



Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

October 17, 2003

Report Number: A-09-03-00043

Mr. Richard Phillips
Chief Financial Officer
Redding Medical Center
P.O. Box 496072
Redding, California 96049-6072

Dear Mr. Phillips:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's report entitled "Review of Medicare Reimbursement for Outpatient Cardiac Rehabilitation Services for Calendar Year 2001, Redding Medical Center, Redding, California." This review was part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services requested by the Administrator of the Centers for Medicare & Medicaid Services to determine the level of provider compliance with national Medicare outpatient cardiac rehabilitation policies. A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The overall objective of our review was to determine whether Medicare properly reimbursed Redding Medical Center (the hospital) for outpatient cardiac rehabilitation services in accordance with section 35-25 of the Medicare Coverage Issues Manual. Specifically, we determined whether:

- The hospital's policies and procedures reflected Medicare outpatient 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 calendar year 2001 were for Medicare covered diagnoses, supported by adequate documentation, and otherwise allowable for reimbursement.

Our review found that the hospital met the Medicare requirement for direct physician supervision although a written policy describing the physician's roles and responsibilities was not established. Further, we found that the hospital's policies and procedures did not fully meet the Medicare requirement that outpatient cardiac rehabilitation services should be provided "incident

to" a physician's professional services. In addition, from our specific claims review for a sample of 30 beneficiaries who received 726 outpatient cardiac rehabilitation services during calendar year 2001, we determined that the hospital was paid for:

- Services for which the diagnoses used to establish the patients' eligibility for outpatient cardiac rehabilitation may not have been supported by medical records (65 services),
- Outpatient cardiac rehabilitation services that were not provided (8 services), and
- Outpatient cardiac rehabilitation services that exceeded the maximum number of allowable services (3 services).

From our sample, the hospital claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to about \$1,239, for which the diagnosis used to establish the patient's eligibility for outpatient cardiac rehabilitation services may not have been supported by medical record documentation, or which were otherwise unallowable.

We attributed these questionable services to weaknesses in the hospital's internal controls and oversight procedures. Existing controls did not ensure that beneficiaries had Medicare covered diagnoses supported by the referring physician's medical records, Medicare was billed only for cardiac rehabilitation services performed, and that the number of cardiac rehabilitation services billed did not exceed the maximum allowed. The sample errors and Medicare payments are part of a larger statistical sample and will be included in a multi-state projection of outpatient cardiac rehabilitation service claims not meeting Medicare coverage requirements.

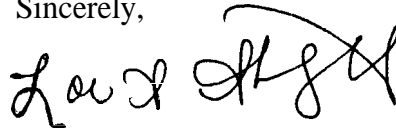
In our report, we recommended that the hospital (1) develop written policies and procedures describing the roles and responsibilities of the physician who provides direct physician supervision of the rehabilitation program; (2) work with its Medicare fiscal intermediary to ensure that its cardiac rehabilitation program is being conducted in accordance with the Medicare requirement that services be provided "incident to" a physician's professional services; (3) work with its Medicare fiscal intermediary to establish the amount of overpayment liability, estimated to be as much as \$1,239, for outpatient cardiac rehabilitation services provided to beneficiaries where medical documentation may not have supported a Medicare covered diagnosis and for services not otherwise allowable; and (4) implement controls to ensure that Medicare is billed only for outpatient cardiac rehabilitation services that are provided and that the number of services billed to Medicare does not exceed the maximum number of services allowed. In a written response to our draft report, the hospital concurred with our findings and recommendations.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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.

In accordance with the principles of the Freedom of Information Act (5 USC, 552, as amended by Public Law 104-231), OIG reports are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 CFR Part 5.)

If you have any questions or comments concerning the matters presented in this report, please direct them to the HHS official named below. To facilitate identification, please refer to report number A-09-03-00043 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
75 Hawthorn Street, 4th Floor
San Francisco, California 94105

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
MEDICARE REIMBURSEMENT
FOR OUTPATIENT CARDIAC
REHABILITATION SERVICES
FOR CALENDAR YEAR 2001**

**REDDING MEDICAL CENTER
REDDING, CALIFORNIA**



**OCTOBER 2003
A-09-03-00043**

Office of Inspector General

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OAS FINDINGS AND OPINIONS

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 awarding agency 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 & 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 Redding Medical Center (the hospital) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- The hospital's policies and procedures reflected Medicare outpatient 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 calendar year 2001 were for Medicare covered diagnoses, supported by adequate documentation, and otherwise allowable for reimbursement.

SUMMARY OF FINDINGS

We determined that the hospital met the Medicare cardiac rehabilitation coverage requirements for direct physician supervision although a written policy describing the physician's roles and responsibilities was not established. Further, we found that the hospital's policies and procedures did not fully meet the Medicare requirement that outpatient cardiac rehabilitation services should be provided "incident to" a physician's professional services. In addition, from our specific claims review for a sample of 30 beneficiaries who received 726 outpatient cardiac rehabilitation services during calendar year 2001, we determined that the hospital was paid for:

- Services for which the diagnoses used to establish the patients' eligibility for outpatient cardiac rehabilitation may not have been supported by medical records (65 services),
- Outpatient cardiac rehabilitation services that were not provided (8 services), and
- Outpatient cardiac rehabilitation services that exceeded the maximum number of allowable services (3 services).

From our sample, the hospital claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to about \$1,239, for which the diagnosis used to

establish the patient's eligibility for outpatient cardiac rehabilitation services may not have been supported by medical record documentation, or which were otherwise unallowable.

We attributed these questionable services to weaknesses in the hospital's internal controls and oversight procedures. Existing controls did not ensure that beneficiaries had Medicare covered diagnoses supported by the referring physician's medical records, Medicare was billed only for cardiac rehabilitation services performed, and that the number of cardiac rehabilitation services billed did not exceed the maximum allowed. The sample errors and Medicare payments are part of a larger statistical sample and will be included in a multi-state projection of outpatient cardiac rehabilitation service claims not meeting Medicare coverage requirements.

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, Mutual of Omaha, should make a determination as to the allowability of the Medicare claims and initiate appropriate recovery action.

RECOMMENDATIONS

We recommend that the hospital:

- Develop written policies and procedures describing the roles and responsibilities of the physician who provides direct physician supervision of the rehabilitation program.
- Work with its Medicare FI to ensure that its cardiac rehabilitation program is being conducted in accordance with the Medicare requirement that services be provided "incident to" a physician's professional services.
- Work with its Medicare FI to establish the amount of overpayment liability, estimated to be as much as \$1,239, for outpatient cardiac rehabilitation services provided to beneficiaries where medical documentation may not have supported a Medicare covered diagnosis and for services not otherwise allowable.
- Implement controls to ensure that Medicare is billed only for outpatient cardiac rehabilitation services that are provided and that the number of services billed to Medicare does not exceed the maximum number of services allowed.

HOSPITAL COMMENTS

In a written response, dated July 31, 2003, to our draft report, the hospital concurred with our findings and recommendations. The full text of the hospital comments is included as an appendix to this report. Attachments provided by the hospital to its comments, including revised policies and procedures, are not appended.

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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 people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by CMS. Medicare currently covers Phase II outpatient cardiac rehabilitation programs conducted in specialized, freestanding 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 outpatient cardiac rehabilitation services is found in section 35-25 of the Medicare Coverage Issues Manual. Under Medicare, outpatient cardiac rehabilitation services are considered reasonable and necessary only for patients with a clear medical need; who are referred by their attending physicians; 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. Services provided in connection with the outpatient 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 therapeutic services provided in a hospital, the Medicare Intermediary Manual states, “[t]he 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 FI based on an ambulatory payment classification. The Medicare FI for the hospital is Mutual of Omaha.

The hospital provides outpatient cardiac rehabilitation services at an outpatient hospital department facility located approximately one-half mile from the hospital's main hospital facility. During calendar year (CY) 2001, the hospital provided outpatient cardiac rehabilitation services to 255 Medicare beneficiaries and received \$98,630 in Medicare reimbursement for these services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

This 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, supported by adequate documentation, and otherwise allowable for reimbursement.

Scope

We reviewed the hospital's 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, as part of a multi-state statistical sample, we reviewed the hospital's records for 30 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001. These records included: cardiac rehabilitation services documentation, inpatient medical records, referring physician referrals and supporting medical records, and Medicare reimbursement data. 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 30 of 255 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 30 beneficiaries during CY 2001.

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

Methodology

To accomplish our objectives, we compared the hospital's policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and identified any differences. We documented how the 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 sampled 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 verified the accuracy of the diagnoses identified on the Medicare claims to each beneficiary's inpatient medical record, physician referral form, and the hospital outpatient cardiac rehabilitation medical record. We also obtained and reviewed the referring physician's medical records for beneficiaries with a Medicare covered diagnosis of stable angina to verify the accuracy of the diagnosis. In addition, we determined if Medicare

reimbursed the hospital beyond the maximum number of services allowed. The medical records have not yet been reviewed by FI staff.

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 our fieldwork at the hospital's outpatient cardiac rehabilitation facility, Redding, California, during the period February through May 2003.

FINDINGS AND RECOMMENDATIONS

We determined that the hospital met the Medicare cardiac rehabilitation coverage requirements for direct physician supervision. The hospital had at least one physician in the exercise area who was immediately available and accessible for an emergency at all times when the exercise program was conducted. However, the hospital did not have written policies and procedures describing the physician's roles and responsibilities because it did not update its policies and procedures manual to reflect its new service environment when its outpatient cardiac rehabilitation program was relocated away from the hospital.

Further, the hospital's policies and procedures did not fully meet the Medicare requirement that outpatient cardiac rehabilitation services be performed "incident to" a physician's professional services. Although the hospital had a medical director who approved the patient treatment plan, he did not personally see the patient or assess the progress of patients during their course of cardiac rehabilitation therapy.

In addition, from our specific claims review for a sample of 30 beneficiaries who received 726 outpatient cardiac rehabilitation services during CY 2001, we determined that the hospital was paid \$1,239 for:

- Services where the diagnoses used to establish the patients' eligibility for outpatient cardiac rehabilitation may not have been supported by medical records (65 services),
- Outpatient cardiac rehabilitation services that were not provided (8 services), and
- Outpatient cardiac rehabilitation services that exceeded the maximum number of allowable services (3 services).

The results from our sample will be included in a multi-state estimate of Medicare reimbursements for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

Our audit conclusions, particularly those regarding Medicare covered diagnoses, were not validated by medical personnel. Therefore, we believe that the FI should determine the allowability of the cardiac rehabilitation services and take proper recovery action.

PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION

Direct Physician Supervision

We determined that the hospital had met the Medicare cardiac rehabilitation coverage requirements for direct physician supervision. The hospital had at least one physician in the exercise area who was immediately available and accessible for an emergency at all times the exercise program was conducted. However, the hospital did not have written policies and procedures specifically addressing direct physician supervision or describing the roles and responsibilities of the physician.

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.

To meet the Medicare requirement, the hospital contracted with three physicians to provide direct physician supervision of the outpatient cardiac rehabilitation program. Our review disclosed that at least one of the three physicians was present in the exercise area, and was immediately available and accessible for emergencies during exercise sessions. Although the three physicians were not involved in the patient treatment plan, we found that their roles and responsibilities included:

- Providing patient education on various cardiac related subjects.
- Monitoring patient conditions during the outpatient cardiac rehabilitation sessions, when requested.
- Responding to emergency situations and initiating contact with the referring physicians.

Although the three physicians provided direct physician supervision at the rehabilitation facility, the hospital did not have written policies and procedures describing the above roles and responsibilities. The hospital did not have written policies and procedures because it relied upon the hospital's policies and procedures that were in place when the cardiac program was initially located at the hospital. When the outpatient cardiac rehabilitation program moved to its current location outside the hospital, the hospital did not modify its written policies and procedures to reflect its policy for direct physician supervision of the outpatient cardiac rehabilitation program.

“Incident to” Physician Services

The hospital's policies and procedures did not fully meet the Medicare requirement that outpatient cardiac rehabilitation services should be provided “incident to” a physician's professional services. The hospital had a medical director who approved the patient treatment plan, but the medical director did not personally see or assess the progress of patients during their course of therapy.

Medicare covers Phase II cardiac rehabilitation services under the “incident to” benefit. 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.

According to the hospital’s policies and procedures, the medical director was required to evaluate each new patient who was referred to the program to determine if the patient qualified for outpatient cardiac rehabilitation. The medical director’s evaluation included reviewing documentation, such as patient history reports, procedural reports, and other records, and approving the exercise treatment plan prepared by the staff. According to the hospital, the medical director’s responsibilities also included:

- Approving a significant change in a patient’s treatment plan if requested by outpatient cardiac rehabilitation staff,
- Consulting with outpatient cardiac rehabilitation staff about patient problems and recommending solutions to the problems, and
- Contacting patients’ referring physicians if requested by outpatient cardiac rehabilitation staff.

However, the hospital’s policies and procedures manual did not require the medical director to evaluate patients in person for the initial evaluation, for the assessment of the course of treatment, or the patient’s progress. Rather, the hospital had policies and procedures that required the cardiac rehabilitation staff to contact the patients’ referring physicians for care when the patients had any significant cardiac symptoms during the outpatient cardiac rehabilitation program.

Our review of the medical records for 30 beneficiaries disclosed that the medical director approved the treatment plan for each beneficiary. Nonetheless, we could not find documentation to support the medical director’s involvement in assessing the patients’ progress. Instead, for the patients presenting cardiac symptoms during the outpatient cardiac rehabilitation exercise sessions, we found letters sent to referring physicians, requesting approval for continuation of or changes to treatment plans. If the referring physician decided that the treatment plan should change, the letter provided a space to allow the referring physicians to prescribe a new treatment plan.

Although the hospital’s medical director approved the patients’ treatment plans, there was no documentation in the medical records to show that a physician personally saw the patient periodically and sufficiently often to assess the course of treatment and the patient’s progress. Accordingly, we concluded that the hospital did not fully meet the Medicare requirement of “incident to” a physician’s professional services.

MEDICARE COVERED DIAGNOSES AND INAPPROPRIATE BILLINGS

Medicare Covered Diagnoses

We determined that documentation in the medical records supported Medicare covered diagnoses of coronary artery bypass graft surgery or acute myocardial infarction claimed by the hospital for 27¹ of the 30 Medicare beneficiaries reviewed. However, we found that documentation in the medical records may not have supported the Medicare covered diagnosis of stable angina² for the three remaining beneficiaries.

Medicare coverage considers outpatient 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.

The three beneficiaries with stable angina diagnoses were initially admitted to the hospital due to unstable angina³, abnormal stress test, or abnormal electrocardiogram. During their inpatient stays, the three beneficiaries underwent cardiac procedures, such as catheterization, stenting, or arteriography. Upon their discharge from the hospital, their attending physician referred them to the outpatient cardiac rehabilitation program. The hospital's outpatient cardiac rehabilitation program staff relied on the attending physician's referral forms as well as inpatient medical records to determine whether patients had Medicare covered diagnoses.

Our review of documentation in the medical records for three beneficiaries disclosed that two beneficiaries continued to experience heart racing or elevated resting blood pressure. However, we were unable to determine whether the symptoms described in the medical records were stable angina-related symptoms. For the remaining beneficiary, we could not find any documentation that the beneficiary continued to experience angina symptoms post-procedure and through completion of the outpatient cardiac rehabilitation program.

The hospital received a potential overpayment of \$1,056 for 65 outpatient cardiac rehabilitation services provided to the three beneficiaries. The overpayment occurred because the hospital's existing controls did not ensure that beneficiaries had Medicare covered diagnoses supported by

¹ Of the 27 beneficiaries, eligibility for 26 beneficiaries was based on the diagnosis of coronary artery bypass graft surgery, and eligibility for 1 beneficiary was based on the diagnosis of acute myocardial infarction.

² 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 at the U.S. National Library of Medicine website (<http://www.nlm.nih.gov/medlineplus/ency/article/000198.htm>).

³ Unstable angina is not a Medicare covered diagnosis for outpatient cardiac rehabilitation.

the referring physician's medical record. The hospital's cardiac rehabilitation program staff relied on a preprinted physician referral form as documentation of a Medicare covered diagnosis of stable angina. The staff did not maintain additional documentation indicating whether the angina symptoms continued to exist post-procedure, or to validate the diagnosis of stable angina.

The FI should review the medical records for the three beneficiaries and determine the allowability of the claims submitted and take appropriate action.

Inappropriate Billings

We found that the hospital inappropriately billed for 11 services provided to 8 beneficiaries, which resulted in an overpayment of about \$183. Of the 11 services, 8 services were billed although they were not provided, and 3 services exceeded the maximum number of allowable services.

Services Not Provided

The hospital received an overpayment of about \$133 for eight outpatient cardiac rehabilitation services that were not provided. Outpatient cardiac rehabilitation services were documented by completing a "Cardiac Rehabilitation Report" form and generating an electrocardiogram strip for each beneficiary's exercise session. For seven outpatient cardiac rehabilitation services, the hospital could not locate either document. For the remaining service, documentation in the beneficiary's medical record disclosed that the exercise session was not provided. These billing errors occurred because the hospital did not have adequate controls to ensure that Medicare was billed only for services performed.

Services Exceeded the Maximum Number of Allowable Services

The hospital received an overpayment of about \$50 for three services that exceeded the maximum number of allowable services.

The Medicare Coverage Issues Manual, section 35-25 states,

[s]ervices provided in connection with a outpatient cardiac rehabilitation exercise program may be considered reasonable and necessary for up to 36 sessions, usually 3 sessions a week in a single 12 week period. Coverage for continued participation in cardiac exercise programs beyond 12 weeks would be allowed only on a case-by-case basis with exit criteria taken into consideration.

The hospital was aware of the maximum number of services allowed under Medicare, and generally would not bill beyond the maximum limit. Occasionally, the hospital allowed beneficiaries to attend more than 36 exercise sessions, and these extra sessions were not supposed to be billed to Medicare. However, due to clerical error, three such services were billed to Medicare.

RECOMMENDATIONS

We recommend that the hospital:

- Develop written policies and procedures describing the roles and responsibilities of the physician who provides direct physician supervision of the rehabilitation program.
- Work with its Medicare FI to ensure that its cardiac rehabilitation program is being conducted in accordance with the Medicare requirement that services be provided “incident to” a physician’s professional services.
- Work with its Medicare FI to establish the amount of overpayment liability, estimated to be as much as \$1,239 for outpatient cardiac rehabilitation services provided to beneficiaries where medical documentation may not have supported a Medicare covered diagnosis and for services not otherwise allowable.
- Implement controls to ensure that Medicare is billed only for outpatient cardiac rehabilitation services that are provided and that the number of services billed to Medicare does not exceed the maximum number of services allowed.

HOSPITAL COMMENTS

In a written response, dated July 31, 2003, to our draft report, the hospital concurred with our findings and recommendations. The hospital developed written policies and procedures describing the roles and responsibilities of the physician providing direct supervision of the rehabilitation program. Further, the hospital is in the process of identifying the appropriate contact person at its Medicare FI to clarify “incident to” requirements and address overpayment liability. The hospital will ensure that its cardiac rehabilitation program is being conducted in accordance with the Medicare requirement that services be provided “incident to” a physician’s professional service and plans to develop and revise its policies and procedures as needed. In addition, the hospital implemented a new procedure to ensure that the number of services billed to Medicare does not exceed the maximum number of services allowed.

The full text of the hospital comments is included as an appendix to this report. Attachments provided by the hospital to its comments, including revised policies and procedures, are not appended.

OIG RESPONSE

Actions proposed by the hospital address the recommendations of this report.

OTHER MATTERS

We found that, as of June 2002, the hospital began to use an incorrect Current Procedural Terminology (CPT) code to bill outpatient cardiac rehabilitation initial evaluations. It used CPT code 99241, representing a physician's office consultation, instead of the correct CPT code 93797 or 93798, which represent an outpatient cardiac rehabilitation service.

The Medicare Carrier Manual Part III, section 2020-A states, “[a] *service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment.*” In addition, Medicare Carrier Manual Part III, section 2020-C defines a consultation, as “*the history and examination of the patient as well as the written report, which is furnished to the attending physician for inclusion in the patient's permanent medical record.*”

The hospital staff provided an initial evaluation service to each patient by gathering past and present medical history and provided that information to the medical director for approval. The medical director did not personally examine the patients, nor did the director furnish a written report to the patients' attending physicians.

The hospital should use the correct CPT code to bill for outpatient cardiac rehabilitation initial evaluation services, and consult with its FI to determine if Medicare billing adjustments are needed.

APPENDIX



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7-31-03

Ms. Lori Ahlstrand
Office of Inspector General
Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Dear Ms Ahlstrand,

Thank you for giving Redding Medical Center (RMC) the opportunity to respond to the "Audit of Medicare Reimbursement for Outpatient Cardiac Rehabilitation Services for the Calendar Year 2001, Report A-09-03-00043."

PURPOSE OF AUDIT

- To determine whether Medicare properly reimbursed RMC for outpatient cardiac rehabilitation services.
- To determine whether policies and procedures at RMC reflected Medicare outpatient cardiac rehabilitation coverage requirements for direct supervision, "incident to" services, and Medicare covered diagnoses.
- To determine whether payments to RMC for outpatient cardiac rehabilitation services provided to Medicare beneficiaries during calendar year (CY) 2001 for Medicare covered diagnoses, supported by adequate documentation, and otherwise allowable for reimbursement.

RECOMMENDATIONS:

- A. Develop written policies and procedures describing the roles and responsibilities of the physician who provides direct physician supervision of the rehabilitation program.

Action Plan:

1. The description of roles and responsibilities for the on-site physician has been added to our Structure Standards, Organizational Chart and the Phase II policy. We also revised the responsibilities for the attending/referring physician.
 2. Responsible person: Cardiac Rehabilitation Coordinator
 3. Completion dates: The policies will be submitted to the Medical Staff committee for approval on August 27, 2003
 4. Exhibits:
 - i. Cardiac Rehabilitation Addendum A (see Page 1 of 2 section d)
 - ii. Cardiac Rehabilitation Organization Addendum B
 - iii. Department Structure Standards Cardiac Rehabilitation including the Role of On-Site Physician (see Page 9 of 10 section 11).
- B. Work with the FI to ensure that its cardiac rehabilitation program is being conducted in accordance with the Medicare requirement that services be provided "incident to" a physician's professional service.

Action Plan:

1. The Cardiac Rehabilitation and the Business Office Director are in the process of identifying the appropriate contact person at Mutual of Omaha.
2. The Cardiac Rehabilitation Coordinator and the Business Office Director will contact and clarify "incident to" with Mutual of Omaha the (FI) by September 2003. They will ensure that the cardiac rehabilitation program is conducted in accordance with Cardiac Rehabilitation Guidelines, section 35- 25. Policies and Procedures will be developed and/or revised as needed.
3. The roles and responsibilities for the attending/referring physician have been added to conduct periodic performance evaluations during the 12-week cardiac rehab program. The nurse responsibilities to address sending periodic reports to attending/referring physician.
4. Responsible Person: Cardiac Rehabilitation Coordinator
5. Completion Dates:
 - i. Meeting with FI: September 2003
 - ii. Policies and procedure approval: August 2003.

6. Exhibits:
 - i. Department Structure Standards, Phase II policy and procedure.
(See exhibits Page 5 of 25 Section c, ii.)
- C. Work with the FI to establish the amount of overpayment liability, estimated to be as much as \$1,239, for outpatient cardiac rehabilitation services provided to beneficiaries where medical documentation may not have supported a Medicare covered diagnosis and for services not otherwise allowed.

Action Plan:

1. The Cardiac Rehabilitation Coordinator and the Business Office Director are in the process of identifying the appropriate contact person at Mutual of Omaha to address overpayment liability.
 2. Since the audit identified opportunities for improvement in our billing system, cardiac rehab staff immediately implemented a new method of submitting charges to our accounting department. Before charges are entered into the computer two nurses, instead of just one, verify the identity of patient and their attendance. A Billing Competencies was developed and each nurse working in the cardiac rehab arena has received an in-service and completed the competency.
 3. Person responsible: Cardiac Rehabilitation Coordinator, Business Office Director
 4. Completion Date:
 - i. Contact FI: pending
 - ii. Billing competency: 3/03 to 6/03
 5. Exhibits:
 - i. Copy of Billing Competencies for active cardiac rehab nurses
- D. Implement controls to ensure that Medicare is billed only for outpatient cardiac rehabilitation services that are provided and that the number of services billed to Medicare does not exceed the maximum number of services allowed.

Action Plan:

1. In addition to a new method of submitting charges, we now remove the charge card after the patient completes his 36th visit to prevent additional charges from being submitted.

2. A Billing Competencies was developed and each nurse working in the cardiac rehab arena has received an in-service and completed the competency.
3. Responsible Person: Cardiac Rehabilitation Coordinator
4. Completion date: March 2003 to June 2003
5. Exhibits:
 - i. Copy of Billing Competencies for active cardiac rehab nurses

Thank you again for giving Redding Medical Center an opportunity to respond to the draft report.

Sincerely,



Richard Phillips
Chief Financial Officer
Redding Medical Center

ACKNOWLEDGMENTS

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