DEPARTMENTOF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

October 27, 2003

Report Number: A-05-03-00084

Thomas Mroczkowski
President and CEO
Northern Michigan Hospital
416 Connable Avenue
Petoskey, MI 49770

Dear Mr. Mroczkowski:

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

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

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To facilitate identification, please refer to report number A-05-03-00084 in all correspondence relating to this report.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF OUTPATIENT CARDIAC REHABILITATION SERVICES

NORTHERN MICHIGAN HOSPITAL PETOSKEY, MICHIGAN

October 2003
A-05-03-00084

Office of Inspector General

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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 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 Northern Michigan 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.

- 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.

- Services related to outpatient cardiac rehabilitation services provided by the Hospital were separately billed by and reimbursed to the Hospital or any other Medicare provider.

RESULTS OF AUDIT

Even though physician supervision is assumed to be met in an outpatient hospital department, the Hospital did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program. Also, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." In addition, from our specific claims review for a sample of 30 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid for:

- Services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (10 beneficiaries);

- Inadequately documented outpatient cardiac rehabilitation services (9 beneficiaries); and

- Initial patient evaluations/orientations conducted by nonphysician personnel that did not include an exercise session (3 beneficiaries).

From our sample, the Hospital claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to approximately $3,738, that did not meet Medicare coverage requirements, which may not have been supported by medical record documentation, or which were otherwise unallowable. The sample errors and Medicare payments are part of a larger statistical sample and will be included in a multistate projection of outpatient cardiac rehabilitation service claims not meeting Medicare coverage requirements.

We attribute these questionable services to weaknesses in the Hospital's internal controls and oversight procedures. Existing controls did not ensure that beneficiaries had Medicare covered diagnoses supported by the referring physician's medical records and that supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained. In addition, the Hospital's staff believed that the initial evaluation/orientation visit could be billed when performed by nonphysician personnel and when no exercise occurred.

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, United Government Services (UGS), should make a determination as to the allowability of the Medicare claims and appropriate recovery action.

RECOMMENDATIONS

We recommend that the Hospital:

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

- Work with UGS to establish the amount of repayment liability for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable.

- Implement controls to ensure that medical record documentation is maintained to support Medicare outpatient cardiac rehabilitation services.

- Bill Medicare for evaluation and orientation visits only when performed by physician personnel or when an exercise session is provided.

AUDITEE'S COMMENTS

In written comments to the draft report, the Hospital stated that it did not disagree with the recommendations and will work with UGS to ensure that they are implemented. However, the Hospital believed that it had complied with the Medicare requirements for direct supervision and

"incident to" services. Regarding the sample results for the stable angina beneficiaries, the Hospital noted that the diagnosis of stable angina and the documentation of that condition are complicated by the fact that medical advances in the field of cardiac care are not directly addressed by the Medicare diagnosis criteria for cardiac rehabilitation services. The Hospital stated that it will work with UGS on these issues.

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

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We could not conclude that reliance placed on "code" emergency response teams or other nearby physicians met the Medicare Coverage Issues Manual, section 35-25 requirements and definition for direct physician supervision. With respect to "incident to" services, section 35-25 of the Medicare Coverage Issues Manual requires that each patient be under the care of a hospital physician and section 3112.4 of the Medicare Intermediary Manual requires that during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. We found no evidence of any hospital physician treating or assessing the beneficiaries during the beneficiaries' participation in the cardiac rehabilitation exercise programs. Regarding the stable angina beneficiaries, the Medicare Coverage Issues Manual considers cardiac rehabilitation programs reasonable and necessary for patients with a clear medical need and a documented diagnosis of stable angina. The medical records appeared to indicate that the beneficiaries did not continue to experience angina symptoms post procedure.

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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 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 United Government Services (UGS). For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 281 Medicare beneficiaries and received $85,891 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[1] 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.

[1] Until the end of calendar year 2001, the Hospital (Provider Number 230105) received Medicare reimbursement for outpatient cardiac rehabilitation services provided at three hospitals: Northern Michigan Hospital, Charlevoix Area Hospital, and Otsego Memorial Hospital.

- 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.

- Services related to outpatient cardiac rehabilitation services[2] provided by the Hospital were separately billed by and reimbursed to the Hospital or any other Medicare provider.

Scope

To accomplish these objectives, we reviewed current policies and procedures and interviewed staff to gain an understanding of the Hospital's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. In addition, we reviewed the Hospital's cardiac rehabilitation services documentation, inpatient medical records, referring physician referrals and supporting medical records, and Medicare reimbursement data for 30 beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001 as part of a multistate statistical sample. 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.

Our sample included 30 of 281 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 30 beneficiaries during CY 2001.

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

Methodology

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

[2] Examples of services considered related to outpatient cardiac rehabilitation included psychotherapy and psychological testing, physical and occupational therapy, and patient education services as a result of a cardiac related diagnosis. These services are generally considered to be included in the outpatient cardiac rehabilitation program and, generally, are not separately reimbursed by Medicare.

record and referral, and the Hospital's outpatient cardiac rehabilitation medical record. The medical records have not yet been reviewed by FI staff.

In addition, we verified that Medicare did not reimburse the Hospital beyond the maximum number of services allowed. We obtained Medicare payment history data for our statistical sample of beneficiaries, identified any claims related to the outpatient cardiac rehabilitation services provided by the Hospital, and ensured that services were not billed separately to Medicare.

In accordance with the intent of CMS' 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 Petoskey, Michigan, during June 2003.

RESULTS OF AUDIT

Even though physician supervision is assumed to be met in an outpatient hospital department, the Hospital did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program staff. In addition, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." Furthermore, from our specific claims review for a sample of 30 beneficiaries receiving outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid for:

- Services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (10 beneficiaries);

- Inadequately documented outpatient cardiac rehabilitation services (9 beneficiaries); and

- Initial patient evaluations/orientations conducted by nonphysician personnel that did not include an exercise session (3 beneficiaries).

PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION

Direct Physician Supervision

Medicare requirements for outpatient cardiac rehabilitation state that direct supervision means that a physician must be in the exercise area and immediately available and accessible for an emergency at all times the exercise program is conducted. The physician supervision requirement is generally assumed to be met where outpatient therapeutic services are performed on hospital premises.

At the Hospital, no physician was actually designated to provide direct physician supervision to the cardiac rehabilitation exercise areas and no documentation existed in the cardiac rehabilitation program's medical records to support physician supervision during exercise sessions. On a day-to-day basis, the cardiac rehabilitation program was staffed and run by

registered nurses and exercise specialists. A cardiac rehabilitation team leader (registered nurse) and rehabilitation services manager were responsible for the day-to-day supervision and management of the cardiac rehabilitation area.

Although the Hospital's cardiac rehabilitation policies did not require the medical director[3] to provide direct physician supervision at all times that the exercise program was conducted, the Hospital's policies did require the cardiac rehabilitation medical director, if available, to attend "code blue" emergencies and review code situations or any other situations requiring emergency medical treatment. In the event the medical director was not available to respond to an emergency, a "code" emergency response team could be called. The "code" emergency team was responsible for responding to any medical emergency that occurred throughout the hospital, including the cardiac rehabilitation exercise area. Cardiac rehabilitation staff also believed that other physicians, located nearby the cardiac rehabilitation exercise area, could respond to any medical emergency and, thus, were also available to "supervise" cardiac rehabilitation services.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe that the Hospital should work with UGS to ensure that the reliance placed on other nearby physicians and the "code" emergency response team, specifically conforms with direct supervision 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, the patient's progress, and, where necessary, to change the treatment program.

At the Hospital, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." According to the Hospital's written policies for its cardiopulmonary rehabilitation program, the cardiac rehabilitation medical director performs the following functions, which, according to the policy, could be accomplished in approximately one to two hours per month:

- Participates in the development, introduction, and evaluation of new cardiac rehabilitation/stress testing services, including assessment of new equipment, new procedures, and new services.

- Participates in a bi-monthly meeting with the cardiac rehabilitation/stress testing manager/team leader to review any unusual occurrences, program changes, clinical problems, quality indicators, and patient satisfaction.

[3] The Hospital contracted with the medical director to provide appropriate medical direction to the cardiac rehabilitation program.

- Maintains an expert knowledge in the field of cardiac rehabilitation/stress testing and risk factor reduction and provides an annual education program to the team.

- Provides consultation to referring physicians regarding the appropriateness of cardiac rehabilitation/stress testing for specific patients. As needed, the director consults with physicians who are dissatisfied with aspects of the cardiac rehabilitation/stress testing service, serving as a liaison between physicians and staff when necessary.

- If available, attends "code blues" and reviews code situations or any situations requiring emergency medical treatment. The director provides consultation for staff if no physician can be reached in clinical situations or when orders not in accordance with program guidelines are received.

- Sees new patients who are in the area temporarily or recently arrive and do not have a local physician.

- Helps in updating emergency procedures and staff competency protocols.

- Reviews the exercise prescription and plan of care and signs the cardiac rehabilitation treatment plan.

Also according to the Hospital's policies, all new beneficiaries meet individually with a cardiac rehabilitation nurse prior to participating in Phase II activities. An initial evaluation performed by the cardiac rehabilitation nurse includes an orientation to the program, formulation of a schedule for exercise sessions, a physical assessment, and completion of a Phase II Treatment Plan. The medical director reviews the exercise prescription and plan of care and signs the cardiac rehabilitation treatment plan. In addition, registered nurses assess all indications of early warning signs and symptoms before, during, and after exercise sessions, document these issues in the patients' records, and discuss these issues with the referring physician or if the referring physician is unavailable, with the medical director.

The Hospital's policies and procedures did not, however, require a hospital physician to personally see the patients periodically and sufficiently often to assess the course of the cardiac rehabilitation treatment. Furthermore, there were no hospital physician evaluations documented in our sampled beneficiaries' records to indicate that the medical director or another hospital physician made an assessment or review of patient progress during the beneficiaries' outpatient cardiac rehabilitation programs.

From our review of the Hospital's outpatient cardiac rehabilitation medical records, we could not locate evidence of any professional services rendered by a hospital physician to the patients participating in the program. Although required under the "incident to" benefit, there was no documentation to support that a hospital physician personally saw the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program. Accordingly, we believe that the Hospital's cardiac rehabilitation program did not meet the requirements to provide an "incident to" service.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

Medicare coverage considers cardiac rehabilitation services reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician, and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) have had coronary artery bypass graft surgery, and/or (3) have stable angina pectoris. Medicare reimburses providers for Phase II outpatient cardiac rehabilitation services and allows one unit of service to be billed per cardiac rehabilitation session. Documentation for these services must be maintained in the patients' medical records.

Our review of the records for 30 of 281 Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to $8,570 during CY 2001, disclosed that Medicare claims for 19 beneficiaries contained 22 errors totaling $3,738. Error categories and underlying causes are presented below.

Medicare Covered Diagnoses

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. As a result, we believe that Medicare may have inappropriately paid $2,436 to the Hospital for the cardiac rehabilitation services provided to these 10 beneficiaries.

Of the 30 sampled beneficiaries, eligibility for 5 beneficiaries was based on the diagnosis of acute myocardial infarction, eligibility for 9 beneficiaries was based on the diagnosis of coronary artery bypass graft surgery, eligibility for 3 beneficiaries was based on a diagnosis of coronary artery bypass graft surgery and acute myocardial infarction, and eligibility for 13 beneficiaries was based on the diagnosis of stable angina.[4] For the 17 beneficiaries with diagnoses of acute myocardial infarction and/or coronary artery bypass graft surgery, medical records contained documentation to support the diagnoses. However, the medical records for 10 of the 13 beneficiaries with diagnoses of stable angina did not appear to indicate that the beneficiary continued to experience stable angina post-procedure.

Of the 10 beneficiaries, 7 beneficiaries were admitted to hospitals with diagnoses of stable angina, unstable angina, chest pain, or chest discomfort. During their inpatient stays, cardiac procedures such as stenting and angioplasty were performed. The remaining three beneficiaries were admitted to hospitals with the diagnosis of unstable angina.[5] During their hospitalizations,

[4] Stable angina was defined as a pain or discomfort in the chest or adjacent areas caused by insufficient blood flow to the heart muscle. This chest pain is relieved by rest or medication within a short period of time (usually 15 minutes). Chest pain of a longer duration or pain appearing with a lower level of effort than before, even at rest, should be considered unstable angina. Symptoms of stable angina included a feeling of tightness, heavy pressure, or squeezing or crushing chest pain that is under the breastbone or slightly to the left; is not clearly localized; may radiate to the shoulder, arm, jaw, neck, back, or other areas; may feel similar to indigestion; is precipitated by activity, stress, or exertion; lasts 1 to 15 minutes; and is usually relieved by rest and/or nitroglycerin. This information was obtained from the MEDLINEplus Medical Encyclopedia, identified at the U.S. National Library and National Institute for Health website (http://www.nlm.nih.gov/medlineplus/ency/article/000198.htm).

[5] Unstable angina is not an outpatient cardiac rehabilitation Medicare covered diagnosis.

two of the beneficiaries had cardiac catheterization procedures and the other one had no cardiac procedures. Upon discharge from the hospitals, these 10 beneficiaries were referred by their physicians to the Hospital's outpatient cardiac rehabilitation program.

The Hospital's cardiac rehabilitation program conducted an initial evaluation with each beneficiary and either identified the beneficiary's diagnosis or relied on a preprinted physician referral (standing order) as documentation of a Medicare covered diagnosis. The cardiac rehabilitation program staff did not maintain additional documentation indicating whether the angina symptoms continued to exist post-procedure, or to validate the diagnosis of stable angina.

To validate the diagnosis of stable angina, we obtained and reviewed the inpatient medical records as well as the medical records of the physicians who referred these 10 beneficiaries for cardiac rehabilitation. The medical records, covering the dates of the beneficiaries' inpatient stays through their completion of Phase II of the cardiac rehabilitation program, did not appear to indicate that the beneficiaries continued to experience angina symptoms post-procedure and through their completion of the program, or had a Medicare covered diagnosis. These questionable services are attributed to the Hospital not ensuring that referrals for beneficiaries with Medicare covered diagnoses were supported by medical documentation prior to providing cardiac rehabilitation services and billing Medicare. Specifically, the Hospital's procedures did not require referring physicians to provide medical documentation supporting stable angina diagnoses used to justify Phase II cardiac rehabilitation services provided at Medicare's expense.

Undocumented Services

The Hospital did not always maintain cardiac rehabilitation service documentation to support the Medicare claims. Because the Hospital's internal controls did not ensure that supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained, the Hospital personnel were unable to locate supporting documentation for nine beneficiaries. These records, stored electronically, could not be retrieved due to computer systems' changes. Medicare reimbursed the Hospital $1,258 for the unsupported claims for these nine beneficiaries.

Initial Evaluation and Orientation

The Hospital's claims included initial patient evaluations, assessments, and orientations conducted by nonphysician personnel that did not include an exercise session. The Hospital's staff believed that new patient initial evaluations, assessments and orientations could be billed to Medicare, even if performed by nonphysician personnel. Since the evaluations, assessments, and orientations for Phase II outpatient cardiac rehabilitation occurred very soon after Phase I (inpatient) cardiac rehabilitation, some beneficiaries were not able to exercise during the visits. Although Medicare allows an evaluation service (without exercise) to be billed only when a physician performs this service, the staff incorrectly believed that these services could be billed. Medicare reimbursed the Hospital $44 for these unallowable services provided to 3 beneficiaries.

Sample Results

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

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

RECOMMENDATIONS

We recommend that the Hospital:

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

- Work with UGS to establish the amount of repayment liability for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable.

- Implement controls to ensure that medical record documentation is maintained to support Medicare outpatient cardiac rehabilitation services.

- Bill Medicare for evaluation and orientation visits only when performed by physician personnel or when an exercise session occurs.

AUDITEE'S COMMENTS

The Hospital stated that it did not disagree with the recommendations and will work with UGS to ensure that they are implemented. However, the Hospital contended that it was in compliance with the Medicare requirements for direct supervision since a physician was immediately available to respond to an emergency at all times the cardiac rehabilitation program was conducted. Further, the Hospital believed that its cardiac rehabilitation patients were seen by their physicians periodically to assess the course of treatment and the patient's progress. Accordingly, the Hospital believed that the "incident to" requirements were also met. Regarding the sample results for the stable angina beneficiaries, the Hospital noted that the diagnosis of stable angina and the documentation of that condition are complicated by the fact that medical advances in the field of cardiac care are not directly addressed by the Medicare diagnosis criteria for cardiac rehabilitation services. The Hospital stated that it will work with UGS on these issues.

The Hospital's written comments are presented in their entirety as APPENDIX C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We could not conclude that reliance placed on "code" emergency response teams or other nearby physicians, when the medical director was unavailable to respond to emergencies, met the Medicare Coverage Issues Manual, section 35-25 requirements and definition for direct physician supervision. With respect to "incident to" services, section 35-25 of the Medicare Coverage Issues Manual requires that each patient be under the care of a hospital physician and section 3112.4 of the Medicare Intermediary Manual requires that during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. We do not believe the Hospital complied with the "incident to" requirements since we found no evidence of any hospital physician treating or assessing the beneficiaries during the beneficiaries' participation in the cardiac rehabilitation exercise programs. Regarding the stable angina beneficiaries, the Medicare Coverage Issues Manual considers cardiac rehabilitation programs reasonable and necessary for patients with a clear medical need and a documented diagnosis of stable angina. The medical records appeared to indicate that the beneficiaries did not continue to experience angina symptoms post procedure. Consequently, we could not conclude that these beneficiaries met the requirements of the Coverage Issues Manual.

APPENDICES

APPENDIX A

STATISTICAL SAMPLE SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. The 30 beneficiaries reviewed were part of a multistate statistical sample. The results from our sample will be included in a multistate estimate of Medicare errors for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

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

Number of Sampled Beneficiaries with Diagnosis	Number of Sampled Beneficiaries with Errors	Medicare Covered Diagnosis	Beneficiaries Not Having Medical Documentation Supporting the Medicare Covered Diagnosis	Invalid Initial Evaluation Billed (non-physician personnel)	No Cardiac Rehabilitation Supporting Documentation	Total Errors per Diagnosis
5	3	**Myocardial Infarction (MI)**	0	2	2	4
9	3	**Coronary Artery Bypass Graft (CABG)**	0	0	3	3
3	2	**MI and CABG**	0	1	1	2
13	11	**Stable Angina Pectoris**	10	0	3	13
30	**19**	**Total**	**10**	**3**	**9**	**22**

APPENDIX B

SAMPLING AND UNIVERSE DATA AND METHODOLOGY

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

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

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

Universe	Population Value	Sample Size	Sample Value	Sampled Beneficiaries with Errors	Sample Errors Value
281	$85,891	30	$8,570	19	$3,738

APPENDIX C

AUDITEE'S WRITTEN COMMENTS TO DRAFT REPORT

Northern Michigan
HOSPITAL
INTENSIVE CARING

416 Connable Avenue
Petoskey, Michigan 49770
(231) 487-4000
www.northernhealth.org

October 1, 2003

Mr. Paul Swanson
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

Re: Audit Report A-05-03-00084

Dear Mr. Swanson:

Northern Michigan Hospital ("NMH") has reviewed the draft report entitled "Review of Outpatient Cardiac Rehabilitation Services" relating to NMH. Overall, NMH does not disagree with the recommendations made by OAS in the report and will work with United Government Services ("UGS"), the fiscal intermediary for NMH, to ensure they are implemented.

While NMH will follow the OAS recommendations, NMH has the following comments and observations concerning the audit findings:

1) **Direct supervision and "incident to" findings** - NMH believes that it has complied with the Medicare requirements for direct supervision since a physician is immediately available to respond to an emergency at all times the cardiac rehabilitation program is conducted. Further, NMH believes that patients in its cardiac rehabilitation program are seen by their physician periodically during the course of treatment in the cardiac rehabilitation program to assess the course of treatment and the patient's progress. Accordingly, NMH believes the "incident to" requirements are also met. NMH will, however, work with UGS as it examines its policies to assure adequate documentation exists supporting physician oversight of each patient's progress.

2) **Medicare covered diagnosis** - Prior to the current audit, NMH had changed its initial evaluation documentation requirements, including those relating to diagnosis supporting entry into NMH's cardiac rehabilitation program. NMH is further reviewing its policies concerning the documentation it will require supporting the diagnosis under which patients are referred to NMH's cardiac

rehab program. NMH would note that the diagnosis of stable angina and the documentation of that condition is complicated by the fact that medical advances in the field of cardiac care are not directly addressed by the Medicare diagnosis criteria for cardiac rehabilitation services. NMH will work with UGS on these issues.

3) **Other findings** - NMH agrees that some records were unavailable due to electronic records systems conversions. NMH also agrees with the finding that evaluation and orientation sessions without exercise should not be billed to Medicare. NMH will take steps to educate its staff further in these areas.

Thank you for the opportunity to comment on the draft report.

Sincerely,

Thomas Mroczkowski
President and CEO