DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services
Region I
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Boston, MA 02203
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DEC 2 6 2003

Report Number: A-01-03-00516

Mr. Craig Melin
President and Chief Executive Officer
Cooley Dickinson Hospital
30 Locust Street
Northampton, Massachusetts 01061

Dear Mr. Melin:

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 Cooley Dickinson 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-01-03-00516 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:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT CARDIAC REHABILITATION SERVICES AT THE COOLEY DICKINSON HOSPITAL

DECEMBER 2003
A-01-03-00516

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 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 the Cooley Dickinson 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 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, the 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 15 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001. We found that medical records provided by the Hospital in support of seven beneficiaries receiving cardiac rehabilitation services, totaling $1,656 in Medicare payments, did not fully support a covered Medicare diagnosis. These cases included four patients with insufficiently supported stable angina diagnoses and three patients with a noncovered chronic pulmonary obstruction diagnosis.

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, Associated Hospital Service, should make a determination as to the allowability of the $1,656 in Medicare payments made on behalf of the seven beneficiaries. 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 $1,656 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 believes, however, that its program meets the requirements for physician supervision and the "incident to" a physician's service provisions. Nevertheless, the Hospital has agreed to resolve these issues with the FI and develop improved documentation policies on physician involvement in the program. The Hospital also stated that its medical director believes that the four cases we identified as not having a Medicare covered diagnosis were properly diagnosed with angina pectoris. The Hospital agreed, however, to discuss these cases with the FI.

We commend the Hospital for its implementation of new documentation requirements and its intentions to work with the FI to assure that its outpatient cardiac rehabilitation program meets Medicare requirements.

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INTRODUCTION

BACKGROUND

Medicare Coverage

The Medicare program, established by title XVIII of the Social Security Act (Act), provides health insurance to individuals aged 65 and over, the disabled, individuals with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the 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 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 Associated Hospital Service. During CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 79 Medicare beneficiaries and received $21,292 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.

- 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 15 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 15 of the 78 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 15 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 Northampton, Massachusetts during July 2003.

The Hospital's response to our draft report is 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, from our specific claims review for a sample of 15 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that medical records provided by the Hospital in support of seven beneficiaries receiving cardiac rehabilitation services, totaling $1,656 in Medicare payments, did not fully support a covered Medicare diagnosis.

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 a physician available

in the cardiac stress test lab adjacent to the cardiac rehabilitation exercise area. According to the Hospital, a physician is available for any emergencies for all hours the cardiac rehabilitation program operates. Emergency department physicians are also available as needed.

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

"INCIDENT TO" PHYSICIAN SERVICES

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 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.

Patients referred to the Hospital's outpatient cardiac rehabilitation program are evaluated by either a registered nurse or exercise specialist and prescribed an individualized treatment plan for exercise training and cardiac risk factor reduction education and counseling. The treatment plan is signed and approved by the medical director of the program.

According to cardiac rehabilitation staff, the medical director attends weekly staff meetings to review individual patient records. Also, the physician is available to staff, as needed, for consultations on individual patient cases. In addition, patients' referring physicians are updated on the patient's progress periodically including if any problems arise during treatment. However, we did not see evidence that the medical director or other Hospital physician personally saw the patients at any time during their course of cardiac rehabilitation to assess their course of treatment and 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 reimbursed the Hospital for outpatient cardiac rehabilitation services when 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 15 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 diagnosis submitted with the Medicare bill to medical record documentation such as stress test results, cardiac rehabilitation program notes, referring physician records and inpatient records. Eight of the Medicare beneficiaries reviewed had covered diagnoses properly supported in each patient's medical records. However, the remaining seven cases in our sample, totaling $1,656 in payments, were for patients whose medical record documentation did not support a covered diagnosis for Medicare reimbursement of outpatient cardiac rehabilitation services. Specifically, we found:

- $1,607 for four beneficiaries whose diagnoses of stable angina were not sufficiently supported by medical record documentation. Such documentation was unclear in providing evidence that stable angina existed at the time of cardiac rehabilitation. For two of these beneficiaries, medical records did not identify any history of stable angina.

- $49 for three beneficiaries for which the Hospital erroneously billed Medicare for cardiac rehabilitation services with a noncovered diagnosis of chronic pulmonary obstruction. The Hospital attributed these errors to a miscoding error for these three patients enrolled in the Hospital's pulmonary rehabilitation 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 four beneficiaries identified with stable angina, determine the allowability of the claims submitted and take appropriate action. Further, the FI should recoup the Medicare payments made under a noncovered diagnosis.

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 $1,656 in Medicare payments identified within this report.

AUDITEE COMMENTS

In its November 24, 2003 response 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. In addition, the Hospital provided comments addressing our report findings.

With regard to the physician supervision requirement, the Hospital stated that its program conforms with CMS requirements for direct physician supervision by having a physician available in the adjacent cardiac stress lab for all hours the program operates and that its emergency department physicians are also available as needed. While the Hospital believes that it is providing safe care and acting in accordance with the requirements, it has agreed to work with the FI in clarifying this issue.

In response to the "incident to" physician services requirement, the Hospital stated that its medical director, a board certified cardiologist, is involved in the various aspects of the cardiac rehabilitation program, including reviewing and signing treatment plans, attending staff meetings to review individual patient records and modifying any changes to treatment plans, and being available to staff throughout the course of treatment to consult on individual patient cases. Patients' referring physicians are updated periodically on patient progress and when any problems arise. The Hospital believes it provides safe care and is acting in accordance with requirements. However, the Hospital has changed its documentation policy to include documentation of physician reviews and interactions.

The Hospital stated that its medical director believes that the four cases we identified as not having a Medicare covered diagnosis were properly diagnosed with angina pectoris. The medical director stated that the diagnosis of angina pectoris is dependent on physician judgment. The Hospital further stated that, given the effectiveness of medications available today, patients may not have characteristic symptoms on exertion at the time they present for the cardiac rehabilitation program. However, the Hospital stated that it will contact the FI to clarify the diagnoses and supporting medical record documentation.

The Hospital concurred with our finding of three cases involving billing errors. The Hospital will discuss this with the FI and plans to implement upfront claims edits to prevent such errors in the future.

OIG RESPONSE

We commend the Hospital for its implementation of new documentation requirements and its intentions to work with the FI to assure that its outpatient cardiac rehabilitation program meets Medicare requirements. With regard to the Hospital's response regarding our identification of four patients not having a Medicare covered diagnosis, we relied upon the following definition of stable angina pectoris when reviewing the Hospital's medical record documentation and identifying our findings:

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

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

We continue to believe that the Hospital should work with the FI to determine the allowability of these cardiac rehabilitation services and the proper recovery action to be taken.

A P P E N D I X

COOLEY DICKINSON HOSPITAL

DARTMOUTH-HITCHCOCK ALLIANCE

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

November 24, 2003

Re: Report Number A –01-03-00516

Dear Mr. Armstrong:

This letter is written in response to your letter dated October 21, 2003 transmitting a draft report entitled "Review of Outpatient Cardiac Rehabilitation Services at the Cooley Dickinson Hospital". We appreciate the opportunity to submit this response wherein we discuss the findings and recommendations in your draft report. At this time, I would like also reference our October 21, 2003 letter to you, copy attached, wherein we advise you that we have received approval to submit our response by December 1, 2003.

Following is a discussion of your findings/recommendations and our comments:

Direct Physician Supervision:

The report indicates that there is a requirement for direct supervision and that this 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 report goes on to say that the physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.

> Comment: As is noted in the draft report, we believe that we meet the direct physician supervision requirement by having a physician available in the cardiac stress test lab adjacent to the cardiac rehabilitation exercise area for all hours the cardiac rehabilitation program operates. Emergency department physicians are also available as needed.
>
> The statements in the report regarding direct supervision appear to be contradictory. As suggested in the report, we will work with the FI to ensure that the reliance placed on nearby physicians and emergency department physicians to provide supervision conforms to the requirements. However, we do believe that we are providing safe care and are acting in accordance with the requirement.

"Incident To" Physician Services:

The report indicates that Medicare covers Phase II cardiac rehabilitation under the "incident to" benefits and that, 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. The report goes on to say 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.

The report indicates that medical record documentation examined showed little evidence that a physician personally sees a patient periodically and that the hospital's cardiac rehabilitation program did not meet the requirements to provide an "incident to" service. The report asks us to work with the FI to ensure that the cardiac rehabilitation program is being conducted in accordance the requirements for services provided "incident to" a physician's service.

> Comment: The medical director of the program, a board certified cardiologist, reviews and signs all treatment plans. The medical director attends weekly staff meetings to review individual patient records and is directly involved in any case requiring modification of the treatment plan and documents accordingly. Throughout the course of the sessions, the medical director is available to staff, as needed, for consultations on individual

patient cases. Also, patients' referring physicians are updated on the patient's progress periodically, as well as being advised of any problems that arise during treatment.

We believe that we have been providing safe care and are acting in accordance with the requirement. However, we acknowledge your concern (expressed in this letter and also during the course of the audit) and have changed our documentation policy to include documentation of the physician reviews/ interactions. Please see the enclosed Medical Director Review Sheet. We have been using it since mid October.

We will contact the FI and have the recommended discussion.

Medicare Covered Diagnoses and Documentation:

The report indicates that there were four patients whose medical records did not sufficiently support a diagnosis of stable angina.

Comment: Our medical director believes that the diagnosis of angina pectoris is a clinical diagnosis based primarily on the patient's history. He tells us there is no diagnostic test that reliably establishes the diagnosis. This means that the diagnosis is dependent on physician judgment. The referring physician has evaluated all patients treated in our program. Treatment is not provided without a written referral including the patient's diagnosis and a signed order for care. He indicates that the standard of care for stable angina includes intensive medication management. Given the effectiveness of the medications available today, patients may not have characteristic symptoms on exertion at the time they present for the rehabilitation program. Even in such instances, he believes the diagnosis of angina pectoris remains appropriate.

We will contact the FI to clarify the diagnoses and supporting medical record documentation.

The report indicates that $49 worth of services was billed erroneously as cardiac rehabilitation services instead of the correct pulmonary rehabilitation services.

Comment: We concur with this finding and will discuss it with the FI. In addition, we plan to implement an upfront claims edit, which will prevent such errors in the future.

Thank you for the opportunity to comment on this draft report. Please call me if you have any questions. I can be reached at 413 582-2243.

Sincerely yours,

Edith Peter
Vice President/CFO

cc: Craig Melin
President/CEO

Cooley Dickinson Hospital
Cardiac Rehabilitation Department

MEDICAL DIRECTOR REVIEW SHEET

Patient Name: _____

	Review Date	Initials
☐ **Clearance to participate in program: Assessment reviewed, patient appropriate for program, medical history reviewed**	_____	_____
☐ **Initial treatment plan and exercise prescription reviewed**	_____	_____
☐ **Adjust treatment plan & exercise prescription(if indicated)**	_____	_____
☐ **Rhythm strip review if change from baseline**	_____	_____
	_____	_____
	_____	_____
☐ **Progress review/assessment of response to treatment plan**	_____	_____
	_____	_____
_____	_____	_____
☐ **Walk through rounds & patient reviews**	_____	_____
	_____	_____
☐ **Discharge summary & progress review**	_____	_____
☐ **Other**		
_____	_____	_____

Signature/Initials

Med Dir rev sheet

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:

Robert Champagne, ***Audit Manager***
Gregory Pasko, ***Senior Auditor***
John Bergeron, ***Auditor***
Maryann Volz, ***Program Analyst***

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