DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

July 21, 2003

Common Identification Number: A-06-03-00033

Mr. Jerry D. Adair, President
Good Shepherd Health System
700 East Marshall Avenue
Longview, Texas 75601

Dear Mr. Adair:

Attached are two copies of our final report, entitled "Review of Good Shepherd Medical Center Outpatient Cardiac Rehabilitation Services."

In written comments, Good Shepherd Medical Center (GSMC) concurred with our recommendations and has taken corrective actions, with one exception. Although GSMC agreed to work with its fiscal intermediary to establish the amount of repayment liability, they contend that the hospital's medical records do support the diagnosis for the twelve beneficiaries in question. GSMC provided the medical records that they believe support the diagnoses.[1] GSMC's comments were included as Appendix C to our report.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please contact me at (214) 767-9206 or e-mail at gsato@oig.hhs.gov.

To facilitate identification, please refer to report number A-06-03-00033 in all correspondence relating to this report.

Sincerely,

Gordon Sato

Gordon Sato
Regional Inspector General
for Audit Services

Enclosures – as stated

[1] The medical records sent with the GSMC response will not be included in the final report for the privacy of patients who were part of our review.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF GOOD SHEPHERD MEDICAL CENTER OUTPATIENT CARDIAC REHABILITATION SERVICES

Inspector General

JULY 2003
A-06-03-00033

Office of Inspector General

http://oig.hhs.gov/

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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 and Medicaid Services 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 Good Shepherd Medical Center (GSMC) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

- Payments to GSMC 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

We determined that GSMC met the Medicare cardiac rehabilitation coverage requirements for direct physician supervision and "incident to" services. However, from our specific claims review of 30 of the 93 Medicare beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that GSMC claimed and received Medicare reimbursement for 12 beneficiaries' services, amounting to $3,737, which may not have met Medicare coverage requirements or which were otherwise unallowable. For these 12 beneficiaries, we determined that:

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files and may not be supported by medical records (all 12 beneficiaries);

- Medicare claims did not list a Medicare-covered diagnosis (8 of the 12 beneficiaries); and

- Services were billed in error (2 of the 12 beneficiaries)[1].

In addition, we found some billing and documentation errors related to some of the remaining 18 beneficiaries. The errors are as follows:

[1] The sum of the number of beneficiaries does not equal 12 because some of the beneficiaries had more than one type of error.

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files (3 beneficiaries); and

- Medicare claims did not list a Medicare-covered diagnosis (6 beneficiaries).

We determined that each of these beneficiaries had a Medicare covered diagnosis documented in the inpatient and/or referring physician's medical records. As such, we are not questioning any Medicare reimbursement related to these 18 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 all of these errors to weaknesses in GSMC's internal controls and oversight procedures. Existing controls did not ensure that: (1) beneficiaries had Medicare covered diagnoses supported by the inpatient and/or referring physician's medical records and that this documentation was maintained in the cardiac rehabilitation file, (2) claims contained a Medicare covered diagnosis, or (3) Medicare was only billed for outpatient cardiac rehabilitation services that occurred.

Our determinations regarding Medicare covered diagnoses were based solely on our review of medical documentation. The medical records have not yet been reviewed by fiscal intermediary (FI) staff. We believe that GSMC's FI, TrailBlazer Health Enterprises, LLC (Trailblazer), should decide on the allowability of the Medicare claims and the proper recovery action to be taken.

RECOMMENDATIONS

We are recommending that GSMC:

- Work with Trailblazer to establish the amount of repayment liability, identified to be as much as $3,737, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable. We also recommend that GSMC work with Trailblazer to establish any repayment liability related to the remaining 63 beneficiaries receiving outpatient cardiac rehabilitation services during 2001 that were not included in our sample.

- Implement controls to ensure that referrals for beneficiaries with Medicare covered diagnoses are supported by medical documentation maintained in the cardiac rehabilitation files prior to providing cardiac rehabilitation services and billing Medicare.

- Implement controls to ensure that outpatient cardiac rehabilitation claims contain a Medicare covered diagnosis before submitting the claim for reimbursement.

- Implement controls to ensure that Medicare is only billed for outpatient cardiac rehabilitation services that occur.

In a written response to our draft report, GSMC has addressed our recommendations and agreed with the findings, with one exception. Although GSMC agreed to work with Trailblazer to establish the amount of repayment liability, they contend that the hospital's medical records do support the diagnosis for the twelve beneficiaries in question. Included with their response, GSMC provided medical records that they believe support the diagnoses.[2] (For complete text, see Appendix C.)

[2] The medical records sent with the GSMC response will not be included in the final report for the privacy of patients who were part of our review.

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

Medicare coverage policy for cardiac rehabilitation services is found in section 35-25 of the Medicare Coverage Issues Manual. Under Medicare, outpatient cardiac rehabilitation is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending 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 cardiac rehabilitation 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 (FI) based on an ambulatory payment classification. The FI for Good Shepherd Medical Center (GSMC) is TrailBlazer Health Enterprises (Trailblazer). For calendar year (CY) 2001, GSMC provided outpatient cardiac rehabilitation services to 93 Medicare beneficiaries and received $27,086 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 GSMC for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

- Payments to GSMC 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 GSMC's current policies and procedures and interviewed staff to gain an understanding of GSMC's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. In addition, we reviewed GSMC'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 GSMC during CY 2001 as part of a multistate statistical sample. We reviewed GSMC's outpatient cardiac rehabilitation procedures for and controls over physician supervision, cardiac rehabilitation staffing, and maintenance and availability of advanced cardiac life support equipment.

Our GSMC sample included 30 of 93 Medicare beneficiaries who received outpatient cardiac rehabilitation services from GSMC 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 GSMC's policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and identified any differences. We documented how GSMC's staff provided direct physician supervision for cardiac rehabilitation services and verified that GSMC'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 GSMC 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. The diagnoses were verified by reviewing GSMC's outpatient cardiac rehabilitation medical records, the physician referrals, and the beneficiaries' inpatient medical records and/or referring physician's medical records. In addition, we verified that Medicare did not reimburse GSMC 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' request for a nationwide analysis, we determined the extent that providers were currently complying with existing Medicare coverage requirements.

We performed fieldwork at GSMC in Longview, Texas and at our field office in Oklahoma City, Oklahoma during February through May 2003.

RESULTS OF AUDIT

We determined that GSMC met the Medicare cardiac rehabilitation coverage requirements for direct physician supervision and "incident to" services. However, from our specific claims review of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that GSMC claimed and received Medicare reimbursement for 12 beneficiaries' services, amounting to $3,737, which may not have met Medicare coverage requirements or which were otherwise unallowable. For these 12 beneficiaries, we determined that:

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files and may not be supported by medical records (all 12 beneficiaries);

- Medicare claims did not list a Medicare-covered diagnosis (8 of the 12 beneficiaries); and

- Services were billed in error (2 of the 12 beneficiaries)[3].

In addition, we found some billing and documentation errors related to some of the remaining 18 beneficiaries. The errors are as follows:

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files (3 beneficiaries); and

- Medicare claims did not list a Medicare-covered diagnosis (6 beneficiaries).

We determined that each of these beneficiaries had a Medicare covered diagnosis documented in the inpatient and/or referring physician's medical records. As such, we are not questioning any Medicare reimbursement related to these 18 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 the services are performed on hospital premises.

[3] The sum of the number of beneficiaries does not equal 12 because some of the beneficiaries had more than one type of error.

At GSMC, the cardiac rehabilitation facility is not located within the main hospital. GSMC has two contracted physicians who are assigned the responsibility of providing direct physician supervision of services provided by non-physician personnel during the cardiac rehabilitation exercise programs. Although GSMC has no written policy dealing with a physician being present at each session, a physician is always present during the sessions. This direct physician supervision is documented via the physician schedule. The physicians are required to sign-in on the physician schedule to denote which physician is present at each session. As such, the physicians are also immediately available for an emergency at all times the exercise program is being conducted. Therefore, we believe that GSMC's cardiac rehabilitation program met the direct physician supervision requirements.

"Incident To" Physician Services

Medicare covers Phase II cardiac rehabilitation under the "incident to" benefit. During any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often enough to assess the course of treatment, the patient's progress, and where necessary change the treatment program.

From our review of GSMC's outpatient cardiac rehabilitation medical records, we were able to locate evidence of physician professional services rendered to the patients participating in the program. These physician services were documented in the cardiac rehabilitation files via the physician's progress notes. The notes were written, dated and signed by a supervising physician for each session. Accordingly, we believe that GSMC's cardiac rehabilitation program met 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. Documentation for these services must be maintained in the patients' medical records.

Our sample review of 30 of 93 GSMC Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to $9,014 during CY 2001, disclosed that Medicare claims for 19 beneficiaries contained 43 errors. However, we are only questioning the Medicare reimbursement of claims for 12 beneficiaries totaling $3,737.

Categories of Errors

Medicare Covered Diagnoses Not Supported in Cardiac Rehabilitation Files and/or Medical Records. Of the 30 sampled beneficiaries, the cardiac rehabilitation files for 15 beneficiaries did not include medical documentation to support the diagnosis identified on the physician referral. GSMC's cardiac rehabilitation program relied on a "check box" physician referral as documentation of a Medicare covered diagnosis. GSMC's cardiac rehabilitation

program staff did not maintain additional documentation to validate the diagnosis. Three of the beneficiaries were diagnosed with coronary artery bypass graft surgery, while the remaining twelve beneficiaries were diagnosed with stable angina.

To validate the diagnoses of these 15 beneficiaries, we obtained and reviewed the inpatient medical records and/or the medical records of the physicians who referred these 15 beneficiaries for cardiac rehabilitation. The medical records covered the dates of the beneficiaries' inpatient stays, or the on-set date per the physician referral, through their completion of Phase II of the cardiac rehabilitation program. The medical records supported the diagnoses for the three coronary artery bypass graft surgery beneficiaries. However, the medical records did not appear to support the diagnoses for the 12 stable angina beneficiaries.

Of the 12 beneficiaries diagnosed with stable angina:

- Ten beneficiaries had inpatient stays at GSMC with a diagnosis of either unstable or stable angina;

- One beneficiary had an inpatient stay at a hospital other than GSMC, but we could not determine the diagnosis for that stay because the records were lost during a hospital flood shortly after the stay; and

- One beneficiary was referred to the outpatient cardiac rehabilitation program without having an inpatient stay for the date of onset per the physician referral.

For the 10 beneficiaries with inpatient stays, cardiac procedures such as stenting, angioplasty, or arteriography were performed. Upon their discharge from the hospital, these beneficiaries were referred to the outpatient cardiac rehabilitation program by their physicians.

Based on our review of these medical records, it did not appear that the records indicated that the 12 beneficiaries continued to experience angina symptoms post-procedure and through their completion of Phase II of the cardiac rehabilitation program. As a result, we believe that Medicare may have inappropriately paid $3,737 to GSMC for the cardiac rehabilitation services provided to these 12 beneficiaries.

Non-Covered Diagnoses on Claims. Medicare paid outpatient cardiac rehabilitation claims that did not contain Medicare covered diagnoses for 14 beneficiaries. Based on our review of the inpatient medical records, we determined that the medical records supported a Medicare covered diagnosis for six of the beneficiaries. The remaining eight beneficiaries were identified as having stable angina per the physician referral and are included in the 12 beneficiaries discussed in the Medicare Covered Diagnoses Unsupported in Cardiac Rehabilitation Files/Medical Records section above. Nevertheless, the claims for all 14 beneficiaries were paid because Trailblazer's claims processing system did not contain edits to reject outpatient cardiac rehabilitation claims not having a Medicare covered diagnosis.

Services Billed in Error. GSMC received Medicare reimbursement for cardiac rehabilitation services that did not occur. GSMC was unable to locate supporting documentation for three specific dates of cardiac rehabilitation services for two beneficiaries. Upon review by GSMC staff, it was determined that the services did not occur. As such, GSMC was inappropriately reimbursed $42. However, this amount is already included in the $3,737 amount discussed in the Medicare Covered Diagnoses Unsupported in Cardiac Rehabilitation Files/Medical Records section above.

Underlying Causes for Errors

Medicare Covered Diagnoses Not Supported in Cardiac Rehabilitation Files and/or Medical Records. GSMC did not ensure referral for beneficiaries with Medicare covered diagnoses were supported by medical documentation prior to providing cardiac rehabilitation services and billing Medicare. Specifically, GSMC procedures did not require referring physicians to provide medical documentation supporting the diagnoses used to justify phase II cardiac rehabilitation services at Medicare expense.

Non-Covered Diagnoses on Claims. GSMC's internal controls did not ensure that outpatient cardiac rehabilitation claims contained a Medicare covered diagnosis before submitting the claim for reimbursement.

Services Billed in Error. GSMC's internal controls did not ensure that Medicare was only billed for outpatient cardiac rehabilitation services that occurred.

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

RECOMMENDATIONS

We recommend that GSMC:

- Work with Trailblazer to establish the amount of repayment liability, identified to be as much as $3,737, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services otherwise unallowable. We also recommend that GSMC work with Trailblazer to establish any repayment liability related to the remaining 63 beneficiaries receiving outpatient cardiac rehabilitation services during 2001 that were not included in our sample.

- Implement controls to ensure that referrals for beneficiaries with Medicare covered diagnoses are supported by medical documentation maintained in the cardiac rehabilitation files prior to providing cardiac rehabilitation services and billing Medicare.

- Implement controls to ensure that outpatient cardiac rehabilitation claims contain a Medicare covered diagnosis before submitting the claim for reimbursement.

- Implement controls to ensure that Medicare is only billed for outpatient cardiac rehabilitation services that actually occur.

AUDITEE COMMENTS

In a written response to our draft report, GSMC agreed with the findings, with one exception. In accordance with our recommendations, GSMC has strengthened their controls related to our findings.

- For Medicare patients diagnosed with stable angina, GSMC now requires a physician's note specifically stating that the patient has stable angina based on references to medical records. Copies of the referenced documentation must also be maintained in the cardiac rehabilitation file.

- GSMC provided extensive training to all employees responsible for cardiac rehabilitation coding and began a review process to ensure that claims contain a covered diagnosis before being submitted for reimbursement.

- GSMC now requires cardiac rehabilitation services to be billed directly from medical records of patients' sessions to prevent services billed in error.

However, GSMC contends the hospital's medical records do support the diagnoses for the 12 beneficiaries in question. Included with their response, GSMC provided medical records that they believe support the diagnoses.[4] GSMC has agreed to work with Trailblazer to establish the amount of repayment liability resulting from our audit and the repayment liability related to the other Medicare beneficiaries who received outpatient cardiac rehabilitation services during 2001. (For complete text, see Appendix C.)

OIG RESPONSE

As previously mentioned, we believe that Trailblazer should determine the allowability of the cardiac rehabilitation services and the proper recovery action to be taken.

[4] The medical records sent with the GSMC response will not be included in the final report for the privacy of patients who were part of our review.

APPENDICES

STATISTICAL SAMPLE SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of our statistically selected sample of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services from GSMC during CY 2001. The total number of errors per diagnosis is greater than the total sample, as some beneficiaries had more than one type of error.

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 IN CR FILES SUPPORTING THE MEDICARE COVERED DIAGNOSIS	BENEFICIARIES POSSIBLY NOT HAVING A COVERED DIAGNOSIS	CLAIM NOT HAVING A COVERED DIAGNOSIS	SERVICES BILLED IN ERROR	NUMBER OF ERRORS PER DIAGNOSIS
7	2	**Acute Myocardial Infarction**	0	0	2	0	2
11	5	**Coronary Artery Bypass Graft**	3	0	4	0	7
12	12	**Stable Angina Pectoris**	12	12	8	2	34
30	**19**	**Total**	**15**	**12**	**14**	**2**	**43**

SAMPLING AND UNIVERSE DATA AND METHODOLOGY

We statistically selected a sample of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services from GSMC during CY 2001. For each beneficiary, we obtained all Medicare claims reimbursement data for outpatient cardiac rehabilitation services and compared this data to GSMC outpatient cardiac rehabilitation service documentation. In addition, we verified the accuracy of the diagnoses identified on the Medicare claims. The diagnoses were verified by reviewing GSMC's outpatient cardiac rehabilitation medical records, the physician referrals, and the beneficiaries' inpatient medical records and/or referring physician's medical records.

The results of our review 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 ERROR VALUE

UNIVERSE	POPULATION VALUE	SAMPLE SIZE	SAMPLE VALUE	SAMPLED BENEFICIARIES WITH ERRORS	SAMPLE ERRORS VALUE
93	$27,086	30	$9,014	19	$3,737

GOOD SHEPHERD
HEALTH SYSTEM

June 26, 2003

Mr. Gordon Sato, Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Dear Mr. Sato:

I appreciate the opportunity to respond to draft report number A-06-03-00033, "Review of Good Shepherd Medical Center Outpatient Cardiac Rehabilitation Services."

We will work with Trailblazer to establish the amount of repayment liability resulting from the audit and to determine any repayment liability related to the other Medicare beneficiaries who received outpatient cardiac rehabilitation services during 2001.

Based on a thorough review by impartial Good Shepherd clinical staff we contend the hospital's medical records do support the stable angina diagnoses for the twelve beneficiaries in question. Attached are portions of each patient's medical records that we believe validate the diagnoses. Pertinent excerpts are marked with brackets in the left margins.

Nevertheless, we have strengthened our controls to ensure that covered diagnoses are supported by medical documentation. A policy has been implemented requiring a physician's note for Medicare patients referred with stable angina specifically stating that the patient has stable angina based on references to the medical record. The policy also requires that copies of referenced documentation be maintained in the cardiac rehabilitation file in addition to hospital medical records.

We evaluated our diagnostic coding methodology relating to cardiac rehabilitation and found that the non-covered diagnostic codes resulted from not adhering to established procedures. Extensive training has been provided to all employees responsible for cardiac rehabilitation coding. Additionally, a review process has been set-up to ensure that claims contain a covered diagnosis before being submitted for reimbursement.

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www.GoodShepherdHealth.org

To prevent services being billed in error we have established new procedures requiring that cardiac rehabilitation services be billed directly from medical records of patients' therapy sessions, rather than from a list of patients attending a session. Training has been provided to all staff involved in the billing process.

Although not an audit recommendation, a policy has been implemented stating that a physician will be present during therapy sessions.

Internal Audit will conduct periodic assessments to ensure that these controls are adequate to prevent problems identified by the audit from reoccurring.

Please contact Harry Stephens, Internal Audit Director, at 903-315-2637 if you have questions or need additional information.

Sincerely,

Jerry D. Adair
President and
Chief Executive Officer

Attachments (Note: The attached 26 pages are protected health information.)

cc: Finance Committee of the Board of Trustees