DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

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

November 7, 2003

Report Number: A-10-03-00009

Ms. Carol Hauth
Service Line Director
Physical Medicine and Rehabilitation
Salem Hospital
Post Office Box 14001
Salem, Oregon 97309-5014

Dear Ms. Hauth:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's final report entitled "Review of Medicare Reimbursement for Outpatient Cardiac Rehabilitation Services for Calendar Year 2001, Salem Hospital, Salem, Oregon." 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 Salem Hospital (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 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 did not provide outpatient cardiac rehabilitation services "incident to" a Hospital physician's professional services. In addition,

from our specific claims review for a non-statistical sample of 10 beneficiaries who received 107 outpatient cardiac rehabilitation services during Calendar Year 2001, we determined that the Hospital was paid for:

- Services for which the diagnosis used to establish the patient's eligibility for cardiac rehabilitation was not supported by medical records (7 services), and

- Initial patient evaluation and orientation services conducted by nonphysician personnel that did not include an exercise session (5 services).

From our sample, the Hospital claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to approximately $183, for which the diagnosis used to establish the patient's eligibility for outpatient cardiac rehabilitation services was not 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 medical records, and that Medicare was billed only for initial patient evaluation and orientation services performed by a physician. This review is part of a larger nationwide review of outpatient cardiac rehabilitation services, and its results may be included in a national roll-up report of all providers reviewed.

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 the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirement that services be provided "incident to" a physician's professional service; (3) work with its Medicare fiscal intermediary to establish the amount of repayment liability, estimated to be as much as $183, for services provided to beneficiaries where medical documentation did not support a Medicare covered diagnosis and for services not otherwise allowable; and (4) bill for initial patient evaluation and orientation services only when performed by a physician. 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-10-03-00009 in all correspondence relating to this report.

Sincerely,

Lori **A.** Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

John Hammarlund, Acting Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
2201 Sixth Avenue, Suite 911
Seattle, Washington **98**121

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

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

SALEM HOSPITAL
SALEM, OREGON

NOVEMBER 2003
A-10-03-00009

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 Salem Hospital (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 (CY) 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 did not provide outpatient cardiac rehabilitation services "incident to" a Hospital physician's professional services. In addition, from our specific claims review for a non-statistical sample of 10 beneficiaries who received 107 outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid for:

- Services for which the diagnosis used to establish the patient's eligibility for cardiac rehabilitation was not supported by medical records (7 services), and

- Initial patient evaluation and orientation services conducted by nonphysician personnel that did not include an exercise session (5 services).

Our review disclosed that the Hospital claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to approximately $183, for which the diagnosis used to establish the patient's eligibility for outpatient cardiac rehabilitation services was not 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 medical records, and that Medicare was billed only for initial patient evaluation and orientation services performed by a physician. This review is part of a larger nationwide review of outpatient cardiac rehabilitation services, and its results may be included in a national roll-up report of all providers reviewed.

Our determinations regarding Medicare covered diagnoses were based solely on our review of the medical record documentation. The medical records were not reviewed by fiscal intermediary (FI) staff. We believe that the Hospital's FI, Medicare Northwest, 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 the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirement that services be provided "incident to" a physician's professional service.

- Work with its Medicare FI to establish the amount of repayment liability, estimated to be as much as $183, for services provided to beneficiaries where medical documentation did not support a Medicare covered diagnosis and for services not otherwise allowable.

- Bill for initial patient evaluation and orientation services only when performed by a physician.

HOSPITAL COMMENTS

In a written response to our draft report, dated October 6, 2003, the Hospital concurred with our findings and recommendations. The Hospital comments are attached in their entirety as an appendix to this report.

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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 cardiac rehabilitation services is found in section 35-25 of the Medicare Coverage Issues Manual. Medicare coverage of cardiac rehabilitation programs is considered 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. 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 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 Medicare Northwest.

The Hospital provides outpatient cardiac rehabilitation services at its Regional Rehabilitation Center (Rehabilitation Center) located approximately 2 miles from the main hospital building. At the Rehabilitation Center, the Hospital provides both inpatient and outpatient rehabilitation services within the Department of Physical Medicine and Rehabilitation Services (Rehabilitation Department). For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 116 Medicare beneficiaries and received $25,199 in Medicare reimbursement for 1,660 services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

To accomplish these objectives, 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, we reviewed the Hospital's records for a non-statistical sample of 10 of 116 Medicare beneficiaries who received 107 outpatient cardiac rehabilitation services during CY 2001. These records included: cardiac rehabilitation services documentation, inpatient medical records, physician referrals, and supporting medical records. We reviewed the Hospital's outpatient cardiac rehabilitation procedures for and controls over physician supervision, cardiac rehabilitation staffing, availability of advanced cardiac life support equipment, and documentation of services provided and billed to Medicare.

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 also verified the accuracy of the diagnoses identified on the Medicare claims to each beneficiary's inpatient medical record, prescribing physician's referral form, and the Hospital's outpatient cardiac rehabilitation medical record. In addition, we determined if Medicare reimbursed the Hospital beyond the maximum number of services allowed. The medical records were not 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 review from April through July 2003 with fieldwork performed at the Rehabilitation Center of the Hospital, Salem, Oregon.

FINDINGS AND RECOMMENDATIONS

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 did not provide outpatient cardiac rehabilitation services "incident to" a Hospital physician's professional services. In addition, from our specific claims review for a non-statistical sample of 10 beneficiaries who received 107 outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid about $183 for:

- Services for which the diagnosis used to establish the patient's eligibility for cardiac rehabilitation was not supported by medical records (7 services), and

- Initial patient evaluation and orientation services conducted by nonphysician personnel that did not include an exercise session (5 services).

Our review of the Hospital is part of a larger nationwide review of outpatient cardiac rehabilitation services. Accordingly, our findings and recommendations may be included in a national roll-up report of all providers reviewed.

Our review 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 met the Medicare 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 describing the physician's roles and responsibilities in relation to direct supervision.

The Hospital contracted with a medical group of five physicians, specializing in physical medicine and rehabilitation, to provide direct physician supervision of the outpatient cardiac rehabilitation program. We found that at least one of the group physicians was present in the exercise area, and was immediately available and accessible for emergencies during exercise sessions.

According to the contract, the physician group was required to provide 24-hour physician coverage for the comprehensive inpatient rehabilitation unit, located on the second floor of the Rehabilitation Center. Although the contract did not specifically address the physician coverage for the outpatient cardiac rehabilitation unit located on the third floor of the Rehabilitation Center, the group physicians on the second floor were considered to be in the exercise area, and were immediately available and accessible for emergencies during exercise sessions. Further,

the Hospital policies and procedures stated that the medical director of the Rehabilitation Department was responsible for providing physician coverage for medical emergencies in the outpatient cardiac rehabilitation unit.

Our review disclosed that the medical director designated two physicians to respond to "code 99" (cardiopulmonary arrest) emergency calls at the Rehabilitation Center, including the outpatient cardiac rehabilitation unit. The outpatient cardiac rehabilitation staff were required to page the two designated physicians to ensure their immediate response in a "code 99" emergency. In addition, the staff was required to call 911 in case an ambulance was required to transport the patient to the main hospital facility.

Although the group physicians provided direct physician supervision at the outpatient cardiac rehabilitation unit, the Hospital did not have written policies and procedures describing the physician's roles and responsibilities in relation to direct supervision. The Hospital did not have written policies and procedures because it was generally understood that the group physicians were responsible to provide physician coverage for emergency situations at the Rehabilitation Center, including the outpatient cardiac rehabilitation unit.

"Incident to" Physician Services

The Hospital did not provide outpatient cardiac rehabilitation services "incident to" a Hospital physician's professional services. There was no Hospital physician involvement in evaluating patients, preparing or approving their treatment plans, or assessing their progress during the 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. Each patient should be under the care of a hospital physician.

At the outpatient cardiac rehabilitation unit, there was no physician to provide professional services of personally seeing patients, assessing their course of treatment and progress, and changing their treatment plan as needed. Instead, the patient's physicians were provided the initial treatment plan and informed of the patient's progress through progress and final reports that were prepared by the outpatient cardiac rehabilitation staff.

The Hospital had a contract with a medical group to provide physician coverage for the comprehensive inpatient rehabilitation unit of the Rehabilitation Department. However, the contract did not require any of the group physicians to personally see the outpatient cardiac rehabilitation patients, or assess the patients' course of treatment and progress and, where necessary, to change the treatment program.

According to the outpatient cardiac rehabilitation unit's current procedures, registered nurses should perform the initial evaluation of each patient and prepare the patient treatment plan for

approval by the patient's referring physician. The initial patient treatment plan should be sent to the referring physician, primary care physician, cardiologist and cardiovascular surgeon and request authorization of the initial treatment plan by the referring physician. The patient's progress reports, including a continuous treatment plan, should be prepared every 30 days and sent to the patient's physician for approval.

Our review of documentation in the medical records disclosed that in CY 2001 the Hospital obtained approval from each patient's physician only for the updated treatment plan listed in the progress reports. The initial patient treatment plans and final reports were sent to the patients' physicians; however, the physicians did not approve them.

The Hospital staff stated that in CY 2001 the Hospital did not obtain approval for the initial treatment plan from the referring physicians because they believed the physician orders were sufficient for approving a patient's treatment for the first 30 days. In February 2002, the Hospital modified its policies and procedures to require the Hospital staff to obtain the patient's referring physician's approval of the initial treatment plan before providing outpatient cardiac rehabilitation services.

The Hospital staff stated that outpatient cardiac rehabilitation services were provided "incident to" the patient's referring physicians' professional services because they had overall responsibility for patient care. However, the referring physicians were not employees of or contracted by the Hospital to provide services at the cardiac rehabilitation program.

From our review of the Hospital's outpatient cardiac rehabilitation medical records, we could not locate any evidence of a Hospital physician's professional services rendered to the patients during the cardiac rehabilitation program. Although required under the "incident to" benefit, there was no documentation to support that a Hospital physician personally saw 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. Accordingly, we believe that the Hospital's cardiac rehabilitation program did not meet the Medicare requirements regarding an "incident to" service.

MEDICARE COVERED DIAGNOSES AND INAPPROPRIATE BILLINGS

Medicare Covered Diagnoses

We determined that documentation in the medical records supported the Medicare covered diagnosis of coronary artery bypass graft claimed by the Hospital for 9 of the 10 Medicare beneficiaries reviewed. However, for the remaining beneficiary, we found that documentation in the medical records did not support the Medicare covered diagnosis of coronary artery bypass graft claimed by the Hospital.

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.

The beneficiary with the unsupported coronary artery bypass graft diagnosis was initially admitted to the Hospital with a diagnosis of aortic stenosis in early 2001. During the inpatient stay, the beneficiary received surgical procedures, including catheterization and aortic valve replacement. A few months after the inpatient stay, the referring physician wrote an order for the beneficiary to participate in the outpatient cardiac rehabilitation program with a diagnosis of "status post prosthetic valve."

The Hospital's cardiac rehabilitation program staff conducted an initial evaluation and admitted the beneficiary on an "Aortic Valve Replacement" diagnosis. The staff informed the patient that the diagnosis used might not be a Medicare covered diagnosis. Nonetheless, the Hospital staff billed for seven outpatient cardiac rehabilitation services and included coronary artery bypass graft as one of the diagnoses on the Medicare claim. The Hospital's policies and procedures stated that the coronary artery bypass graft procedure should be performed within 12 months prior to outpatient cardiac rehabilitation. However, we could not find documentation in the medical records that the patient received a coronary artery bypass graft procedure within 12 months prior to outpatient cardiac rehabilitation.

The Hospital's policies and procedures had a list of diagnoses or symptoms for which patients could be admitted to the outpatient cardiac rehabilitation program. The list included coronary artery bypass graft, acute myocardial infarction, stable angina pectoris, arrhythmias, hypertension, and pacemakers. The policies and procedures did not indicate specifically what diagnoses were covered by Medicare.

Therefore, we concluded that Medicare inappropriately paid about $107 to the Hospital for the seven cardiac rehabilitation services provided to the beneficiary. This overpayment occurred because the Hospital did not ensure that the beneficiary had a Medicare covered diagnosis supported by documentation in the medical records prior to providing cardiac rehabilitation services and billing Medicare.

Inappropriate Billings

We determined that the Hospital inappropriately billed five initial patient evaluation and orientation services that were provided by nonphysician personnel, resulting in an overpayment of about $76. These billing errors occurred because the Hospital did not have adequate controls to ensure that Medicare was billed only for initial evaluation and orientation services performed by physician personnel. The Hospital staff incorrectly believed that the initial evaluation and orientation services could be billed to Medicare when performed by nonphysician personnel.

The Hospital claims included five initial patient evaluation sessions that should have been performed by a physician but were provided by registered nurses. These sessions did not include cardiac rehabilitation exercise. Medicare allowed a new patient evaluation and orientation service to be reimbursed only if a physician provided the service. If the service was provided by nonphysician personnel, the service was considered to be routine and not separately billable 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 the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirement that services be provided "incident to" a physician's professional service.

- Work with its Medicare FI to establish the amount of repayment liability, estimated to be as much as $183, for services provided to beneficiaries where medical documentation did not support a Medicare covered diagnosis and for services not otherwise allowable.

- Bill for initial patient evaluation and orientation services only when performed by a physician.

HOSPITAL COMMENTS

In a written response to our draft report dated October 6, 2003, the Hospital concurred with our findings and recommendations. The Hospital indicated that it implemented changes to its policies and procedures to address the issues in the report. Further, the hospital planned to request a review of the new changes by its Medicare FI to ensure that it is meeting the "direct supervision" and "incident to" requirements, and billing services to Medicare correctly. The Hospital also indicated that it refunded to the Medicare FI the amount owing for services provided to the beneficiary where medical documentation did not support a Medicare covered diagnosis, and will work with the Medicare FI to make any other necessary refunds promptly. The Hospital comments are attached in their entirety as an appendix to this report.

OIG RESPONSE

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

OTHER MATTERS

We believe that one of the physician referral forms used by the Hospital to support a patient's outpatient cardiac rehabilitation services might be inadequate.

The Hospital used a "Transfer Orders To Intermediate Care Unit For Cardiovascular Surgical Patient" form as documentation supporting a physician's referral for outpatient cardiac rehabilitation services provided to five beneficiaries. The form had a comprehensive list of preprinted physician orders for patients who underwent cardiovascular surgeries at the Hospital. The referring physician filled out this form while patients were still hospitalized.

One of the line items on the preprinted order list was for "Cardiac Rehab[ilitation] – Phase I/II" with two check boxes entitled "Yes" and "No." However, the form was not clear as to whether the patient was prescribed to Phase I or Phase II of the cardiac rehabilitation program. Phase I rehabilitation is considered part of the hospital stay and is covered as part of the Medicare diagnosis-related group allowance for the hospital stay.

Further, the form did not require the referring physician to indicate the patient's diagnosis to ensure the patent was eligible for outpatient cardiac rehabilitation services.

APPENDIX

SALEM HOSPITAL
REGIONAL HEALTH SERVICES

Post Office Box 14001
Salem, Oregon 97309-5014
503.561.5200

October 6, 2003

Ms. Lori Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General, DHS
50 United Nations Plaza
San Francisco, CA 94102

Report Number: A-10-03-00009

Dear Ms. Ahlstrand:

Enclosed is Salem Hospital's response to the U.S. Department of Health and Human Services, Office of Inspector General's draft report entitled "Audit of Medicare Reimbursement for Outpatient Cardiac Rehabilitation Services for Calendar Year 2001".

Salem Hospital always strives to provide patient care of the highest quality, within the regulations governing our various programs. We welcome objective appraisals, such as provided by your office.

We will be responding to your recommendations, and have begun this process with our fiscal intermediary, Medicare Northwest.

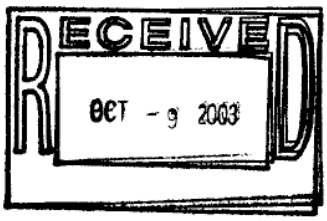
Please contact either of us if you have any further questions, or require clarification of the enclosed documents.

Sincerely,

Carol Hauth, PT
Service Line Director
Physical Medicine and Rehabilitation
503-561-5982

Janet Denton, RN, MM
Compliance Officer
503-561-5249

Enclosures
cc: Norman Gruber, President and CEO
Jeff Cushing, Executive Vice President
Deborah Glass, RN, MSN, Vice President for Patient Care
Kathleen Dowling, Vice President for Fiscal Services
Jon Pelkey, Cardiac Service Line Director



Response to Review of Salem Hospital
Cardiac Rehabilitation Services
2003

Recommendation	Response
Salem Hospital (SH) should develop written policies and procedures describing the roles and responsibilities of the physician who provides direct physician supervision of the rehabilitation program.	SH is amending the policies and procedures to show more clearly the physicians' roles and responsibilities. We are also defining the job description for the Medical Director. SH will ask Medicare Northwest to review these documents to ensure that the "direct supervision" requirement is more clearly met.
SH should work with its Medicare fiscal intermediary, Medicare Northwest, to ensure that SH's Outpatient Cardiac Rehabilitation program is being conducted in accordance with the Medicare coverage requirement that services be provided "incident to" a physician's professional service.	SH did make policy and procedure changes in 2002 as noted in the report; further changes occurred following the auditors' verbal report in March, 2003. SH will ask Medicare Northwest to review the policies, procedures and program changes to ensure that SH is meeting the "incident to" requirement.
SH should reimburse Medicare for services provided to beneficiaries which were not supported by medical record documentation or which were otherwise unallowed.	SH refunded the amount owing for the patient who did not meet diagnostic criteria at the time of the OIG auditors' visit. We will work with Medicare Northwest and make any other necessary refunds promptly. Additionally, SH has implemented changes to the admitting procedures to assure that Medicare beneficiaries are screened for Medicare approved diagnoses, and those patients not meeting

	screening criteria are formally notified by presentation of an Advanced Beneficiary Notice (ABN).
SH should ensure that billings for initial evaluation and orientation services are not submitted for these services when not performed by a physician.	SH has implemented changes to the admission process. SH will ask Medicare Northwest to review the revised process to ensure that services are billed correctly.
SH should make changes to one of the physician referral forms used by the hospital.	All of SH's inpatient forms on which physicians authorize Cardiac Rehabilitation will be reviewed, and revised as needed.

ACKNOWLEDGMENTS

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

Jerry McGee, *Audit Manager*
Jessica Kim, *Senior Auditor*
George Stokes, *Auditor*
Rogers Shellman, *Auditor*

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