DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

November 19, 2003

Common Identification Number: A-06-03-00041

Mr. Allyn R. Harris
Interim President and CEO
Wilson N. Jones Medical Center
500 North Highland
Sherman, Texas 75092

Dear Mr. Harris:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's (OIG) report entitled "Review of Wilson N. Jones Medical Center Cardiac Rehabilitation Services." Our review was 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.

The overall objective of our review was to determine whether Medicare properly reimbursed Wilson N. Jones Medical Center (Hospital) for outpatient cardiac rehabilitation services. Medicare Coverage Issues Manual, Section 35-25, Section A requires that services for cardiac rehabilitation programs be furnished under the direct supervision of a physician.

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 Section 1861(s)(2)(A) and (B) of the Social Security Act, 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 30 of the 160 Medicare beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital claimed and received Medicare reimbursement for 13 beneficiaries' services, amounting to $4,656, which may not have met Medicare coverage requirements or which were otherwise unallowable.

In addition, we determined that 16 beneficiaries had a Medicare covered diagnosis that was not supported in the cardiac rehabilitation files. However, 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 16 beneficiaries.

We attributed all of these questionable services to weaknesses in the Hospital's internal controls and oversight procedures.

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 the Hospital's FI, TrailBlazer Health Enterprises, LLC (Trailblazer), should make a determination as to the allowability of the Medicare claims and the proper recovery action to be taken.

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.

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To facilitate identification, please refer to common identification number A-06-03-00041 in all correspondence relating to this report.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures – 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 WILSON N. JONES MEDICAL CENTER CARDIAC REHABILITATION SERVICES

Inspector General

NOVEMBER 2003
A-06-03-00041

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 & 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 Wilson N. Jones Medical Center (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 AUDIT

Even though physician supervision is assumed to be met in an outpatient hospital department, the Hospital did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program. 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." Further, from our specific claims review of 30 of the 160 Medicare beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital claimed and received Medicare reimbursement for 13 beneficiaries' services, amounting to $4,656, which may not have met Medicare coverage requirements or which were otherwise unallowable. For these 13 beneficiaries, we determined that:

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files (all 13 beneficiaries) and may not be supported by medical records (12 of the 13 beneficiaries); and

- Multiple units of service were billed for a single cardiac rehabilitation visit (1 of the 13 beneficiaries).

In addition, we determined that 16 of the remaining 17 beneficiaries had a Medicare covered diagnosis that was not supported in the cardiac rehabilitation files. However, 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 16 beneficiaries.

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

We attribute all of these questionable services to weaknesses in the Hospital'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, or (2) only one unit of service was billed for each outpatient cardiac rehabilitation service.

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 the Hospital'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 the Hospital:

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

- Work with Trailblazer to establish the amount of repayment liability, identified to be as much as $4,656, 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 the Hospital work with Trailblazer to establish any repayment liability related to the remaining 130 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 only one unit of service is billed for each outpatient cardiac rehabilitation service.

AUDITEE COMMENTS

In a written response to our draft report, Hospital officials generally agreed with our findings and recommendations and have taken steps to make the changes they believe are necessary to comply with Medicare requirements. Specifically, the Hospital has: (1) appointed a Medical Director for the Cardiac Rehabilitation Program who will be present during the scheduled exercise classes and will be available in case of emergencies and (2) modified or established internal controls to ensure that all documentation will be appropriate and reviewed prior to submitting claims for reimbursement. In addition, the Hospital will work with Trailblazer to establish the amount of repayment liability.

OIG RESPONSE

We acknowledge the steps that the Hospital has taken in response to our draft report. However, we suggest that the Hospital work with Trailblazer not only to establish the amount of repayment liability, but also to ensure that the changes made will satisfy the "incident to" Medicare coverage requirement.

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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 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 therapeutic services provided in a hospital, the Medicare Intermediary Manual states, "The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises."

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

Cardiac Rehabilitation Programs

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

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

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

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

Medicare reimburses outpatient hospital departments for cardiac rehabilitation services under the outpatient prospective payment system. Cardiac rehabilitation services are paid by a Medicare FI based on an ambulatory payment classification. The FI for the Hospital is Trailblazer. For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 160 Medicare beneficiaries and received $52,284 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 the Hospital's policies and procedures and interviewed staff to gain an understanding of the Hospital's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. In addition,

we reviewed the Hospital's cardiac rehabilitation services documentation, referring physician referrals, inpatient medical records and/or referring physician's medical records, and Medicare reimbursement data for 30 beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001 as part of a multi state statistical sample. We reviewed WNJMC'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 sample included 30 of 160 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 30 beneficiaries during CY 2001.

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

Methodology

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

For each sampled beneficiary, we obtained the CY 2001 Medicare outpatient cardiac rehabilitation paid claims and lines of service and compared this data to the Hospital 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 the Hospital'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 the Hospital 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 the Hospital in Sherman, Texas and at our field office in Oklahoma City, Oklahoma during April through June 2003.

RESULTS OF AUDIT

Even though physician supervision is assumed to be met in an outpatient hospital department, the Hospital did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program. 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." Further, from our specific claims review of 30 of the 160 Medicare

beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital claimed and received Medicare reimbursement for 13 beneficiaries' services, amounting to $4,656, which may not have met Medicare coverage requirements or which were otherwise unallowable. For these 13 beneficiaries, we determined that:

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files (all 13 beneficiaries) and may not be supported by medical records (12 of the 13 beneficiaries); and

- Multiple units of service were billed for a single cardiac rehabilitation visit (1 of the 13 beneficiaries).

In addition, we determined that 16 of the remaining 17 beneficiaries had a Medicare covered diagnosis that was not supported in the cardiac rehabilitation files. However, 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 16 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.

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. Although the Hospital cardiac rehabilitation staffing policy stated that the program is staffed by a team "…under the supervision of the Medical Director…," the Hospital did not have a medical director during CY 2001. The cardiac rehabilitation team was staffed exclusively by registered nurses. Other disciplines, such as exercise physiologists and physical therapists, are maintained on a consultation basis by the team. Although the Hospital was in the process of recruiting a medical director during our on-site review, there was no physician in CY 2001 providing direct supervision or in the exercise area and immediately available for an emergency at all times the exercise program was being conducted.

Instead, the Hospital relied on the hospital emergency team, "Dr. Quick", to respond to any medical emergencies. Although Medicare policy provides that direct physician supervision is assumed to be met in an outpatient hospital department, we believe that the Hospital should work with Trailblazer to ensure that the reliance placed on "Dr. Quick" to provide this supervision specifically conforms with the 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.

At the Hospital, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." 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 enough to assess the course of treatment, the patient's progress, and where necessary 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. Documentation for these services must be maintained in the patients' medical records.

Our sample review of 30 of 160 the Hospital Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to $11,247 during CY 2001, disclosed that Medicare claims for 29 beneficiaries contained 42 errors. However, we are only questioning the Medicare reimbursement of claims for 13 beneficiaries totaling $4,656.

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 29 beneficiaries did not include medical documentation to support the diagnosis identified on the physician referral. The Hospital's cardiac rehabilitation program staff relied on the physician referral as documentation of a Medicare covered diagnosis. The Hospital's cardiac rehabilitation program staff did not maintain additional documentation to validate the diagnosis.

To validate the diagnoses of these 29 beneficiaries, we obtained and reviewed the inpatient medical records and/or the medical records of the physicians who referred these beneficiaries for cardiac rehabilitation. The medical records covered the dates of the beneficiaries' inpatient stays, or the date per the physician referral, through their completion of Phase II of the cardiac rehabilitation program. The medical records supported the diagnoses for 17 beneficiaries. However, the medical records did not appear to support the diagnoses for 12 beneficiaries diagnosed with stable angina.

Of these 12 beneficiaries:

- Five beneficiaries had cardiac procedures such as stenting, angioplasty, or angiography around the onset dates per the physician referrals. These beneficiaries were then referred to the outpatient cardiac rehabilitation program by their physicians.

- Seven beneficiaries were referred to the outpatient cardiac rehabilitation program without evidence of any cardiac procedures in the referring physician's medical records.

Based on our review of these medical records, it did not appear that the records indicated that the 12 beneficiaries experienced angina symptoms post-procedure and/or through their completion of Phase II of the cardiac rehabilitation program. As a result, we believe that Medicare may have inappropriately paid $4,642 to the Hospital for the cardiac rehabilitation services provided to these 12 beneficiaries.

Multiple Units Billed. The Hospital billed two units of services for a single cardiac rehabilitation session for one beneficiary. Medicare policy counts a cardiac rehabilitation session as one unit of service. Medicare reimbursed an additional $14 to the Hospital for this beneficiary because Trailblazer's 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.

Underlying Causes for Errors

Medicare Covered Diagnoses Not Supported in Cardiac Rehabilitation Files and/or Medical Records. The Hospital 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, the Hospital procedures did not require referring physicians to provide medical documentation supporting the diagnoses used to justify phase II cardiac rehabilitation services at Medicare expense.

Multiple Units Billed. The Hospital did not have controls to ensure that Medicare was billed only one unit of service for each cardiac rehabilitation session. The Hospital staff believes the extra unit billed was due to a data entry error.

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 the Hospital:

- Work with Trailblazer to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for

direct physician supervision and for services provided "incident to" a physician's professional service.

- Work with Trailblazer to establish the amount of repayment liability, identified to be as much as $4,656, 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 the Hospital work with Trailblazer to establish any repayment liability related to the remaining 130 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 only one unit of service is billed for each outpatient cardiac rehabilitation service.

OTHER MATTERS

During our review, we determined that the Hospital received Medicare reimbursement for a cardiac rehabilitation service that did not occur. Upon review of the Outpatient Exercise Record for this service, it was determined that the beneficiary did not exercise on the date in question. As such, the session did not occur and the Hospital was inappropriately reimbursed $14. However, the date of service for this session was in CY 2002 and outside of our audit period. Therefore, although the $14 is unallowable, this amount will not be included in the nationwide roll-up report of CY 2001 outpatient cardiac rehabilitation services.

AUDITEE COMMENTS

In a written response to our draft report, Hospital officials generally agreed with our findings and recommendations and have taken steps to make the changes they believe are necessary to comply with Medicare requirements. Specifically, the Hospital has: (1) appointed a Medical Director for the Cardiac Rehabilitation Program who will be present during the scheduled exercise classes and will be available in case of emergencies and (2) modified or established internal controls to ensure that all documentation will be appropriate and reviewed prior to submitting claims for reimbursement. In addition, the Hospital will work with Trailblazer to establish the amount of repayment liability.

OIG RESPONSE

We acknowledge the steps that the Hospital has taken in response to our draft report. However, we suggest that the Hospital work with Trailblazer not only to establish the amount of repayment liability, but also to ensure that the changes made will satisfy the "incident to" Medicare coverage requirement.

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 the Hospital 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	MULTIPLE UNITS OF SERVICE BILLED	TOTAL NUMBER OF ERRORS PER DIAGNOSIS
1	1	**Acute Myocardial Infarction**	1	0	0	1
15	14	**Coronary Artery Bypass Graft**	14	0	1	15
14	14	**Stable Angina Pectoris**	14	12	0	26
30	**29**	**Total**	**29**	**12**	**1**	**42**

SAMPLING AND UNIVERSE DATA AND METHODOLOGY

We statistically selected a sample of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. For each beneficiary, we obtained all Medicare claims reimbursement data for outpatient cardiac rehabilitation services and compared this data to the Hospital 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 the Hospital'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 multi state 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
160	$52,284	30	$11,247	29	$4,656

Wilson N. Jones
MEDICAL CENTER

August 13, 2003

Common Identification Number: A-06-03-00041

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

Dear Mr. Sato:

The following information is provided in response to the "draft report" dated July 14, 2003.

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

Response:

Effective, May 28, 2003, Wilson N. Jones Medical Center made arrangements for a cardiologist to serve as Director of the Cardiac Rehabilitation Program. In accordance with the guidelines, Dr. Kamal Rathod is present during the scheduled exercise classes and is immediately available in case of emergencies in the cardiac rehabilitation department. In conjunction with the duties as the Medical Director, Dr. Rathod modifies the patient treatment plan according to the patient's progress. He also confers with the patient's primary care physician of any noted changes. All changes in status are appropriately documented in the patient's medical care record.

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

Response:

Wilson N. Jones Medical Center will work with Trailblazer to establish the amount of repayment liability upon final response and acceptance of the "Review of Wilson N. Jones Medical Center Cardiac Rehabilitation Services" report and findings.

- Implement controls to ensure that referral 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.

Response:

Consistent with the recommendations discussed during the onsite review, Wilson N. Jones Medical Center has removed preprinted diagnoses from the physician order form. Referring physicians have been provided copies of the Medicare approved criteria for program participation and have been provided education regarding the requirements for admission to the Cardiac Rehabilitative Program. Policies have been implemented requiring that, prior to program admission, the referring physician must provide the following documentation to the Medical Director of Cardiac Rehabilitation Program:

1) Current History & Physical,
2) Baseline 12 lead EKG (post procedure, within the last 30-60 days),
3) Baseline HbAlc (required for diabetic recipients),
4) Copy of modified stress test (post cardiac event and evidence of patient compliance on current medications),
5) Copy of most recent chest x-ray,
6) Copy of most recent labs,
7) Signed patient consent form.

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

Response:

Adequate internal controls have been implemented to eliminate the potential for error and monitor the patient billing process.

At the department level, the daily charge report is reviewed and compared to the daily patient census for appropriateness of services provided by the cardiac rehabilitation staff. All items are reconciled prior to the submission of records to the Health Information Management (H.I.M.) Department for coding. Once items are received, H.I.M. ensures that all required documentation is charted in conjunction with the time services were provided before performing the necessary coding of the record for billing submission.

H.I.M has provided education to coding personnel to ensure that the proper documentation is available in support of the Medicare covered diagnoses. H.I.M. staff works on an ongoing basis with the Cardiac Rehabilitation Department personnel and physicians to ensure compliance in documentation in each participant's medical record.

In addition, education is provided of any changes in Medicare Rules and Regulations pertaining to the operation of the Cardiac Rehabilitation Program.

In conclusion, we believe we have taken the required action to bring the program into compliance. We also have modified or established sufficient internal controls to ensure that all documentation is appropriate and reviewed prior to submitting claims for reimbursement from Medicare or other third party payers. Wilson N. Jones Medical Center will also work with the fiscal intermediary for correction and refund of any sums deemed to have been received in error as a result of the program audit performed by your office.

If you have any questions or comments about this response, please contact J. Colby Dinges, Chief Operating Officer, at (903) 870-4548.

Sincerely,

Allyn R. Harris
Interim President and CEO

ARH/jcd