

**SEP 29 2003**

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

Report Number: A-01-03-00506

Mr. Marc Lory
President and Chief Executive Officer
Manchester Memorial Hospital
71 Haynes Street
Manchester, Connecticut 06040

Dear Mr. Lory:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled, "Review of Outpatient Cardiac Rehabilitation Services at the Manchester Memorial Hospital." A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to Report Number A-01-03-00506 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Charlotte Yeh, M.D.
Regional Administrator
Centers for Medicare and Medicaid Services – Region I
Department of Health and Human Services
Room 2325, JFK Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT CARDIAC
REHABILITATION SERVICES
AT THE
MANCHESTER MEMORIAL HOSPITAL**



**SEPTEMBER 2003
A-01-03-00506**

Office of Inspector General

<http://oig.hhs.gov>

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



EXECUTIVE SUMMARY

BACKGROUND

This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the Administrator of the Centers for Medicare and Medicaid Services (CMS) to determine the level of provider compliance with national Medicare outpatient cardiac rehabilitation policies.

OBJECTIVE

The overall objective of our review was to determine whether Medicare properly reimbursed Manchester Memorial Hospital (Hospital) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- Hospital policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, “incident to” services, and Medicare covered diagnoses, and
- Payments to the Hospital for outpatient cardiac rehabilitation services provided to Medicare beneficiaries during calendar year 2001 were for Medicare covered diagnoses, were supported by adequate documentation, and were otherwise allowable for reimbursement.

RESULTS OF AUDIT

Our review disclosed that the Hospital relies upon physicians working nearby in the Hospital and in its emergency department for physician supervision coverage of its outpatient cardiac rehabilitation program. However, medical record documentation we examined showed little evidence that a physician personally sees a patient periodically throughout the program.

In addition, from our specific claims review for a sample of 10 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we found that medical and billing records provided by the Hospital in support of its cardiac rehabilitation services did not always:

- Support the diagnoses used to establish the patients’ eligibility for cardiac rehabilitation (2 beneficiaries).
- Follow the coding guidelines for submission of a Medicare claim for outpatient cardiac rehabilitation services as detailed by the FI (7 beneficiaries).

We attribute these findings to weaknesses in the Hospital’s internal controls and oversight procedures. Our determinations regarding Medicare covered diagnoses were based solely on our review of the medical record documentation. The medical records have not yet been reviewed by fiscal intermediary (FI) staff. We believe that the Hospital’s FI, Empire Medicare Services, should make a determination as to the allowability of the \$318 in Medicare payments made on

behalf of the two beneficiaries with uncertain eligibility. The errors and costs are part of a larger nationwide review of outpatient cardiac rehabilitation service claims and may be included in a nationwide roll-up report of all providers reviewed.

RECOMMENDATIONS

We recommend that the Hospital:

- Work with the FI to ensure that the Hospital’s outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for (1) direct physician supervision and (2) services provided “incident to” a physician’s professional service,
- Work with the FI in clarifying the diagnoses and supporting medical record documentation required for Medicare coverage of outpatient cardiac rehabilitation services and in determining the allowability of \$318 in Medicare payments identified within this report, and
- Implement controls so that all required billing codes are included in Medicare billings for outpatient cardiac rehabilitation services.

In response to our draft report (see APPENDIX), the Hospital generally agreed with our recommendations. However, the Hospital provided comments to clarify its understanding of the stable angina issue. The Hospital stated that the criteria it uses for making patient eligibility determinations for cardiac rehabilitation is based on guidelines established by the FI in its local medical review policy for cardiac rehabilitation. Specifically, the Hospital cited the FI’s criteria defining chronic stable angina and stated that its patients had met this criteria. Further, the Hospital has revised its policies and procedures to document physician communications in support of the “incident to” provision of the Social Security Act. Lastly, the Hospital stated that it had implemented a new claims editing system to correct the billing problems identified in our audit. The Hospital stated that it will address the specific issues identified in our report with the FI and request its assessment of the Hospital’s conformance with Medicare requirements.

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INTRODUCTION

BACKGROUND

Medicare Coverage

The Medicare program, established by title XVIII of the Social Security Act (Act), provides health insurance to individuals aged 65 and over, the disabled, individuals with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS). The CMS currently covers certain Phase II outpatient cardiac rehabilitation programs conducted in specialized, free-standing cardiac rehabilitation clinics and in outpatient hospital departments under the “incident to” benefit (section 1861(s)(2)(A) of the Act).

Medicare coverage policy for cardiac rehabilitation services is found in section 35-25 of the Medicare Coverage Issues Manual. Under Medicare, outpatient cardiac rehabilitation is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician, and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) have had coronary artery bypass graft surgery, and/or (3) have stable angina pectoris. Services provided in connection with the cardiac rehabilitation program may be considered reasonable and necessary for up to 36 sessions, usually 3 sessions per week in a single 12-week period. Each cardiac rehabilitation session is considered to be one unit of service.

Cardiac rehabilitation is provided by nonphysician personnel, who are trained in both basic and advanced life support techniques and exercise therapy for coronary disease, under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise area and immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require a physician to be physically present in the exercise room itself. For outpatient cardiac rehabilitation provided in a hospital, the Medicare Intermediary Manual states, “The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.”

In order to be covered under the “incident to” benefit in an outpatient hospital department, services must be furnished as an integral, although incidental part of the physician’s professional service in the course of diagnosis or treatment of an illness or injury. This does not mean that each occasion of service by a nonphysician need also be the occasion of the actual rendition of a personal professional service by the physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient’s progress and, where necessary, to change the treatment program.

Cardiac Rehabilitation Programs

Cardiac rehabilitation consists of comprehensive programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Cardiac rehabilitation programs are typically divided into three phases, as follows:

- Phase I. Phase I rehabilitation is initiated in the acute convalescent period following a cardiac event during the hospital phase of treatment. This phase of cardiac rehabilitation is considered part of the hospital stay and is covered as part of the Medicare diagnosis-related group allowance for the hospital stay.
- Phase II. Phase II begins with a physician's prescription (referral) after the acute convalescent period and after it has been determined that the patient's clinical status and capacity will allow for safe participation in an individualized progressive exercise program. This phase requires close monitoring and is directed by a physician who is on-site. Phase II outpatient cardiac rehabilitation is covered by Medicare.
- Phase III. Phase III begins after completion of Phase II and involves a less intensively monitored aerobic exercise program. Phase III level programs are considered maintenance and are not covered by Medicare.

Medicare reimburses outpatient hospital departments for cardiac rehabilitation services under the outpatient prospective payment system. Cardiac rehabilitation services are paid by a Medicare fiscal intermediary (FI) based on an ambulatory payment classification. The FI for Manchester Memorial Hospital (Hospital) is Empire Medicare Services. For calendar year (CY) 2001, the Hospital provided outpatient cardiac rehabilitation services to 78 Medicare beneficiaries and received \$27,083 in Medicare reimbursements for these services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the CMS Administrator to determine the level of provider compliance with Medicare coverage requirements for outpatient cardiac rehabilitation services. As such, the overall objective of our review was to determine whether Medicare properly reimbursed the Hospital for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- The Hospital's policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, "incident to" services, and Medicare covered diagnoses.

- Payments to the Hospital for outpatient cardiac rehabilitation services provided to Medicare beneficiaries during CY 2001 were for Medicare covered diagnoses, were supported by adequate documentation, and were otherwise allowable for reimbursement.

Scope

To accomplish these objectives, we reviewed the Hospital's current policies and procedures and interviewed staff to gain an understanding of the Hospital's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. In addition, we reviewed the Hospital's cardiac rehabilitation services documentation, inpatient medical records, physician referrals, and Medicare reimbursement data for a judgmental sample of 10 beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001 as part of a nationwide review of outpatient cardiac rehabilitation services. We reviewed the Hospital's outpatient cardiac rehabilitation procedures for and controls over physician supervision, cardiac rehabilitation staffing, maintenance and availability of advanced cardiac life support equipment, and documentation of services provided and billed to Medicare.

The Hospital sample included 10 of the 78 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 10 beneficiaries during CY 2001.

Our audit was conducted in accordance with generally accepted government auditing standards.

Methodology

We compared the Hospital's current policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and identified any differences. We documented how Hospital staff provided direct physician supervision for cardiac rehabilitation services and verified that the Hospital's cardiac rehabilitation program personnel were qualified in accordance with Medicare requirements. We also verified the availability of advanced cardiac life support equipment in the cardiac rehabilitation exercise area.

For each beneficiary, we obtained the CY 2001 Medicare outpatient cardiac rehabilitation paid claims and lines of service and compared this data to the Hospital's outpatient cardiac rehabilitation service documentation. We reviewed the medical records maintained by the cardiac rehabilitation program to determine whether services were provided "incident to" a physician's professional service. We also verified the accuracy of the diagnoses identified on the Medicare claims to each beneficiary's inpatient medical record, the physician referral, and the Hospital outpatient cardiac rehabilitation medical record. In addition, we determined if Medicare reimbursed the Hospital beyond the maximum number of services allowed.

In accordance with the intent of CMS's request for a nationwide analysis, we determined the extent to which providers were currently complying with existing Medicare coverage requirements. We performed fieldwork at the Hospital located in Manchester, Connecticut during March 2003.

The Hospital's response to our draft report is appended to this report (see APPENDIX).

FINDINGS AND RECOMMENDATIONS

Our review disclosed that the Hospital relies upon physicians working nearby in the Hospital and in its emergency department for physician supervision coverage of its outpatient cardiac rehabilitation program. However, medical record documentation we examined showed little evidence that a physician personally sees a patient periodically throughout the program.

In addition, from our specific claims review for a sample of 10 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we found that medical and billing records provided by the Hospital in support of its cardiac rehabilitation services did not always:

- Support the diagnoses used to establish the patients' eligibility for cardiac rehabilitation (2 beneficiaries).
- Follow the coding guidelines for submission of a Medicare claim for outpatient cardiac rehabilitation services as detailed by the FI (7 beneficiaries).

We identified \$318 in Medicare payments made on behalf of the two beneficiaries with uncertain eligibility. The Medicare claim coding errors identified above do not affect the allowability of the billed services as such coding is generally informational in nature.

Our determinations regarding Medicare covered diagnoses were based solely on our review of the medical record documentation. The medical records have not yet been reviewed by the Medicare FI staff. We believe that the Hospital's FI should make a determination as to the allowability of the Medicare claims and appropriate recovery action. The results from our sample will be included in a nationwide roll-up report identifying Medicare reimbursements for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

The results of our audit are discussed in detail below.

DIRECT PHYSICIAN SUPERVISION

Medicare requirements for outpatient cardiac rehabilitation state that direct supervision means that a physician must be in the exercise area and immediately available and accessible for an emergency at all times the exercise program is conducted. The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.

The Hospital's cardiac rehabilitation facility is located within the Hospital. We found that while no physician is permanently assigned to the exercise room, the Hospital stated that it meets the direct physician supervision requirement by having a physician available in the cardiac stress lab adjacent to the cardiac rehabilitation exercise area. According to the Hospital, a physician is available for any emergencies for all hours the cardiac rehabilitation program operates. Emergency department physicians are also available as needed.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe the Hospital should work with the FI to ensure that the reliance placed on nearby physicians and emergency department physicians to provide this supervision conforms with the requirements.

“INCIDENT TO” PHYSICIAN SERVICES

We found that the Hospital did not adhere to its policies and procedures and Medicare requirements for ensuring that its cardiac rehabilitation services were provided under the “incident to” provision of the Social Security Act (Act). Medicare covers outpatient cardiac rehabilitation under the “incident to” a physician's professional services benefit of the Act, section 1861(s)(2)(A). In an outpatient hospital department, the “incident to” benefit does not require that a physician perform a personal professional service on each occasion of service by a nonphysician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program.

We could not identify the physician professional services to which the cardiac rehabilitation services were provided “incident to.” Patients referred to the Hospital's outpatient cardiac rehabilitation program are evaluated by Hospital staff and prescribed an individualized treatment plan for exercise training and cardiac risk factor reduction education and counseling. The treatment plan is signed and approved by the medical director of the program.

Cardiac rehabilitation staff told us that, during the course of the patients' cardiac rehabilitation sessions, Hospital physician involvement included a weekly review of each patient's progress. In addition, patients' referring physicians are updated on the patient progress midway and at the end of the program. While such reviews and reports may have come about, we did not find documentation to support such encounters in the

patients' medical records. Further, we did not see evidence that the medical director or other Hospital physician personally saw the patient at any time during the patients' course of cardiac rehabilitation to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program. Accordingly, we believe that the Hospital's cardiac rehabilitation program did not meet the requirements to provide an "incident to" service.

MEDICARE COVERED DIAGNOSES

Medicare paid the Hospital for outpatient cardiac rehabilitation services where the diagnoses used to establish eligibility for cardiac rehabilitation did not appear to be supported by the notes in the beneficiaries' medical records. Medicare coverage considers cardiac rehabilitation services reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician, and have (1) a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) had coronary artery bypass graft surgery, and/or (3) stable angina pectoris. Medicare only reimburses providers for Phase II outpatient cardiac rehabilitation services and allows one unit of service to be billed per cardiac rehabilitation session. Documentation for these services must be maintained in the patients' medical records.

We reviewed the medical and billing records of a judgmental sample of 10 Medicare beneficiaries receiving outpatient cardiac rehabilitation services at the Hospital during CY 2001. In order to determine whether the patient had a covered diagnosis, we compared the covered diagnosis submitted with the Medicare bill to medical record documentation such as stress test results, cardiac rehabilitation program notes, referring physician records and inpatient records. Eight of the Medicare beneficiaries reviewed had covered diagnoses properly supported in the patient's medical records. However, the remaining two cases in our sample, totaling \$318 in payments, were patients whose services were billed with a stable angina pectoris diagnosis on the Medicare claim form. In one case, the patient also underwent an angioplasty procedure with stent placement prior to cardiac rehabilitation. It was unclear from the medical records whether stable angina pectoris was present post procedure at the start of cardiac rehabilitation therapy. Likewise, the second patient was admitted to the program with a stable angina pectoris diagnosis. While the medical records for the patient showed significant coronary artery disease, no signs or observations of chest pains associated with stable angina pectoris were evident.

As a result, we believe that the Hospital did not always adequately document the diagnosis to support the cardiac rehabilitation services provided and charged to Medicare. The FI should review the medical records for the two beneficiaries, determine the allowability of the claims submitted and take appropriate action.

BILLING REQUIREMENTS FOR CARDIAC REHABILITATION SERVICES

We found that the Hospital did not always follow FI billing requirements for the submission of outpatient cardiac rehabilitation claims. Under the FI's local medical

review policy (LMRP) #PM002A00, cardiac rehabilitation claims are required to contain certain billing codes describing specific aspects of the services provided. Contrary to the FI coding requirements, the Hospital did not provide all of the following codings on its outpatient cardiac rehabilitation claims for 7 of the 10 beneficiaries reviewed:

- Occurrence Code 11 – date of onset of symptoms or illness,
- Occurrence Code 46 – date treatment began, and
- Value Code 53 – total number of cardiac rehabilitation visits.

The effect of these billing errors does not affect the allowability of the billed services as such coding is generally informational in nature. However, the inclusion of these billing codes is an important factor in monitoring the allowability of services submitted to the Medicare program for reimbursement.

RECOMMENDATIONS

We recommend that the Hospital:

- Work with the FI to ensure that the Hospital’s outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for (1) direct physician supervision and (2) services provided “incident to” a physician’s professional service,
- Work with the FI in clarifying the diagnoses and supporting medical record documentation required for Medicare coverage of outpatient cardiac rehabilitation services and in determining the allowability of the \$318 in Medicare payments identified within this report, and
- Implement controls so that all required billing codes are included in Medicare billings for outpatient cardiac rehabilitation services.

AUDITEE RESPONSE

In its September 12, 2003 response to our draft report (see APPENDIX), the Hospital generally agreed with our recommendations. However, the Hospital offered the following comments to clarify its understanding of the stable angina issue. The Hospital stated that the criteria it uses for making patient eligibility determinations for cardiac rehabilitation is based on guidelines established by the FI in its LMRP for cardiac rehabilitation. Specifically, the Hospital cited the FI’s criteria defining chronic stable angina and stated that its patients had met this criteria. The Hospital states that all of its patients had tested positive for exercise-induced ischemia in a pre-entry stress test. The Hospital also added that it does not believe that the absence of documented instances of chest pain necessarily means that the individual no longer has stable angina. To resolve this issue, the Hospital is in the process of gathering the appropriate medical record documentation and submitting it to the FI for its assessment as to the allowability of the claims in question.

As we recommended, the Hospital also plans to contact the FI for its assessment of the sufficiency of the Hospital's direct physician supervision of the cardiac rehabilitation program. Further, to document that cardiac rehabilitative services were provided under the "incident to" provision of the Act, the Hospital has changed its documentation policy to include in the medical record the tracking tool used to document physician follow up communications.

In regard to our finding which addressed FI billing requirements for submitting outpatient cardiac rehabilitation claims, the Hospital stated that it had implemented a new claims editing system in 2002 which will not submit a claim for payment without the necessary billing codes.

ADDITIONAL OIG COMMENTS

We commend the Hospital for its intentions to work with the FI to assure that its outpatient cardiac rehabilitation program meets Medicare requirements. With regard to the Hospital's response addressing the issue of stable angina, we relied upon the following definition when reviewing the Hospital's medical record documentation and basing our conclusions:

Stable angina is defined as a pain or discomfort in the chest or adjacent areas caused by insufficient blood flow to the heart muscle. This chest pain is relieved by rest or medication within a short period of time (usually 15 minutes). Chest pain of a longer duration or pain appearing with a lower level of effort than before, even at rest, should be considered unstable angina. Symptoms of stable angina included a feeling of tightness, heavy pressure, or squeezing or crushing chest pain that is under the breastbone or slightly to the left; is not clearly localized; may radiate to the shoulder, arm, jaw, neck, back, or other areas; may feel similar to indigestion; is precipitated by activity, stress, or exertion; lasts 1 to 15 minutes; and is usually relieved by rest and/or nitroglycerin.

This information was obtained from the MEDLINEplus Medical Encyclopedia, identified at the U.S. National Library and National Institute for Health website (<http://www.nlm.nih.gov/medlineplus/ency/article/000198.htm>).

APPENDIX

71 Haynes Street
Manchester, CT 06040



A-01-03-00506
Appendix
Page 1 of 4
Phone (860) 533-3400

September 12, 2003

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Inspector General, Region I
John F. Kennedy Federal Building
Boston, MA 02203

RE: **CIN#A-01-03-00506**
Response to OIG Review of Cardiac Rehabilitative Services at
Manchester Memorial Hospital

Dear Mr. Armstrong:

This letter serves as ECHN's formal response to the OIG review of Manchester Memorial Hospital's Cardiac Rehabilitative Services. We would like to take this opportunity to address the concerns identified in the report of your findings.

1. Medicare Covered Diagnosis - Your report indicated that there were two patients whose medical record documentation did not clearly reflect a diagnosis of stable angina pectoris. Specifically, you questioned the lack of documentation reflecting signs or observations of chest pains associated with stable angina pectoris. Without this specific documentation your concern was that the services that these individuals received were not eligible for the \$318 in Medicare reimbursement that the hospital was paid.

We differ with your conclusion and would like to offer an explanation as to why we believe our assessment of these individuals' eligibility is consistent with the Medicare requirements. The criteria we use for making patient eligibility determinations for the Cardiac Rehabilitative Service program is based on the guidelines established in the Empire Medicare Services Local Medical Review Policy for Phase II Cardiac Rehabilitation (copy enclosed). The specific diagnosis criteria for chronic stable angina indicate that all patients must have a pre-entry stress test that is positive for exercise-induced ischemia within 6 months of starting cardiac rehab. All of our patients with stable angina have had a positive stress test and the results are included in their medical record. Further, we do not believe that the absence of documented indications of chest pain necessarily means that the individual no longer has stable angina. It is our understanding that when an interventional cardiologist chooses to stent a patient who comes in with stable angina, usually only the "culprit" artery is stented. Although the patient may not present with the classical symptoms of "angina", there is no proof that coronary artery disease is not still present in the patient. Stable angina is so unique in patients, that 40% of heart patients do not have pain, but rather shortness of breath, fatigue or other individualized symptoms.

In an effort to resolve this issue, as you suggested, we are in the process of gathering the appropriate medical record documentation and submitting it to Empire Medicare Services for their assessment as to the allowability of the claims in question.

2. Billing Requirements - Your report also indicated that we did not always follow the FI billing requirements for submitting claims. Despite the fact that these billing errors did not affect the allowability of the billed services, you recommended that we implement controls so that all required billing codes are included in Medicare billings for future outpatient cardiac rehabilitation services.

Please be assured that this problem has already been identified and resolved prior to the March 2003 OIG audit. In 2001 (the timeframe for the audit sample) ECHN was using a claim edit system called PC Ace to edit Medicare claims. The software did not require that the occurrence and value codes appear on the claim. We changed our Medicare claims editing system in 2002 to SSI. This new system does edit for the items in question. It will not release a claim until the missing items have been reviewed and added to the claim.

3. Direct Physician Supervision of Program - Your report also raised some concerns with respect to the program's reliance on supervision provided by nearby physicians and emergency department physicians to provide the appropriate supervision mandated by the Medicare Coverage requirements. Although you acknowledge that the physician supervision requirement is generally met where the services are performed on hospital premises, you recommended that we work with the FI to ensure that our supervision policy is sufficient to conform with the requirements.

At this point we have not contacted Empire Medicare Services to request their assessment of our supervision policy. However, we intend to address this with them when we address the issue described below relating to the "incident to" physician services and the issue relating to the eligibility criteria for stable angina patients.

4. "Incident To" Physician Services - Lastly, you raised a concern related to our policies and procedures for ensuring that Cardiac Rehabilitative Services were provided under the "incident to" provisions of the Social Security Act. You stated that although we communicated to you that there was hospital physician involvement that included a weekly review of each patient's progress and that the patient's referring physician was updated halfway through the program, there was no documentation to support such encounters in the patient medical records. We acknowledge your concern and have changed our documentation policy to include in the medical record the tracking tool that we use to document the physician follow up communications. Please see the enclosed Manchester Memorial Hospital Cardiac Rehabilitation Department Physician/Staff Communication Policy and Procedure.

As mentioned above, we intend to work with the Empire Medicare Services to request their assessment of our policy's conformance with the Medicare requirements. We are preparing a package of information that we will be sending to them early next week.

Please feel free to contact us if you have any questions or concerns regarding this matter. You may reach me directly at (860) 646-1222 x3652.

Sincerely,



Patricia A. Hall
ECHN Corporate Compliance & Privacy Officer

cc: Marc H. Lory, President and CEO

MANCHESTER MEMORIAL HOSPITAL
CARDIAC REHABILITATION DEPARTMENT
POLICY AND PROCEDURE MANUAL

Policy number 1120

Page number 1

- I. TOPIC: PHYSICIAN/STAFF COMMUNICATION
- II. Purpose:
To establish guidelines for on-going communication between staff and the Phase II patient's physician during the duration of Phase II Cardiac Rehab.
- III. Policy:
 1. Reports will be delivered every three weeks and on a per diem basis to the Phase II patient's referring physician. This report will be generated from the Scott Care monitoring system.
 2. This report may include:
 - a. Dates covered in the report.
 - b. Medications including dosages
 - c. Number of session attended by patient during this time period.
 - d. Baseline weight during reporting period
 - e. Resting heart rate and blood pressure during time period.
 - f. Target heart rate achieved and on which modality.
 - g. MET level achieved during exercise
 - h. Comments documented by staff during any untoward events during exercise.
 - i. Comments/goals set by staff and patient
 - j. Educational sessions provided and attended to by patient during time period.
 3. The Cardiac Rehab nurse will document communication follow up with the referring physician. This will be documented on a tracking tool and be retained in the patient's permanent Cardiac Rehabilitation chart.
 4. Any changes prescribed by the referring physician at this time will be documented by physician and/or staff.

PHYSICIAN/STAFF COMMUNICATION FLOWSHEET

Patient's name _____ Physician _____

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
REPORT												
ANY CHANGE												
FOLLOW UP												

COMMENTS _____

SIGNATURES _____

ACKNOWLEDGMENTS

This report was prepared under the direction of Michael Armstrong, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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Gregory Pasko, *Senior Auditor*

John Bergeron, *Auditor*

Maryann Volz, *Program Analyst*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.