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

REGION V
OFFICE OF
INSPECTOR GENERAL

November 4, 2003

Report Number: A-05-03-00097

Ms. Mary Quinn Crow
Vice President of Patient Care Services
Northfield Hospital
2000 North Avenue
Northfield, Minnesota 55057-1697

Dear Ms. Crow:

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 – Northfield Hospital, Northfield, Minnesota." 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.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OIG audit reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the act which the Department chooses to exercise (see 45 CFR part 5).

To facilitate identification, please refer to report number A-05-03-00097 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 Gamer, Regional Administrator
Centers for Medicare &Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite **600**
Chicago, Illinois **6060**1-5519

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF OUTPATIENT CARDIAC REHABILITATION SERVICES

NORTHFIELD HOSPITAL
NORTHFIELD, MINNESOTA

November 2003

A-05-03-00097

Office of Inspector General

http://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov/

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

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 Northfield 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.

RESULTS OF REVIEW

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. 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." Also, from our specific claims review for all 33 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid for:

- Multiple units of service for a single cardiac rehabilitation visit (33 beneficiaries);

- 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 (8 beneficiaries); and

- Initial patient evaluations/orientations conducted by non-physician personnel that did not include an exercise session (1 beneficiary).

We determined that the Hospital claimed and received Medicare reimbursement of $27,013 for outpatient cardiac rehabilitation services that did not meet Medicare coverage requirements,

which may not have been supported by medical record documentation, or which were otherwise unallowable. The errors and Medicare payments are part of a larger nationwide review of outpatient cardiac rehabilitation service claims and may be included in a nationwide roll-up report of all providers reviewed.

We attribute these questionable services to weaknesses in the Hospital's internal controls and oversight procedures. Existing controls did not ensure that only one unit of service was billed to Medicare per outpatient cardiac rehabilitation session and that beneficiaries had Medicare covered diagnoses supported by the referring physicians' medical records. In addition, existing controls did not ensure that outpatient cardiac rehabilitation documentation was maintained, and that services billed to Medicare for initial cardiac rehabilitation evaluations without exercise sessions were performed by a physician.

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 staff. We believe that the Hospital's fiscal intermediary, Noridian Government Services (Noridian), should make a determination as to the allowability of the Medicare claims and appropriate recovery action.

RECOMMENDATIONS

We recommend that the Hospital:

- Work with Noridian 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 Noridian to establish the amount of repayment liability, estimated to be $27,013, 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 only one unit of service is billed to Medicare for each outpatient cardiac rehabilitation visit.

- Implement controls to ensure that outpatient cardiac rehabilitation service documentation is maintained.

- Implement controls to ensure that outpatient cardiac rehabilitation initial evaluations without exercise are either performed by a Hospital physician or not billed to Medicare.

AUDITEE'S COMMENTS

The Hospital indicated that its emergency department physicians are in very close proximity to the cardiac rehabilitation department and provide emergency medical response to the program at all times. Regarding "incident to" requirements, the Hospital believed that requiring another

physician, who is not familiar with the patient, to manage the patient within the cardiac exercise area would be unnecessarily duplicative and potentially confusing to the patient. For the sample errors, the Hospital agreed with the report findings and has updated its billing system. In addition, the Hospital indicated that it has acquired new software that will prompt the required documentation to support the stable angina diagnosis and an "angina scoring scale" has been added to the documentation form for each cardiac rehabilitation visit. The Hospital indicated that it is discussing the report findings with Noridian.

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

While we agree that emergency department physicians are in close proximity to the cardiac rehabilitation exercise area, we could not conclude that reliance on these physicians met the CMS Coverage Issues Manual, section 35-25, requirements and definition for direct physician supervision. With respect to "incident to" services, section 35-25 of CMS's Coverage Issues Manual requires that each patient be under the care of a hospital physician and section 3112.4 of the Intermediary Manual requires that during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment 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.

TABLE OF CONTENTS

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 the CMS. CMS currently covers Phase II outpatient cardiac rehabilitation programs conducted in specialized, free-standing cardiac rehabilitation clinics and in outpatient hospital departments under the "incident to" benefit (section 1861(s)(2)(A) of the Act).

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

Cardiac rehabilitation is provided by nonphysician personnel, who are trained in both basic and advanced life support techniques and exercise therapy for coronary disease, under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise area and immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require a physician to be physically present in the exercise room itself. For outpatient therapeutic services provided in a hospital, the Medicare Intermediary Manual states, "The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises."

In order to be covered under the "incident to" benefit in an outpatient hospital department, services must be furnished as an integral, although incidental part of the physician's professional service in the course of diagnosis or treatment of an illness or injury. This does not mean that each occasion of service by a nonphysician need also be the occasion of the actual rendition of a personal professional service by the physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program.

Cardiac Rehabilitation Programs

Cardiac rehabilitation consists of comprehensive programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Cardiac rehabilitation programs are typically divided into three phases, as follows:

- Phase I. Phase I rehabilitation is initiated in the acute convalescent period following a cardiac event during the hospital phase of treatment. This phase of cardiac rehabilitation is considered part of the hospital stay and is covered as part of the Medicare diagnosis-related group allowance for the hospital stay.

- Phase II. Phase II begins with a physician's prescription (referral) after the acute convalescent period and after it has been determined that the patient's clinical status and capacity will allow for safe participation in an individualized progressive exercise program. This phase requires close monitoring and is directed by a physician who is on-site. Phase II outpatient cardiac rehabilitation is covered by Medicare.

- Phase III. Phase III begins after completion of Phase II and involves a less intensively monitored aerobic exercise program. Phase III level programs are considered maintenance and are not covered by Medicare.

Medicare reimburses outpatient hospital departments for cardiac rehabilitation services under the outpatient prospective payment system. Cardiac rehabilitation services are paid by a Medicare fiscal intermediary based on an ambulatory payment classification. The fiscal intermediary for the Hospital is Noridian. For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 33 Medicare beneficiaries and received $32,655 in Medicare reimbursements for these services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

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

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

Scope

To accomplish these objectives, we reviewed 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 cardiac rehabilitation services documentation, inpatient medical records, physician referrals and supporting medical records, and Medicare reimbursement data for all 33 beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001 as part of a nationwide review of outpatient cardiac rehabilitation services. We reviewed the Hospital's outpatient cardiac rehabilitation procedures for and controls over physician supervision, cardiac rehabilitation staffing, maintenance and availability of advanced cardiac life support equipment, and documentation of services provided and billed to Medicare.

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

Methodology

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

For each beneficiary, we obtained the CY 2001 Medicare outpatient cardiac rehabilitation paid claims and lines of service and compared this data to the Hospital's outpatient cardiac rehabilitation service documentation. We reviewed the medical records maintained by the cardiac rehabilitation program to determine whether services were provided "incident to" a physician's professional service. We also verified the accuracy of the diagnoses identified on the Medicare claims to each beneficiary's inpatient medical record, the physician referral, and the Hospital's outpatient cardiac rehabilitation medical record. The medical records have not yet been reviewed by Noridian. In addition, we determined whether Medicare reimbursed the Hospital beyond the maximum number of services allowed.

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

RESULTS OF REVIEW

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 all 33 beneficiaries

receiving outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid for:

- Multiple units of service for a single cardiac rehabilitation visit (33 beneficiaries);
- 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 (8 beneficiaries); and
- Initial patient evaluations/orientations conducted by non-physician personnel that did not include an exercise session (1 beneficiary).

PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION

Direct Physician Supervision

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

At the Hospital, no physician was actually designated to provide direct physician supervision to the cardiac rehabilitation exercise area 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 the program's cardiac rehabilitation coordinator (a licensed occupational therapist). According to the Hospital's policies, the outpatient cardiac rehabilitation sessions were supervised by therapists knowledgeable in cardiac rehabilitation. The cardiac rehabilitation program's medical director was an emergency department physician, who could respond to any medical emergency in the cardiac rehabilitation department (depending upon availability and work schedule). In the event the medical director was not available to respond to an emergency, other emergency department physicians and 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.

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 Noridian to ensure that the reliance placed on emergency department physicians and the "code" emergency response team to provide this supervision specifically conforms with the Medicare requirements.

"Incident To" Physician Services

Medicare covers Phase II cardiac rehabilitation under the "incident to" benefit. In an outpatient hospital department, the "incident to" benefit does not require that a physician perform a

personal professional service on each occasion of service by a nonphysician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient, periodically and sufficiently often, to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program.

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 cardiac rehabilitation policies, all patients referred to cardiac rehabilitation received an initial evaluation or assessment that included the development of a plan of care and treatment goals within a specified time frame. The assessment included subjective information (medical history and psychological and social assessments), objective findings related to diagnoses, functional assessments, definitions of problems and treatment goals, and a treatment plan, including the frequency and duration of care. This initial assessment and subsequent reassessments were performed by and signed by a licensed occupational therapist. Each beneficiary's plan of care was signed by the occupational therapist performing the assessment and the referring physician indicating certification for the need of services furnished under the treatment plan and while under the referring physician's care.

However, no Hospital physician assessed or evaluated the beneficiaries prior to or during their cardiac rehabilitation program. No Hospital physician (including the medical director) periodically observed patients during exercise sessions. The Hospital's staff believed that only referring physicians needed to be involved in the plans of care or monitoring a patient's progress in meeting the program goals. Consequently, the cardiac rehabilitation staff provided referring physicians with only an updated plan of progress (generally, every 30 days).

From our review of the Hospital's outpatient cardiac rehabilitation medical records, we could not locate evidence of any Hospital physician's professional services rendered 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 33 Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to $32,655 during CY 2001, disclosed that Medicare claims for the 33 beneficiaries contained 52 errors totaling $27,013.

Multiple Units Billed

The Hospital's internal controls did not ensure that only one unit of service was billed per cardiac rehabilitation session. Specifically, staff believed cardiac rehabilitation services should be billed in 15-minute increments, rather than one unit per visit. As a result, the Hospital billed and received reimbursement from Medicare on behalf of the 33 beneficiaries for between 2 to 8 units per visit on each date of service. Medicare made an inappropriate reimbursement of $24,323 to the Hospital for the extra units billed for the beneficiaries.

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 $1,613 to the Hospital for the cardiac rehabilitation services provided to these 10 beneficiaries.

Of the 33 sampled beneficiaries, eligibility for 11 beneficiaries was based on the diagnosis of acute myocardial infarction, eligibility for 5 beneficiaries was based on the diagnosis of coronary artery bypass graft surgery, eligibility for 4 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.[1] For the 20 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 beneficiaries had the Medicare covered diagnosis of stable angina or continued to experience stable angina post-procedure.

Of the 10 beneficiaries, 8 beneficiaries were admitted to area hospitals with diagnoses of angina (stable and unstable), chest pain, or chest discomfort. During their inpatient stays, cardiac procedures such as mitral valve replacement, angioplasty, and stenting were performed. The two other beneficiaries did not have a procedure performed. One was admitted complaining of a shortness of breath, but no chest pain. The other was admitted with a diagnosis of unstable angina.[2]

Generally, the Hospital received notification from other area hospitals that inpatient hospital beneficiaries were interested in outpatient cardiac rehabilitation services upon their discharge.

[1] 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).

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

After receiving the information, the Hospital requested the beneficiaries' attending physicians to provide a referral for their patients prior to participating in the Hospital's outpatient cardiac rehabilitation program. The cardiac rehabilitation program conducted an initial assessment with each beneficiary and either identified the beneficiary's diagnosis or relied on the physician referral as documentation of a Medicare covered diagnosis. The cardiac rehabilitation program's 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 for the 13 beneficiaries, we reviewed the inpatient medical records and the medical records of the referring physicians. The medical records covered the dates of the beneficiaries' inpatient stays through their completion of Phase II of the cardiac rehabilitation program. For the eight beneficiaries who underwent cardiac procedures, the medical records did not appear to indicate that the beneficiaries continued to experience angina symptoms post-procedure and through their completion of Phase II of cardiac rehabilitation. For the two beneficiaries with no procedures performed, the medical records did not appear to support the diagnosis of stable angina.

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, 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 expense.

Undocumented Services

The Hospital did not always maintain cardiac rehabilitation service documentation to support the Medicare claim. The Hospital was unable to locate supporting cardiac rehabilitation documentation for all dates of services for cardiac rehabilitation for four beneficiaries. In addition, documentation for specific dates of service could not be located for four additional beneficiaries. We were unable to determine why records could not be found. However, since the Hospital had moved to a new building within the past year, some records may have been lost. Medicare made reimbursements of $1,061 for the unsupported claims for these eight beneficiaries.

Initial Evaluation and Orientation

One claim included a service by nonphysician personnel for an initial patient evaluation and orientation that did not include an exercise session. A new patient evaluation service, without exercise, is reimbursable by Medicare only when a physician provides the service. Medicare inappropriately reimbursed an additional $16 to the Hospital for the one beneficiary.

Overall Results

The results from our review will be included in a nationwide roll-up report 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 a summary of the errors identified from our review of the 33 beneficiaries and the review methodology.) Our audit conclusions, particularly those regarding Medicare covered diagnoses, were not validated by medical personnel. Therefore, we believe that Noridian 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 Noridian 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 Noridian to establish the amount of repayment liability, estimated to be $27,013, 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 only one unit of service is billed to Medicare for each outpatient cardiac rehabilitation visit.

- Implement controls to ensure that outpatient cardiac rehabilitation service documentation is maintained.

- Implement controls to ensure that outpatient cardiac rehabilitation initial evaluations without exercise are either performed by a Hospital physician or not billed to Medicare.

AUDITEE'S COMMENTS

The Hospital indicated that its emergency department physicians are in very close proximity to the cardiac rehabilitation department and provide emergency medical response to the program at all times. Regarding "incident to" requirements, the Hospital stated that it purchased software to document physician visits and provide the patient's primary physician with exercise information. The Hospital said that the primary physician will summarize discussions with the patient and that this information will be documented in the patient's record in the cardiac rehabilitation facility. The Hospital believed, however, that requiring another physician, who is not familiar with the patient, to manage the patient within the cardiac exercise area would be unnecessarily duplicative and potentially confusing to the patient. For the sample errors, the Hospital agreed with the report findings and has updated its billing system. Regarding multiple unit billings, the Hospital stated that its billing system improperly tracked cardiac rehabilitation visits in 15-minute increments and indicated that a new system has been implemented to bill patients on a "per visit" basis. For the stable angina documentation errors, the Hospital commented that the new software will prompt the required documentation to support the diagnosis and an "angina scoring scale" has been added to the documentation form for each cardiac rehabilitation visit. The Hospital is discussing the report findings with Noridian.

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

OFFICE OF INSPECTOR GENERAL'S RESPONSE

While we agree that emergency department physicians are in close proximity to the cardiac rehabilitation exercise area, we could not conclude that reliance on these physicians met the Coverage Issues Manual, section 35-25, requirements and definition for direct physician supervision. We could not conclude that physicians with other emergency room critical responsibilities would be immediately available at all times as required by the Coverage Issues Manual. With respect to "incident to" services, section 35-25 of CMS's Coverage Issues Manual requires that each patient be under the care of a hospital physician and section 3112.4 of the Intermediary Manual requires that during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment 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.

APPENDICES

APPENDIX A

SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of the 33 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. The results of our review will be included in a nationwide roll-up report to CMS 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	Multiple Units Billed	No Supporting Documentation	Initial Evaluation Not Performed By Physician Personnel	Total Errors per Diagnosis
11	11	**Myocardial Infarction (MI)**	0	11	2	0	13
5	5	**Coronary Artery Bypass Graft (CABG)**	0	5	1	0	6
4	4	**MI and CABG**	0	4	1	0	5
13	13	**Stable Angina Pectoris**	10	13	4	1	28
33	**33**	**Total**	**10**	**33**	**8**	**1**	**52**

APPENDIX B

SAMPLING AND UNIVERSE DATA AND METHODOLOGY

We selected for review all 33 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 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 review will be included in a nationwide roll-up report to CMS of Medicare errors 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
33	$32,655	33	$32,655	33	$27,013

APPENDIX C

AUDITEE'S WRITTEN COMMENTS TO DRAFT REPORT

Northfield Hospital

September 30, 2003

Report No. A-05-03-00097

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

Dear Mr. Swanson:

Thank you for the opportunity to comment on the draft report entitled "Review of Outpatient Cardiac Rehabilitation Services at Northfield Hospital, Northfield, MN." I appreciate your consideration of the views of Northfield's staff and management. I will include in my comments actions Northfield Hospital is taking in response to your recommendations.

With regard to the direct physician supervision requirement the hospital requests clarification as to the intent and satisfaction criteria for this requirement. Northfield Hospital's Emergency Department physicians who practice in very close proximity to the Cardiac Rehab Department provide emergency medical response to the program at all times. Medical direction and review of all program practices are provided by a designated ED physician. Medical oversight of individual patient progress during the course of treatment is monitored regularly by the patient's primary physician and, when appropriate, the patient's cardiologist.

In response to recommendations under this standard, cardiac rehab software has been purchased that will prompt documentation of physician visits and provide the patient's primary physician with information re: the exercise load and CV response to facilitate patient management. The primary MD will summarize discussions with the patient and that information will become part of the patient's record in the cardiac rehab facility.

I am uncertain if this meets the "incident to" requirement stated, but it seems to me that requiring another physician who is not familiar with the patient to manage the patient within the cardiac exercise area would be unnecessarily duplicative and potentially confusing to the patient. I would appreciate more information regarding compliance with this requirement.

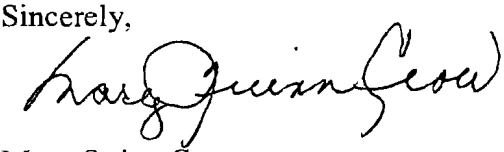
"The hospital was paid for multiple units of service for a single cardiac visit." The hospital's billing system tracked cardiac rehab visits in 15 minute increments. A new system has been implemented to bill patients per visit rather than as previously billed.

Regarding the documentation for patients with the diagnosis of stable angina, the new cardiac rehab software will prompt the required documentation to support the diagnosis. Additionally an "angina scoring scale" has been added to the documentation form for each cardiac rehab visit.

For those records where documentation was inadequate to support the billing of services (8), two problem areas have been corrected. We did discover some data entry errors which billed wrong dates for service. A process improvement occurred regarding this issue and this problem has been corrected. There were also three records which could not be located following our recent move to our new facility. These records remain unavailable and unfortunately may be permanently missing.

We are in discussions with Noridian Government Services to review this draft report. I appreciate the opportunity to offer comments at this time.

Sincerely,



Mary Quinn Crow
Vice President of Patient Care Services

cc: Ken Bank, President & CEO
Margy Henry, Cardiac Rehab Coordinator