DEPARTMENT OF HEALTH & HUMAN SERVICES REGION III

Memorandum

Date NOV 2 0 2003

From Regional Inspector General for Audit Services

Subject Audit Report – REVIEW OF OUTPATIENT CARDIAC REHABILITATION SERVICES AT HOLY CROSS HOSPITAL, SILVER SPRING, MARYLAND (Report Number A-03-03-00007)

To

Sonia A. Madison
Regional Administrator
Centers for Medicare & Medicaid Services

Attached are two copies of the Department of Health and Human Services (HHS), Office of Inspector General's report entitled "Review of Outpatient Cardiac Rehabilitation Services at Holy Cross Hospital, Silver Spring, Maryland." This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The objectives of our review were to ascertain whether Holy Cross Hospital's (Holy Cross) policies and procedures complied with Medicare requirements and whether Medicare properly reimbursed Holy Cross for outpatient cardiac rehabilitation services. Should you have any questions or comments concerning the matters commented on in this report, please contact me or have your staff contact Eugene Berti, Audit Manager at 215-861-4474.

To facilitate identification, please refer to Report Number A-03-03-00007 in all correspondence relating to this report.

Stephen Virbitsky

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

NOV 20 2003

Report Number: A-03-03-00007

Kevin Sexton
President and Chief Executive Officer
Holy Cross Hospital
1500 Forest Glen Road
Silver Spring, Maryland 20910-1484

Dear Mr. Sexton:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General's report entitled "Review of Outpatient Cardiac Rehabilitation Services at Holy Cross Hospital, Silver Spring, Maryland." This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The objectives of our review were to ascertain whether Holy Cross Hospital's (Holy Cross) policies and procedures complied with Medicare requirements and whether Medicare properly reimbursed Holy Cross for outpatient cardiac rehabilitation services. Should you have any questions or comments concerning the matters commented on in this report, please direct them to the HHS official named below.

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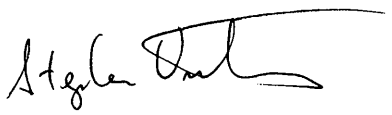
To facilitate identification, please refer to Report Number A-03-03-00007 in all correspondence relating to this report.

Sincerely yours,



Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:
Ms. Sonia Madison
Regional Administrator
Centers for Medicare & Medicaid Services, Region III
Public Ledger Building, Suite 216
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT CARDIAC REHABILITATION SERVICES AT HOLY CROSS HOSPITAL, SILVER SPRING, MARYLAND

NOVEMBER 2003
A-03-03-00007

Office of Inspector General

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the Administrator of the Centers for Medicare & Medicaid Services (CMS) to determine the level of provider compliance with national Medicare outpatient cardiac rehabilitation policies.

OBJECTIVE

The overall objective of our review was to determine whether Medicare properly reimbursed Holy Cross Hospital (Holy Cross) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- Holy Cross' policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, "incident to" services, and Medicare covered diagnoses, and

- Payments to Holy Cross 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

Holy Cross met Medicare's requirements for (1) direct physician supervision and (2) providing "incident to" services. Specifically, Holy Cross contracted with two physicians to directly supervise the services provided by its cardiac rehabilitation program. The physicians' responsibilities included the daily supervision of the cardiac center, patients' initial physical assessment, approval of cardiac rehabilitation treatment plans, and observation of patients' daily progress. One of the physicians was always in the exercise area during regularly scheduled exercise sessions.

In addition, from our specific claims review for a sample of 30 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that Holy Cross received Medicare payments of $7,470 for:

- Services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (10 beneficiaries);
- Services exceeding 36 sessions (2 beneficiaries);
- Duplicate claims for a service for a single cardiac rehabilitation session (1 beneficiary);
- Services for which Holy Cross' medical records did not contain a physician referral (1 beneficiary);
- Services for which Holy Cross' medical records did not contain documentation (3 beneficiaries); and

- Services for which Holy Cross' medical records did not contain electrocardiogram strips or an exercise flow sheet (15 beneficiaries).

The sample errors and Medicare payments are part of a larger statistical sample and will be included in the multistate projection of outpatient cardiac rehabilitation service claims not meeting Medicare coverage requirements.

We attribute these questionable services to weaknesses in Holy Cross' internal controls and oversight procedures. Most notably, Holy Cross did not consistently ensure that beneficiaries had a Medicare covered diagnosis supported by the referring physicians' medical records, that supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained, and that the covered diagnoses were adequately supported in the medical records.

Our determinations regarding Medicare covered diagnoses were based solely on our review of medical record documentation. We believe that Holy Cross' fiscal intermediary (FI), Mutual of Omaha (Mutual), should make a determination as to the allowability of the Medicare claims and appropriate recovery action.

RECOMMENDATIONS

We recommend that Holy Cross:

- Work with Mutual to establish the amount of repayment liability, estimated to be $7,470, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable and

- Enhance existing policies to ensure that (1) medical record documentation is obtained and maintained to support Medicare outpatient cardiac rehabilitation services and (2) cardiac rehabilitation staff bill only for Phase II cardiac rehabilitation services rendered.

AUDITEE'S COMMENTS

Holy Cross agreed to work with its staff to ensure that patients' Medicare diagnoses are appropriately documented, reinforce the need to maintain referral documentation in the patients' files, and emphasize the importance of maintaining all appropriate documentation for services. However, Holy Cross generally disagreed with our findings and recommendations and raised concerns related to the amount of the estimated liability. Holy Cross asserted that (1) most of the Medicare covered diagnoses were supported in the medical records and (2) additional services were provided for which payments have not been received. Holy Cross' comments are included as APPENDIX B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We reviewed Holy Cross' comments and made limited adjustments to our findings and recommendations. We continue to recommend that Holy Cross work with Mutual to address the claims that we believe may be unsupported by medical documentation or that are otherwise unallowable. As discussed in this report and in Holy Cross' comments, medical personnel did not validate our audit conclusions; therefore, we recommended Holy Cross work with Mutual to determine whether the questioned claims warrant repayment. Additionally, we acknowledge that our paid claims data did not include payments for many services for which we observed documentation, but our audit objective was to determine whether *payments* to Holy Cross were appropriate, not whether *services rendered* were billed and appropriate.

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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. Medicare coverage of outpatient cardiac rehabilitation programs 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.

- 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. However, since 1977 Maryland's hospitals have operated under a waiver from Medicare's reimbursement methodology for hospital services. Under the waiver, Medicare reimburses Maryland hospitals on the basis of rates set by the State's Health Services Cost Review Commission. The FI for Holy Cross is Mutual. For CY 2001, Holy Cross provided outpatient cardiac rehabilitation services to 81 Medicare beneficiaries and received $109,498 in Medicare reimbursement 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 Holy Cross for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- Holy Cross' policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, "incident to" services, and Medicare covered diagnoses; and

- Payments to Holy Cross 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 Holy Cross' policies and procedures and interviewed staff to gain an understanding of its management of Holy Cross' outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. In addition, we reviewed Holy Cross' cardiac rehabilitation services documentation, hospital medical records, referring physician supporting medical records and referrals, and Medicare reimbursement data for a statistical sample of beneficiaries who received outpatient cardiac rehabilitation services from Holy Cross during CY 2001 as part of a multistate statistical sample. We reviewed Holy Cross' outpatient cardiac rehabilitation procedures for and controls over physician supervision, cardiac rehabilitation staffing, maintenance and availability of advanced cardiac life support (ACLS) equipment, and documentation of services provided to beneficiaries and paid by Medicare.

The sample included 30 of 81 Medicare beneficiaries who received outpatient cardiac rehabilitation services from Holy Cross 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 Holy Cross' policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and the FI's Local Medical Review Policy and identified any differences. We documented how Holy Cross' staff provided direct physician supervision for cardiac rehabilitation services and verified that Holy Cross' cardiac rehabilitation program personnel were qualified in accordance with Medicare requirements. We also verified the availability of ACLS 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 Holy Cross' 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 hospital medical record, the referring physician's medical record and referral (for beneficiaries with angina or no readily identifiable Medicare covered diagnosis), and Holy Cross' outpatient cardiac rehabilitation medical record. In addition, we verified that Medicare did not reimburse Holy Cross beyond the maximum number of services allowed.

The medical records have not yet been reviewed by FI staff. In accordance with the intent of CMS's request for a nationwide analysis, we determined the extent to which providers were currently complying with existing Medicare coverage requirements.

We performed our fieldwork at Holy Cross, Silver Spring, Maryland and the Philadelphia Regional Office between March and July 2003.

RESULTS OF AUDIT

Holy Cross met Medicare's requirements for (1) direct physician supervision and (2) providing "incident to" services. Specifically, Holy Cross contracted with two physicians to directly supervise the services provided by its cardiac rehabilitation program staff. The physicians' responsibilities included the daily supervision of the Holy Cross' Cardiac Enhancement Center (CEC), patients' initial physical assessments, approval of cardiac rehabilitation treatment plans, and observation of patients' daily progress. One of the physicians was always in the exercise area during regularly scheduled exercise sessions.

In addition, from our specific claims review for a sample of 30 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that Holy Cross received Medicare payments of $7,470 for:

- Services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (10 beneficiaries);
- Services exceeding 36 sessions (2 beneficiaries);
- Duplicate claims for a service for a single cardiac rehabilitation session (1 beneficiary);
- Services for which Holy Cross' medical records did not contain a physician referral (1 beneficiary);
- Services for which Holy Cross' medical records did not contain documentation (3 beneficiaries); and
- Services for which the Holy Cross' medical records did not contain electrocardiogram (ECG) strips or an exercise flow sheet (15 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 when the outpatient therapeutic services are performed on hospital premises. However, if the services are furnished outside the hospital, they must be rendered under the direct personal supervision of a physician who is treating the patient.

Because the Holy Cross CEC provides its services outside the hospital, it contracts with two physicians to directly supervise the cardiac rehabilitation program during regularly scheduled exercise sessions. According to Holy Cross' policies, a physician (and at least one registered nurse) must be on-site during exercise sessions. During our fieldwork, we observed that a physician was in the facility at all times Phase II exercise sessions were being conducted. We also obtained the CY 2001 physician schedule that documented which physician was scheduled

to be in the facility. Holy Cross had a physician scheduled everyday the Phase II sessions were scheduled.

The physicians were immediately available and accessible for an emergency at all times because during exercise hours, the physicians were either in the exercise area or in their office located within the exercise area. Holy Cross' policies stated that in the event of an emergency (a patient is declared unstable), the registered nurse will notify the on-site physician who is responsible for determining treatment based on ACLS guidelines. We obtained documentation of a CY 2001 emergency event. We found that the beneficiary began to feel dizzy and her heart rate slowed dramatically. The records indicated that the physician on-duty evaluated and stabilized the patient and called for an ambulance.

Holy Cross met Medicare's direct physician supervision requirement by having a doctor on-site during exercise hours. Accordingly, we are not making a recommendation to Holy Cross regarding direct physician supervision. However, direct physician supervision requirements will be addressed in a national summary report to CMS.

"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, the patient's progress and, where necessary, to change the treatment program.

At Holy Cross, the contracted physicians personally saw the patients throughout the exercise program, beginning with the orientation. According to Holy Cross' policies, during the orientation, one of the registered nurses performs a history and physical of the patient including demographic information, cardiovascular history, risk factors, and medications. During this time, the on-site physician meets with the patient to discuss history and current symptoms and conducts a physical examination. The physician then signs the physical assessment. Although we did not observe a new patient orientation, we validated that the physician participated in the orientation by the physicians' notes and signatures on the assessments.

During the exercise program, the on-site physician visited with the patients each time they exercised as he walked through the CEC. When the physician was not visiting with patients, he was either in the physicians' office just off the main exercise area or seated at the monitoring station located in the middle of the CEC. Additionally, according to the physicians' position descriptions, each time the patient exercises at the CEC, the physician on-duty reviews and initials the patients' exercise flow sheets. We reviewed the 30 sampled beneficiaries' flow sheets and determined 1 of the physicians signed all of the exercise sessions included in the scope of our review.

As discussed above, we determined that Holy Cross' cardiac program met the requirements for providing "incident to" services. Accordingly, we are not making a recommendation to Holy

Cross regarding "incident to" services. However, "incident to" requirements will be addressed in a national summary report to CMS.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

Medicare coverage policy 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. Additionally, Medicare allows one unit of service to be billed per cardiac rehabilitation session and requires the provider to maintain documentation for these services in the patients' medical records.

Our statistical sample of 30 of 81 Holy Cross Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to $37,918 during CY 2001, disclosed that Medicare claims for 23 beneficiaries contained 32 errors totaling $7,470. Some claims had more than one type of error. Categories of errors and underlying causes are presented below.

Categories of Errors

Medicare Covered Diagnoses

For 10 beneficiaries, Holy Cross billed and received Medicare payments for outpatient cardiac rehabilitation services when the diagnosis used to establish the beneficiaries' eligibility to enter the program may not have been supported by the medical records. As shown in APPENDIX A, Table 1, we determined that sampled beneficiaries participated in the cardiac rehabilitation program based on the following Medicare covered diagnoses: myocardial infarction (7 beneficiaries); coronary artery bypass graft surgery (12 beneficiaries); and myocardial infarction and coronary artery bypass graft surgery (1 beneficiary). Of the remaining 10 beneficiaries, eligibility for 9 beneficiaries was based on a diagnosis of angina, unspecified, and eligibility for 1 beneficiary was not based on a Medicare covered diagnosis.

For 18 beneficiaries with diagnoses of myocardial infarction, coronary artery bypass graft surgery, or both, medical records contained documentation to support the diagnoses. For the remaining 12 beneficiaries,[1] the CEC's medical records did not contain sufficient documentation that the beneficiaries: (1) experienced stable angina after a cardiac procedure or cardiology office visit or (2) had a Medicare covered diagnosis within 1 year prior to beginning the cardiac rehabilitation program.

Our review of the medical records revealed that 8 of the 12 beneficiaries received treatment at Holy Cross or another local hospital for cardiac related symptoms such as stable angina, atrial fibrillation, and heart disease. According to the hospital records, the eight beneficiaries underwent cardiac catheterization procedures, and many also underwent angioplasty and stenting. Upon discharge from the hospital, these beneficiaries and the remaining four who did

[1] One beneficiary participated in the program based on a coronary artery bypass graft surgery diagnosis, one beneficiary participated based on a myocardial infarction diagnosis, nine beneficiaries participated based on an unspecified angina diagnosis, and one beneficiary did not have a Medicare-covered diagnosis.

not have recent hospitalizations were referred to the outpatient cardiac rehabilitation program by their physicians.

When the physicians referred these 12 beneficiaries to Holy Cross' CEC, the cardiac rehabilitation staff conducted an initial assessment and prepared a patient information sheet to record intake information including details of the patient's diagnosis. The staff also completed the history and physical and risk stratification based on medical record information, interviews with the patient and family, discussions with physicians, and clinical observation. However, the CEC did not maintain sufficient documentation indicating whether the angina symptoms continued to exist post-procedure/office visit or to validate a stable angina diagnosis.

Consequently, to validate a stable angina diagnosis or another Medicare covered diagnosis, we obtained and reviewed the hospital medical records and/or the referring physicians' medical records for these 12 beneficiaries. The medical records obtained covered the dates of the beneficiaries' recent hospital visit/stay or doctor's visit through their completion of Phase II of the cardiac rehabilitation program.

However, our review of subsequent medical records disclosed that 10 of the 12 beneficiaries' medical records did not clearly reveal that the beneficiaries (1) experienced or continued to experience angina symptoms post-procedure or post-office visit and throughout their completion of Phase II of the cardiac rehabilitation program or (2) had a Medicare covered diagnosis within 1 year prior to beginning the cardiac rehabilitation program. As a result, Medicare may have inappropriately paid $6,667 to Holy Cross for the cardiac rehabilitation services provided to these 10 beneficiaries.

Billing Procedures

Services Exceeded 36 Sessions

For 2 beneficiaries, Holy Cross billed and received payment for 6 services that exceeded Medicare's 36-session limit. For 1 beneficiary, Holy Cross provided 72 services; 42 services were provided in 2001, but only 5 appeared in our sample. Contrary to Medicare requirements, Holy Cross did not provide documentation that it requested written approval from Mutual for additional services. There is no monetary effect for this error because we questioned this beneficiary's services in the Medicare Covered Diagnoses finding. The second beneficiary, whose services exceeded the 36-session limit, completed the Phase II program and was enrolled in the Phase III program. Holy Cross incorrectly billed the Phase III service as a Phase II service and received $63 for this claim.

Duplicate Billing

Holy Cross submitted a duplicate bill for one date of service involving one beneficiary. Both claims included the same date of service and the same procedure code (93798: outpatient cardiac rehabilitation services with continuous ECG monitoring), but different charge amounts. Holy Cross explained that they typically bill a separate claim for the initial assessment, which involves the physician personally assessing the patient. In this instance, Holy Cross billed the

initial assessment using the exercise session procedure code. Mutual did not determine the claim was a duplicate and paid Holy Cross $111 for the duplicate procedure.

Documentation of Services

Missing Referral

Holy Cross could not provide a physician referral for 1 beneficiary with a total of 12 services. Similar to Medicare requirements, Holy Cross' own procedures required a referral upon beginning the cardiac rehabilitation program. Holy Cross received $629 for the 10 services provided to this beneficiary during CY 2001.

No Documentation

Holy Cross billed Medicare for three beneficiaries (three services) when Holy Cross did not document that the beneficiary received a Phase II cardiac rehabilitation service. Specifically, Holy Cross did not provide any supporting documentation that the three beneficiaries received Phase II cardiac services on the dates billed. For each Phase II exercise session, Holy Cross required all beneficiaries to enter data on the exercise flow sheet and wear ECG monitoring devices. Holy Cross could not provide the exercise flow sheet, or the ECG data, to support the billed services. There is no monetary effect for this error because we questioned the reimbursements for these services previously in the report.

Insufficient Documentation

For 15 beneficiaries, Holy Cross billed and received payments for 31 services that were not sufficiently documented on either the patients' exercise flow sheet or ECG printouts. As previously discussed, during an exercise session beneficiaries enter data on their flow sheet and wear ECG leads. After each session, the physician reviews and initials the patient's flow sheet, and the cardiac staff prints the ECG readings and affixes the readings in the patient's file. Although Holy Cross could not provide the missing documentation for these services, we concluded that the patients did receive the services based on our review of additional documentation.

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

Underlying Causes for Errors

Medicare Covered Diagnoses

Holy Cross did not ensure that beneficiaries' stated Medicare covered diagnoses were supported by medical documentation prior to providing cardiac rehabilitation services and billing Medicare. Without such documentation, Holy Cross could not ensure the patients' participation in the cardiac program was in compliance with Medicare requirements.

Billing Procedures

Services Exceeded 36 Sessions

Neither Holy Cross nor Mutual had billing system edits to determine if services exceeded 36 sessions. The Holy Cross cardiac rehabilitation staff were aware of the 36-session limit, but a Holy Cross billing official acknowledged that Holy Cross does not have billing system edits to prohibit Holy Cross from billing for greater than 36 Phase II cardiac rehabilitation sessions. Similarly, a Mutual representative stated that Mutual does not have system edits to deny payment for cardiac rehabilitation services beyond 36 sessions.

In one instance, the Holy Cross CEC staff stated that they received verbal approval from Mutual for the patient to continue in the program beyond 36 sessions. We contacted Mutual who did not have any record of such approval. Mutual added that to receive approval, the provider must submit a written request to Mutual's Medical Director.

Additionally, the CEC billed for one beneficiary with one excess service due to a data entry error. The CEC's record indicated the patient completed the Phase II (billable) services and the patient planned to continue into Phase III (non-billable). The excess service was the patient's initial Phase III session.

Duplicate Billing

Holy Cross' duplicate billing likely resulted because Holy Cross intended to bill separately for the assessment service, but Holy Cross inadvertently coded the service as a monitored exercise session.

Documentation of Services

Missing Referral

A Holy Cross CEC representative stated that the patient forgot his referral at his first visit to the CEC. Holy Cross admitted they failed to follow-up and request the referral.

No Documentation

Holy Cross could not explain why it billed for these three undocumented services, but stated that it was likely a data entry error.

Insufficient Documentation

For the one beneficiary without a service on the exercise flow sheet for the date billed, a Holy Cross CEC representative explained that it was probably a date error. Specifically, the patients enter the information on the flow sheet, including the date. The patient may have entered an incorrect date. For the 14 beneficiaries with missing ECG strips, Holy Cross could not locate the

requested data. A Holy Cross cardiac rehabilitation official stated the information was likely misplaced or misfiled.

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

RECOMMENDATIONS

We recommend that Holy Cross:

- Work with Mutual to establish the amount of repayment liability, estimated to be $7,470, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable and

- Enhance existing policies to ensure that (1) medical record documentation is obtained and maintained to support Medicare outpatient cardiac rehabilitation services and (2) cardiac rehabilitation staff bill only for Phase II cardiac rehabilitation services rendered.

AUDITEE'S COMMENTS

Although Holy Cross agreed to work with its staff to ensure documentation is adequate in the future, it generally disagreed with our findings and recommendations. Holy Cross specifically agreed to work with its staff to ensure that patients' Medicare diagnoses are appropriately documented in future cases, reinforce the need to maintain referral documentation in the patients' files, and emphasize the importance of maintaining all appropriate documentation for services. But Holy Cross raised concerns related to the amount of estimated liability and asserted that (1) most of the Medicare covered diagnoses were supported in the medical records and (2) additional services were provided for which payments have not been received.

In its response, Holy Cross specifically disagreed with:

- the existence of weaknesses in their internal control and oversight procedures;

- seven of the beneficiaries whose payments we questioned because the Medicare covered diagnoses may not have been supported;

- the beneficiaries whose billed services exceeded 36 sessions; and

- the duplicate bills for one date of service.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We are pleased that Holy Cross agreed to work with its staff to improve their documentation of cardiac rehabilitation program services. We reviewed Holy Cross' specific comments along with our working papers, but we generally did not adjust our findings or recommendations as

discussed below. Because we are not clinically trained medical reviewers, we determined an *estimated* liability. Therefore, we recommended that Holy Cross work with Mutual to make the final determinations. During that time, we encourage Holy Cross to discuss its concerns related to unpaid services.

With respect to Holy Cross' specific concerns, we continue to report that the errors resulted from internal control and oversight procedure weaknesses. Specifically, we found that Holy Cross medical records did not adequately support the covered diagnoses and did not consistently support its Medicare billings and reimbursements for outpatient cardiac rehabilitation services.

Regarding the results of the seven beneficiaries whose payments we questioned because the Medicare covered diagnoses may not have been supported, we reviewed the information provided by Holy Cross in its response to our draft report in conjunction with documentation previously provided. We modified our findings to reflect that one beneficiary did have a Medicare covered diagnosis, and the services were, therefore, reasonable and necessary. For the remaining six beneficiaries, we again recommend that Holy Cross work with Mutual to determine whether the medical record documentation supported a Medicare covered diagnosis.

With respect to the two beneficiaries whose services we reported as exceeding 36 sessions, the Medicare Coverage Issues Manual provides that services provided in connection with the cardiac rehabilitation program may be considered reasonable and necessary for up to 36 sessions. The covered services relate only to Phase II services.

For one beneficiary, it did appear that Holy Cross only received payment for 35 Phase II services even though the records indicated the beneficiary received 36 services. Regardless, the service that we questioned was the 37th service and was actually a Phase III service. Phase III services, as defined on page 2 of this report, are considered maintenance and are not covered by Medicare.

For the other beneficiary, our report identified that the beneficiary received 72 services total, 42 of which were provided in CY 2001. We do not know how many total services Holy Cross received payment for since 30 of the services were provided in CY 2000, outside the scope of this review. Regardless, Holy Cross did not provide documentation that it requested written approval from Mutual to continue the program. As noted in our report, we did not question any payments related to this finding for this beneficiary because we questioned the payments elsewhere in the report.

We acknowledge Holy Cross' comments that the duplicate services represented two different charges, but Holy Cross inappropriately billed both services using the procedure code for a monitored cardiac rehabilitation session. The beneficiary only received one such service; therefore, the second service is duplicative.

OTHER MATTERS

Incorrect Diagnoses Codes

For 10 beneficiaries, Holy Cross billed Medicare using an angina diagnosis code when the Holy Cross CEC had documentation to support that the beneficiary had a coronary artery bypass graft surgery. Specifically, Holy Cross billed Medicare for services based on the angina diagnosis code (413.9) when the patients' correct diagnosis, according to the referral and medical records, was coronary artery bypass graft surgery (V4581). A Holy Cross CEC representative explained that several years ago Medicare continually denied cardiac rehabilitation claims for patients with coronary artery bypass graft surgery diagnoses. Holy Cross discussed the issue with the former FI, and, according to Holy Cross CEC staff, the former FI instructed Holy Cross to use the angina diagnosis code for coronary artery bypass graft surgery claims.

This incorrect practice continued through our on-site fieldwork in March 2003. Even though we were able to support a coronary artery bypass graft surgery diagnosis for the ten beneficiaries, and the angina code (413.9) used by Holy Cross is a covered code, the claims were coded incorrectly. Holy Cross CEC said that Holy Cross was still using the incorrect code during our audit in 2003. We are including this issue in the report for information purposes to ensure that Holy Cross addresses the issue with Mutual.

Incomplete Referrals

For two beneficiaries, the physicians' referrals did not include a diagnosis or the reason the beneficiary should be enrolled in the cardiac rehabilitation program. As discussed in the Medicare Covered Diagnoses section of this report, we determined one of the beneficiaries recently underwent coronary artery bypass graft surgery, and we could not determine whether the other beneficiary participated in the cardiac program based on a Medicare covered diagnosis.

During CY 2001, Mutual did not have a requirement that the referral needed to state the diagnosis. Instead, Mutual's policies were consistent with Medicare requirements which stated that Medicare covers cardiac rehabilitation services 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, or (2) have had coronary bypass surgery, and/or (3) have stable angina pectoris. Mutual's current policies require that the referral identify the diagnosis. Specifically, Mutual now requires a physician order and a diagnosis from [a] physician with the date of onset.

We believe that Holy Cross should not accept incomplete referrals. Without a complete referral, Holy Cross cannot ensure that the patient's participation in the cardiac rehabilitation program meets Medicare requirements or complies with Mutual's policy.

APPENDICES

APPENDIX A

STATISTICAL SAMPLE SUMMARY OF ERRORS

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

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

			Diagnosis Errors	Billing Procedure Errors		Documentation Errors			
Sampled Beneficiaries with Diagnosis	Diagnosis	Sampled Beneficiaries with Errors	Beneficiaries not having Documentation to Support Diagnosis	Services Exceeded 36 Sessions	Duplicate Billing	Missing Referral	No Documentation	Insufficient Documentation	Total Errors per diagnosis
7	Myocardial Infarction (MI)	3	1	1	0	0	1	3	6
12	Coronary Artery Bypass Graft Surgery (CABG)	9	1	0	1	1	0	7	10
1	MI and CABG	1	0	0	0	0	0	1	1
9	Angina, Unspecified	9	7	1	0	0	2	3	13
1	No Covered Diagnosis	1	1	0	0	0	0	1	2
30		**23**	**10**	**2**	**1**	**1**	**3**	**15**	**32**

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October 1, 2003

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
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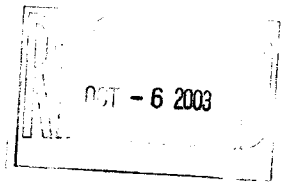

RE: Report Number A-03-03-00007

Dear Mr. Virbitsky:

This letter is in response to the draft audit report titled "Review of Outpatient Cardiac Rehabilitation Services at Holy Cross Hospital, Silver Spring, Maryland", received on Sept 4, 2003. We appreciate the opportunity to review and respond to the findings in this draft report, and are presenting our response within this letter. Overall, we appreciate your finding that Holy Cross physicians properly oversee our cardiac rehabilitation program services. However, we have concerns about many of the findings relative to billing for our services. We disagree, on the basis of our review, specifically with your statement about the existence of weaknesses in Holy Cross' internal controls and oversight procedures.

We address each of the exceptions listed in order below. As audit staff noted throughout the audit, they were not a clinically trained staff. Their findings, we believe, are related to the need for clinical training to appropriately review the medical record for the support of the Medicare appropriate diagnosis determination and other issues. Our exceptions reflect a review of the applicable medical records by our medical director and our findings are listed in the order the exceptions were noted in the draft report..

Regarding your citation of 11 beneficiaries where you concluded, "the beneficiaries' eligibility may not have been supported by the medical records". Our records show that seven of the eleven patients had information in the medical record to support a Medicare appropriate diagnosis:

Patient #	Our finding relative to Medicare appropriate diagnosis documentation
1	Persantine stress test: "stress images of the heart reveal extensive areas of marked hypoperfusion involving the apex, anteroseptal, inferoseptal, inferior, and inferolateral segments." Previous catheterization in 1997 post cardiac arrest showed two vessel coronary disease.
7	CABG 1998. Began complaining of shortness of breath in September 2000. This was diagnosed by thallium stress test and catheterization as being an occlusion of his LAD graft. He did not experience "classical anginal symptoms" which is not uncommon in diabetics.
8	Discharge summary 8/22/00. "On an outpatient basis he underwent a radioisotope stress test which showed depressed left ventricular function in a segmental fashion compatible with ischemic cardiomyopathy." He was then admitted for cardiac catheterization which showed "diffuse coronary artery disease with a high-grade obstruction in a sizable intermediate branch". The catheterization report goes on to describe "diffuse atherosclerosis involving all vessels".
21	Hospital admission report of a woman with long standing CAD: CABG 1995, MI 1990, MI 2000, PTCA 10/90, PTCA/stent 3/00. Admission of 5/21/2001 was for chest pain and to rule out an MI. She was then referred to cardiac rehab and had one visit before her symptomatic arrhythmias prevented her from continuing.
22	From stress test "Limited work capacity due to severe deconditioning. No angina today but recent chest pain and ST abnormalities and PVCs suggestive of ischemia"

23	From both ER record and cath report "unstable angina symptoms, EKG changes, and elevated troponin and cardiac enzymes." DX= MI
24	Several MD office notes describing "clear cut angina" two weeks after PTCA. Restarted Toprol and referred to cardiac rehab with instructions to take nitroglycerin prior to exercise. One month later office note mentions "periodic assessment of chronic angina", "going to cardiac rehab and seems to be doing well", "will continue present medication regimen" which includes using nitroglycerin prior to exercise.

From this analysis we disagree with 7 of the 11 findings in this area and these cases included charges of $4,717.50 of the originally cited $8,995 of inappropriately documented billings. This leaves us with four records where while we feel that the diagnosis and treatment were appropriate, the documentation in the record does not directly support a Medicare appropriate diagnosis. We will be working with staff to ensure that the conditions that merit the cardiac enhancement services are appropriately documented in future cases.

Regarding the finding that our billing (and payments) for two patients exceeded the 36 session limit - our review showed the following:

Patient #	Specifics regarding the session limits and payments
11	The last date billed as phase II was actually her first session in phase III. That was our billing error. However, we were only reimbursed for 36 total visits and therefore this error has no financial impact.
19	This patient did attend our program longer than 36 visits. There is a letter from his Cardiologist requesting that he continue because of continuing angina. However, we were only paid for 5 visits and this would indicate that correction of the billing and payment process would result in a financial finding in our favor.

It is worth noting that the auditors also discovered that the hospital had not received payment for services properly billed in substantially more cases and for more dollar value than the total cases that were cited as being billed in error.

Regarding the finding that we had one duplicate billing for a single beneficiary on a single date of service:

Patient #	Specifics regarding the "duplicate" charge
16	Per our review of the patient record, the patient had an orientation and rehab session on the same day, there were actually two separate charges billed for these two services, therefore the $111.00 finding in this case is in error. This patient had 36 total phase II rehab sessions, and we were paid for 35.

Regarding a missing referral for one case in 2001:

Patient #	Specifics regarding the referral
12	We cannot locate the referral, though the patient remembers his physician giving him one. That particular physician is no longer in the area.

We will continue to reinforce the need to include referral documentation in the patient file.

Regarding a lack of documentation for three services:

Patient #	Specifics regarding documentation
11	This session should have been billed as a phase III session which is documented in the medical record.
19	Incorrect date. The billed date was 5/11/01, it should have been 5/9/01. There is proper documentation for 5/9.
21	Incorrect date. The billed date was 6/15/01, it should have been 6/11/01. There is proper documentation for 6/11.

While the billing date is wrong in two of these cases, the service was delivered, and the correct amount billed. We regard this as a clerical error, and will address it along with other documentation issues in ongoing training with staff.

Regarding Insufficient Documentation for 31 services provided to 15 beneficiaries: your auditors conclusion in these cases was that based on other documentation, these services were provided. Our review also indicated that these services were provided, and we have reinforced with CEC staff the importance of maintaining the appropriate documentation for all services.

In all we believe that the documentation supported our payments in all but 4 "appropriate Medicare diagnoses" cases with a value of $4,277.50 and one "lost referral" case with a value of $629.00. Given that the auditors found numerous cases where our billing did not result in payment, we believe that the financial aspects of the audit should not result in any adjustment of prior payments. We have reviewed all of the findings with our staff and we expect that this review and the follow up that it has generated will result in improved CEC documentation in the future. We appreciate this opportunity to respond to your draft findings and ask that any follow up discussion be directed to Carolyn Simonsen, Vice President of Quality and Care Management at 301-754-7474.

Sincerely,

Kevin J. Sexton
President & CEO

ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff that contributed includes:

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