DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

October 20, 2003

Common Identification Number: A-06-03-00053

Mr. David D. Whitaker
President & Chief Executive Officer
Norman Regional Hospital
901 North Porter, Box 1308
Norman, Oklahoma 73070-1308

Dear Mr. Whitaker:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General's (OIG) report entitled "Review of Norman Regional Hospital Outpatient 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 and 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 Norman Regional Hospital (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) 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 19 of the 38 Medicare beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital claimed and received Medicare reimbursement for three beneficiaries' services, amounting to $521, which may not have met Medicare coverage requirements or which were otherwise unallowable.

In addition, we found documentation errors related to the remaining 16 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 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, Chisholm Administrative Services, 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 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) (Act), OIG 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 common identification number A-06-03-00053 in all correspondence relating to this report.

Sincerely yours,

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 NORMAN REGIONAL HOSPITAL OUTPATIENT CARDIAC REHABILTATION SERVICES

Inspector General

OCTOBER 2003
A-06-03-00053

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 Norman Regional Hospital (Hospital) for outpatient cardiac rehabilitation services. Specifically, we determined whether the:

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

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

RESULTS OF REVIEW

Even though physician supervision is assumed to be met in an outpatient hospital department, the Hospital did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program. In addition, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." Further, from our specific claims review of 19 of the 38 Medicare beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital claimed and received Medicare reimbursement for three beneficiaries' services, amounting to $521, which may not have met Medicare coverage requirements or which were otherwise unallowable. For these three beneficiaries, we determined that:

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files (all three beneficiaries) and may not be supported by medical records (one of the three beneficiaries);
- Multiple units of service were billed for a single cardiac rehabilitation visit (one of the three beneficiaries);
- Outpatient cardiac rehabilitation service was billed in error (one of the three beneficiaries); and
- Beneficiaries' physician referrals were inadequate (all three beneficiaries).[1]

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

In addition, we found documentation errors related to the remaining 16 beneficiaries. The errors are as follows:

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files (all 16 beneficiaries); and
- Beneficiaries' physician referrals were inadequate (all 16 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 16 beneficiaries.

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 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, (2) only one unit of service was billed for each outpatient cardiac rehabilitation service, (3) Medicare was only billed for outpatient cardiac rehabilitation services that were provided, and (4) referrals for outpatient cardiac rehabilitation contained adequate information.

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, Chisholm Administrative Services (Chisholm) should make a determination as to the allowability of the Medicare claims and the proper recovery action to be taken.

RECOMMENDATIONS

We are recommending that the Hospital:

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

- Work with Chisholm to establish the amount of repayment liability, identified to be as much as $521, for services provided to beneficiaries where medical documentation may not have supported the Medicare covered diagnosis and for services not otherwise allowable. We also recommend that the Hospital work with Chisholm to establish any repayment liability related to the remaining 19 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.

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

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

In a written response to our draft report, Hospital officials agreed to implement the recommendations identified and take steps to make the changes necessary to comply with Medicare requirements. However, the Hospital disagrees with our findings related to direct physician supervision and "incident to" services. The Hospital believes they are in compliance with Medicare requirements regarding these two areas. As such, the Hospital plans to delay any changes regarding direct physician supervision and "incident to" services until they have received further guidance from their FI, Chisholm. (For complete text, see APPENDIX C.)

We acknowledge that the Medicare Intermediary Manual states that the physician supervision requirement is generally assumed to be met where outpatient therapeutic services are performed on hospital premises. However, the Medicare Coverage Issues Manual (section 35-25 entitled Cardiac Rehabilitation Programs) more specifically requires that the services of nonphysician personnel be furnished under the direct supervision of a physician who is immediately available and accessible for an emergency at all times. We could not conclude that the Hospital met this requirement. While we would also acknowledge that Medicare's instructions regarding "incident to" services may be confusing, we found no evidence of any hospital physician treating or assessing the beneficiaries during the cardiac rehabilitation exercise programs, as required by the Intermediary Manual.

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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 Norman Regional Hospital (Hospital) is Chisholm. For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 38 Medicare beneficiaries and received $13,550 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, inpatient medical records, referring physician referrals and supporting medical records, and Medicare reimbursement data for 19 beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. We determined whether the Hospital's outpatient cardiac rehabilitation program had procedures for and controls over physician supervision, cardiac rehabilitation staffing, and maintenance and availability of advanced cardiac life support equipment.

Our sample included 19 of 38 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 19 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'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. 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's request for a nationwide analysis, we determined the extent to which providers were currently complying with existing Medicare coverage requirements. We performed fieldwork at the Hospital located in Norman, Oklahoma and at our field office in Oklahoma City, Oklahoma during May through July 2003.

RESULTS OF REVIEW

Even though physician supervision is assumed to be met in an outpatient hospital department, the Hospital did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program. 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 19 of the 38 Medicare beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital claimed and received Medicare reimbursement for three beneficiaries' services, amounting to $521, which may not have met Medicare coverage requirements or which were otherwise unallowable. For these three beneficiaries, we determined that:

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files (all three beneficiaries) and may not be supported by medical records (one of the three beneficiaries);
- Multiple units of service were billed for a single cardiac rehabilitation visit (one of the three beneficiaries);
- Outpatient cardiac rehabilitation service was billed in error (one of the three beneficiaries); and
- Beneficiaries' physician referrals were inadequate (all three beneficiaries).[2]

In addition, we found documentation errors related to the remaining 16 beneficiaries. The errors are as follows:

- Beneficiaries had a Medicare covered diagnosis which was not supported in the cardiac rehabilitation files (all 16 beneficiaries); and
- Beneficiaries physician referrals were inadequate (all 16 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 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.

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

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. The consulting services agreement between the Hospital and its medical director for cardiac rehabilitation services stated that the medical director was responsible for providing consultative, educational, and administrative services. The Hospital did not appear to have a requirement that the medical director provide direct physician supervision or be in the exercise area and immediately available for an emergency at all times the exercise program is being conducted. Instead, the Hospital assigned the "Code Blue Team" of physicians with the responsibility of responding to any medical emergencies occurring within the cardiac rehabilitation exercise area.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe that the Hospital should work with Chisholm to ensure that the reliance placed on the "Code Blue Team" to provide this supervision specifically conforms with Medicare 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, to assess the course of treatment and the patient's progress, and, where necessary, to change the treatment program.

At the Hospital, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." The consulting services agreement between the Hospital and its medical director for cardiac rehabilitation services stated that, among other services, the medical director's responsibility included the overview of patient evaluation for medical necessity related to phase II cardiac rehabilitation. However, from our review of the Hospital's outpatient cardiac rehabilitation medical records, we could not locate evidence of any hospital physician professional services rendered to the patients participating in the program. Although required under the "incident to" benefit, there was no documentation to support that a hospital physician personally saw the patient, periodically and sufficiently often, to assess the course of treatment and the patient's progress, and, where necessary, to change the treatment program. Accordingly, we believe that the Hospital's cardiac rehabilitation program did not meet the requirements to provide an "incident to" service.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

Medicare coverage considers cardiac rehabilitation services reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician, and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) have had coronary artery bypass graft surgery, and/or (3) have stable angina pectoris. Medicare only 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 sample review of 19 of 38 Hospital Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to $7,112 during CY 2001, disclosed that Medicare claims for 19 beneficiaries contained 41 errors. However, we are only questioning the Medicare reimbursement of claims for three beneficiaries totaling $521.

Categories of Errors

Medicare Covered Diagnoses Not Supported in Cardiac Rehabilitation Files and/or Medical Records. None of the cardiac rehabilitation files for the 19 sampled beneficiaries included medical documentation to support the diagnosis identified on the physician referral. The Hospital's cardiac rehabilitation program 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 all 19 beneficiaries, we obtained and reviewed the inpatient medical records and/or the medical records of the physicians who referred these 19 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 18 of the beneficiaries. However, the medical records did not appear to support the diagnosis for one beneficiary.

This beneficiary's physician referral to cardiac rehabilitation listed myocardial infarction as the Medicare covered diagnosis. The inpatient records stated that, upon admission to the hospital, the beneficiary presented with "unstable angina versus non-Q wave myocardial infarction". However, the discharge summary identified unstable angina, a diagnosis not covered by Medicare, as the discharge diagnosis.

Based on our review of the medical records, it did not appear that the records indicated that this beneficiary had a Medicare covered diagnosis. As a result, we believe that Medicare may have inappropriately paid $493 to the Hospital for the cardiac rehabilitation services provided to this beneficiary.

Multiple Units Billed. The Hospital billed two units of service 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 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. The Hospital received Medicare reimbursement for a cardiac rehabilitation service that was not provided. Upon review of the Cardiac Rehabilitation Session

Report, the beneficiary did not exercise on the date in question due to high blood pressure. As such, the Hospital was inappropriately reimbursed $14 for a service that was not provided.

Inadequate Referrals. For all 19 beneficiaries, the Hospital 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 referral was a non-covered diagnosis; and
- The physician referral was not dated.

However, we are not questioning any claims for these errors. We verified that 18 of the 19 beneficiaries had a Medicare covered diagnosis and the cardiac rehabilitation was medically necessary based on those diagnoses. The claims for the remaining beneficiary were questioned in the *Medicare Covered Diagnoses Not Supported in Cardiac Rehabilitation Files and/or Medical Records* section above.

Underlying Causes for Errors

Medicare Covered Diagnoses Not Supported in Cardiac Rehabilitation Files and/or Medical Records. The Hospital did not ensure referrals for beneficiaries with Medicare covered diagnoses were supported by medical documentation prior to providing cardiac rehabilitation services and billing Medicare. Specifically, the Hospital's procedures did not require referring physicians to provide medical documentation supporting 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 could not explain why the extra unit was billed.

Services Billed in Error. The Hospital's internal controls did not ensure that Medicare was only billed for outpatient cardiac rehabilitation services that were provided.

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

Our review conclusions, particularly the conclusion regarding the Medicare covered diagnosis, were not validated by medical personnel. Therefore, we believe that Chisholm 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 Chisholm to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare requirement that the services be provided "incident to" a physician's professional service.

- Work with Chisholm to establish the amount of repayment liability, identified to be as much as $521 for services provided where medical documentation may not have supported Medicare covered diagnoses and for services otherwise unallowable. We also recommend that the Hospital work with Chisholm to establish any repayment liability related to the remaining 19 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.

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

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

AUDITEE COMMENTS

In a written response to our draft report, Hospital officials agreed to implement the recommendations identified and take steps to make the changes necessary to comply with Medicare requirements. However, the Hospital disagrees with our findings related to direct physician supervision and "incident to" services.

The Hospital believes that our direct physician supervision finding is contradictory to our statement that physician supervision is generally assumed to be met when the services are performed on hospital premises. The Hospital's cardiac rehabilitation program is hospital based, and they have designated their "Code Blue Team" to respond to any medical emergency occurring within the cardiac rehabilitation area. In addition to the "Code Blue Team", other physicians are located within close proximity of the exercise area and are immediately accessible to assist staff in the event of an emergency. The Hospital considers this procedure to be compliant with the Medicare requirements for providing direct physician supervision.

Regarding "incident to" physician services, the Hospital believes there are inconsistencies between CMS's Intermediary Manual, Hospital Manual, and the Carrier's Manual. Because of these inconsistencies and subsequent confusion, the Hospital does not believe that they fail to meet the requirements for "incident to" physician services benefit.

The Hospital plans to delay any changes regarding direct physician supervision and "incident to" services until they have received further guidance from their fiscal intermediary, Chisholm.

OIG RESPONSE

We acknowledge that the Medicare Intermediary Manual states that the physician supervision requirement is generally assumed to be met where outpatient therapeutic services are performed on hospital premises. However, the Medicare Coverage Issues Manual (section 35-25 entitled Cardiac Rehabilitation Programs) more specifically requires that the services of nonphysician personnel be furnished under the direct supervision of a physician who is immediately available and accessible for an emergency at all times. We could not conclude that the reliance upon the "Code Blue Team" and physicians with other responsibilities would be immediately available at *all* times as required by the Coverage Issues Manual. With respect to "incident to" services, Section 35-25 of the Coverage Issues Manual requires that each patient be under the care of a hospital physician, and section 3112.4 of the Intermediary Manual requires that during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment. While we would also acknowledge that Medicare instructions regarding "incident to" services may be confusing, we found no evidence of any hospital physician treating or assessing the beneficiaries during the cardiac rehabilitation exercise programs, as required by the Medicare Manuals.

APPENDICES

SAMPLE SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of 19 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	SERVICES BILLED IN ERROR	INADEQUATE REFERRALS	TOTAL ERRORS PER DIAGNOSIS
3	3	**Acute Myocardial Infarction**	3	1	0	0	3	7
16	16	**Coronary Artery Bypass Graft**	16	0	1	1	16	34
0	0	**Stable Angina Pectoris**	0	0	0	0	0	0
19	19	**Total**	19	1	1	1	19	41

SAMPLING AND UNIVERSE DATA AND METHODOLOGY

We reviewed a sample of 19 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. For each beneficiary, we obtained all Medicare claims reimbursement data for outpatient cardiac rehabilitation services and compared this data to the Hospital's outpatient cardiac rehabilitation service documentation. In addition, we 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 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
38	$13,550	19	$7,112	19	$521

Norman Regional Hospital

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September 2, 2003

CERTIFIED MAIL,
RETURN RECEIPT REQUESTED
7002241000036650660

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

RE: Audit Report Number: A-06-03-00053

Dear Mr. Sato:

This letter is written in response to your letter dated August 13, 2003 to Norman Regional Hospital, in which our written comments were requested by the U.S. Department of Health and Human Services, Office of Inspector General's draft report, "Review of Norman Regional Hospital's Outpatient Cardiac Rehabilitation Services". We appreciate the opportunity to submit this response and further discuss the findings and recommendations listed in the draft report. Of particular interest to us are the sections referring to Direct Physician Supervision and "Incident To" Physician Services.

Regarding Direct Physician Supervision: the draft letter states that there is a requirement for direct supervision, meaning that a physician must be in the exercise area and immediately available and accessible for an emergency at all times when the exercise program is being conducted. In addition, it states that the physician supervision requirement is generally assumed to be met when the services are performed on hospital premises. We find these two statements confusing and contradictory. Our cardiac rehabilitation program is hospital based, and we have designated our "Code Blue Team" to respond to any medical emergency occurring within the cardiac rehabilitation area. In addition to the "Code Blue Team", other physicians are located within close proximity of the exercise area and are immediately accessible to assist staff in case of an emergency. We have considered this procedure to be compliant with the Medicare requirements for providing Direct Physician Supervision. However, based upon the draft report recommendations, we will request our Fiscal Intermediary, Chisholm Administrative Services, to review our procedure and determine whether our reliance on the "Code Blue Team" to provide Direct Physician Supervision conforms with Medicare requirements.

The other area of concern for us deals with "Incident To" Physician Services. The draft letter we received quoted a statement from Section 3112.4 of CMS's Intermediary Manual regarding "incident to" services. We find there are obvious inconsistencies between CMS's Intermediary Manual – Section 3112.4, CMS's Hospital Manual – Section 230.4, and the Carrier's Manual – Section 2050. Because of these inconsistencies and subsequent confusion, we question the draft report asserting that we failed to meet the "incident to" benefit. We provide cardiac rehabilitation services based on a physician's order, conducted by hospital personnel, and under hospital medical staff supervision.

We are in the process of implementing the recommendations identified in the draft report, and are taking steps to make the changes necessary to comply with Medicare requirements. However, we will delay changes regarding Direct Physician Supervision and "Incident To" Physician Services until we have received further guidance from Chisholm Administrative Services.

Again, we appreciate the opportunity to participate in this audit and to submit our written responses to the draft report. If you have any questions, please do not hesitate to contact me.

Sincerely,

David D. Whitaker, FACHE
President & Chief Executive Officer