DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

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

August 26, 2003

Report No. A-06-03-00039

Ms. Sheila Henson
Director, Corporate Compliance
Deaconess Hospital
5501 North Portland Avenue
Oklahoma City, OK 73112

Dear Ms. Henson:

Enclosed are two copies of the Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services (OAS), final report entitled "Review of Deaconess Hospital Outpatient Cardiac Rehabilitation Services."

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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG/OAS 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.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at http://oig.hhs.gov.

To facilitate identification, please refer to report number A-06-03-00039 in all correspondence relating to this report.

Sincerely yours,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General for
Audit Services

Enclosure- as stated

Direct Reply to HHS Action Official:

James R. Farris, MD.
Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF DEACONESS HOSPITAL OUTPATIENT CARDIAC REHABILITATION SERVICES

AUGUST 2003
A-06-03-00039

Office of Inspector General

http://oig.hhs.gov/

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS Office of Inspector General. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the Administrator of the Centers for Medicare & Medicaid Services 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 Deaconess Hospital (DH) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

- Payments to DH 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

We determined that DH met the Medicare cardiac rehabilitation coverage requirements for direct physician supervision. However, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." Further, from our specific claims review of all 19 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that DH claimed and received Medicare reimbursement for five beneficiaries' services, amounting to $462, which were not supported by medical record documentation or which were otherwise unallowable. For these five beneficiaries, we determined that Medicare paid for:

- Undocumented outpatient cardiac rehabilitation services (one of the five beneficiaries);
- Multiple units of service for a single cardiac rehabilitation visit (one of the five beneficiaries);
- Services billed in error (two of the five beneficiaries);
- Services in excess of the standard Medicare limit (four of the five beneficiaries); and
- Services for beneficiaries with inadequate physician referrals (four of the five beneficiaries).[1]

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

In addition, we found some billing and documentation errors related to 13 of the remaining 14 beneficiaries. We determined that each of these beneficiaries had Medicare covered diagnoses documented in the inpatient and/or referring physician's medical records. As such, we are not questioning any Medicare reimbursement related to these 13 beneficiaries. The errors are as follows:

- Beneficiaries' physician referrals were inadequate (thirteen beneficiaries); and
- Medicare claims did not list a Medicare covered diagnosis (two beneficiaries). [2]

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 DH's internal controls and oversight procedures. Existing controls did not ensure that:

- Supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained;
- Only one unit of service was billed for each outpatient cardiac rehabilitation service;
- Medicare was only billed for outpatient cardiac rehabilitation services that were provided;
- Outpatient cardiac rehabilitation services billed for each beneficiary were within the standard limit for Medicare coverage;
- Referrals for outpatient cardiac rehabilitation contained adequate information; and
- Claims for outpatient cardiac rehabilitation contained a Medicare covered diagnosis.

RECOMMENDATIONS

We are recommending that DH:

- Work with its Medicare fiscal intermediary, Chisholm Administrative Services, to ensure that DH's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirement that the services be provided "incident to" a physician's professional service.

- Reimburse Medicare $462 for CY 2001 outpatient cardiac rehabilitation services provided to beneficiaries which were not supported by medical record documentation or which were otherwise unallowable.

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

[2] The sum of the number of beneficiaries does not equal 13 because some of the beneficiaries had more than one type of error.

- Implement controls to ensure that only one unit of service is billed for each outpatient cardiac rehabilitation service.

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

- Implement controls to ensure that outpatient cardiac rehabilitation services billed for each beneficiary are within the standard limit for Medicare coverage.

- Implement controls to ensure that the beneficiaries' physician referrals for outpatient cardiac rehabilitation contain adequate information.

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

In a written response to our draft report, DH officials agreed with the findings and recommendations, and indicated that they have taken corrective action to improve documentation and charge capture procedures. They have also refunded some of the questioned amounts identified during our audit. These officials indicated that the remainder of the questioned amounts would be refunded promptly, including the questioned amounts related to CY 2000. (For complete text, see APPENDIX C.)

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 Centers for Medicare & 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 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 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 Deaconess Hospital (DH) is Chisholm Administrative Services (CAS). For calendar year (CY) 2001, DH provided outpatient cardiac rehabilitation services to 19 Medicare beneficiaries and received $7,457 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 DH for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

- Payments to DH 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 DH's current policies and procedures and interviewed staff to gain an understanding of DH's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. In addition, we reviewed DH's cardiac rehabilitation services documentation, inpatient medical records, physician referrals, and Medicare reimbursement data for the 19 beneficiaries who received outpatient cardiac rehabilitation services from DH during CY 2001 as part of a nationwide review of outpatient cardiac rehabilitation services. We reviewed DH'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 review included all 19 DH Medicare beneficiaries who received outpatient cardiac rehabilitation services from DH during CY 2001. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 19 beneficiaries during CY 2001.

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

Methodology

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

For each beneficiary, we obtained the CY 2001 Medicare outpatient cardiac rehabilitation paid claims and lines of service and compared this data to DH'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 DH's outpatient cardiac rehabilitation medical record. In addition, we determined if Medicare reimbursed DH beyond the maximum number of services allowed.

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 DH located in Oklahoma City, Oklahoma and at our Oklahoma City Field Office during the period March through June 2003.

RESULTS OF REVIEW

We determined that DH met the Medicare cardiac rehabilitation coverage requirements for direct physician supervision. However, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." Further, from our specific claims review of all 19 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that DH claimed and received Medicare reimbursement for five beneficiaries' services, amounting to $462, which were not supported by medical record documentation or which were otherwise unallowable. For these five beneficiaries, we determined that Medicare paid for:

- Undocumented outpatient cardiac rehabilitation services (one of the five beneficiaries);
- Multiple units of service for a single cardiac rehabilitation visit (one of the five beneficiaries);
- Services billed in error (two of the five beneficiaries);
- Services in excess of the standard Medicare limit (four of the five beneficiaries); and
- Services for beneficiaries with inadequate physician referrals (four of the five beneficiaries).[3]

In addition, we found some billing and documentation errors related to 13 of the remaining 14 beneficiaries. We determined that each of these beneficiaries had Medicare covered diagnoses and the cardiac rehabilitation was medically necessary based on those diagnoses. As such, we are not questioning any Medicare reimbursement related to these 13 beneficiaries. The errors are as follows:

- Beneficiaries' physician referrals were inadequate (thirteen beneficiaries); and
- Medicare claims did not list a Medicare covered diagnosis (two beneficiaries).[4]

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

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

[4] The sum of the number of beneficiaries does not equal 13 because some of the beneficiaries had more than one type of error.

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 DH, the medical director has been identified as the physician responsible for coverage of outpatient cardiac rehabilitation services. The clinical notes for the outpatient cardiac rehabilitation services identify the monitoring physician for each session. DH's policies and procedures state that the medical director is "on site and/or available" during outpatient cardiac rehabilitation sessions. As such, the medical director would be immediately available for an emergency at all times the exercise program is being conducted. Further, DH's policies and procedures state "…the emergency room physicians and code blue team can be called in case of an emergency at any time." Therefore, we believe that DH'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. 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 DH, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." The contract for cardiac rehabilitation services between DH and the medical director states that the medical director "…will provide guidance and advise the rehabilitation personnel in their observations of all patients admitted into the program." According to DH's policies and procedures, once admitted to the program, cardiac rehabilitation staff only contacts the medical director and/or referring physician:

- To obtain instruction if patients experience symptoms or situations that necessitate temporarily deferring physical activity or terminating the exercise session; and

- To provide periodic patient progress reports.

From our review of DH'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 DH'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 all 19 DH Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to $7,457 during CY 2001, disclosed 27 errors totaling $462 for 18 beneficiaries.

Categories of Errors

Undocumented Services. DH did not maintain cardiac rehabilitation service documentation to support the Medicare claims of one beneficiary. DH's staff was unable to locate supporting cardiac rehabilitation documentation for the beneficiary's entire cardiac rehabilitation program. Medicare made inappropriate reimbursements of $82 to DH for six unsupported services.[5]

Multiple Units Billed. DH billed two units of service for a single cardiac rehabilitation session on four separate occasions for one beneficiary. Medicare policy counts a session at the cardiac rehabilitation center as one unit of service. Medicare reimbursed an additional $56 to DH for this beneficiary with multiple unit billings because CAS' claim processing system did not have an edit in place to ensure that Medicare only paid for one unit of service for each cardiac rehabilitation session.

Services Billed in Error. DH received Medicare reimbursement for cardiac rehabilitation services that were not provided. DH's staff was unable to locate supporting documentation for cardiac rehabilitation services for two beneficiaries. Upon review by DH staff, it was determined that the services did not occur. As such, DH was inappropriately reimbursed $28.

Services Exceeding Standard Medicare Limit. DH received inappropriate Medicare reimbursement for services in excess of the standard Medicare limit for four beneficiaries. According to the Medicare Coverage Issues Manual, claims for coverage

[5] DH also received $193 from Medicare for fifteen unsupported CY 2000 services that were part of the same cardiac rehabilitation program, but outside of our audit period. Although the $193 is unallowable, this amount will not be included in the nationwide roll-up report of CY 2001 outpatient cardiac rehabilitation services.

of cardiac rehabilitation exercise programs beyond 36 sessions are reviewed by the FI. When claims are accompanied by acceptable documentation that the patient has not reached an exit level, coverage may be extended, but should not exceed a maximum of 24 weeks. The CAS did not review documentation before paying the sessions exceeding the standard Medicare limit for these four beneficiaries because CAS does not currently have edits to identify cardiac rehabilitation claims that require medical review and approval for payment. As such, DH was inappropriately reimbursed $296 for services exceeding the standard Medicare limit.

Inadequate Referrals. For seventeen beneficiaries, DH did not maintain adequate physician referrals for outpatient cardiac rehabilitation. We identified the following errors related to the beneficiaries' physician referrals:

- The number of outpatient cardiac rehabilitation sessions that the beneficiary should attend were not prescribed by the physician;
- The diagnosis establishing the beneficiary's eligibility for Medicare coverage was not specified;
- The diagnosis listed on the claim was a non-Medicare covered diagnosis; and
- The physician did not sign the referral.

However, we are not questioning any claims for these errors because we verified that each of these beneficiaries had Medicare covered diagnoses and the cardiac rehabilitation was medically necessary based on those diagnoses.

Non-Covered Diagnoses on Claims. Medicare paid outpatient cardiac rehabilitation claims that did not contain Medicare covered diagnoses for two beneficiaries. However, we are not questioning any claims due to this error. Based on our review of the inpatient medical records, we determined that the medical records supported a Medicare covered diagnosis for both beneficiaries. Nevertheless, the claims for both beneficiaries were paid because CAS' claims processing system did not contain edits to reject outpatient cardiac rehabilitation claims not having a Medicare covered diagnosis.

Underlying Causes for Errors

Undocumented Services. DH's internal controls did not ensure supporting documentation for Medicare billings and reimbursement for outpatient cardiac rehabilitation services was maintained.

Multiple Units Billed. DH did not have controls to ensure that Medicare was billed only one unit of service for each cardiac rehabilitation session. DH's staff believes that when transferring information into a new database, a new account was set up for the beneficiary without deleting the beneficiary's old account. Therefore, two units were billed by mistake.

Services Billed in Error. DH did not have controls in place to ensure that Medicare was only billed for outpatient cardiac rehabilitation services that were provided. DH staff

believes that, in one case, the person responsible for posting charges must have posted from a schedule, rather than documentation of an actual service.

Services Exceeding Standard Medicare Limit. DH billed in excess of the Medicare standard limit for the following reasons:

- Cardiac rehabilitation staff misnumbered the sessions on the clinical notes (two beneficiaries with a total of three sessions in excess of the standard Medicare limit); and

- DH billed sessions related to the same Medicare covered diagnosis as two separate rehabilitation programs. However, when the sessions for both programs are combined, the number of sessions exceeds the standard Medicare limit (two beneficiaries with a total of eighteen sessions in excess of the standard Medicare limit).

Inadequate Referrals. DH's internal controls did not ensure that the beneficiaries' physician referrals for outpatient cardiac rehabilitation contained adequate information.

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

The results of our review may be included in a nationwide roll-up report of all outpatient cardiac rehabilitation providers reviewed. (See APPENDICES A and B for specific error types and dollar values.)

RECOMMENDATIONS

We recommend that DH:

- Work with CAS to ensure that DH's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirement that the services be provided "incident to" a physician's professional service.

- Reimburse Medicare $462 for CY 2001 outpatient cardiac rehabilitation services provided to beneficiaries which were not supported by medical record documentation or which were otherwise unallowable.

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

- Implement controls to ensure that only one unit of service is billed for each outpatient cardiac rehabilitation service.

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

- Implement controls to ensure that outpatient cardiac rehabilitation services billed for each beneficiary are within the standard limit for Medicare coverage.

- Implement controls to ensure that the beneficiaries' physician referrals for outpatient cardiac rehabilitation contain adequate information.

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

AUDITEE COMMENTS

In written response to our draft report, DH officials agreed with the findings and recommendations. They have undertaken corrective action to improve documentation and charge capture procedures. Specifically, DH will:

- Revise the medical director contract outlining specific requirements for program and process oversight. They will amend policy and procedures to reflect changes in the contract and ask CAS to review the changes to ensure that they are meeting the "incident to" requirements.

- Provide physician and staff education on required documentation and covered diagnoses. A process will be put into place to ensure an accurate count for number of session.

- Conduct a hospital-wide process improvement initiative to improve charge capture. The new procedures will address verification of charges.

In addition, DH has refunded some of the questioned amounts. Officials at DH indicated that the remaining questioned amounts would be refunded promptly, including the CY 2000 amounts identified that do not have supporting documentation. (For complete text, see APPENDIX C.)

APPENDICES

APPENDIX A

SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of the 19 Medicare beneficiaries who received outpatient cardiac rehabilitation services from DH during CY 2001. The 19 beneficiaries reviewed were part of a nationwide review of CY 2001 outpatient cardiac rehabilitation services. The total number of errors per diagnosis is greater than the total number of beneficiaries because some beneficiaries had more than one type of error. The results of our review may be included in a nationwide roll-up report.

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

Number of Beneficiaries with Diagnosis	Number of Beneficiaries with Errors	Medicare Covered Diagnosis	No Cardiac Rehabilitation Supporting Documentation	Multiple Units of Service Billed	Service Billed in Error	Services in Excess of Standard Medicare Limit	Non-Covered Diagnosis on Claim	Inadequate Referrals	Total Errors per Diagnosis
6	6	**Acute Myocardial Infarction**	0	0	2	2	0	6	10
13	12	**Coronary Artery Bypass Graft**	1	1	0	2	2	11	17
0	0	**Stable Angina Pectoris**	0	0	0	0	0	0	0
19	**18**	**Total**	**1**	**1**	**2**	**4**	**2**	**17**	**27**

APPENDIX B

SAMPLING AND UNIVERSE DATA AND METHODOLOGY

We reviewed all 19 Medicare beneficiaries who received outpatient cardiac rehabilitation services from DH during CY 2001. For each beneficiary, we obtained all Medicare claims reimbursement data for outpatient cardiac rehabilitation services and compared this data to DH'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 physician referral, and DH's outpatient cardiac rehabilitation service records. The results of our review may be included in a nationwide roll-up report of outpatient cardiac rehabilitation services.

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
19	$7,457	19	$7,457	18	$462

Deaconess Hospital

July 24, 2003

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

5501 N. Portland
Oklahoma City
Oklahoma
73112-2099
405. 604. 6000

Dear Mr. Sato:

Thank you for your draft report A-06-03-00039 on the audit conducted regarding Cardiac Rehabilitation services at Deaconess Hospital. Enclosed you will find our responses to the recommendations.

We have undertaken corrective action to improve the documentation and charge capture procedures supporting the quality care Deaconess provides its patients. In addition to the information provided in our responses, we asked our third party compliance audit firm to look at recent cardiac rehabilitation records. They reviewed 24 records from CY 2003 and found only one discrepancy. Therefore, we feel there has been significant improvement since CY 2001.

After you review our responses, please feel free to contact me with any questions.

Sincerely,

Sheila Henson

Sheila Henson
Director, Corporate Compliance

Enclosures

Response to Review of Deaconess Hospital
Cardiac Rehabilitation Services
2003

RECOMMENDATION	RESPONSE
Deaconess Hospital (DH) should work with its Medicare fiscal intermediary, Chisholm Administrative Services, to ensure that DH's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirement that the services be provided "incident to" a physician's professional service.	DH will revise the Medical Director contract outlining specific requirements for program and process oversight. DH will amend policy and procedures to reflect changes in the contract. DH will ask Chisholm to review these changes to ensure it is meeting the "incident to" requirements.
DH should reimburse Medicare $462 for CY 2001 outpatient cardiac rehabilitation services provided to beneficiaries which were not supported by medical record documentation or which were otherwise unallowable.	DH has refunded some of the accounts in question. The remainder will be refunded promptly. DH will also refund CY 2000 charges for one beneficiary identified during the audit that do not have supporting documentation. DH feels the documentation may have existed at time service was rendered. However, upon converting paper documentation to CD-ROM, some documents were lost. The reimbursement for these charges total $215.
DH should implement controls to ensure that medical record documentation is maintained to support Medicare outpatient cardiac rehabilitation services.	DH will initiate a new procedure for open and closed medical record review audits. This will be incorporated into the Performance Improvement plan and be reported to the PI Council on a regular basis. DH will also provide education to all Outpatient Cardiac Rehab staff on required documentation and covered diagnoses. A process will be put into place to ensure an accurate count for number of sessions.

Response to Review of Deaconess Hospital
Cardiac Rehabilitation Services
2003

DH should implement controls to ensure that only one unit of service is billed for each outpatient cardiac rehabilitation service. DH should implement controls to ensure that Medicare is only billed for outpatient cardiac rehabilitation services that are provided. DH should implement controls to ensure that outpatient cardiac rehabilitation services billed for each beneficiary are within the standard limit for Medicare coverage.	The auditing process referred to above will address these issues. DH will conduct physician and staff education regarding information requirements. DH has already implemented a process for patient certification and recertification for additional controls. Please refer to attached certification forms. DH is conducting a hospital-wide process improvement initiative to improve charge capture. New procedures will address verification of charges. Please see attached template.
DH should implement controls to ensure that the beneficiaries' physician referrals for outpatient cardiac rehabilitation contain adequate information. DH should implement controls to ensure that outpatient cardiac rehabilitation claims contain a Medicare covered diagnosis before submitting the claim for reimbursement.	DH has provided education on required documentation and covered diagnoses to all Outpatient Cardiac Rehab staff and will do the same for physicians. Open record audits referred to previously will also ensure proper documentation is in place prior to billing the claim.

Deaconess Hospital
Outpatient Cardiac Rehabilitation
5501 N. Portland
Oklahoma City, OK 73112
Phone: (405) 604-4363 / Fax: (405) 604-6285

Plan of Care / Statement of Necessity for Cardiac Rehabilitation Services

Patient Name:_____ **Primary Diagnosis:** _____ **Secondary Diagnosis:** _____

Referral Source:_____ **DOB:**_____ **Onset Date:**_____

Prior Hospitalization:_____ **Start of Care (SOC):**_____ **Provider #:**_____

Social Security #:_____ **Prior Level of Function:**_____

Thank you for your referral. The Plan of Care and following information is based on the information from the initial evaluation.

Assessment / key information:_____

_____

_____

Problem List:

- ☐ **METS LEVEL:** _____
- ☐ **BLOOD PRESSURE:** ____/____
- ☐ ↓ Activity Tolerance
- ☐ ↓ ROM
- ☐ ↓ Strength
- ☐ **Activity-induced Dysrhythmia**
- ☐ **Activity-induced Angina**
- ☐ ↓ Flexibility / Joint Mobility
- ☐ ↓ Transfer Abilities
- ☐ ↓ ADL / Functional Abilities

Other_____

Treatment Plan:

- ☐ Monitored Exercise Program
- ☐ Therapeutic Activities
- ☐ Interval Training
- ☐ Follow-Up ECG Stress Test / other test _____
- ☐ Weight Training / PRE's
- ☐ Flexibility Training
- ☐ Patient Education

Other_____

Patient / Family readiness to learn indicated by: ☐ Asking questions ☐ Trying to perform skills ☐ Interest ☐ Other_____

Persons(s) to be included in education: ☐ Patient (P) ☐ Family Support Person (FSP); list:_____

Barriers to Learning / Limitations: ☐ Yes ☐ No

If yes, check those that apply and list measures taken to address Barriers to Learning / Limitations:

☐ Language ☐ Cultural ☐ Cognitive ☐ Sensory Deficits-Vision/Hearing/Speech ☐ Altered Mental Status (i.e. Sedation, Confusion)
☐ Religious ☐ Emotional ☐ Reading/Writing ☐ Financial ☐ Physical ☐ Other_____

Measures taken:_____

Patient Goal (s):_____

Rehabilitation Potential: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Short Term Goals: To be accomplished in _____ weeks / treatments:

1. _____
2. _____
3. _____

Long Term Goals: To be accomplished in _____ weeks / treatments:

- ☐ **1. Patient will achieve a stable level of exercise tolerance without ischemia or dysrhythmia.**
- ☐ **2. Patient will stabilize symptoms of angina or dyspnea at the maximum exercise level.**
- ☐ **3. Patients' resting blood pressure and heart rate are within normal limits.**
- ☐ **4. Stress Test is not positive during exercise.**
- ☐ **5. Patient will be able to perform ADL(s): _____**
- ☐ **6. Patient will be able to ambulate _____ (feet / yards / blocks / miles) with _____ decrease in cardio function.**
- ☐ **7. Other: _____**

Frequency / Duration: Patient to be seen _____ times per week for _____weeks:

Patient / Caregiver education and instruction:

☐ Self Care ☐ Activity Modification ☐ Exercises ☐ Nutrition ☐ Smoking Cessation ☐ Home Exercise ☐ CVD

Evaluator:_____ **Date:**_____

Certification Period:_____ - _____

I certify that the above Cardiac Rehabilitation Services are being furnished while the patient is under my care. I agree with the treatment plan and certify that this service is necessary.

Physician UPIN:_____

Physician Signature:_____ **Date:**_____

Please sign and return to Deaconess Hospital or you may fax the signed copy to (405) 604-6285. Thank you.

Deaconess Hospital
Outpatient Cardiac Rehabilitation
5501 N. Portland
Oklahoma City, OK 73112
Phone: (405) 604-4363/ Fax: (405) 604-6285

Continued Plan of Care / Re-certification for Cardiac Rehabilitation Services

Patient Name:_____ **Diagnosis:**_____

Referral Source:_____ **DOB:**_____ **Onset Date:**_____

Prior Hospitalization:_____ **Start of Care (SOC):**_____ **Visits from SOC:**_____

Thank you for your referral of the above patient to Deaconess Hospital. The Plan of Care and following information is based on the patient's current status:

The patient's goal status is as follows:

Long-Term Goal / Measure:	Status at last certification	Current Status

Problem List:

- ☐ **METS LEVEL:** _____
- ☐ **BLOOD PRESSURE:** ____/____
- ☐ ↓ Activity Tolerance
- ☐ ↓ ROM
- ☐ ↓ Strength
- ☐ **Activity-induced Dysrhythmia**
- ☐ **Activity-induced Angina**
- ☐ ↓ Flexibility / Joint Mobility
- ☐ ↓ Transfer Abilities
- ☐ ↓ ADL / Functional Abilities

Other_____

Treatment Plan:

- ☐ Monitored Exercise Program
- ☐ Therapeutic Activities
- ☐ Interval Training
- ☐ Follow-Up ECG Stress Test / other test _____
- ☐ Weight Training / PRE's
- ☐ Flexibility Training
- ☐ Patient Education

Other_____

Patient Goal (s) has been updated and includes:_____

Goals for this certification period include:

- ☐ **1. Patient will achieve a stable level of exercise tolerance without ischemia or dysrhythmia.**
- ☐ **2. Patient will stabilize symptoms of angina or dyspnea at the maximum exercise level.**
- ☐ **3. Patients' resting blood pressure and heart rate are within normal limits.**
- ☐ **4. Stress Test is not positive during exercise.**
- ☐ **5. Patient will be able to perform ADL(s):** _____
- ☐ **6. Patient will be able to ambulate** _____ **(feet / yards / blocks / miles) with** _____ **decrease in cardio function.**
- ☐ **7. Other:** _____

Frequency / Duration: Patient to be seen _____ **times per week for** _____**weeks:**

Patient / Caregiver education and instruction:

☐ Self Care ☐ Activity Modification ☐ Exercises ☐ Nutrition ☐ Smoking Cessation ☐ Home Exercise ☐ CVD

Evaluator:_____ **Certification Period:**_____ - _____

☐ **I certify that the above Cardiac Rehabilitation Services are being furnished while the patient is under my care. I agree with the treatment plan and certify that this service is necessary.**

☐ **I have reviewed the following Cardiac Rehabilitation Plan of Care and request the following changes:**

- ☐ Modify frequency and duration of the Plan of Care to:____ times per week for _____weeks.
- ☐ Discharge from Cardiac Rehabilitation
- ☐ Other:_____

Physician Name / UPIN #:_____ **Date:**_____

Physician Signature:_____

Please sign and return to Deaconess Hospital or you may fax the signed copy to (405) 604-6285. Thank you.

Deaconess Hospital

MEDICARE CERTIFICATION TRACKING LOG –OUTPATIENT CARDIAC REHABILITATION

(20 patients per page)

Patient Name	Physician	DISC	CERT	RE-CERT	1st Fax/Mailing (SOC Date)		2nd Fax/mailing (End of 1st Week)		3rd Fax/mailing (End of 2nd Week)		Personally Delivered (End of 3rd Week)		Date Received
		PT OT SP Cardiac	✓	✓	Sent	Due in 1 week	Sent	Due in 1 week	Sent	Due in 1 week	Sent	Due in 1 week	

APPENDIX C
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DEACONESS HOSPITAL PROCEDURE	PROCEDURE NUMBER: PAGE: DATE:
DEPARTMENT:	CATEGORY:
SUBJECT: CHARGE CAPTURE PROCEDRUE	
DEFINITION: The documentation, posting, and reconciliation of charges for services rendered. PURPOSE: To ensure charges are captured and posted timely, accurately and completely. EQUIPMENT: Computer, charge sheets, daily patient log, departmental charge report PERFORMANCE SPECIFICATIONS: Unit Secretary and RN	

PROCEDURE:

Charge Capture

1. A daily patient log or schedule is generated.
2. The patient enters the outpatient department and is checked off on the patient log. After registration, a patient chart is generated which includes a charge form for marking charges.
3. Charges are marked on the charge form by the RN during or after the patient visit. Only procedures that are documented in the patient chart may be marked on the charge sheet. If physician order or physician documentation is lacking, the physician will be contacted to complete the record. Completed charge sheets are placed in a designated area for pick up by *designated charge entry personnel.*
4. *Designated charge entry personnel* will make a tic mark on the patient schedule/log to indicate that a charge sheet has been filled out for each patient seen on that date of service. Charge entry personnel will notify the lead nurse if a charge sheet is not found for each patient on the schedule/log.
5. Charges will be entered into Series (AS400) on the day of service using the correct account number, date of service, CDM (Charge Description Master) number, and quantity. The charge entry clerk will date and initial the charge form and the patient log to indicate that patient charges have been entered into Series.
6. The charge form will be placed in the patient chart.

Charge Reconciliation

1. Charges marked on the charge sheet will be validated against the documentation in the patient chart to ensure that all charges marked have been documented; and that all documented procedures have been marked on the charge sheet.
2. *Designated personnel* will verify the charges entered into Series (using Accounts Receivable Inquiry "ARI" function or the Departmental Charge Report) against the charge sheet. Date of service, CDM, and quantity must be accurate. If the charges in Series are not correct, a screen print of the charges will be made and corrections will be noted.
3. *Designated personnel* will add or correct charges in Series. ARI will be accessed again to verify that the charges are modified appropriately. The screen print of charges will be shredded.

PREVIOUSLY REVISED:	PREPARED BY:	APPROVED BY: