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-09-03-00052

Mr. John B. Harrison
Corporate Compliance Officer
Tucson Medical Center
5301 East Grant Road
Tucson, Arizona 85712

Dear Mr. Harrison:

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, Tucson Medical Center, Tucson, Arizona." 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 his review and any action deemed necessary.

The overall objective of our review was to determine whether Medicare properly reimbursed Tucson Medical Center (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's policies and procedures did not fully meet the Medicare requirement that outpatient cardiac rehabilitation services should be provided "incident to" a physician's professional services. In addition, from our

specific claims review for a non-statistical sample of 10 beneficiaries who received 273 outpatient cardiac rehabilitation services during Calendar Year 2001, we determined that the Hospital was paid for:

- Services for which the diagnosis used to establish the patient's eligibility for cardiac rehabilitation may not have been supported by medical records (21 services), and

- Inadequately documented outpatient cardiac rehabilitation services (63 services).

Our review disclosed that the Hospital claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to approximately $1,156, for which the diagnosis 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. 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.

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 $1,156, for services provided to beneficiaries where medical documentation may not have supported a Medicare covered diagnosis and for services not otherwise allowable; and (3) 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 concurred with our findings and recommendations.

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.

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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-09-03-00052 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

TUCSON MEDICAL CENTER
TUCSON, ARIZONA

NOVEMBER 2003
A-09-03-00052

Office of Inspector General

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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 Tucson Medical Center (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's policies and procedures did not fully meet the Medicare requirement that outpatient cardiac rehabilitation services should be provided "incident to" a physician's professional services. In addition, from our specific claims review for a non-statistical sample of 10 beneficiaries who received 273 outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid for:

- Services for which the diagnosis used to establish the patient's eligibility for cardiac rehabilitation may not have been supported by medical records (21 services), and

- Inadequately documented outpatient cardiac rehabilitation services (63 services).

Our review disclosed that the Hospital claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to approximately $1,156, for which the diagnosis 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. 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, Blue Cross and Blue Shield of Arizona, 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 $1,156, for services provided to beneficiaries where medical documentation may not have supported a Medicare covered diagnosis and for services not otherwise allowable.

- 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 26, 2003, the Hospital concurred with our findings and recommendations. The Hospital comments are attached in their entirety as **APPENDIX A** to this report.

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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 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 Blue Cross and Blue Shield of Arizona. For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 61 Medicare beneficiaries and received $18,087 in Medicare reimbursement for 1,295 services. The Hospital is a teaching hospital.

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 61 Medicare beneficiaries who received 273 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 identified any differences. We documented how the Hospital staff provided direct physician supervision for cardiac rehabilitation services and verified that its 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 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 review from April through July 2003 with fieldwork conducted at the Hospital in Tucson, Arizona.

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's policies and procedures did not fully meet the Medicare requirement that outpatient cardiac rehabilitation services should be provided "incident to" a physician's professional services. In addition, from our specific claims review for a non-statistical sample of 10 beneficiaries who received 273 outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital was paid about $1,156 for:

- Services for which the diagnosis used to establish the patient's eligibility for cardiac rehabilitation may not have been supported by medical records (21 services), and

- Inadequately documented outpatient cardiac rehabilitation services (63 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 blue" emergency response team, including medical interns and residents, to provide physician supervision of the area during exercise sessions.

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.

On a day-to-day basis, the cardiac rehabilitation program was staffed and run by registered nurses, exercise physiologists, and physical therapists. A cardiac rehabilitation manager (physical therapist), who was also the Director of Therapy and Exercise Services, was responsible for the supervision of the cardiac rehabilitation program.

The cardiac rehabilitation department did not have specific policies and procedures that addressed the direct physician supervision requirement of Medicare. Instead, the outpatient

cardiac rehabilitation procedures stated that the "code blue" team should be called for the management of a cardiac arrest. Further, the Hospital's patient care procedures stated that the "code blue" team was responsible for responding to any medical emergency that occurred throughout the Hospital, which included the cardiac rehabilitation unit. It also stated that the physician in charge of the team should be "the attending physician or his/her delegate, the senior medical resident in attendance, or an intern/resident with a senior medical resident supervising."

At the Hospital, the chief resident was responsible for ensuring that the "code blue" team had physician coverage 24 hours a day, 7 days a week. To accomplish the physician coverage, the chief resident prepared a monthly schedule indicating the names of residents and interns assigned to the daily "code blue" work shifts. The physicians would be on call to respond to "code blue" emergencies within the Hospital, including the outpatient cardiac rehabilitation department. Cardiac rehabilitation staff stated that in addition to the "code blue" team, the emergency room physicians, located about 150 to 200 feet away from the cardiac rehabilitation exercise area, were also immediately available and accessible for an emergency at all times the exercise program was conducted.

Although Medicare policy provides that physician supervision is generally 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 blue" emergency response team to provide physician supervision specifically conforms to Medicare requirements.

"Incident to" Physician Services

The Hospital's policies and procedures did not fully meet the Medicare requirement that outpatient cardiac rehabilitation services should be provided "incident to" a physician's professional services. The Hospital had a medical director who approved the patient treatment plan, but the medical director did not personally see or assess the progress of patients during their course of therapy.

Medicare covers outpatient 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.

According to the Hospital's cardiac rehabilitation procedures, the medical director was required to review the treatment plan of each new patient who was referred to the program. The medical director's evaluation included reviewing documentation, such as patient history reports, medication list, and the Phase II evaluation form prepared by the outpatient cardiac rehabilitation staff. The Phase II evaluation form included a patient assessment, problem list, treatment goals, and treatment plan. The medical director's responsibilities also included:

- Acting in an administrative role as a liaison between physician staff and cardiac rehabilitation staff to mediate and provide advice on medical issues,

- Monitoring the cardiac rehabilitation program (but does not supervise the cardiac rehabilitation staff), and

- Reviewing cardiac rehabilitation policies and procedures.

However, the cardiac rehabilitation procedures did not require the medical director to evaluate patients in person for the initial evaluation, the assessment of the course of treatment, or the patient's progress. Rather, the procedures required the cardiac rehabilitation staff to notify the patients' referring physicians when a change in the frequency of treatment or discontinuation of the exercise were necessary due to the patient's condition. If the referring physicians did not respond, the staff was required to contact the medical director regarding the recommended changes. Further, the Hospital procedures required that a progress summary, including progress, goals and plans of continued treatment, should be prepared for the referring physicians every 30 days of treatment.

Our review of the medical records for 10 beneficiaries disclosed that the medical director approved the treatment plan for 9 of the 10 beneficiaries. Nonetheless, we could not find documentation to support the medical director's involvement in assessing the patients' progress or changes in the treatment plan. Instead, we found that initial, progress, and final cardiac rehabilitation reports were sent to referring physicians. But, we could not find any response from the referring physicians regarding the reports sent to them.

Although the Hospital's medical director approved the patient's treatment plans, there was no documentation in the medical records to show that a physician personally saw the patient periodically and sufficiently often to assess the course of treatment and the patient's progress. Accordingly, we concluded that the Hospital did not fully meet the Medicare requirement of "incident to" a physician's professional services.

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

MEDICARE COVERED DIAGNOSES AND INAPPROPRIATE BILLINGS

Medicare Covered Diagnoses

We determined that documentation in the medical records supported the Medicare covered diagnoses of CABG, myocardial infarction, or stable angina 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 diagnosis of stable angina[1].

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 beneficiary with the stable angina diagnosis completed a Phase II cardiac rehabilitation program in early 1999[2], and made a request to the beneficiary's cardiologist for a second Phase II program in late 2000. Based on the beneficiary's request, the cardiologist referred the beneficiary to the Hospital's outpatient cardiac rehabilitation program. Subsequent to the referral, the cardiologist performed a stress test which showed the beneficiary developed angina pectoris at a certain heart rate.

Other than the stress test, the medical records did not include documentation to show that the beneficiary received any other cardiac-related procedures, such as catheterization, angioplasty, angiography, or stenting before entering the Phase II cardiac rehabilitation program for the second time. The beneficiary did not have any cardiac events, such as a heart attack or unstable angina[3], before starting the program. In addition, the medical records did not appear to indicate that the beneficiary continued to experience angina symptoms through completion of the cardiac rehabilitation program.

Therefore, Medicare may have inappropriately paid about $283 to the Hospital for the 21 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.

[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] The Hospital claimed stable angina as a Medicare covered diagnosis for the 20 Phase II cardiac rehabilitation services provided to the beneficiary in 1999.

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

Inappropriate Billings

We determined that the Hospital obtained inappropriate Medicare payments of about $873 for 63 services[4] provided to 2 beneficiaries. None of the services were supported by adequate documentation.

The current procedural terminology code 93798 used by the Hospital to bill Medicare for outpatient cardiac rehabilitation services required continuous electrocardiogram (ECG) monitoring per session. The Hospital's cardiac rehabilitation procedures stated that, for the Phase II outpatient cardiac rehabilitation services, continuous monitoring of ECG, heart rate, blood pressure, and symptoms throughout the exercise session was required. But, the procedures did not specifically require that ECG strips be kept as part of the medical records for each patient. The procedures stated, "Phase II documentation will include the services received, the response to treatment, assessment and disposition of any reported pain and any changes in the treatment plan.… Documentation will be placed in the patient's outpatient chart."

The cardiac rehabilitation staff documented the cardiac rehabilitation services provided to patients by completing a session form. See **APPENDIX B** for a sample of this form. Although the Hospital had the session forms for the two beneficiaries, it failed to keep the ECG strips. From our review of the forms for the two beneficiaries, we could not find any evidence that the Hospital provided continuous ECG monitoring.

Therefore, we determined that Medicare inappropriately paid about $873 to the Hospital for the outpatient cardiac rehabilitation services provided to the two beneficiaries. These potential 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 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 $1,156, for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable.

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

[4] The Hospital submitted claims with a total of 66 outpatient cardiac rehabilitation services. Medicare reimbursed 63 of the 66 services, and the payments for the remaining 3 services were applied to the Medicare annual deductibles.

HOSPITAL COMMENTS

In a written response to our draft report, dated September 26, 2003, the Hospital concurred with our findings and recommendations. The Hospital comments are attached in their entirety as **APPENDIX A** to this report. The Hospital will follow up with its FI to (1) ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision of patient care and for services provided "incident to" a physician's professional service; (2) confer with its FI's medical personnel to validate the report's findings regarding services provided to the identified Medicare beneficiaries where medical documentation may not have supported a Medicare covered diagnoses and for services not otherwise allowable; and (3) review the Hospital's present controls regarding maintenance of medical records for cardiac rehabilitation patients.

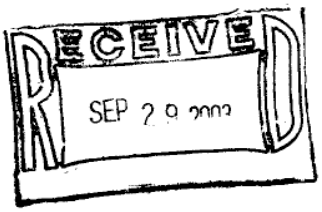
OIG RESPONSE

Actions proposed by the Hospital address the recommendations of this report.

APPENDICES

APPENDIX A

TMC HEALTHCARE



September 26, 2003

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
50 United Nations Plaza, Rm. 171
San Francisco, CA 94102

Re: Report Number A-09-03-00052

Dear Ms. Ahlstrand:

This letter is in response to the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' draft report entitled "Audit of Medicare Reimbursement for Outpatient Cardiac Rehabilitation Services for Calendar Year 2001. Tucson Medical Center, Tucson, AZ". TMC HealthCare has reviewed the recommendations made by your office and will follow up with our Fiscal Intermediary (FI) to:

- Ensure that TMC HealthCare's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare Coverage requirements for physician supervision of patient care and for services provided "incident to" a physician's professional service.

- Confer with FI medical personnel to validate the report's findings regarding services provided to the identified Medicare beneficiaries where medical documentation may not have supported a Medicare covered diagnosis and for services not otherwise allowable.

- Review TMC's present controls regarding maintenance of medical records for cardiac rehabilitation patients.

Thank you for the opportunity to participate in this audit. Should you have any further questions or concerns, please do not hesitate to contact me.

Sincerely,

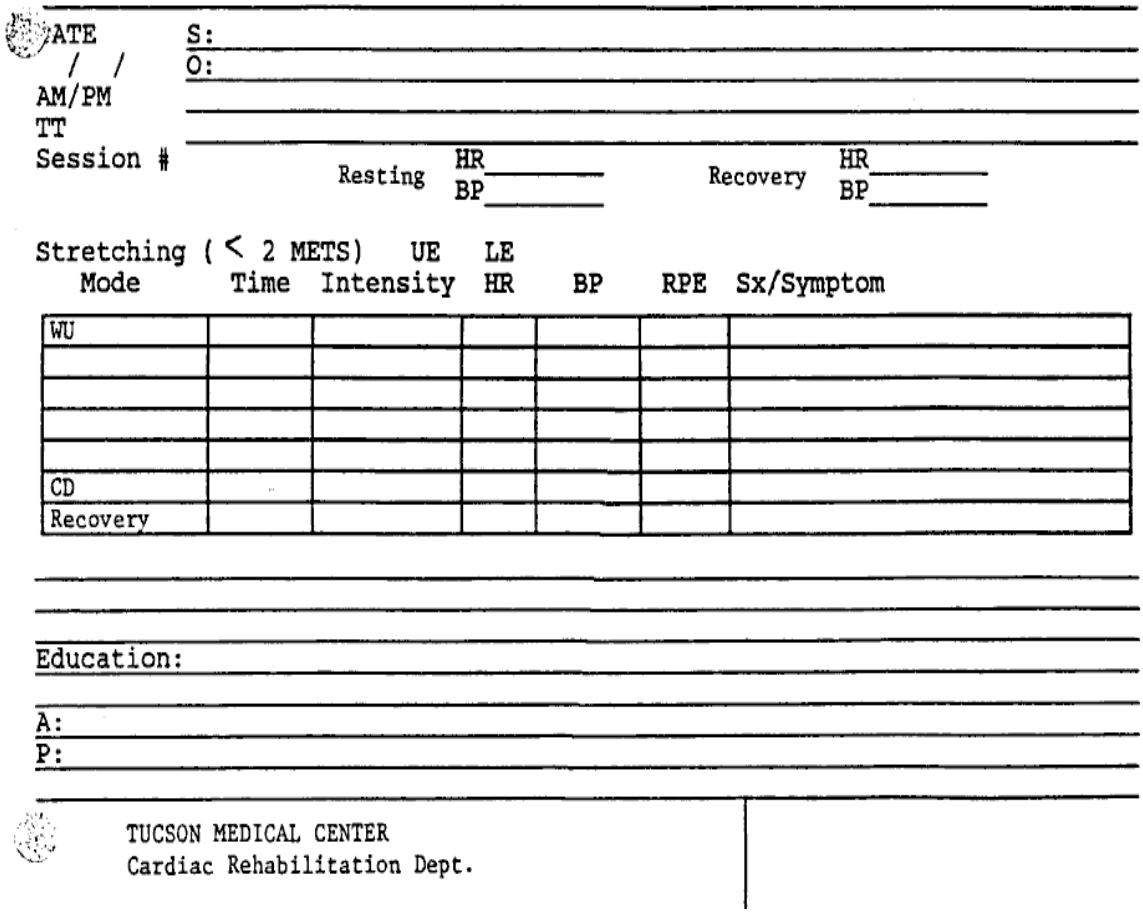
John B. Harrison
Corporate Compliance Officer

cc: Frank Alvarez
Tracy Nuckolls
Judy Rich

5301 East Grant Road • Tucson, Arizona 85712 • (520) 327-5461

APPENDIX B

SAMPLE FORM OF DOCUMENTATION FOR OUTPATIENT CARDIAC REHABILITATION SERVICES



DATE
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S:
O:

Resting HR_____ BP_____ Recovery HR_____ BP_____

Stretching (< 2 METS) UE LE

Mode	Time	Intensity	HR	BP	RPE	Sx/Symptom
WU						
CD						
Recovery						

Education:

A:
P:

TUCSON MEDICAL CENTER
Cardiac Rehabilitation Dept.

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*
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