) of the Act states that no payment may be made under part A or part B for any expenses incurred for items or services "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth …."

For 4 of the 257 selected claims, the Hospital incorrectly billed Medicare for the removal of teeth. The Hospital stated that these were isolated cases that occurred in the operating room and that the Hospital no longer performs dental services. As a result of these errors, the Hospital received overpayments of $25,326.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations (42 CFR § 419.45) require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPPS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier "FB" and reduced charges on a claim that includes a procedure code for the insertion of a

replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than $1 for the device.

For 2 of the 257 selected claims, the Hospital received full credit for replaced devices but did not report the "FB" modifier and reduced charges on its claims. The Hospital attributed this to human error and incorrect processing. As a result of these errors, the Hospital received overpayments of $13,167.

Incorrectly Billed Observation Services

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made 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."

The Manual, chapter 4, § 290.1, states: "Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services …." Section 290.2.2 states: "Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order …. Observation time ends when all medically necessary services related to observation care are completed." Reported observation time would not include the time patients remain in the hospital after treatment is finished, for custodial care, or for other social reasons."

For 11 of the 257 selected claims, the Hospital incorrectly billed Medicare for observation services which either occurred prior to obtaining a signed physician's order (8 errors) or for time the patients remained in the hospital after treatment was finished (3 errors). The Hospital attributed this to its outpatient observation monitoring process. As a result of these errors, the Hospital received overpayments of $9,308.

Incorrectly Billed Outpatient Services With Modifier -59

The Manual, chapter 1, § 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately …." In addition, chapter 23, § 20.9.1.1, states: "The '-59' modifier is used to indicate a distinct procedural service …. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)."

For 2 of the 257 selected claims, the Hospital incorrectly billed Medicare for HCPCS codes, appended with modifier -59, which were already included in the payments for other services billed on the same claim. The Hospital stated that this occurred because of staff confusion about the interpretation of billing requirements. As a result of these errors, the Hospital received overpayments of $2,294.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $736,220, consisting of $582,777 in overpayments for 87 incorrectly billed inpatient claims and $153,443 in overpayments for 207 incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

LAHEY CLINIC COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital concurred with most of our findings and recommendations but disagreed that it incorrectly billed 11 claims for inpatient short stays. For these claims, we maintain that the stays did not meet the medical necessity requirements for inpatient admissions.

The Hospital stated that it is committed to complying with all regulations and standards governing Federal health care programs, improving internal controls, and proactively auditing and monitoring to minimize the risk of errors. We acknowledge the Hospital's efforts to implement stronger controls. The Hospital's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A: RISK AREAS REVIEWED AND BILLING ERRORS

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Short Stays	61	$247,158	56	$228,684
Same-Day Discharges and Readmissions	30	757,632	22	199,977
Manufacturer Credits for Replaced Medical Devices	15	440,996	4	111,440
Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	21	372,063	4	36,097
Claims Paid in Excess of Charges	3	94,725	1	6,579
Transfers	2	16,862	0	0
Inpatient Totals	**132**	**$1,929,436**	**87**	**$582,777**
Outpatient				
Claims Billed With Services Performed During the DRG Payment Window	192	$100,042	172	$69,365
Claims Paid in Excess of Charges	5	68,934	3	32,940
Dental Services	4	25,326	4	25,326
Manufacturer Credits for Replaced Medical Devices	9	217,533	2	13,167
Claims Billed With Observation Services That Resulted in Outlier Payments	11	25,280	11	9,308
Claims Billed With Modifier -59	5	21,894	2	2,294
Claims Billed With Evaluation and Management Services	30	22,751	13	1,043
Services Billed During Home Health Episodes	1	418	0	0
Outpatient Totals	**257**	**$482,178**	**207**	**$153,443**
Inpatient and Outpatient Totals	**389**	**$2,411,614**	**294**	**$736,220**

APPENDIX B: LAHEY CLINIC COMMENTS

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March 6, 2013

A teaching hospital of Tufts University School of Medicine

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Report Number: A-01-12-00502

Dear Mr. Armstrong:

Lahey Clinic Hospital, Inc. (Lahey) appreciates the opportunity to comment on the Government's report. Lahey is committed to complying with all regulations and standards governing Federal health care programs, improving internal controls, and proactively auditing and monitoring to minimize the risk of errors.

Lahey's responses to the Government's specific recommendations are set forth below. Unless otherwise stated, Lahey accepts the Governments findings and is processing the necessary adjustments through its Medicare Administrative Contractor, NHIC.

Incorrectly Billed as Inpatient: Lahey identified 48 claims from the OIG's sample that did not meet the criteria for an inpatient admission due to the fact that the physician order or the medical record contained ambiguities. Lahey fully appreciates and recognizes the need to clearly document the physician's decision making process. Lahey has and will continue to educate appropriate staff and physicians on Medicare regulations and guidance in this area. In addition, Lahey has instituted a process by which case managers and physician advisors review inpatient determinations and evaluate the documentation in the medical record.

Lahey respectfully disagrees with the Government's assertion that inpatient stays were inappropriate in the other 11 cases and believes that, for each, the medical record supports the criteria for inpatient admission. CMS recognizes in its own guidance that the decision to admit a patient is a complex medical judgment that calls for the consideration of many factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and outpatients, the hospital's by-laws and admission policies, and the relative appropriateness of treatment in each setting. Lahey's decision is determined by national screening criteria, evidenced-based practice, clinical judgment and consideration of the beneficiary's medical history and presenting condition for each of these claims, and it is Lahey's position that each claim met the criteria for inpatient admission.

Incorrectly Billed as Separate Inpatient Stays: Lahey has created additional controls to ensure that the Case Management Department reviews all same day discharges and readmissions. In addition, Case Management created its own daily readmission report.

Incorrectly billed diagnosis-Related Group Codes: Lahey has established controls to provide for increased management oversight and quality assurance in coding.

Inpatient Credit for Replaced Medical Device Not Reported: Lahey received and reported to CMS a credit for one claim sampled by the Government; however this claim had not been reported to CMS prior to being sampled by the Government.

Incorrectly Billed as Outpatient: Lahey has established controls to provide for increased management oversight and quality assurance in Patient Financial Services.

Incorrectly Billed Evaluation and Management Services, Number of Units, or Healthcare Common Procedure Coding System Codes: Lahey will provide education in those areas where errors occurred and explore the use of flags to highlight claims that were paid in excess of charges.

Services Not Billable to Medicare: Lahey identified that 4 isolated claims for Dental Services were performed in the operating room and as such, Dental costs were charged that missed our billing edits. These Dental services are no longer provided.

Outpatient Credit for Replaced Medical Device Not Reported: Lahey had not applied the "FB" modifier on 2 claims sampled by the Government when it re-processed the claims. Lahey provided education to its Patient Financial Services team on how to re-process these types of credits.

Incorrectly Billed Observation Services: Lahey fully appreciates and recognizes the need to clearly document the physician's orders for observation. Lahey has and will continue to educate appropriate staff and physicians on Medicare regulations and guidance in this area. In addition, Lahey has instituted a process by which case managers and physician advisors review observation orders to ensure completeness and accuracy.

Incorrectly Billed Outpatient Services with Modifier – 59: The Government identified 2 isolated claims within their sample that contained an error. Lahey provided education to its Patient Financial Services and Coding teams on the regulatory guidelines for the use of modifier – 59.

Lahey Clinic Hospital, Inc. and Affiliates is an organization recognized nationally for its quality of service. That recognition is directly attributable to the commitment of all our dedicated health care professionals, members of our support staff and the members of our research community. Lahey is also committed to compliance with applicable Federal and State laws and regulations and the Government's Medicare compliance review.

Please do not hesitate to contact me if you have any further questions or require additional information.

Sincerely,

James J. Kenney
Director of Internal Audit
Lahey Clinic Hospital, Inc.