DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

JAN 30 2004
Report Number: A-07-03-00158

Ms. Carolyn Hicks
Director of Cardiac Rehabilitation Services
Spencer Municipal Hospital
1200 First Avenue East
Spencer, Iowa 57301-4321

Dear Ms. Hicks:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS), final report entitled, **"Review of Cardiac Rehabilitation Services at Spencer Municipal Hospital, Spencer, Iowa."** A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official 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 report number A-07-03-00158 in all correspondence relating to this report.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:
HHS ACTION OFFICIAL

Joe Tilghman, Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF CARDIAC REHABILITATION SERVICES AT SPENCER MUNICIPAL HOSPITAL, SPENCER, IOWA

JANUARY 2004
A-07-03-00158

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/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the Administrator of the Centers for Medicare & Medicaid Services (CMS) to determine the level of provider compliance with national Medicare outpatient cardiac rehabilitation policies.

OBJECTIVE

The overall objective of our review was to determine whether Medicare properly reimbursed Spencer Municipal Hospital (Spencer), Spencer, Iowa for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

- Payments to Spencer 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, Spencer did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program. Also, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." In addition, our review showed physicians signing referrals after the patient started rehabilitation and not signing off on approvals before discharging their patients. During our audit period, Medicare paid $13,208 for 48 beneficiaries who received cardiac rehabilitation services.

Concerning the reported diagnoses and documentation, we determined that Medicare paid $4,026 for services for 16 beneficiaries with a diagnosis of stable angina pectoris, which were, in our opinion, not supported in the medical records.

Our determinations regarding Medicare covered diagnosis were based solely on our review of the medical record documentation. The medical records have not yet been reviewed by fiscal intermediary (FI) staff. We believe that Spencer's FI, Cahaba Government Benefit Administrators (Cahaba) should make a determination as to the

allowability of the Medicare claims and appropriate recovery action. 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.

RECOMMENDATIONS

We recommend that Spencer:

- Work with its Medicare FI, Cahaba to ensure that the outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirement for direct physician supervision, and for the requirement that the services be provided "incident to" a physician's professional service.

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

- Review with the FI the beneficiaries with a diagnosis of stable angina pectoris and determine whether this is correct given the conditions described in the patient records. If the FI agrees with our assessment that the beneficiary was not eligible for the services, Spencer should reimburse Medicare $4,026.

SPENCER'S COMMENTS

Spencer generally concurred with our findings and has taken positive actions to follow through with our recommendations. They did contact the FI, as we recommended, concerning direct physician supervision and "incident to" physician services, and found both issues a "very gray area and are unable to get a true grasp on what is expected of us." However, they indicated that they will make some "preliminary changes" to be more in compliance "until there is a definitive ruling or decision." Furthermore, they listed the policies they would continue to use and some potential changes to their cardiac rehabilitation program. Unfortunately, one option under consideration is "the elimination of the Phase II part of the program.

They have, also, agreed with our recommendation concerning medical records and had "implemented new physician orders" to ensure that documentation is maintained to support the outpatient cardiac rehabilitation services. In addition, Spencer agreed with our recommendation concerning the diagnosis of stable angina pectoris and is "in the process of reimbursing Cahaba $4,026." Spencer's response in included in its entirety as Appendix B.

OIG'S RESPONSE

We commend Spencer for quickly taking action to address our recommendations. They should continue to work with their FI to resolve the issues of direct physician supervision and "incident to" physician services

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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 hospital outpatient 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 evaluations, 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 Spencer is Cahaba. For CY 2001, Spencer provided outpatient cardiac rehabilitation services to 48 Medicare beneficiaries and received $13,208 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 Spencer for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

- Payments to Spencer 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 Spencer's current policies and procedures and interviewed staff to gain an understanding of Spencer's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. In addition, we reviewed Spencer's cardiac rehabilitation services documentation, inpatient medical records, physician's referrals and supporting medical records, and Medicare reimbursement data for all beneficiaries who received outpatient cardiac rehabilitation services from Spencer during CY 2001. Specifically, we reviewed Spencer'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.

We selected all 48 Medicare beneficiaries who received outpatient cardiac rehabilitation services from Spencer during CY 2001. We reviewed all Medicare paid claims ($13,208) for cardiac rehabilitation services provided to these 48 beneficiaries during CY 2001.

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

Methodology

We compared Spencer's current policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and identified any differences. We documented how Spencer's staff provided direct physician supervision for cardiac rehabilitation services and verified that Spencer'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 Spencer's outpatient cardiac rehabilitation service documentation. We reviewed the medical records maintained by Spencer's 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, the Spencer's outpatient cardiac rehabilitation medical records, and the referring physician's medical records for those beneficiaries with a diagnosis of stable angina.

In addition, we determined if Medicare reimbursed Spencer beyond the maximum number of services allowed. We obtained Medicare payment history data for our beneficiaries, identified any claims related to the outpatient cardiac rehabilitation services provided by Spencer, and ensured that services were not billed separately to Medicare.

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 during June 2003 at Spencer Municipal Hospital, Spencer, Iowa, a rural 71-bed hospital operated by the city government, and subsequently at the Kansas City Regional Office.

RESULTS OF REVIEW

Physician involvement in the outpatient cardiac rehabilitation program at Spencer needs to be better identified. Even though physician supervision is assumed to be met in an outpatient hospital department, Spencer did not designate a physician to directly supervise the services provided by its cardiac rehabilitation staff. Also, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." In addition, our review showed physicians signing referrals after the patient started rehabilitation and not signing off on approvals for the discharge of their patients from the cardiac rehabilitation program.

Concerning the reported diagnoses and documentation, we determined that Medicare paid $4,026 for services for 16 beneficiaries with a diagnosis of stable angina pectoris, which, may not have been supported in the medical records.

See Appendix A for a summary of errors.

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 Spencer, 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 direct physician supervision during exercise sessions. The registered nurses staffed and ran the cardiac rehabilitation

program on a day-to-day basis. The cardiac rehabilitation coordinator, who is a registered nurse, is responsible for the day-to-day supervision of the cardiac rehabilitation area.

Spencer's outpatient cardiac rehabilitation policies and procedures provided support that the medical director was responsible for overseeing the cardiac rehabilitation program and intervention with respective medical staff. There did not appear to be 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, Spencer utilized a "code-blue" emergency response team of physicians and staff to respond to any medical emergency that occurred throughout the hospital, including the cardiac rehabilitation exercise area. There had been no emergencies in the cardiac rehabilitation exercise area for several years.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe that Spencer should work with Cahaba to ensure that reliance placed on the emergency response team to provide this supervision specifically conforms to the 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 hospital 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 Spencer, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." According to Spencer's policies and procedures, each patient that is referred to Spencer's outpatient cardiac rehabilitation program attends a personal interview/orientation session to determine an individualized plan of care, which involves a hospital-based exercise, counseling and education program. Registered nurses, who conduct the initial assessment and patient orientation, as well as the ongoing assessments, staff the cardiac rehabilitation unit. It appears that the cardiac rehabilitation staff contacted physicians, usually the attending physicians, only when a determination of the new onset of signs/symptoms was made during the ongoing assessments. In addition to their responsibilities, the cardiac nurses administered the discharge of the patients from cardiac rehabilitation.

From our review of Spencer'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 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 Spencer's cardiac rehabilitation program did not meet the requirements to provide an "incident to" service.

Cardiac Rehabilitation Services Not Approved Prior to Beginning Services

Our review of the 48 Medicare patients' files showed 23 beneficiaries had physician referrals signed after the patient started rehabilitation. In addition, the attending physicians did not sign off on the discharge of their patients. Cahaba stated that as long as the cardiac rehabilitation program was medically necessary and met Medicare requirements, it was allowable even if the approvals were late. However, we believe that controls should be established to ensure that the appropriate physician signs (1) a patient's treatment plan before it is started and (2) a patient's discharge.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

Medicare coverage criteria considers cardiac rehabilitation services reasonable and necessary only for patients, who are referred by their attending physician with a clear medical need that includes having: (1) a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) a coronary artery bypass graft surgery, and/or (3) 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. During our audit period, Medicare paid $13,208 for 48 beneficiaries who received cardiac rehabilitation services.

Our review of these 48 Medicare beneficiaries disclosed the following diagnoses:

- Acute myocardial infarction (15 beneficiaries receiving 319 services)
- Coronary artery bypass graft surgery (17 beneficiaries receiving 375 services)
- Stable angina (16 beneficiaries receiving 307 services)

Spencer did not support the diagnosis of stable angina for the 16 beneficiaries because the medical records indicated that those beneficiaries did not continue to experience pain or discomfort. Consequently, Medicare paid $4,026 for services based on an eligibility determination that was not supported by notes in the medical records.

These 16 beneficiaries had initially been admitted to Spencer or another hospital with a diagnosis of either unstable[1] or stable angina.[2] During the inpatient stays, cardiac

[1] Unstable angina is not a Medicare covered diagnosis for outpatient cardiac rehabilitation.
[2] Stable angina was defined as a pain or discomfort in the chest or adjacent areas caused by insufficient blood flow to the heart muscle. This chest pain is relieved by rest or medication within a short period of

procedures such as stenting, angioplasty, or valve replacements were performed. Upon their discharge from the hospital, these beneficiaries were referred to the outpatient cardiac rehabilitation program by their physicians. (These beneficiaries also had not experienced an acute myocardial infarction, which would have qualified them for cardiac rehabilitation treatment.)

Spencer's cardiac rehabilitation program conducted an intake assessment with each of the 16 beneficiaries and either identified the beneficiary's diagnosis or relied on a preprinted physician referral as documentation of a Medicare covered diagnosis. Spencer's cardiac rehabilitation program staff did not maintain additional documentation indicating whether the angina symptoms continued to exist post-procedure, or to validate the diagnosis of stable angina.

Consequently, to validate the diagnosis of stable angina, we obtained and reviewed for the 16 beneficiaries the medical records obtained by the hospital from the referring physician. The records did not document that the beneficiaries continued to experience angina symptoms post-procedure through the completion of Phase II of their cardiac rehabilitation program. Based on the records, we believe Medicare paid $4,026 for services to 16 beneficiaries with an undocumented diagnosis.

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

RECOMMENDATIONS

We recommend that Spencer:

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

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

- Review with its Medicare FI the beneficiaries diagnosed with stable angina pectoris and determine whether this was the correct diagnosis given the conditions

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time (usually 15 minutes). Chest pain of a longer duration or pain appearing with a lower level of effort than before, even at rest, should be considered unstable angina. Symptoms of stable angina included a feeling of tightness, heavy pressure, or squeezing or crushing chest pain that is under the breastbone or slightly to the left; is not clearly localized; may radiate to the shoulder, arm, jaw, neck, back, or other areas; may feel similar to indigestion; is precipitated by activity, stress, or exertion; lasts 1 to 15 minutes; and is usually relieved by rest and/or nitroglycerin. This information was obtained from the MEDLINE plus Medical Encyclopedia, identified at the U.S. National Library and National Institute for Health website (http://www.nlm.nih.gov/medlineplus/ency/article/000198.htm).

described in the patient records. If the FI agrees with our interpretation of the documentation, Spencer should reimburse Medicare $4,026.

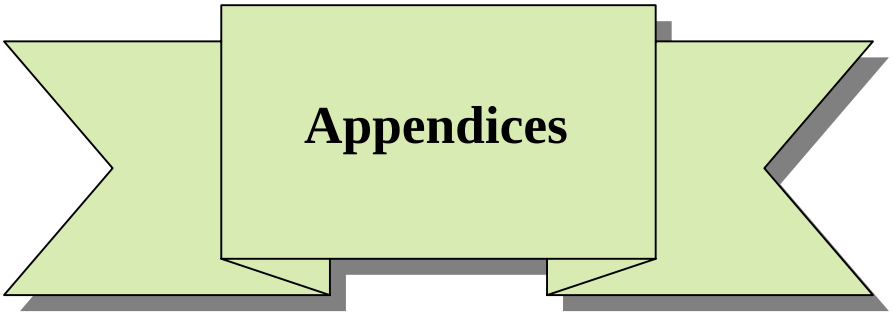
SPENCER'S COMMENTS

Spencer generally concurred with our findings and has taken positive actions to follow through with our recommendations. They did contact the FI, as we recommended, concerning direct physician supervision and "incident to" physician services, and found both issues a "very gray area and are unable to get a true grasp on what is expected of us." However, they indicated that they will make some "preliminary changes" to be more in compliance "until there is a definitive ruling or decision." Furthermore, they listed the policies they would continue to use and some potential changes to their cardiac rehabilitation program. Unfortunately, one option under consideration is "the elimination of the Phase II part of the program.

They have, also, agreed with our recommendation concerning medical records and have "implemented new physician orders" to ensure that documentation is maintained to support the outpatient cardiac rehabilitation services. In addition, Spencer agreed with our recommendation concerning the diagnosis of stable angina pectoris and is "in the process of reimbursing Cahaba $4,026." Spencer's response is included in its entirety as Appendix B.

OIG'S RESPONSE

We commend Spencer for taking action to address our recommendations. They should continue to work with their FI to resolve the issues of direct physician supervision and "incident to" physician services.


Appendices

APPENDIX A

SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of our selected all of 48 Medicare beneficiaries who received outpatient cardiac rehabilitation services from Spencer during CY 2001. The total Medicare paid for the 48 beneficiaries services received was $13,208. The results of our review may be included in a nationwide rollup report of outpatient cardiac rehabilitation services.

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

Medicare Covered Diagnosis	Number of Beneficiaries with Diagnosis	Number of Beneficiaries with Errors	Beneficiaries Not Having Medical Documentation Supporting the Medicare Covered Diagnosis	Total Errors per Diagnosis	Errors Value
Acute Myocardial Infarction	15	0	0	0	0
Coronary Artery Bypass Graft	17	0	0	0	0
Stable Angina Pectoris	16	16	16	16	$4,026
Total	**48**	**16**	**16**	**16**	**$4,026**

Spencer Hospital

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Spencer, Iowa 51301-4321
Phone: 712-264-6198

December 1, 2003

Mr. James P Aasmundstad
Regional Inspector General for Audit Services
Office of Inspector General
Offices of Audit Services
Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

RE: Audit Report Number: A-07-03-00158

Dear Mr. Aasmundstad:

Spencer Hospital is responding to the U. S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Service's (OAS) draft report dated November 7, 2003 entitled "Cardiac Rehabilitation Services at Spencer Municipal Hospital, Spencer, Iowa." Our facility appreciates the opportunity to provide you with our formal response.

Your recommendations were:

Work with our Medicare Fiscal Intermediary, Cahaba, to ensure that the outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirement for direct physician supervision, and for the requirement that the services be provided "incident to" a physician's professional service.

Implement controls to ensure that medical records documentation is maintained to support outpatient cardiac rehabilitation services.

Review with the fiscal intermediary the beneficiaries with a diagnosis of stable angina pectoris and determine whether this is correct given the conditions described in the patient records. If the fiscal intermediary agrees with our assessment that the beneficiary was not eligible for the services, Spencer should reimburse Medicare $4,026.

Response:

We did contact our fiscal intermediary, Cahaba, and talk with them on the concern of "incident to" and direct physician supervision. We continue to find this a very gray area and are unable to get a true grasp on what is expected of us. Until there is a definitive ruling or decision we have made some preliminary changes. Every patient will continue to visit with their primary care physician, cardiologist and/or cardiovascular surgeon during their time in cardiac rehabilitation. Progress reports will continue to be sent to the primary care physician every two weeks for their review, signature and return to our participant's chart. Primary care physician's will be promptly contacted for any adverse sign or symptoms that occur during a patient's time in cardiac rehabilitation. If emergency services are needed, these individuals will be immediately taken to our Emergency Department for evaluation. If a code situation should arise, our Emergency Department physician is part of the Code Blue Team and will respond to our area.

Spencer Hospital is looking into several other options such as, moving our cardiac rehabilitation out of the hospital setting and to a physician's clinic, hiring a physician to devote his time to cardiac rehabilitation, or no longer offering a Phase II program. We are still building projections, but the elimination of the Phase II part of the program seems to be a realistic option.

We also reviewed with our fiscal intermediary, Cahaba, the diagnosis of stable angina. We have notified our referring physicians and cardiologists of the definition of stable angina that you have chosen. We are in the process of reimbursing Cahaba $4026 as was stated in the draft report.

Our Cardiac Rehabilitation program has implemented new physician orders. Signed admission orders must be received from the physician before the individual is able to begin the program. We have added exercise orders which are sent and received back from the physician after an individual has participated in the program for two weeks. Dismissal orders are received from each referring physician for their participant prior to the dismissal of the individual from the program.

Thank you for the opportunity to respond to your draft report. If you have any further questions, please do not hesitate to contact us.

Sincerely yours,

Doug Doorn,
CFO/Vice President of Financial Services

ACKNOWLEDGEMENTS

This report was prepared under the direction of James P. Aasmundstad. Other principal Office of Audit Services staff that contributed include:

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