DEPARTMENT OF HEALTH AND HUMAN SERVICES **Office of Inspector General**
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

November 3, 2003

Report Number: A-04-03-01005

Rodney Smith
Chief Executive Officer
1401 West Seminole Boulevard
Sanford, Florida 32771

Dear Mr. Smith:

The enclosed report provides the results of our ***Review of Outpatient Cardiac Rehabilitation Services – Central Florida Regional Hospital, Sanford, Florida.*** This review was in response to Centers for Medicare & Medicaid Services' request for Office of Inspector General assistance in determining whether outpatient cardiac rehabilitation programs meet the current requirements outlined in the Medicare Coverage Issues Manual (Section 35-25).

The overall objective of our review was to determine whether Medicare properly reimbursed Central Florida Regional Hospital (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; and, payments to the Hospital for outpatient cardiac rehabilitation services provided to Medicare beneficiaries during calendar year (CY) 2001 were for Medicare covered diagnoses, were supported by adequate documentation, and were otherwise allowable for reimbursement.

Although physician supervision is assumed to be met in an outpatient hospital department, the Hospital did not designate a physician to supervise the services provided through its cardiac rehabilitation program. Further, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." In addition, from our specific claims review for Medicare covered diagnoses, allowability and documentation for the sample of 30 beneficiaries receiving outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital received $2,003 in Medicare reimbursement for:

- services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (4 beneficiaries); and,

- sessions in excess of acceptable limits (19 beneficiaries).

We recommend that the Hospital: (1) work with First Coast to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services provided "incident to" a physician's professional service; (2) work with First Coast to establish the amount of repayment

liability for services, identified as $2,003, provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable; and, (3) implement controls to ensure sessions billed to Medicare do not exceed limits (up to 36 sessions).

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (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.

In accordance with the principles of the Freedom of Information Act, (5 United States Code 552, as amended by Public Law 104-231), Office of Inspector General reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act (see 45 Code of Federal Regulations Part 5).

If you have any questions or comments about this report, please contact Don Czyzewski, Audit Manager, at 305-536-5309, extension 10. To facilitate identification, please refer to report number A-04-03-01005 in all correspondence relating to this report.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT CARDIAC REHABILITATION SERVICES – CENTRAL FLORIDA REGIONAL HOSPITAL, SANFORD, FLORIDA

NOVEMBER 2003
A-04-03-01005

Notices

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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 Central Florida Regional Hospital (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; and,

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

RESULTS OF AUDIT

Although physician supervision is assumed to be met in an outpatient hospital department, the Hospital did not designate a physician to supervise the services provided through its cardiac rehabilitation program. Further, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." In addition, from our specific claims review for Medicare covered diagnoses, allowability and documentation for the sample of 30 beneficiaries receiving outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital received $2,003 in Medicare reimbursement for:

- services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (4 beneficiaries); and

- sessions in excess of acceptable limits (19 beneficiaries).

It should be noted that the sample errors and Medicare payments are part of a larger statistical sample and will be included in a multistate projection of outpatient cardiac rehabilitation service claims not meeting Medicare coverage requirements. We attribute these questionable services to weaknesses in the Hospital's internal controls and oversight procedures. Existing controls did

not ensure that service limits were not exceeded. In addition, the Hospital staff believed that the initial evaluation/orientation visit plus 36 exercise sessions were within the limits imposed by Medicare.

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, First Coast Service Options, Inc. (First Coast), should make a determination as to the allowability of the Medicare claims and appropriate recovery action.

RECOMMENDATIONS

We recommend that the Hospital:

- work with First Coast to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services provided "incident to" a physician's professional service;

- work with First Coast to establish the amount of repayment liability for services, identified as $2,003, provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable; and

- implement controls to ensure sessions billed to Medicare do not exceed limits (up to 36 sessions).

HOSPITAL'S COMMENTS

The Hospital indicated that it has adequate processes and systems in place to meet the physician supervision and "incident to" requirements. In addition, the Hospital stated that the regulations for cardiac rehabilitation included no specific guidelines for expected documentation. In both instances, the Hospital has agreed to work with First Coast to ensure compliance with the Medicare coverage requirements. With regard to the sample results, the Hospital stated that it would work with First Coast to establish the amount of repayment liability and that its billing procedures were modified.

The Hospital comments are summarized at the end of the RESULTS OF AUDIT section of this report and are presented in their entirety as APPENDIX C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We acknowledge that the Medicare Intermediary Manual (Section 3112.4, entitled Outpatient Therapeutic Services) states that the physician supervision requirement is generally assumed to be met where the services are performed on hospital premises. However, the Medicare Coverage Issues Manual (Section 35-25, entitled Cardiac Rehabilitation Programs) more specifically

requires that the physician be immediately available and accessible. Because both the medical director and the emergency room physicians were located in another building, we could not conclude that the Hospital met the requirements. While we acknowledge the Hospital's process concerning "incident to" services, we did not find evidence of any hospital physician personally seeing the patients as required by the Medicare Manuals.

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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. CMS currently covers 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 physicians, 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 therapeutic services 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 FI based on an ambulatory payment classification. The FI for the Hospital is First Coast. For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 72 Medicare beneficiaries and received $26,649 in Medicare reimbursements for these 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; and

- 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, referring physician referrals and supporting medical records, and Medicare reimbursement data for 30 beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001 as part of a multistate statistical sample. Specifically, 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.

The sample included 30 of 72 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

We compared the Hospital's current policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and FI local medical review policy (LMRP) and identified any differences. We documented how the Hospital's staff provided 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, the referring physician's medical record and referral, and the Hospital's outpatient cardiac rehabilitation medical record. The medical records have not yet been reviewed by FI staff. In addition, we verified whether 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 the provider was currently complying with existing Medicare coverage requirements. We performed fieldwork at Central Florida Regional Hospital, Sanford, Florida, and at our field offices in Tallahassee and Miami, Florida during the period March through July 2003. The Hospital's comments on the draft report are included in their entirety as APPENDIX C to this report. A summary of the Hospital's comments and our response follow the Recommendations section.

RESULTS OF AUDIT

Although physician supervision is assumed to be met in an outpatient hospital department, the Hospital did not designate a physician to supervise the services provided through its cardiac rehabilitation program. Further, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." In addition, from our specific claims review for Medicare covered diagnoses, allowability, and documentation for the sample of 30 beneficiaries receiving outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital received $2,003 in Medicare reimbursement for:

- services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (4 beneficiaries); and
- sessions in excess of acceptable limits (19 beneficiaries).

PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION

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.

During our audit period, the cardiac rehabilitation staff stated that a physician was designated to provide physician supervision to the cardiac rehabilitation exercise area during exercise sessions; however, we found no documentation in the cardiac rehabilitation program's medical records to support physician supervision during exercise sessions. On a day-to-day basis, the cardiac rehabilitation program was staffed and run by registered nurses and exercise physiologists. A clinical director, who was a registered nurse, was responsible for the day-to-day supervision of the cardiac rehabilitation area.

Subsequent to our audit period, the Hospital changed their policies and procedures for direct physician supervision. The Hospital stated that a medical advisor was located in the building until November 2002. After the medical advisor moved his office, the provider utilized Emergency Services physicians (Emergency Room Department) to supervise outpatient cardiac rehabilitation services. The outpatient cardiac rehabilitation department is located in a separate building on the hospital campus within 399 feet of the Emergency Room. The Hospital staff cited the Emergency Medical Treatment and Labor Act that states that when a patient comes to the hospital with an emergency medical condition, the Hospital is required to stabilize the medical condition. Additional regulations state that all patients are considered as "coming to" the Emergency Room when they are within 250 yards and exhibit an emergency medical condition. The Hospital staff believed direct physician supervision was met under these regulations.

The Hospital stated that the program has never had a code event occur in the department. If a code emergency should occur, the procedures require the cardiac rehabilitation staff to call the Emergency Services physician and 911, and begin life support procedures. The Emergency Services physician was responsible to direct by phone any medical emergency that occurred in the cardiac rehabilitation exercise area. When stabilized, the patient would be transported to the Emergency Room by either the cardiac rehab staff or the 911 team. The code team from the Hospital would not respond to emergencies occurring at the outpatient cardiac rehabilitation department.

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

"Incident To" Physician Services

Medicare covers Phase II cardiac rehabilitation 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 hospital 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.

At the Hospital, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." According to the Hospital's policies and procedures, each patient referred to the Hospital's outpatient cardiac rehabilitation program attends a personal intake session to determine an individualized plan of care for exercise training, and cardiac risk factor reduction education and counseling. This session includes, among other services, a focused physical assessment of the patient's condition and symptoms since discharge from the hospital, and a functional capacity assessment to help determine an individualized exercise prescription.

Based on the assessment, an individualized plan of care, which addresses the exercise plan, cardiac risk factor educational/counseling plan, psychosocial plan, discharge plan, and outcome measurement plan is developed. Patients generally attend the Phase II cardiac rehabilitation program 3 days per week. An ongoing assessment is done by the cardiac rehabilitation clinician prior to each exercise session. This assessment includes a determination based on new onset of signs/symptoms, blood pressure, and heart rate and rhythm. The registered nurses who staffed the cardiac rehabilitation unit conducted the intake sessions, as well as the ongoing assessments.

In addition, according to the Hospital's policies and procedures, a progress report is sent at midpoint and when an event requiring intervention occurred to the referring physician. In the event a patient is absent because of an event or illness that required physician care, the referring physician must provide a note indicating the patient can return to exercise and any limitations. From our review of the Hospital's outpatient cardiac rehabilitation medical records, we located evidence of notification of events requiring intervention and notes indicating permission for the patient to return to exercise. We did not find evidence of the 6-week evaluation sent to the physicians.

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. Therefore, we could not conclude whether the "incident to" provision was met. Accordingly, we believe that the Hospital's cardiac rehabilitation program should work with First Coast to ensure that the "incident to" provision conforms to the requirements.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

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 (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. 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.

Our statistical sample of 30 of 72 Hospital's Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to $12,001 during CY 2001, disclosed that Medicare claims for 22 beneficiaries contained 23 errors. Some beneficiaries had more than one type of error.

Categories of Errors

Medicare Covered Diagnoses. Medicare paid the Hospital for outpatient cardiac rehabilitation services with diagnoses establishing eligibility for cardiac rehabilitation, which did not appear to be supported by the notes in the beneficiaries' medical records. Of the 30 sampled beneficiaries, eligibility for 1 beneficiary was based on the diagnosis of acute myocardial infarction, eligibility for 23 beneficiaries was based on the diagnosis of coronary artery bypass graft surgery, eligibility for 5 beneficiaries was based on the diagnosis of stable angina, and 1 beneficiary did not participate in cardiac rehabilitation[1]. For the 24 beneficiaries with diagnoses of acute myocardial infarction or coronary artery bypass graft surgery, medical records contained documentation to support the diagnoses. However, the medical records for four of the five beneficiaries with diagnoses of stable angina did not appear to indicate that he/she continued to experience stable angina post-procedure.

These four beneficiaries had been admitted as an inpatient to the hospital with a diagnosis of unstable[2] or stable angina.[3] During the inpatient stays, two beneficiaries had cardiac procedures such as stenting, angioplasty, or valve replacements. The other two beneficiaries did not undergo therapeutic cardiac procedures. After their discharge from the hospital, their physicians referred these beneficiaries to the outpatient cardiac rehabilitation program.

To validate the diagnosis of stable angina, we obtained and reviewed the inpatient medical records as well as the medical records of the physicians who referred these four beneficiaries for cardiac rehabilitation. The medical records covered the dates of the beneficiaries' inpatient stays through their completion of Phase II of the cardiac rehabilitation program. We were unable to determine if the beneficiaries continued to experience angina symptoms post-procedure and through their completion of Phase II of the cardiac rehabilitation program. As a result, we believe that Medicare may have inappropriately paid $1,723 to the Hospital for the cardiac rehabilitation services provided to these four beneficiaries.

Number of Sessions Exceeded Limits. For 19 of the 30 beneficiaries, the Hospital billed for one session beyond the established limit of 36 sessions. The Hospital normally billed for 1 unit of service for the initial evaluation to set exercise parameters and establish protocols in addition to Medicare's 36 allowable sessions. Medicare policy allows for services provided in connection

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[1] We determined one beneficiary did not participate in the cardiac rehabilitation program. The claim was submitted in error and cancelled. This claim would not be counted as an error.

[2] Unstable angina is not a Medicare covered diagnosis for outpatient cardiac rehabilitation.

[3] Stable angina was 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).

with the cardiac rehabilitation program for up to 36 sessions when reasonable and necessary. Coverage for continued participation in cardiac exercise programs beyond 36 sessions would be allowed only on a case-by-case basis with exit criteria taken into consideration. Medicare policy does not provide reimbursement for an initial assessment in addition to the 36 sessions. As a result, the Hospital received an additional $280 for these claims from Medicare.

The results from our sample will be included in a multistate estimate of Medicare reimbursements for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment. (See APPENDICES A and B for specific sampling and universe data, methodology, errors, and dollar values.)

Underlying Causes for Errors

Medicare Covered Diagnoses. The Hospital's cardiac rehabilitation program conducted an intake assessment with each beneficiary. In addition, the staff accepted the physician referral with no evidence that they did an evaluation of the diagnosis. The staff would review the diagnosis, but they indicated they would not question the physician's diagnosis on the referral.

Number of Sessions Exceeded Limits. The Hospital normally billed for one unit of service for the initial evaluation to set exercise parameters and establish protocols, plus 36 units of service for the regular rehabilitation exercise sessions. The staff thought the limit applied to the exercise sessions.

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

RECOMMENDATIONS

We recommend that the Hospital:

- work with First Coast to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services provided "incident to" a physician's professional service;

- work with First Coast to establish the amount of repayment liability for services, identified as $2,003, provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable; and

- implement controls to ensure sessions billed to Medicare do not exceed limits (up to 36 sessions).

HOSPITAL'S COMMENTS

In written comments to the draft report, the Hospital cited the Medicare policies that direct physician supervision is assumed to be met in an outpatient hospital department. The Hospital further stated "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," and that a physician is not required to be physically present in the exercise room itself. Regarding the requirements for "incident to" services, the Hospital indicated it has a process in place to notify the medical director and the referring physician of the patients' progress and events that require intervention. The Hospital believed it has adequate processes and systems in place to meet the physician supervision and "incident to" requirements. Also, the Hospital stated that the regulations for cardiac rehabilitation included no specific guidelines for expected documentation. In summarizing its comments on physician involvement, the Hospital said that it would work with First Coast to ensure that its outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements.

With regards to the sample results, the Hospital agreed to work with First Coast to establish the amount of repayment liability. The Hospital further stated that it has implemented controls to ensure only one unit of service per beneficiary is billed for each session, and has utilized a continuous monitoring process to ensure requirements are met.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We are in agreement with your references to the Medicare policies. However, the Medicare Coverage Issues Manual further states "…provided the contractor does not determine that the physician is too remote from the patients' exercise area to be considered immediately available and accessible." Because the medical director and the emergency room physicians were located in another building, we could not conclude a physician would be immediately available at all times as required by the Coverage Issues Manual. With respect to "incident to" services, Section 35-25 of the Coverage Issues Manual requires that each patient be under the care of a hospital physician, and Section 3112.4 of the Intermediary Manual requires that 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. We acknowledge the Hospital's process to notify the medical director and the referring physician of the patient's progress and of patient events that require intervention. However, we did not find evidence of any hospital physician personally seeing the patients as required by the Medicare Manuals.

APPENDICES

APPENDIX A

STATISTICAL SAMPLE SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. The total number of errors per diagnosis is greater than the number of beneficiaries with errors, as some beneficiaries had more than one type of error. The 30 beneficiaries reviewed were part of a multistate statistical sample. The results from our sample will be included in a multistate estimate of Medicare errors for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

Table 1. Summary of Errors by Beneficiary Diagnosis and Type of Error

Number of Sampled Beneficiaries with Diagnosis	Number of Sampled Beneficiaries with Errors	Medicare Covered Diagnosis	Beneficiaries Not Having Medical Documentation Supporting the Medicare Covered Diagnosis	Units Billed Exceed Limits	Total Errors per Diagnosis
1	1	**Myocardial Infarction**	0	1	1
23	17	**Coronary Artery Bypass Graft**	0	17	17
5	4	**Stable Angina**	4	1	5
1	0	**None**	0	0	0
30	**22**	**Total**	**4**	**19**	**23**

APPENDIX B

SAMPLING AND UNIVERSE DATA AND METHODOLOGY

We randomly selected a sample of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. For each beneficiary, we obtained all Medicare claims reimbursement data for outpatient cardiac rehabilitation services and compared this data to the Hospital's outpatient cardiac rehabilitation service documentation. In addition, we determined whether the diagnoses identified on each beneficiary's inpatient medical records, the referring physician's medical records and referral, and the Hospital's outpatient cardiac rehabilitation service records supported the Medicare claims.

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

Table 1. Calendar Year 2001 Outpatient Cardiac Rehabilitation Service Universe and Sampling Data and Error Value

Universe	Population Value	Sample Size	Sample Value	Sampled Beneficiaries with Errors	Sample Errors Value
72	$26,649	30	$12,001	22	$2,003

September 17, 2003

Charles J. Curtis
Regional Inspector General for Audit Services
Region IV – Office of Inspector General
U.S. Department of Health and Human Services
61 Forsythe Street, S.W. Suite 3T41
Atlanta, GA 30303

RE: Audit Report No..A-04-03-01005

Dear Mr. Curtis:

This letter is written in response to your letter dated, August 2003, in which you requested our written comments to your office's draft report entitled, "Review of Outpatient Cardiac Rehabilitation Services – Central Florida Regional Hospital".

Based on your recommendations, Central Florida Regional Hospital will work with our Fiscal Intermediary (First Coast), to accomplish the following:

- ensure that our outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services provided "incident to" a physician's professional service and,
- to establish the amount of repayment liability for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable.

Our cardiac rehabilitation staff members have implemented controls to ensure that only one unit of service per beneficiary is billed for each cardiac rehabilitation session. CFRH also utilizes a continuous monitoring process to ensure that requirements under the Cardiac Rehabilitation LMRP are met in regards to appropriate billing. The monitoring process involves a team of staff members, and the Cardiac Rehabilitation Program Manager is included as a team member.

We appreciate the opportunity to make further comments relating to Central Florida Regional Hospital's Outpatient Cardiac Rehabilitation Program. The draft report states that "no documentation to support physician supervision during exercise sessions" was found; yet, Medicare's policy states that direct physician supervision is assumed to be met in an outpatient hospital department. We could not find nor obtain confirmation that specific documentation is required by Medicare. Medicare policy

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Charles J. Curtis, Regional Inspector
General for Audit Services
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September 17, 2003

further states, "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 also states that a physician is not required to be physically present in the exercise room itself.

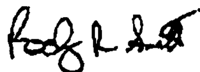
In the Medicare coverage policy, services considered under the "incident to" benefit must be furnished as an integral, although incidental part of the physician's professional service in the course of diagnosis or treatment of an illness or injury. It goes further to state that during any course of treatment 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. Your audit report (page 5) recognizes that CFRH has a process in place to notify the Medical Director and the referring physician of the patients' progress and of patient events that require intervention. While this process may not have always been followed, no specific guidelines for expected documentation is mentioned in the coverage policy.

CFRH's Outpatient Cardiac Rehabilitation Program department staff communicates with each referring physician (at the start, mid-point and end of the treatment plan) to review policy and procedure, provide general oversight for daily operation, and perform as a resource for clinical concerns. Patient concerns are addressed as they arise and the referring physician advised of any potential issues or concerns.

We believe we have adequate processes and systems in place to meet the physician supervision and incident to requirements. However, as you have suggested and as we have previously indicated, we will work with First Coast on both these issues.

We enjoyed the opportunity to participate in this nation-wide audit. Should you have any questions, please do not hesitate to contact me.

Sincerely,



Rodney R. Smith, Chief Executive Officer
Central Florida Regional Hospital

RRS/aj