



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

August 29, 2003

Report Number: A-05-03-00056

Mr. Jesse Peterson Hall
Senior Vice President, Hospitals and Clinics
Evanston Hospital
2650 Ridge Avenue
Evanston, Illinois 60201

Dear Mr. Hall:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General final report entitled, "Review of Outpatient Cardiac Rehabilitation Services – Evanston Northwestern Healthcare, Evanston, Illinois." 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. 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-05-03-00056 in all correspondence relating to this report.

Sincerely,

A handwritten signature in cursive script that reads "Paul Swanson".

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Page 2 – Mr. Jesse Peterson Hall

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Regional Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT CARDIAC
REHABILITATION SERVICES**

**EVANSTON NORTHWESTERN
HEALTHCARE
EVANSTON, ILLINOIS**



**August 2003
A-05-03-00056**

Office of Inspector General

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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 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 Evanston Northwestern Healthcare (ENH) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- ENH's policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, "incident to" services, and Medicare covered diagnoses.
- Payments to ENH 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.
- Services related to outpatient cardiac rehabilitation services provided by ENH were separately billed by and reimbursed to ENH or any other Medicare provider.

RESULTS OF AUDIT

Even though physician supervision is assumed to be met in an outpatient hospital department, ENH did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program. In addition, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." In addition, from our specific claims review for a sample of 30 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that ENH was paid for:

- services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (2 beneficiaries);
- initial patient evaluations/orientations conducted by non-physician personnel that did not include an exercise session (11 beneficiaries); and
- inadequately documented outpatient cardiac rehabilitation services (2 beneficiaries).

From our sample, ENH claimed and received Medicare reimbursement for outpatient cardiac rehabilitation services, amounting to approximately \$564 that did not meet Medicare coverage

requirements, which may not have been supported by medical record documentation, or which were otherwise unallowable. The sample errors and costs are part of a larger statistical sample and will be included in a multi-state projection of outpatient cardiac rehabilitation service claims not meeting Medicare coverage requirements.

We attribute these questionable services to weaknesses in ENH's internal controls and oversight procedures. Existing controls did not ensure that beneficiaries had Medicare covered diagnoses supported by the referring physician's medical records and that supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained. In addition, ENH staff believed that the initial evaluation/orientation visit could be billed to Medicare when performed by nonphysician personnel.

Our determinations regarding Medicare covered diagnoses 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 ENH's FI, AdminaStar, should make a determination as to the allowability of the Medicare claims and appropriate recovery action.

RECOMMENDATIONS

We recommend that ENH:

- Work with AdminaStar to ensure that ENH's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services being provided "incident to" a physician's professional service.
- Work with AdminaStar 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.
- Bill evaluation and orientation visits only when performed by physician personnel in accordance with AdminaStar local medical review policy.
- Implement controls to ensure that medical record documentation is maintained to support Medicare outpatient cardiac rehabilitation services.

AUDITEE'S COMMENTS

ENH indicated that, through its cardiac rehabilitation medical directors and emergency procedures, it met the requirements for direct physician supervision. Concerning the "incident to" requirements, ENH stated that it considered CMS' guidance to be conflicting and unclear. With regard to the sample results, it indicated that AdminaStar's local medical review policy (LMRP) provides that patients undergoing angioplasty or stenting as treatment for angina may still be eligible for outpatient cardiac rehabilitation. It believed that the two beneficiaries in question qualified under this policy. ENH agreed with the remaining errors from our sample review. In summary, it indicated that it will implement and take action on all the

recommendations. ENH's comments are summarized at the end of the RESULTS OF AUDIT section of this report and are presented in their entirety as APPENDIX C. (Twenty-eight pages of policies and procedures that were submitted by ENH with its comments are not appended.)

OFFICE OF INSPECTOR GENERAL'S RESPONSE

While we agree that ENH had designated medical directors for its outpatient cardiac rehabilitation program and that emergency procedures were in place, we could not conclude that reliance on "code blue" emergency response teams met CMS' Coverage Issues Manual requirements for direct supervision when the medical director was unable to respond to an emergency. While we would also acknowledge that CMS' instructions regarding "incident to" services are confusing, we found no evidence of any hospital physician treating or assessing the beneficiaries during cardiac rehabilitation exercise programs, as required by the Intermediary Manual. Regarding the sample results, the LMRP in effect during our audit period did not include provisions for coverage of outpatient cardiac rehabilitation at Medicare's expense solely on the basis of treatment that involved angioplasty or stenting.

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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 Centers for Medicare & Medicaid Services (CMS). The CMS currently covers Phase II outpatient cardiac rehabilitation programs conducted in specialized, free-standing cardiac rehabilitation clinics and in outpatient hospital departments under the “incident to” benefit (section 1861(s)(2)(A) of the Act).

Medicare coverage policy for cardiac rehabilitation services is found in section 35-25 of the Medicare Coverage Issues Manual. 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 (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 cardiac rehabilitation provided in a hospital, the Medicare Intermediary Manual states, “The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.”

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

Cardiac Rehabilitation Programs

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

- Phase I. Phase I rehabilitation is initiated in the acute convalescent period following a cardiac event during the hospital phase of treatment. This phase of cardiac rehabilitation is considered part of the hospital stay and is covered as part of the Medicare diagnosis-related group allowance for the hospital stay.
- Phase II. Phase II begins with a physician's prescription (referral) after the acute convalescent period and after it has been determined that the patient's clinical status and capacity will allow for safe participation in an individualized progressive exercise program. This phase requires close monitoring and is directed by a physician who is on-site. Phase II outpatient cardiac rehabilitation is covered by Medicare.
- Phase III. Phase III begins after completion of Phase II and involves a less intensively monitored aerobic exercise program. Phase III level programs are considered maintenance and are not covered by Medicare.

Medicare reimburses outpatient hospital departments for cardiac rehabilitation services under the outpatient prospective payment system. Cardiac rehabilitation services are paid by a Medicare fiscal intermediary (FI) based on an ambulatory payment classification. The FI for Evanston Northwestern Healthcare (ENH) is AdminaStar. For calendar year (CY) 2001, ENH provided outpatient cardiac rehabilitation services to 161 Medicare beneficiaries and received \$55,617 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 ENH¹ for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

¹ ENH includes three hospitals: Evanston, Glenbrook, and Highland Park. Outpatient cardiac rehabilitation services provided at these locations were billed under the Medicare provider number for ENH.

- Payments to ENH 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.
- Services related to outpatient cardiac rehabilitation services² provided by ENH were separately billed by and reimbursed to ENH or any other Medicare provider.

Scope

To accomplish these objectives, we reviewed ENH's current policies and procedures and interviewed staff to gain an understanding of ENH's management of their outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. In addition, we reviewed ENH's cardiac rehabilitation services documentation, inpatient medical records, referring physician referrals and supporting medical records, and Medicare reimbursement data for 30 beneficiaries who received outpatient cardiac rehabilitation services from ENH during CY 2001 as part of a multi-state statistical sample. We reviewed ENH'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.

The ENH sample included 30 of 161 Medicare beneficiaries who received outpatient cardiac rehabilitation services from ENH during CY 2001. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 30 beneficiaries during CY 2001.

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

Methodology

We compared ENH's current policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and FI local medical review policy (LMRP) and identified any differences. We documented how ENH staff provided direct physician supervision for cardiac rehabilitation services and verified that ENH'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 ENH's outpatient cardiac rehabilitation service documentation. We reviewed the medical records maintained by the cardiac rehabilitation program to determine whether services were provided "incident to" a physician's professional service. We also verified the accuracy of the diagnoses identified on the Medicare claims to each beneficiary's inpatient medical record, the referring physician's medical

² Examples of services considered related to outpatient cardiac rehabilitation included psychotherapy and psychological testing, physical and occupational therapy, and patient education services as a result of a cardiac related diagnosis. These services are generally considered to be included in the outpatient cardiac rehabilitation program and, generally, are not separately reimbursed by Medicare.

record and referral, and the ENH outpatient cardiac rehabilitation medical record. The medical records have not yet been reviewed by FI staff.

In addition, we verified that Medicare did not reimburse ENH beyond the maximum number of services allowed. We obtained Medicare payment history data for our statistical sample of beneficiaries, identified any claims related to the outpatient cardiac rehabilitation services provided by ENH, and ensured that services were not billed separately to Medicare.

In accordance with the intent of CMS's request for a nationwide analysis, we determined the extent to which providers were currently complying with existing Medicare coverage requirements. We performed fieldwork at ENH hospitals and cardiac rehabilitation centers; located in Evanston, Glenview, and Highland Park, Illinois; during the period March through April 2003.

RESULTS OF AUDIT

Even though physician supervision is assumed to be met in an outpatient hospital department, ENH did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program staff. In addition, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." In addition, from our specific claims review for a sample of 30 beneficiaries receiving outpatient cardiac rehabilitation services during CY 2001, we determined that ENH was paid for:

- services where the diagnoses used to establish the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (2 beneficiaries);
- initial patient evaluations/orientations conducted by non-physician personnel that did not include an exercise session (11 beneficiaries); and
- inadequately documented outpatient cardiac rehabilitation services (2 beneficiaries).

PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION

Direct Physician Supervision

Medicare requirements for outpatient cardiac rehabilitation state that direct supervision means that a physician must be in the exercise area and immediately available and accessible for an emergency at all times the exercise program is conducted. The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.

At ENH, no physician was actually designated to provide direct physician supervision to the cardiac rehabilitation exercise areas and no documentation existed in the cardiac rehabilitation program's medical records to support physician supervision during exercise sessions. On a day-to-day basis, the cardiac rehabilitation program was staffed and run by registered nurses, exercise

physiologists, and other staff. A cardiac rehabilitation manager (registered nurse or exercise physiologist) was responsible for the day-to-day supervision of the cardiac rehabilitation area.

Although ENH's cardiac rehabilitation policies did not require the medical directors³ to provide the direct physician supervision, while the exercise program was being conducted, the cardiac rehabilitation medical directors were responsible for the cardiac rehabilitation program policies and protocols and could respond to any medical emergency. This assumes that they were available and were not performing other cardiac duties.

Highland Park Hospital. The ENH Cardiac Rehabilitation Program Emergency Plan for Highland Park Hospital states the following.

...Because the emergency situation requires prompt and coordinated action, properly trained personnel are essential. Two professionals supervise all Phase II exercise sessions. Usually, the staff consists of a cardiac rehabilitation nurse (CRN) and an exercise physiologist or two CRNs. Whereas a physician is generally not present during the exercise session, it is necessary that the medical director, or his designee, be in the hospital should his assistance be needed.

Should the physician be not readily available in either phase, it is the nurse (CRN) who functions as the team leader during the emergency situation until relieved by a physician or paramedic team. If an emergency occurs during an exercise session, the physician available or the EMS should be immediately summoned....

In addition, the Highland Park Hospital's cardiac rehabilitation policies required cardiac rehabilitation staff to contact the patient's physician and/or the cardiac rehabilitation medical director for treatment during emergencies.

Evanston and Glenbrook Hospitals. Evanston and Glenbrook Hospitals did not have a specific Cardiac Rehabilitation Program Emergency Plan. However, Evanston and Glenbrook Hospital cardiac rehabilitation policies required cardiac rehabilitation staff to contact the medical director and/or the patient's physician when emergencies occurred.

In the event the medical directors were not available to "supervise" and respond to an emergency, ENH cardiac rehabilitation staff would contact available cardiologists whose offices were located nearby. In addition, a "code" emergency response team could be called. The "code" emergency team was responsible to respond to any medical emergency that occurred throughout the hospital, including the cardiac rehabilitation exercise area. Cardiac rehabilitation staff also believed that other physicians, located nearby the cardiac rehabilitation exercise area, could respond to any medical emergency and, thus, were also available to "supervise" cardiac rehabilitation services.

³ There were two cardiac rehabilitation medical directors for ENH. One medical director was responsible for cardiac rehabilitation services at Evanston and Glenbrook Hospitals, while another medical director was responsible for cardiac rehabilitation services at Highland Park Hospital.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe that ENH should work with AdminaStar to ensure that the reliance on other nearby physicians and the “code” emergency response team for supervision, when medical directors were not available, conforms to specific 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 physician must personally see the patient periodically and sufficiently often to assess the course of treatment, the patient’s progress, and, where necessary, the need to change the treatment program.

At ENH, we could not identify the physician professional services to which the cardiac rehabilitation services were provided “incident to.” ENH’s policies and procedures for cardiac rehabilitation state the following.

...All patients entering Phase II Cardiac Rehabilitation must receive an initial evaluation and orientation to the program. A one and a half hour appointment is scheduled prior to beginning the Phase II program. The patient’s medical record, current graded exercise stress test, recent lipid profile results and any other pertinent data are gathered. During the evaluation process, the medical history is obtained from the patient and medical record reviewed. The graded exercise stress test is reviewed. A cardiovascular risk factor analysis is completed, reviewed, and discussed with the patient. Lipid profile results are reviewed and discussed with the patient. Skinfold analysis and body mass index is performed, ideal body weight is determined, and the staff and patient set mutual goals for the program and desired outcomes. The patient is assessed for level of current and previous pain (i.e. anginal/musculoskeletal)...Upon completion of the evaluation and orientation, the staff will identify and document a patient problem list and develop a plan of care. Controllable risk factors are documented in the plan of care....

The cardiac rehabilitation nurses conducted the initial evaluation and orientation sessions, as well as the ongoing assessments throughout the rehabilitation program.

Evanston and Glenbrook Hospitals. For the cardiac rehabilitation programs at Evanston and Glenbrook hospitals, the Medical Director of Outpatient Cardiac Rehabilitation reviewed the patients’ exercise prescription completed by the cardiac rehabilitation nurses and signed the form. In addition, the Medical Director reviewed the initial history and physical assessment sheet for each patient and co-signed the form. However, there was no documentation to indicate any other hospital physician assessments or services during beneficiaries’ cardiac rehabilitation programs.

Highland Park Hospital. For the cardiac rehabilitation program at Highland Park Hospital, new patients' exercise prescriptions and history and physical assessments were discussed with the Medical Director of Outpatient Cardiac Rehabilitation during monthly cardiac rehabilitation team meetings. However, the Medical Director of Outpatient Cardiac Rehabilitation did not sign the exercise plans or history and physical assessment forms. And, there was no documentation to indicate any other hospital physician assessments or services during beneficiaries' cardiac rehabilitation programs.

According to ENH's policies and procedures, cardiac rehabilitation staff only contacted the physicians (the Medical Directors and/or referring physicians) when a determination of the new onset of signs/symptoms (including untoward events or emergencies) was made during the cardiac rehabilitation staff ongoing assessments.

From our review of ENH's outpatient cardiac rehabilitation medical records, we could not locate evidence of any hospital physician professional services rendered to the patients participating in the program. Although required under the "incident to" benefit, there was no documentation to support that a hospital physician personally saw the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment program. Accordingly, we believe that ENH's cardiac rehabilitation program did not meet the requirements to provide an "incident to" service.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

Medicare coverage considers cardiac rehabilitation services reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician, and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) have had coronary artery bypass graft surgery, and/or (3) have stable angina pectoris. Medicare only reimburses providers for Phase II outpatient cardiac rehabilitation services and allows one unit of service to be billed per cardiac rehabilitation session. Documentation for these services must be maintained in the patients' medical records. Our sample of 30 of 161 Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to \$9,348 during CY 2001, disclosed that Medicare claims for 15 beneficiaries contained 15 errors totaling \$564. Error categories and underlying causes are presented below.

Medicare Covered Diagnoses

Medicare paid ENH for outpatient cardiac rehabilitation services where the diagnoses establishing eligibility for cardiac rehabilitation did not appear to be supported by the notes in the beneficiaries' medical records. As a result, we believe that Medicare may have inappropriately paid \$338 to ENH for the cardiac rehabilitation services provided to two of the sampled beneficiaries.

Of the 30 sampled beneficiaries, eligibility for 11 beneficiaries was based on the diagnosis of acute myocardial infarction, eligibility for 13 beneficiaries was based on the diagnosis of coronary artery bypass graft surgery, eligibility for 4 beneficiaries was based on a diagnosis of coronary artery bypass graft surgery and acute myocardial infarction, and eligibility for 2

beneficiaries was based on the diagnosis of stable angina. For the 28 beneficiaries with diagnoses of acute myocardial infarction and/or coronary artery bypass graft surgery, medical records contained documentation to support the diagnoses. The medical records for the two beneficiaries with diagnoses of stable angina did not appear to indicate that the beneficiary continued to experience stable angina post-procedure.

These two beneficiaries had initially been admitted to other hospitals with diagnoses of coronary atherosclerosis and stable angina,⁴ or had a history of variant angina.⁵ During the inpatient stays, cardiac procedures such as angioplasty and/or stenting were performed. Upon their discharge from the hospital, these beneficiaries were referred to the ENH outpatient cardiac rehabilitation program by their physicians. ENH conducted an initial evaluation and orientation with each beneficiary and either identified the beneficiary's diagnosis or relied on a physician referral as documentation of a Medicare covered diagnosis. The ENH cardiac rehabilitation program staff did not maintain additional documentation indicating that the angina symptoms continued to exist post-procedure or validating the diagnosis of stable angina.

To validate the diagnosis of stable angina, we obtained and reviewed the inpatient medical records; as well as, the referring physician's medical records. The medical records covered the dates of the beneficiaries' inpatient stays through their completion of Phase II of the cardiac rehabilitation program. Our review of these medical records did not appear to indicate that the beneficiaries continued to experience angina symptoms post-procedure and through their completion of Phase II of the cardiac rehabilitation program. These unallowable services are attributed to ENH not ensuring that referrals for beneficiaries with Medicare covered diagnoses were supported by medical documentation prior to providing cardiac rehabilitation services and billing Medicare. Specifically, ENH procedures did not require referring physicians to provide medical documentation supporting stable angina diagnoses used to justify phase II cardiac rehabilitation services at Medicare expense.

Initial Evaluation and Orientation

ENH received Medicare reimbursement for claims that included initial patient evaluations and orientations conducted by non-physician personnel when the services did not include an exercise session. The ENH staff believed that new patient initial evaluations and orientations could be billed to Medicare, even if performed by nonphysician personnel. Since the evaluation and orientation sometimes lasted up to an hour and one half, staff personnel believed that the initial evaluations and orientations should be billed. Cardiac rehabilitation staff, who billed for these

⁴ 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 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, identified at the U.S. National Library and National Institute for Health website (<http://www.nlm.nih.gov/medlineplus/ency/article/000198.htm>).

⁵ Variant angina is also known as Prinzmetal's angina. Unlike typical (stable) angina, it nearly always occurs when a person is at rest. It doesn't follow physical exertion or emotional stress, either. This information was obtained from the American Heart Association website (<http://www.americanheart.org>).

services, were unaware that Medicare and AdminaStar LMRP only allow an evaluation service to be reimbursed when a physician provided this service. Based on Medicare and AdminaStar LMRP, these services were considered nonphysician routine services and not billable to Medicare. Medicare reimbursed ENH \$177 for these unallowable services to 11 beneficiaries.

Undocumented Services

ENH did not always maintain cardiac rehabilitation service documentation to support the Medicare claim. Because ENH's internal controls did not ensure supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained, it was unable to locate supporting cardiac rehabilitation documentation for specific dates of services for cardiac rehabilitation for two beneficiaries. Medicare made inappropriate reimbursements of \$49 to ENH for the unsupported claims for the two beneficiaries.

Sample Results

The results from our sample will be included in a multi-state estimate of Medicare reimbursements for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment. (See APPENDICES A and B for specific sampling and universe data, methodology, error types and dollar values.)

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

RECOMMENDATIONS

We recommend that ENH:

- Work with AdminaStar to ensure that ENH's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services being provided "incident to" a physician's professional service.
- Work with AdminaStar 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.
- Bill evaluation and orientation visits only when performed by physician personnel in accordance with AdminaStar local medical review policy.
- Implement controls to ensure that medical record documentation is maintained to support Medicare outpatient cardiac rehabilitation services.

AUDITEE'S COMMENTS

In written comments to the draft report, ENH stated that the hospital does have “designated physicians” responsible for the supervision of patients in its outpatient cardiac rehabilitation program and that its policies cover this physician supervision. It believed that, through its cardiac rehabilitation medical directors and emergency procedures, it met the requirements for direct physician supervision. Regarding the requirements for “incident to” services, ENH considered the guidance in the Intermediary Manual and the Hospital Manual to be conflicting and unclear. In summarizing its comments on physician involvement, ENH said that it will work directly with AdminaStar to ensure that its outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements.

Concerning the sample results, ENH stated that AdminaStar’s local medical review policy (LMRP) provides that patients that undergo percutaneous transluminal coronary angioplasty (PTCA) or coronary artery stenting as treatment for angina may still be eligible for cardiac rehabilitation if the program begins within ninety days. It believed that the two beneficiaries in question qualified under this policy. It also said that the medical documentation for one of the two beneficiaries included a physician’s note that the “patient was having some upper chest discomfort...treat as angina.” For the second beneficiary, it stated that while the patient did not have documented symptoms of angina post PTCA, there was documentation in the patient’s chart indicating three episodes of angina while participating in the cardiac rehabilitation program. ENH agreed with the remaining errors from our sample review.

ENH’s comments are presented in their entirety as APPENDIX C. (Twenty-eight pages of policies and procedures that were submitted by ENH with its comments are not appended.)

OFFICE OF INSPECTOR GENERAL’S RESPONSE

We agree that ENH had designated medical directors for its outpatient cardiac rehabilitation program, and that physician supervision and emergency procedures were in place. We also agree that the physician supervision requirement is generally assumed to be met where the services are performed on hospital premises; however, we could not conclude that reliance on “code blue” emergency response teams met CMS’ Coverage Issues Manual requirements for direct supervision when the medical director was unable to respond to an emergency. With respect to “incident to” services, section 35-25 of CMS’ Coverage Issues Manual requires that each patient be under the care of a hospital physician, and section 3112.4 of the Intermediary Manual requires that during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment. This was not done.

Regarding the sample errors, the LMRP in effect during our audit period (calendar year 2001) did not provide for outpatient cardiac rehabilitation coverage for beneficiaries based solely on PTCA or stenting. A revised LMRP, effective July 1, 2002, made this change. In addition, the physician’s note for the one beneficiary that said “having some upper chest discomfort...treat as angina” also said “may not be” (next to the word angina). For the second beneficiary, since the patient did not have documented symptoms of angina post PTCA, the beneficiary did not meet

Medicare coverage requirements for outpatient cardiac rehabilitation at the time of the referral and acceptance to the program.

APPENDICES

APPENDIX A

STATISTICAL SAMPLE SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services from ENH during CY 2001. The 30 beneficiaries reviewed were part of a multi-state statistical sample. The results from our sample will be included in a multi-state estimate of Medicare errors for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

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

Number of Sampled Beneficiaries with Diagnosis	Number of Sampled Beneficiaries with Errors	Medicare Covered Diagnosis	Beneficiaries Not Having Medical Documentation Supporting the Medicare Covered Diagnosis	Invalid Initial Evaluation Billed (nonphysician personnel)	No Cardiac Rehabilitation Supporting Documentation	Total Errors per Diagnosis
11	6	Myocardial Infarction (MI)	0	5	1	6
13	4	Coronary Artery Bypass Graft (CABG)	0	4	0	4
4	3	MI and CABG	0	2	1	3
2	2	Stable Angina Pectoris	2	0	0	2
30	15	Total	2	11	2	15

APPENDIX B

SAMPLING AND UNIVERSE DATA AND METHODOLOGY

We randomly selected a sample of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services from ENH during CY 2001. For each beneficiary, we obtained all Medicare claims reimbursement data for outpatient cardiac rehabilitation services and compared this data to ENH outpatient cardiac rehabilitation service documentation. In addition, we determined whether the diagnoses identified on the Medicare claims were supported by each beneficiary's inpatient medical records, the referring physician's medical records and referral, and the ENH's outpatient cardiac rehabilitation service records.

The results from our sample will be included in a multi-state estimate of Medicare reimbursements for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

Table 1. Calendar Year 2001 Outpatient Cardiac Rehabilitation Service Universe and Sampling Data and Projected Error Value

Universe	Population Value	Sample Size	Sample Value	Sampled Beneficiaries with Errors	Sample Errors Value
161	\$55,617	30	\$9,348	15	\$564

APPENDIX C

ENH'S WRITTEN COMMENTS TO DRAFT REPORT

Evanston Hospital

July 22, 2003

Paul Swanson
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

Re: Audit Report No. A-05-03-00056

Dear Mr. Swanson:

Evanston Northwestern Healthcare received the *draft* report, entitled "Review of Outpatient Cardiac Rehabilitation Services at Evanston Northwestern Healthcare, Evanston, Illinois" on June 23, 2003. ENH appreciates the opportunity to validate or formally respond to the OIG findings. The key leaders involved in the Outpatient Cardiac Rehabilitation Program have reviewed the findings in the OIG Report. The enclosure refers to the specific OIG findings, which is followed by ENH's response and supporting documents. Responses provide clarification for processes already in place as well as notification of implementation of modifications to existing processes.

I provide the system-wide administrative leadership for the Outpatient Cardiac Rehabilitation Program. If you have any questions or are in need of supporting documents, please contact me at 847-570-2008.

Sincerely,



Jesse Peterson Hall
Senior Vice President, Hospitals and Clinics
Evanston Hospital

Enclosure(s)

Review of Outpatient Cardiac Rehabilitation Services at Evanston Northwestern Healthcare
In reference to Audit Report No. A-05-03-00056

1) OIG FINDING – Direct Physician Supervision: At ENH, no physician was actually designated to provide direct physician supervision to the cardiac rehabilitation exercise areas and no documentation existed in the cardiac rehabilitation program’s medical records to support physician supervision during exercise sessions. This finding further stated that Evanston and Glenbrook Hospitals did not have a specific Cardiac Rehabilitation Program Emergency Plan. However, Evanston and Glenbrook Hospital Cardiac Rehabilitation policies required cardiac rehabilitation staff to contact the medical director and/or the patient’s physician when emergencies occur.

ENH RESPONSE: ENH does have designated physicians responsible for the supervision of patients and has appointed physician directors for the Outpatient Cardiac Rehabilitation Program. Dr. Gary Wilner is responsible for the Outpatient Cardiac Rehabilitation Program at the Evanston and Glenbrook sites. He has held this position since 1991. Dr. V. A. Menon is the designated physician director for the Highland Park site. In addition, compliance is evidenced in the OPCR Policy entitled “Physician Supervision”.

Attachment A-Policy, Physician Supervision

Also, the OPCR policy, “Emergency Procedures”, addresses the triaging of patients by a staff nurse and when to contact the primary care physician, the Cardiac Rehab Medical Director, and the activation of Code Blue. Additional evidence that ENH has an emergency plan for OPCR is contained in the “Code Blue” hospital site specific policies.

The CMS definition of “incident to” states that the physician supervision requirement is generally assumed to be met where the services are performed on the hospital premises.

Attachment B-Policy, Emergency Procedures (OPCR)

Attachment C-Policy, Code Blue-Evanston Site

Attachment D-Policy, Code Blue-Glenbrook Site

Attachment E-Policy, Code Blue-Highland Park site

ENH plans to discuss the OIG finding with AdminaStar to ensure that our current emergency plan conforms to specific requirements.

2) OIG FINDING – “Incident To” Physician Services: 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 non-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, the patient’s progress, and, where necessary, the need to change the treatment program. In summary, there was no documentation to indicate any other physician assessments or services during the beneficiaries’ cardiac rehabilitation programs.

ENH RESPONSE: The Medicare Hospital Manual states, “To be covered as **incident to** physicians’ services, the services and supplies must be furnished on a physician’s order by hospital personnel under hospital medical staff supervision in the hospital, or if outside the hospital, under the direct personal

supervision of a physician who is treating the patient". In the Medicare Intermediary Manual, Part 3, it states that "this does not mean that each occasion of service by a non-physician need also be the occasion of the actual rendition of a personal professional service by a physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often enough to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regime". And "... **the physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.** The hospital medical staff that supervises the service need not be in the same department as the ordering physician. However, if the services are provided outside the hospital, they must be rendered under the direct personal supervision of a physician who is treating the patient."...Referenced from Medicare Hospital Manual (Section 230.4 A). As indicated, the two manuals are conflicting between themselves and are unclear. ENH is aware of the services covered under the CMS and AdminaStar local medical review policy (LMRP). The requirement for a physician to **personally see** the patient at intervals was not known. ENH will take appropriate necessary action once CMS clarifies the requirement.

It should be noted that at the Evanston, Glenbrook and Highland Park Hospital OPCR sites, the following three items are currently in place:

- a) A physician order is required for a patient to enter the Cardiac Rehab Program
- b) Care is rendered by hospital personnel
- c) Care is supervised by the Medical Director

3) *OIG FINDING – Medicare Covered Diagnoses:* Medicare paid ENH for outpatient cardiac rehabilitation services where the diagnoses establishing eligibility for cardiac rehabilitation did not appear to be supported by the notes in the beneficiaries' medical record. As a result, we believe that Medicare may have inappropriately paid \$338 to ENH for the cardiac rehabilitation services provided to two (2) of the sampled beneficiaries. The medical records for the two beneficiaries with diagnosis of stable angina did not appear to indicate that the beneficiary continued to experience stable angina post-procedure. ...Specifically, ENH procedures did not require referring physicians to provide medical documentation supporting stable angina diagnoses used to justify phase II cardiac rehabilitation services at Medicare expense.

ENH RESPONSE: ENH always requires a physician referral for OPCR and the referring physician is required to indicate the patient's diagnosis on the form and to sign it. The AdminaStar LMRP states that patients "that undergo PTCA or coronary artery stenting as a treatment for their angina may still be eligible for cardiac rehabilitation if the program begins within ninety (90) days". Documentation in ENH medical records of these two (2) beneficiaries was as follows:

Beneficiary #1: Patient had atypical angina, underwent PTCA 5/22/00. In the chart there was a copy of a physician note from an office visit on 9/26/00 stating:....patient having some upper chest discomfort....treat as angina. Patient was then referred to Cardiac Rehabilitation for a visit.

Beneficiary #2: Patient had PTCA on 5/30/01, and began Cardiac Rehab on 6/26/01. While the patient did not have documented symptoms of angina post PTCA, there is documentation in the patient's chart that she had three episodes of angina while participating in the Cardiac Rehab Program. The patient had a

repeat PTCA after the second episode of angina.

ENH feels strongly that the LMRP was met for both of the above beneficiaries. However, additional staff training will be provided to ensure that prior to providing services and billing, documentation to support diagnoses will be reviewed.

4) *OIG FINDING – Initial Evaluation and Orientation:* The ENH claims included eleven (11) initial patient evaluations and orientations conducted by non-physician personnel that did not include an exercise session.

ENH RESPONSE: In order to assure inclusion of an exercise session during the initial patient evaluation/orientation, the OPCR team has revised their practice. ENH will now monitor the patient during at least one short exercise and the Patient Care Plan, EKG rhythm strip and exercise prescription will be reviewed and signed by the Medical Director. Policies have been updated and supporting documentation will be retained. This practice will meet one, if not two, of the Group 1 services required in the LMRP.

5) *OIG FINDING – Undocumented Services:* The ENH did not maintain cardiac rehabilitation service documentation to support Medicare claim for two (2) beneficiaries. Because the Medicare covered diagnoses were not validated by medical personnel, OIG suggests that AdminaStar should determine the allowability of the cardiac rehabilitation services and the proper recovery action to be taken.

ENH RESPONSE: ENH will initiate steps to improve controls to ensure that documentation to support outpatient cardiac rehabilitation services is maintained. Additionally, ENH plans to meet and discuss the issue with AdminaStar regarding any repayment liability.

The following summarizes ENH's overall response to the OIG findings:

- a) ENH will work directly with AdminaStar 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 services provided "incident to" a physician's professional service.
- b) ENH will meet with AdminaStar to determine if any repayment liability exists.
- c) ENH will bill for evaluation and orientation visits only when supervised by physician personnel in accordance with AdminaStar local medical review policy.
- d) ENH will implement internal controls to ensure that medical record documentation is maintained to support Medicare Outpatient Cardiac Rehabilitation Services.