DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

November 7, 2003

Report Number: A-09-03-00045

Mr. Mark Howard, FACHE
Chief Executive Officer/President
MountainView Hospital
3100 North Tenaya Way
Las Vegas, Nevada 89128

Dear Mr. Howard:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's final report entitled "Review of Medicare Reimbursement for Outpatient Cardiac Rehabilitation Services for Calendar Year 2001, MountainView Hospital, Las Vegas, Nevada." This review was part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services 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. A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The overall objective of our review was to determine whether Medicare properly reimbursed MountainView Hospital (the Hospital) for outpatient cardiac rehabilitation services in accordance with section 35-25 of the Medicare Coverage Issues Manual. Specifically, we determined whether:

- The Hospital's policies and procedures reflected Medicare outpatient 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 2001 were for Medicare covered diagnoses, supported by adequate documentation, and otherwise allowable for reimbursement.

Our review found that even though physician supervision is generally 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 staff. Further, the Hospital did not provide outpatient cardiac rehabilitation services "incident to" a physician's professional services. In addition, from our specific claims review for a non-statistical sample of 10 beneficiaries who received 129 outpatient cardiac rehabilitation services during Calendar Year 2001, we determined that the Hospital was paid for:

- Services for which the diagnoses used to establish the patient's eligibility for cardiac rehabilitation may not have been supported by medical records (12 services),

- Initial patient evaluation and orientation services conducted by nonphysician personnel that did not include an exercise session (9 services), and

- Inadequately documented outpatient cardiac rehabilitation services (2 services).

Our review disclosed that the Hospital claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to approximately $350, for which the diagnoses used to establish the patient's eligibility for outpatient cardiac rehabilitation services may not have been supported by medical record documentation, or which were otherwise unallowable.

We attributed these questionable services to weaknesses in the Hospital's internal controls and oversight procedures. Existing controls did not ensure that beneficiaries had Medicare covered diagnoses supported by the medical records, and that supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained. In addition, the Hospital staff incorrectly believed that the initial evaluation and orientation services could be billed to Medicare when performed by nonphysician personnel. This review is part of larger nationwide review of outpatient cardiac rehabilitation services, and its results may be included in a national roll-up report of all providers reviewed.

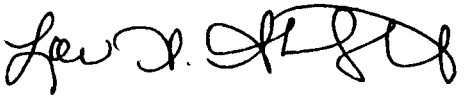
In our report, we recommended that the Hospital (1) work with the fiscal intermediary to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services provided "incident to" a physician's professional service; (2) work with the fiscal intermediary to establish the amount of repayment liability, estimated to be as much as $350, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable; (3) bill for evaluation and orientation services only when performed by a physician; and (4) implement controls to ensure that documentation is maintained in the medical records to support Medicare outpatient cardiac rehabilitation services that are provided. In a written response to our draft report, the Hospital agreed to take actions based on our recommendations, although it did not concur with our findings regarding direct physician supervision and "incident to" physician services.

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

In accordance with the principles of the Freedom of Information Act (5 USC, 552, as amended by Public Law 104-231), OIG reports are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

If you have any questions or comments concerning the matters presented in this report, please direct them to the HHS official named below. To facilitate identification, please refer to report number A-09-03-00045 in all correspondence relating to this report.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Jeff Flick, Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
75 Hawthorn Street, 4th Floor
San Francisco, California 94105

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF MEDICARE REIMBURSEMENT FOR OUTPATIENT CARDIAC REHABILITATION SERVICES FOR CALENDAR YEAR 2001

MOUNTAINVIEW HOSPITAL LAS VEGAS, NEVADA

NOVEMBER 2003
A-09-03-00045

Office of Inspector General

http://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov/

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, 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.)

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

- The Hospital's policies and procedures reflected Medicare outpatient 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, supported by adequate documentation, and otherwise allowable for reimbursement.

SUMMARY OF FINDINGS

Even though physician supervision is generally 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 staff. Further, the Hospital did not provide outpatient cardiac rehabilitation services "incident to" a physician's professional services. In addition, from our specific claims review for a non-statistical sample of 10 beneficiaries who received 129 outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid for:

- Services for which the diagnoses used to establish the patient's eligibility for cardiac rehabilitation may not have been supported by medical records (12 services),

- Initial patient evaluation and orientation services conducted by nonphysician personnel that did not include an exercise session (9 services), and

- Inadequately documented outpatient cardiac rehabilitation services (2 services).

Our review disclosed that the Hospital claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to approximately $350, for which the diagnoses used to establish the patient's eligibility for outpatient cardiac rehabilitation services

may not have been supported by medical record documentation, or which were otherwise unallowable.

We attributed these questionable services to weaknesses in the Hospital's internal controls and oversight procedures. Existing controls did not ensure that beneficiaries had Medicare covered diagnoses supported by the medical records, and that supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained. In addition, the Hospital staff incorrectly believed that the initial evaluation and orientation services could be billed to Medicare when performed by nonphysician personnel. This review is part of a larger nationwide review of outpatient cardiac rehabilitation services, and its results may be included in a national roll-up report of all providers reviewed.

Our determinations regarding Medicare covered diagnoses were based solely on our review of the medical record documentation. The medical records were not reviewed by fiscal intermediary (FI) staff. We believe that the Hospital's FI, Mutual of Omaha, should make a determination as to the allowability of the Medicare claims and initiate appropriate recovery action.

RECOMMENDATIONS

We recommend that the Hospital:

- Work with its FI 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 its FI to establish the amount of repayment liability, estimated to be as much as $350, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable.

- Bill for evaluation and orientation services only when performed by a physician.

- Implement controls to ensure that documentation is maintained in the medical records to support Medicare outpatient cardiac rehabilitation services that are provided.

HOSPITAL COMMENTS

In a written response to our draft report, dated September 18, 2003, the Hospital agreed to take actions based on our recommendations, although it did not concur with our findings regarding direct physician supervision and "incident to" physician services. The Hospital believed that it had adequate processes and systems in place to meet the physician supervision and "incident to" requirements. The Hospital stated that its outpatient cardiac rehabilitation program was located at the Hospital premises, and that the "code 99" team, including emergency room physicians, was available for emergencies throughout the facility. Further, the Hospital had a process in place to notify the referring physician of the patients' progress and of patient events that require

intervention. The Hospital could not find nor obtain confirmation that Medicare required specific documentation for physician supervision or "incident to" a physician's professional service. The Hospital comments are attached in their entirety as an appendix to this report.

OIG RESPONSE

We acknowledge that the Medicare Intermediary Manual states that the physician supervision requirement is generally assumed to be met where the services are performed on hospital premises. However, the Medicare Coverage Issues Manual, section 35-25, more specifically requires that the services of nonphysician personnel be furnished under the direct supervision of a physician. We could not conclude that the Hospital met the "incident to" requirements because we found no evidence of any Hospital physician treating or assessing the beneficiaries during the cardiac rehabilitation exercise programs as required by the Medicare Intermediary Manual.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Coverage

The Medicare program, established by title XVIII of the Social Security Act (Act), provides health insurance to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by CMS. Medicare currently covers Phase II outpatient cardiac rehabilitation programs conducted in specialized, freestanding 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. Medicare coverage of cardiac rehabilitation programs is considered reasonable and necessary only for patients with a clear medical need; who are referred by their attending physician; and have (1) a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) had coronary artery bypass graft (CABG) surgery, and/or (3) 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, "[t]he 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 Medicare FI for the Hospital is Mutual of Omaha. For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 26 Medicare beneficiaries and received $5,024 in Medicare reimbursement for 321 services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

This 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 outpatient 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, supported by adequate documentation, and otherwise allowable for reimbursement.

Scope

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 records for a non-statistical sample of 10 of 26 Medicare beneficiaries who received 129 outpatient cardiac rehabilitation services during CY 2001. These records included: cardiac rehabilitation services documentation, inpatient medical records, prescribing physician referrals and supporting medical records. We reviewed the Hospital's outpatient cardiac rehabilitation procedures for and controls over physician supervision, cardiac rehabilitation staffing, availability of advanced cardiac life support equipment, and documentation of services provided and billed to Medicare.

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

Methodology

To accomplish our objectives, we compared the Hospital's policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and FI local medical review policy, and identified any differences. We documented how the Hospital 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 verified the accuracy of the diagnoses identified on the Medicare claims to each beneficiary's inpatient medical record, prescribing physician's referral form, and the Hospital's outpatient cardiac rehabilitation medical record. We also obtained and reviewed the referring physician's medical records for a beneficiary with a Medicare covered diagnosis of stable angina to verify the accuracy of the diagnosis. In addition, we verified whether Medicare reimbursed the Hospital beyond the maximum number of services allowed. The medical records were not 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 our fieldwork at the Hospital in Las Vegas, Nevada, during the period March through June 2003.

FINDINGS AND RECOMMENDATIONS

Even though physician supervision is generally 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 staff. Further, the Hospital did not provide outpatient cardiac rehabilitation services "incident to" a physician's professional services. In addition, from our specific claims review for a non-statistical sample of 10 beneficiaries who received 129 outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid about $350 for:

- Services for which the diagnoses used to establish the patient's eligibility for cardiac rehabilitation may not have been supported by medical records (12 services),

- Initial patient evaluation and orientation services conducted by nonphysician personnel that did not include an exercise session (9 services), and

- Inadequately documented outpatient cardiac rehabilitation services (2 services).

Our review of the Hospital is part of a larger nationwide review of outpatient cardiac rehabilitation services. Accordingly, our findings and recommendations may be included in a national roll-up report of all providers reviewed.

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

PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION

Direct Physician Supervision

At the Hospital, no physician was actually designated to provide direct physician supervision to the cardiac rehabilitation exercise area. Instead, the Hospital utilized a "code 99" emergency response team, including emergency room physicians, to provide direct physician supervision of the area.

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.

The Hospital's outpatient cardiac rehabilitation procedures stated that the registered nurse was responsible for the management of emergencies in the area. We found that the cardiac rehabilitation program was staffed and run by an exercise physiologist and registered nurses on the days when the Phase II outpatient cardiac rehabilitation services were provided. An exercise physiologist was responsible for the day-to-day supervision of the area.

The procedures further stated that all Hospital policies regarding cardiac and respiratory arrest management should be followed. The Hospital policies required the emergency department to provide 24-hour medical staff coverage by contracting with a physician group specializing in emergency medicine. We found that the Hospital utilized a "code 99" emergency response team, including emergency room physicians, to provide direct physician supervision of outpatient cardiac rehabilitation services. The "code 99" team was responsible for responding to any medical emergency that occurred throughout the Hospital, including the cardiac rehabilitation exercise area. Cardiac rehabilitation staff believed that the emergency room physicians, located about 100 to 150 feet away from the cardiac rehabilitation exercise area, were immediately available and accessible for an emergency at all times when the exercise program was conducted. The average response time of the "code 99" team to medical emergencies within the Hospital was less than 3 minutes.

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 the FI to ensure that the reliance placed on the "code 99" emergency response team to provide direct physician supervision specifically conforms with Medicare requirements.

"Incident to" Physician Services

The Hospital did not provide outpatient cardiac rehabilitation services "incident to" a physician's professional services. There was no physician involvement in evaluating patients, preparing or approving their treatment plans, or assessing their progress during the course of therapy.

Medicare covers cardiac rehabilitation services under the "incident to" benefit. In an outpatient hospital department, the "incident to" benefit does not require that a physician perform a personal professional service on each occasion of service by a nonphysician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient, periodically and sufficiently often, to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program. The physician should be an employee of or contracted by the hospital to perform the professional services for the patient.

At the Hospital, there was no physician employed or contracted to provide professional services of personally seeing patients, assessing their course of treatment and progress, and changing their treatment plan as needed. Instead, an exercise physiologist was responsible for evaluating each patient to prepare the patient's treatment plan.

The Hospital staff stated that outpatient cardiac rehabilitation services were provided "incident to" referring physicians' professional services because they had overall responsibility for patient care. However, the referring physicians were not employees of or contracted with the Hospital to provide services at the cardiac rehabilitation program.

According to the Hospital's outpatient cardiac rehabilitation procedures, the patient treatment plan should be sent to the referring physicians for approval. However, we found that the Hospital did not obtain approval from the referring physicians. Further, there was no response

documented in the medical records from the referring physicians regarding patients' treatment plans, although interim and final progress reports addressed to the physicians were found.

From our review of the Hospital's outpatient cardiac rehabilitation medical records, we could not locate evidence of any physician professional services rendered to the patients during the cardiac rehabilitation 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 the Hospital's cardiac rehabilitation program did not meet the Medicare requirements regarding an "incident to" service.

MEDICARE COVERED DIAGNOSES AND INAPPROPRIATE BILLINGS

Medicare Covered Diagnoses

We determined that documentation in the medical records supported the Medicare covered diagnosis of CABG claimed by the Hospital for 9 of the 10 Medicare beneficiaries reviewed. However, for the remaining beneficiary, we found that documentation in the medical records may not have supported the Medicare covered diagnoses of stable angina[1] or CABG.

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 have (1) a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) had CABG surgery, and/or (3) stable angina pectoris. The FI's local medical review policy specifically states that the CABG procedure should be performed within 12 months prior to outpatient cardiac rehabilitation.

For the beneficiary with dual diagnoses of stable angina and CABG, the Hospital submitted two Medicare claims for a total of 12 outpatient cardiac rehabilitation sessions. The first claim with nine sessions was submitted with a Medicare covered diagnosis of stable angina. The second claim with three sessions was submitted with a Medicare covered diagnosis of CABG. The medical records included two referrals from two physicians in the same medical group.

It appeared to us that the first claim with a Medicare covered diagnosis of stable angina was based on a physician's referral stating, "angina…." Although the referral did not indicate whether the beneficiary had stable or unstable angina[2], the Hospital's cardiac rehabilitation

[1] Stable angina is 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 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 MEDLINEplus Medical Encyclopedia at the U.S. National Library of Medicine website (http://www.nlm.nih.gov/medlineplus/ency/article/000198.htm).

[2] Unstable angina is not a Medicare covered diagnosis for outpatient cardiac rehabilitation.

program staff relied on the referral as documentation of a Medicare covered diagnosis of stable angina. No additional documentation was maintained in the records to validate the diagnosis.

Consequently, to validate the diagnosis of stable angina, we obtained and reviewed the medical records of both referring physicians. These medical records did not appear to indicate that the beneficiary continued to experience angina symptoms through completion of the cardiac rehabilitation program. The physician who wrote the initial referral with a "prior CABG" diagnosis stated in the medical records that "a referral to a dietician [is made] for a weight loss regimen and hopefully in the setting of some increased activity during cardiac rehab[ilitation] and decreased caloric intake we will see some weight loss which would be beneficial from both a cardiovascular standpoint and in terms of her chronic arthritic condition with the bilateral knee replacement." The other physician who indicated an "angina" diagnosis on the physician referral form did not personally see the beneficiary and provided the referral to the Hospital after reviewing the beneficiary's medical records. During the outpatient cardiac rehabilitation program period, the medical records indicated the beneficiary experienced chest pain on one occasion.

The second claim with a Medicare covered diagnosis of CABG was based on a physician referral form that stated "prior CABG." Even though the referral did not indicate that the CABG procedure was performed within the preceding 12-month period as required by Medicare, the Hospital's cardiac rehabilitation program staff relied on the referral as documentation of a Medicare covered diagnosis of CABG. The staff failed to validate the diagnosis with available medical records that showed the CABG procedure was performed several years prior and, therefore, the use of CABG diagnosis did not meet the Medicare requirement.

Therefore, Medicare may have inappropriately paid about $175[3] to the Hospital for the cardiac rehabilitation services provided to the beneficiary. This potential overpayment occurred because the Hospital did not ensure that the beneficiary had a Medicare covered diagnosis supported by documentation in the medical records prior to providing cardiac rehabilitation services and billing Medicare. Specifically, the Hospital procedures did not require the cardiac rehabilitation staff to obtain the medical records from referring physicians and validate the diagnoses used to bill Medicare for outpatient cardiac rehabilitation services.

Inappropriate Billings

We determined that the Hospital inappropriately billed 11 services provided to 9 beneficiaries, resulting in an overpayment of about $175. Of the 11 services, 9 were performed by nonphysician personnel, and 2 were not supported by adequate documentation.

---

[3] Medicare paid about $191 ($15.90 per exercise session multiplied by 12 sessions) for the beneficiary. The initial evaluation and orientation session was disallowed for this beneficiary. See *Initial Evaluation and Orientation Services Performed by Nonphysician Personnel* on Page 8 of this report. To avoid the double error count, we subtracted $16 (a rounded amount of $15.90 per session) from the $191.

Initial Evaluation and Orientation Services Performed by Nonphysician Personnel

The Hospital claims included nine initial patient evaluation and orientation sessions that should have been performed by a physician but were conducted by nonphysician personnel. These sessions did not include a cardiac rehabilitation exercise session. This occurred because the Hospital staff incorrectly believed that the initial evaluation and orientation services could be billed to Medicare when performed by nonphysician personnel. However, Medicare and the FI's local medical review policy allowed a new patient evaluation service to be reimbursed only if a physician provided the service. If the service was provided by nonphysician personnel, the service was considered to be routine and not separately billable to Medicare.

Medicare reimbursed about $143 to the Hospital for the nine services. These billing errors occurred because the Hospital did not have adequate controls to ensure that Medicare was billed only for services performed by physician personnel.

Inadequate Documentation

The Hospital did not maintain adequate documentation to support two outpatient cardiac rehabilitation services. Medicare reimbursed about $32 to the Hospital for these two services.

The current procedural terminology code of 93798 used by the Hospital to bill Medicare for outpatient cardiac rehabilitation services required continuous electrocardiogram (EKG) monitoring per session. The Hospital's cardiac rehabilitation procedures stated that EKG strips should be kept to meet minimal documentation requirements. The cardiac rehabilitation staff were required to document the cardiac rehabilitation services provided to patients by completing a "Daily Patient Exercise Record" form. Although the Hospital had the form, it failed to keep EKG strips for two services. From our review of the forms for the two services, we could not find any evidence that the Hospital provided continuous EKG monitoring.

The billing errors occurred because the Hospital did not have adequate controls to ensure that supporting documentation for outpatient cardiac rehabilitation services was maintained in the medical records.

RECOMMENDATIONS

We recommend that the Hospital:

- Work with its FI to ensure that the Hospital's 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.

- Work with its FI to establish the amount of repayment liability, estimated to be as much as $350, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable.

- Bill for evaluation and orientation services only when performed by a physician.

- Implement controls to ensure that documentation is maintained in the medical records to support Medicare outpatient cardiac rehabilitation services that are provided.

HOSPITAL COMMENTS

In a written response to our draft report, dated September 18, 2003, the Hospital agreed to take actions based on our recommendations, although it did not concur with our findings regarding direct physician supervision and "incident to" physician services.

The Hospital agreed to work with its FI to accomplish the following:

- Ensure that the Hospital's 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.

- Establish the amount of repayment liability for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable.

Further, the Hospital implemented chart audits to assure all patients have covered diagnoses.

The Hospital believed that it had adequate processes and systems in place to meet the physician supervision and "incident to" requirements. The Hospital disagreed with our finding of "no documentation to support physician supervision during exercise sessions." The Hospital stated that our finding was confusing because the review also disclosed that the Hospital's outpatient cardiac rehabilitation program was located at the Hospital premises, and that the "code 99" team, including emergency room physicians, was available for emergencies throughout the facility.

The Hospital stated that it could not find nor obtain confirmation that Medicare required specific documentation for direct physician supervision. Further, the Hospital mentioned our finding that the Hospital had a process in place to notify the referring physician of the patients' progress and of patient events that require intervention. It stated that "[w]hile this process may not have always been followed, no specific guidelines for expected documentation is mentioned in the coverage policy." The Hospital comments are attached in their entirety as an appendix to this report.

OIG RESPONSE

We acknowledge that the Medicare Intermediary Manual (section 3112.4, entitled Outpatient Therapeutic Services) states that the physician supervision requirement is generally assumed to be met where the 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. Accordingly, we could not conclude that the Hospital's reliance on nearby physicians and/or emergency physician teams met the "direct" supervision requirement specific to cardiac rehabilitation programs.

With respect to "incident to" services, section 35-25 of the Medicare Coverage issues Manual specifically requires that each patient be under the care of a hospital physician and section 3112.4 of the Medicare 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 and the patient's progress and, where necessary, to change the treatment regimen. We do not believe that the Hospital complied with the "incident to" requirements since we found no evidence of any Hospital physician treating or assessing the beneficiaries, or providing direct supervision over the services, during the beneficiaries' participation in the cardiac rehabilitation exercise programs.

APPENDIX

MOUNTAINVIEW HOSPITAL

September 18, 2003

Lori Ahlstrand
Regional Inspector General for Audit Services
Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

RE: Audit Report No. A-09-03-00045

Dear Ms Alstrand:

This letter is written in response to your letter dated, September 5, 2003, in which you requested our written comments to your office's draft report entitled, "Review of the Outpatient Cardiac Rehabilitation Services at MountainView Hospital, 3100 N. Tenaya Way, Las Vegas, Nevada.

Based on your recommendations, MountainView Hospital will work with our Fiscal Intermediary (FI name), to accomplish the following:

- ensure that our 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 and,
- to establish the amount of repayment liability for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable.

We appreciate the opportunity to make further comments relating to MountainView Hospital's Outpatient Cardiac Rehabilitation Program. The draft report states that "no documentation to support physician supervision during exercise sessions" was found; yet, Medicare's policy states that direct physician supervision is assumed to be met in an outpatient hospital department. We could not find nor obtain confirmation that specific documentation is required by Medicare. Medicare policy further states, "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 also states that a physician is not required to be physically present in the exercise room itself. We find this to be confusing since the results of your audit, acknowledge that our Cardiac Rehab Program is located on hospital property and within close proximity to both our Cardiac Cath Lab and our Emergency Services Department. Our "Code 99 Team" is available 24/7 and includes physician participation for

emergencies throughout the facility. Our documentation supported a physician response time of less than three minutes.

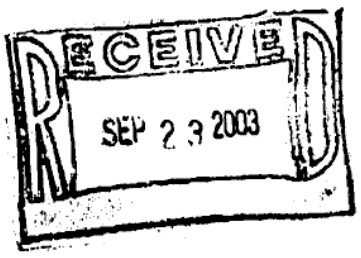
In the Medicare coverage policy, services considered under the "incident to" benefit must be furnished as an integral, although incidental part of the physician's professional service in the course of diagnosis or treatment of an illness or injury. It goes further to state that during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program. Your audit report recognizes that we have a process in place to notify the referring physician of the patients' progress and of patient events that require intervention. While this process may not have always been followed, no specific guidelines for expected documentation is mentioned in the coverage policy.

We believe we have adequate processes and systems in place to meet the physician supervision and incident to requirements. We have also implemented chart audits to assure all patients have covered diagnosis. However, as you have suggested and as we have previously indicated we will work with Fiscal Intermediary on both these issues.

We enjoyed the opportunity to participate in this nation-wide audit. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Mark Howard, FACHE
CEO/President
MountainView Hospital



ACKNOWLEDGMENTS

This report was prepared under the direction of Lori Ahlstrand, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Jerry McGee, *Audit Manager*
Jessica Kim, *Senior Auditor*
George Stokes, *Auditor*
Rogers Shellman, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.