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NOV 12 2003

Report Number: A-01-03-00507

Mr. Thomas Pipicelli
President and Chief Executive Officer
The William W. Backus Hospital
326 Washington Street
Norwich, Connecticut 06360

Dear Mr. Pipicelli:

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

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

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To facilitate identification, please refer to Report Number A-01-03-00507 in all correspondence relating to this report.

Sincerely yours,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

James Kerr
Regional Administrator
Centers for Medicare and Medicaid Services
26 Federal Plaza, Room 3811
New York, New York 10278-0063

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT CARDIAC REHABILITATION SERVICES AT THE WILLIAM W. BACKUS HOSPITAL

NOVEMBER 2003
A-01-03-00507

Office of Inspector General

http://oig.hhs.gov

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

EXECUTIVE SUMMARY

BACKGROUND

This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the Administrator of the Centers for Medicare & 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 William W. Backus Hospital (Hospital) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- 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 REVIEW

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

In addition, we reviewed the medical and billing records for a sample of 10 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001. We found that medical records provided by the Hospital in support of three beneficiaries receiving cardiac rehabilitation services did not fully support a covered Medicare diagnosis. Specifically, we were unable to determine whether $1,307 in payments for beneficiaries billed with a stable angina pectoris diagnosis met Medicare coverage requirements.

We attribute these questionable services to weaknesses in the Hospital's internal controls and oversight procedures. Our determinations regarding Medicare covered diagnoses were based solely on our review of the medical record documentation. The medical records have not yet been reviewed by fiscal intermediary (FI) staff. We believe that the Hospital's FI, Empire Medicare Services, should make a determination as to the allowability of the $1,307 in Medicare payments made on behalf of the three beneficiaries with questionable diagnoses. The errors and Medicare payments are part of a larger nationwide review of outpatient cardiac rehabilitation service claims and may be included in a nationwide roll-up report of all providers reviewed.

RECOMMENDATIONS

We recommend that the Hospital:

- Work with its Medicare FI to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for (1) direct physician supervision and (2) services provided "incident to" a physician's professional service, and

- Work with its Medicare FI in clarifying the diagnoses and supporting medical record documentation required for Medicare coverage of outpatient cardiac rehabilitation services and in determining the allowability of $1,307 in Medicare payments identified within this report.

AUDITEE COMMENTS AND OIG RESPONSE

In response to our draft report (see APPENDIX), the Hospital generally agreed with our recommendations to work with the FI in ensuring that its program meets Medicare requirements for the issues identified in our report. The Hospital has implemented procedures and plans additional procedures to improve its documentation of direct physician supervision. However, the Hospital stated that it meets the physician supervision requirement by virtue of its cardiac rehabilitation services being provided on Hospital premises. We acknowledge that the Medicare Intermediary Manual states that the physician supervision requirement is generally assumed to be met where outpatient therapeutic services are performed on hospital premises. However, the Medicare Coverage Issues Manual, section 35-25, more specifically requires that the services of nonphysician personnel be furnished under the direct supervision of a physician.

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INTRODUCTION

BACKGROUND

MEDICARE COVERAGE

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

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

Cardiac rehabilitation is provided by nonphysician personnel, who are trained in both basic and advanced life support techniques and exercise therapy for coronary disease, under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise area and immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require a physician to be physically present in the exercise room itself. For outpatient 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 Empire Medicare Services. For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 102 Medicare beneficiaries and received $30,942 in Medicare reimbursements for these services.

OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

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

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

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

SCOPE

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

The Hospital review included 10 of the 102 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 10 beneficiaries during CY 2001.

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

METHODOLOGY

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

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

record. In addition, we determined if Medicare reimbursed the Hospital beyond the maximum number of services allowed.

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

The Hospital's comments to our draft report are appended to this report (see APPENDIX).

RESULTS OF REVIEW

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

In addition, we reviewed the medical and billing records for a sample of 10 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001. We found that medical records provided by the Hospital in support of three beneficiaries receiving cardiac rehabilitation services did not fully support a covered Medicare diagnosis. Specifically, we were unable to determine whether $1,307 in payments for beneficiaries billed with a stable angina pectoris diagnosis met 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 the Medicare FI staff. We believe that the Hospital's FI should make a determination as to the allowability of the Medicare claims and appropriate recovery action.

The results of our audit are discussed in detail below.

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.

The Hospital's cardiac rehabilitation facility is located within the Hospital. We found that while no physician is permanently assigned to the exercise room, the Hospital stated that it meets the direct physician supervision requirement by having physicians accessible on call or available from its emergency or telemetry departments. According to the Hospital, a physician is available for any emergencies for all hours the cardiac rehabilitation program operates.

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

"INCIDENT TO" PHYSICIAN SERVICES

Medicare covers Phase II cardiac rehabilitation under the "incident to" a physician's professional service 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.

At the Hospital, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." The Hospital's written policies and procedures for its outpatient cardiac rehabilitation program require its medical director to perform "…a retrospective evaluation of the program. A routine examination of the Progress Notes/Flow Sheets will be carried out by him." According to the Hospital, cardiac rehabilitation staff hold monthly meetings with the medical director and patients' referring physicians are updated on patient progress monthly. While such meetings and reports may have come about, we did not find documentation to support such encounters in the patients' medical records. Further, we did not see evidence that the medical director or other Hospital physician personally saw the patient at any time during the patients' course of cardiac rehabilitation to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program. Accordingly, we believe that the Hospital's cardiac rehabilitation program did not meet the requirements to provide an "incident to" service.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

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

reimburses providers for Phase II outpatient cardiac rehabilitation services and allows one unit of service to be billed per cardiac rehabilitation session. Documentation for these services must be maintained in the patients' medical records.

We reviewed the medical and billing records of a judgmental sample of 10 Medicare beneficiaries receiving outpatient cardiac rehabilitation services at the Hospital during CY 2001. In order to determine whether the patient had a covered diagnosis, we compared the covered diagnosis submitted with the Medicare bill to medical record documentation such as stress test results, cardiac rehabilitation program notes, referring physician records and inpatient records. Seven of the Medicare beneficiaries reviewed had covered diagnoses properly supported in the patient's medical records. However, the remaining three cases in our sample, totaling $1,307 in payments, were patients whose services were billed with a stable angina pectoris diagnosis on the Medicare claim form. In one case, the patient also underwent an angioplasty procedure with stent placement prior to cardiac rehabilitation. It was unclear from the medical records whether stable angina pectoris was present post procedure at the start of cardiac rehabilitation therapy. Likewise, the other two patients were admitted to the program with a stable angina pectoris diagnosis. While the medical records for both patients showed a history of coronary artery disease, it was also unclear whether the symptoms of stable angina pectoris were evident when the patient began the program.

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

The results of our review may be included in a nationwide roll-up report identifying Medicare reimbursements for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

RECOMMENDATIONS

We recommend that the Hospital:

- Work with its Medicare FI to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for (1) direct physician supervision and (2) services provided "incident to" a physician's professional service, and

- Work with its Medicare FI in clarifying the diagnoses and supporting medical record documentation required for Medicare coverage of outpatient cardiac rehabilitation services and in determining the allowability of the $1,307 in Medicare payments identified within this report.

AUDITEE COMMENTS

In its October 13, 2003 comments to our draft report (see APPENDIX), the Hospital generally agreed with our recommendations to work with its Medicare FI in resolving the issues identified in our report. However, the Hospital provided comments addressing our recommendations.

With respect to direct physician supervision, the Hospital stated that while its records did not document physician contacts with the cardiac rehabilitation department, such contacts occur frequently. The Hospital has addressed this documentation issue by maintaining a log of physician contacts, developing a hospital-wide information system, and requesting documentation of subsequent patient visits to their physicians. Nevertheless, the Hospital did affirm that it has met the physician supervision requirement because its outpatient cardiac rehabilitation program is located on hospital premises.

In regard to our identification of cardiac rehabilitation services provided to three patients with noncovered diagnoses, the Hospital stated that it believed that these patients' diagnoses met Medicare coverage requirements. However, the Hospital recognized that there may be documentation or other errors that may make the records in question inappropriate. The Hospital expressed interest in working with its Medicare FI in resolving this issue for each specific patient identified.

OIG RESPONSE

We commend the Hospital for its corrective actions taken and its intentions to work with its Medicare FI to assure that its outpatient cardiac rehabilitation program meets Medicare requirements.

With regard to the Hospital's physician supervision 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 services of nonphysician personnel be furnished under the direct supervision of a physician. Accordingly, we could not conclude that the Hospital's reliance on on-call physicians and/or emergency or telemetry physicians met the "direct" supervision requirement specific to cardiac rehabilitation programs.

A P P E N D I X

The William W. Backus Hospital

October 13, 2003

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

Dear Mr. Armstrong:

Please consider this letter the formal response of The William W. Backus Hospital to your draft report entitled "Review of Outpatient Cardiac Rehabilitation Services at The William W. Backus Hospital." We appreciate being given the opportunity to provide you with our written comments regarding your draft report and regarding actions taken or contemplated on your recommendations.

We will respond to your two recommendations in order:

1. Recommendation 1. *"Work with its Medicare FI to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for (1) direct physician supervision and (2) services provided "incident to" a physician's professional service."*

   With respect to "direct physician supervision" we would state that although our records within the cardiac rehab department failed to note when a patient's physician came to the department, or was telephoned by the department or telephoned directly to the department for information regarding a patient, this in fact occurs on a several times a day basis. The majority of patients referred to our program are treated by Cardiology Associates, a group practice that has six of the seven community cardiologists, including the Director of Cardiology, Dr. James Healy. Dr. Healy indicates that he and other members of his group regularly communicate with the cardiac rehabilitation program regarding not only its patients, but with respect to patients referred by other physicians who utilize Cardiology Associates as a referral base. Dr. Healy indicates that generally several times a day physicians in his group or other physicians who refer to the Cardiac Rehabilitation program here are in communication with our program.

We have not done a good job of documenting physician on-going relationships with respect to referred patients. To that end, we have already begun (effective October 6, 2003) documenting in a log kept within the Cardiac Rehabilitation Program when each physician comes in or calls. Likewise, documentation is made of calls from the program to physicians' offices with respect to questions regarding patients. This will also be documented in each appropriate patient record. We will also document each time any patient goes to another department in the hospital to do an event.

We are moving to a hospital-wide information system (Meditech) through which emergency department visits will be easily obtained with a diagnosis and what lab work was completed on each patient. Likewise, cardiac catherization reports will be easily obtained in the future.

Additionally, we intend to implement having the physician offices send us documentation on any subsequent visits for the appropriate patient records.

Finally, we would like to reaffirm the background statement made in your introduction to the effect that "The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises." As you know, our outpatient cardiac rehabilitation program is located on the hospital premises, and therefore it would appear that we do meet the requirement of direct physician supervision. Nonetheless, we do intend to improve our documentation and will work with our physicians to gain their assistance in improving our documentation of their continuing involvement with our cardiac rehabilitation patients.

2. Recommendation 2. *"Work with its Medicare FI in clarifying the diagnoses and supporting medical record documentation required fro Medicare coverage of outpatient cardiac rehabilitation services and in determining the allowability of $1,307 in Medicare payments identified within this report.*

We will certainly work with our Medicare Fiscal Intermediary in clarifying the diagnosis and supporting medical records for the three unnamed beneficiaries receiving cardiac rehabilitation services determined not to fully support a covered Medicare diagnosis. We have requested Dr. Healy to review the stable angina pectoris diagnosis (four patients) of the 10 beneficiaries whose records were reviewed. Dr. Healy is personally aware of the cases of two of the four beneficiaries, and it is his opinion that each of these does meet Medicare coverage requirements. However, we recognize that there could be documentation errors in either of these two cases or other errors that might make all or some of the three records that are questioned inappropriate. We look forward to working with the Fiscal Intermediary to try to answer any questions they may have with respect to each specific patient.

Likewise, we look forward to the opportunity to learn from our discussions with the Fiscal Intermediary if there are better ways for us to document services being appropriately provided in order to assure that each Medicare payment we receive is appropriate.

Again, we thank you for the opportunity to address your draft report and we look forward to working with you and your office as you complete your view of our cardiac rehabilitation program.

Sincerely,

Richard H. Finley
Vice President, Legal Affairs

Cc: Thomas P. Pipicelli, President & CEO
Daniel E. Lohr, Senior Vice President & CFO
Mark A. Santamaria, COO
James Healy, MD, Director of Cardiology

ACKNOWLEDGMENTS

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

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