



Office of Audit Services
Region I
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December 8, 2003

Report Number: A-01-03-00514

Mr. David Phelps
Chief Executive Officer
Berkshire Health Systems
725 North Street
Pittsfield, Massachusetts 01201

Dear Mr. Phelps:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled, "Review of Outpatient Cardiac Rehabilitation Services at the Berkshire Medical Center." A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

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

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To facilitate identification, please refer to Report Number A-01-03-00514 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in cursive script that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Joe Tilghman
Regional Administrator
Centers for Medicare and Medicaid Services – Region VII
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT CARDIAC
REHABILITATION SERVICES
AT THE
BERKSHIRE MEDICAL CENTER**



**DECEMBER 2003
A-01-03-00514**

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 HHS divisions 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 the Berkshire Medical Center (Hospital) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- Hospital's policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, "incident to" services, and Medicare covered diagnoses, and
- Payments to the Hospital for outpatient cardiac rehabilitation services provided to Medicare beneficiaries during Calendar Year (CY) 2001 were for Medicare covered diagnoses, were supported by adequate documentation, and were otherwise allowable for reimbursement.

RESULTS OF REVIEW

Our review disclosed that the Hospital relies upon physicians working nearby in the Hospital and on its emergency code teams for direct physician supervision coverage of its outpatient cardiac rehabilitation program. However, the medical record documentation we examined showed little evidence that a hospital physician personally sees a patient periodically throughout the program.

In addition, we reviewed the medical and billing records for a sample of 10 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001. We found that medical records provided by the Hospital in support of three beneficiaries receiving cardiac rehabilitation services, totaling \$1,138 in Medicare payments, did not fully support a covered Medicare diagnosis. These cases included two patients with insufficiently supported stable angina diagnoses and one patient with a noncovered congestive heart failure diagnosis.

We attribute these questionable services to weaknesses in the Hospital's internal controls and oversight procedures. Our determinations regarding Medicare covered diagnoses were based solely on our review of the medical record documentation. The medical records have not yet been 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 \$1,138 in Medicare payments made on behalf of the three beneficiaries with questionable diagnoses. The errors and Medicare payments are part of a larger nationwide review of outpatient cardiac rehabilitation service claims and may be included in a nationwide roll-up report of all providers reviewed.

RECOMMENDATIONS

We recommend that the Hospital:

- Work with its Medicare FI to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for (1) direct physician supervision and (2) services provided "incident to" a physician's professional service, and
- Work with its Medicare FI in clarifying the diagnoses and supporting medical record documentation required for Medicare coverage of outpatient cardiac rehabilitation services and in determining the allowability of \$1,138 in Medicare payments identified within this report.

AUDITEE COMMENTS AND OIG RESPONSE

In response to our draft report (see Appendix), the Hospital generally agreed with our recommendations to work with the FI in ensuring that its program meets Medicare requirements for the issues identified in our report. The Hospital contends, however, that it meets CMS and FI requirements for physician supervision in that its medical director or designated physician is immediately available to the cardiac rehabilitation program and that the program itself is located on the Hospital's premises. The Hospital stated that two of the three cardiac rehabilitation patients we identified as not having a Medicare covered diagnosis were indeed properly billed to Medicare.

We commend the Hospital for its intentions to work with the FI to ensure that its outpatient cardiac rehabilitation program meets Medicare requirements. We agree that the Hospital had a medical director or designated cardiologist for its outpatient cardiac rehabilitation program, and that physician supervision and emergency procedures were in place. The physician supervision requirement is generally assumed to be met when outpatient therapeutic services are performed on hospital premises. However, we could not conclude, as required by the definition of direct physician supervision in the Medicare Coverage Issues Manual, section 35-25, that a physician was in the exercise area at all times the exercise program was conducted.

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	i
INTRODUCTION	1
BACKGROUND	1
MEDICARE COVERAGE	1
CARDIAC REHABILITATION PROGRAMS	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
OBJECTIVE	2
SCOPE	3
METHODOLOGY	3
RESULTS OF REVIEW	4
PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION	4
DIRECT PHYSICIAN SUPERVISION	4
“INCIDENT TO” PHYSICIAN SERVICES	5
MEDICARE COVERED DIAGNOSES AND DOCUMENTATION	5
RECOMMENDATIONS	6
AUDITEE COMMENTS	7
OIG RESPONSE	7
APPENDIX	
BERKSHIRE MEDICAL CENTER RESPONSE TO DRAFT REPORT	

INTRODUCTION

BACKGROUND

MEDICARE COVERAGE

The Medicare program, established by title XVIII of the Social Security Act (the Act), provides health insurance to individuals aged 65 and over, the disabled, individuals with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by CMS. CMS currently covers certain Phase II outpatient cardiac rehabilitation programs conducted in specialized, free-standing cardiac rehabilitation clinics and in outpatient hospital departments under the “incident to” benefit (section 1861(s)(2)(A) of the Act).

Medicare coverage policy for cardiac rehabilitation services is found in section 35-25 of the Medicare Coverage Issues Manual. Under Medicare, outpatient cardiac rehabilitation is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending 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 therapeutic services provided in a hospital, the Medicare Intermediary Manual states, “The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.”

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

CARDIAC REHABILITATION PROGRAMS

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

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

Medicare reimburses outpatient hospital departments for cardiac rehabilitation services under the outpatient prospective payment system. Cardiac rehabilitation services are paid by a Medicare FI based on an ambulatory payment classification. The FI for the Hospital is Mutual of Omaha. For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 140 Medicare beneficiaries and received \$45,053 in Medicare reimbursements for these services.

OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

Our review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the CMS Administrator to determine the level of provider compliance with Medicare coverage requirements for outpatient cardiac rehabilitation services. As such, the overall objective of our review was to determine whether Medicare properly reimbursed the Hospital for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

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

SCOPE

To accomplish these objectives, we reviewed the Hospital's current policies and procedures and interviewed staff to gain an understanding of the Hospital's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. In addition, we reviewed the Hospital's cardiac rehabilitation services documentation, inpatient medical records, physician referrals, attending physician records, and Medicare reimbursement data for a judgmental sample of 10 beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001 as part of a nationwide review of outpatient cardiac rehabilitation services. We reviewed the Hospital'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 Hospital review included 10 of the 140 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 10 beneficiaries during CY 2001.

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

METHODOLOGY

We compared the Hospital's current policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and identified any differences. We documented how the Hospital's staff provided direct physician supervision for cardiac rehabilitation services and verified that the Hospital's cardiac rehabilitation program personnel were qualified in accordance with Medicare requirements. We also verified the availability of advanced cardiac life support equipment in the cardiac rehabilitation exercise area.

For each beneficiary, we obtained the CY 2001 Medicare outpatient cardiac rehabilitation paid claims and lines of service and compared this data to the Hospital's outpatient cardiac rehabilitation service documentation. We reviewed the medical records maintained by the cardiac rehabilitation program to determine whether services were provided "incident to" a physician's professional service. We also verified the accuracy of the diagnoses identified on the Medicare claims to each beneficiary's inpatient medical record, the physician referral, and the Hospital's outpatient cardiac rehabilitation medical

record. In addition, we determined if Medicare reimbursed the Hospital beyond the maximum number of services allowed.

In accordance with the intent of CMS's request for a nationwide analysis, we determined the extent to which providers were currently complying with existing Medicare coverage requirements. We performed fieldwork at the Hospital located in Pittsfield, Massachusetts during May and June 2003.

The Hospital's comments to our draft report are appended to this report (see Appendix).

RESULTS OF REVIEW

Our review disclosed that the Hospital relies upon physicians working nearby in the Hospital and in its emergency department for physician supervision coverage of its outpatient cardiac rehabilitation program. However, medical record documentation we examined showed little evidence that a physician personally sees a patient periodically throughout the program.

In addition, we reviewed the medical and billing records for a sample of 10 beneficiaries who received outpatient cardiac rehabilitation services during CY 2001. We found that medical records provided by the Hospital in support of three beneficiaries receiving cardiac rehabilitation services, totaling \$1,138 in Medicare payments, did not fully support a covered Medicare diagnosis.

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 the Medicare FI staff. We believe that the Hospital's FI should make a determination as to the allowability of the Medicare claims and appropriate recovery action.

The results of our audit are discussed in detail below.

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.

The Hospital's cardiac rehabilitation facility is located within the Hospital. We found that while no physician is permanently assigned to the exercise room, the Hospital stated that it meets the direct physician supervision requirement by having a physician available

in the cardiac stress test lab located nearby the cardiac rehabilitation exercise area. According to the Hospital, a physician is available for any emergencies for all hours the cardiac rehabilitation program operates. Emergency department physicians are also available as needed.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe the Hospital should work with the FI to ensure that the reliance placed on nearby physicians and emergency department physicians to provide this supervision conforms with the requirements.

“INCIDENT TO” PHYSICIAN SERVICES

Medicare covers Phase II cardiac rehabilitation under the “incident to” benefit. In an outpatient hospital department, the “incident to” benefit does not require that a physician perform a personal professional service on each occasion of service by a nonphysician. However, during any course of treatment rendered by auxiliary personnel, the 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.

Patients referred to the Hospital’s outpatient cardiac rehabilitation program are evaluated by its registered nursing staff and prescribed an individualized treatment plan for exercise training and cardiac risk factor reduction education and counseling. The treatment plan is signed and approved by the medical director of the program.

According to cardiac rehabilitation nursing staff, the medical director heads a bi-weekly staff meeting to discuss individual patient cases and the overall operation of the program. Also, the physician is available to staff daily for consultations on individual patient cases. In addition, patients’ referring physicians are updated on patients’ progress midway, at the end of the program, and if any problems arise during treatment. However, we did not see evidence that the medical director or other Hospital physician personally saw the patients at any time during their course of cardiac rehabilitation to assess their course of treatment and progress and, where necessary, to change the treatment program. Accordingly, we believe that the Hospital’s cardiac rehabilitation program did not meet the requirements to provide an “incident to” service.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

Medicare reimbursed the Hospital for outpatient cardiac rehabilitation services when the diagnoses used to establish eligibility for cardiac rehabilitation did not appear to be supported by the notes in the beneficiaries’ medical records. 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 coronary artery bypass graft surgery, and/or (3) stable angina pectoris. Medicare reimburses providers for Phase II outpatient cardiac rehabilitation services and allows

one unit of service to be billed per cardiac rehabilitation session. Documentation for these services must be maintained in the patients' medical records.

We reviewed the medical and billing records of a judgmental sample of 10 Medicare beneficiaries receiving outpatient cardiac rehabilitation services at the Hospital during CY 2001. In order to determine whether the patient had a covered diagnosis, we compared the diagnosis submitted with the Medicare bill to medical record documentation such as stress test results, cardiac rehabilitation program notes, referring physician records and inpatient records. Seven of the Medicare beneficiaries reviewed had covered diagnoses properly supported in each patient's medical records. However, the remaining three cases in our sample, totaling \$1,138 in payments, were patients whose medical record documentation did not support a covered diagnosis for Medicare reimbursement. In one case, the patient also underwent an angioplasty procedure with stent placement prior to cardiac rehabilitation. It was unclear from the medical records whether stable angina pectoris was present post procedure at the start of cardiac rehabilitation therapy. Likewise, the second patient was admitted to the program with a stable angina pectoris diagnosis. While the medical records for the patient showed a long history of illness, no signs or observations of chest pains or related symptoms associated with stable angina pectoris were evident. In the third case, the patient had a noncovered congestive heart failure diagnosis.

As a result, we believe that the Hospital did not always adequately document the diagnosis to support the cardiac rehabilitation services provided and charged to Medicare. Our audit 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 the proper recovery action to be taken.

The results of our review may be included in a nationwide roll-up report identifying Medicare reimbursements for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

RECOMMENDATIONS

We recommend that the Hospital:

- Work with its Medicare FI to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for (1) direct physician supervision and (2) services provided "incident to" a physician's professional service, and
- Work with its Medicare FI in clarifying the diagnoses and supporting medical record documentation required for Medicare coverage of outpatient cardiac rehabilitation services and in determining the allowability of the \$1,138 in Medicare payments identified within this report.

AUDITEE COMMENTS

In its November 20, 2003 response to our draft report (see Appendix), the Hospital generally agreed with our recommendations to work with its Medicare FI in resolving the issues identified in our report. In addition, the Hospital provided comments addressing our report findings.

With regard to the physician supervision requirement, the Hospital contends that its program complies with CMS Coverage Issues Manual section 35-25 and the FI's local medical review policy. The Hospital quoted its policies calling for its medical director or a designated cardiologist to be immediately available during all phase II exercise sessions and to respond to all codes and medical emergencies in a timely manner. These physicians are available in an office setting immediately adjacent to the exercise room. The Hospital stated that it does not rely on emergency department physicians or an emergency code team to cover medical emergencies.

To meet the "incident to" physician services requirement, the Hospital plans to improve its documentation and to increase the frequency of cardiologist and attending physician involvement in patient care. In addition, the Hospital reiterated the physician involvement that it states is presently in place.

The Hospital stated that two of the three cardiac rehabilitation patients we identified as not having a Medicare covered diagnosis were indeed properly billed to Medicare. Both the medical director and program director felt that there were sufficient symptoms of stable angina in the patients' medical records to support the coding of these claims. The Hospital plans to request FI review of these two cases. The third case involved a billing error for which the Hospital has initiated recovery action.

OIG RESPONSE

We commend the Hospital for its intentions to work with the FI to ensure that its outpatient cardiac rehabilitation program meets Medicare requirements.

We agree that the Hospital had a medical director or designated cardiologist 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 when outpatient therapeutic services are performed on hospital premises. However, we could not conclude, as required by definition of direct physician supervision in the Medicare Coverage Issues Manual, section 35-25, that a physician was in the exercise area at all times the exercise program was conducted. With regard to the role of Hospital emergency code teams in responding to cardiac rehabilitation program emergencies, we maintain that code team involvement was conveyed to us during our walk-through of the unit. However, the Hospital's emphasis in its policies and procedures toward the involvement of its medical director or designated

cardiologist in emergency response is significant in demonstrating direct physician supervision.

APPENDIX



725 North Street
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(413) 447-2000

November 20, 2003

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region 1
John F. Kennedy Federal Building
Boston, MA 02203

Re: Audit Report Number A-01-03-00514

Dear Mr. Armstrong:

This letter is in response to your letter dated October 7, 2003 that included the Office of Inspector General's draft report entitled "Review of Outpatient Cardiac Rehabilitation Services at Berkshire Medical Center." We appreciate the opportunity to submit a formal response to your report and to further discuss the OIG's findings and recommendations.

Your report has been reviewed by the administrative staff of the Cardiac Rehabilitation Program along with staff from the Compliance Office and Legal Office. Based upon your comments and recommendations we want to assure the OIG that the Berkshire Medical Center (BMC) will:

- Work with our FI, Mutual of Omaha, to verify that our cardiac rehabilitation program continues to be conducted in accordance with Medicare coverage requirements for (1) direct physician supervision and (2) services provided "incident to" a physician's professional service, and
- Work with Mutual of Omaha to clarify the diagnosis and supporting medical record documentation for Medicare coverage of outpatient cardiac rehabilitation services and verify the allowability of the \$1,138 in Medicare payments identified within this report.

Audit Results

Direct Physician Supervision

OIG Comments:

- Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department.
- 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 the physician to be physically present in the exercise room itself.
- The hospital relies upon physicians working nearby in the hospital and on its emergency code teams for physician supervision coverage of its outpatient cardiac rehabilitation program.

BMC Response:

BMC complies with Medicare's requirements of direct supervision as follows:

- The OIG's report acknowledged that "the hospital's cardiac rehabilitation (CR) facility is located within the hospital.

- CMS Coverage Issues Manual 35-25 and Mutual of Omaha's LMRP 99-1R2 both state that "the case in which a contractor determines that the presence of a physician in an office across the hall from the exercise room who is available at all times for an emergency meets the requirements that a physician is immediately available and accessible."
- Our CR Policy Manual states "The Medical Director or designated Cardiologist will be immediately available during all Phase II exercise sessions."
- Our CR Emergency Procedures Manual states "The Medical Director or a qualified Cardiologist designee will be immediately available during the time period that the Phase II cardiac rehabilitation program is operational. He will respond to all codes and medical emergencies in a timely manner."
- Our Medical Director and Cardiologists are available in an office setting that is immediately adjacent to the exercise room.
- We do not rely upon emergency department physicians or an emergency code team to cover medical emergencies and did not state this at any time during the audit.

"Incident To" Physician Services

OIG Comments:

- There appeared to be a lack of "evidence that the medical director or other hospital physician personally saw the patients at any time during their course of cardiac rehabilitation to assess their course of treatment and progress and, where necessary, to change the treatment program."

BMC Response:

BMC will better meet the Medicare requirements for "incident to" physician service, by a) improving documentation and b) increasing the frequency of cardiologist or attending physicians involvement in patient care in addition to the following already in place:

- Patients enter the CR program through a physician order, either from their attending physician and/or a cardiologist. Care is managed by the patients referring physician including periodic face-to-face encounters with that physician.
- The CR medical director is primarily responsible for program oversight, guidance and availability in the event of a medical emergency. He reviews and signs each patient's treatment plan, discharge summary and exercise prescription and changes to that prescription. The medical director is available for problems/concerns regarding the patient's condition.
- The referring physician and /or cardiologist are routinely kept updated regarding the patient's progress at different intervals throughout the course of treatment. The CR program routinely requests copies of physician office notes documenting patient/physician interaction.

Medicare Covered Diagnosis

OIG Comments:

- There was evidence that "the hospital did not always adequately document the diagnosis to support the CR services provided and charged to Medicare".
- Case 1 - It was unclear from the medical records whether stable angina pectoris was present post procedure at the start of CR therapy.
- Case 2 - Patient was admitted to the program with a stable angina pectoris diagnosis. While the medical records for the patient showed a long history of illness, no signs or observations of chest pains or related symptoms associated with stable angina pectoris were evident.
- Case 3 - The patient had a non-covered diagnosis of congestive heart failure.

BMC Response:

- Case 1 & 2 - Both the Medical Director and the Program Director of CR felt there was sufficient symptoms of stable angina evidenced in the medical record to support the coding of these claims. However, we will request a review at the intermediary level.
- Case 3 - We agree this is not a Medicare covered diagnosis, however the patients secondary insurance would cover the diagnosis. The hospital erroneously neglected to include a proper code indicating Medicare not to pay the bill when the bill was submitted for the purpose of denial of the claim and establishment of a right to secondary insurance. Medicare erroneously paid the account and the erroneous payment was not discovered internally by billing staff.

Corrective Action**Direct Physician Supervision and "Incident To" Physician Services,**

- BMC will work directly with Mutual of Omaha, our FI, so that the outpatient cardiac rehabilitation program continues to be conducted in accordance with the Medicare coverage requirements for both direct physician supervision and for services provided "incident to" a physician's professional service.
- BMC will work on a plan to improve the gathering of appropriate documentation from the patient's attending physician.
- BMC has had one conversation with the Mutual's Medical Director in regards to the above and will continue to pursue their guidance in moving forward.

Medicare Covered Diagnosis

- Cases 1 & 2 - BMC will forward these records to Mutual for internal review and comment regarding the appropriateness of the diagnosis coding and supporting documentation.
- Case 3 - BMC has already initiated a refund on this account for \$455 to Mutual.
- BMC will implement internal controls to verify that patient's with a non-covered Medicare diagnosis, which are subsequently covered by secondary insurers, will be appropriately coded for denial as intended.
- The CR Program Director has attended an educational conference sponsored by Mutual of Omaha addressing coverage issues.

Thank you for the opportunity to formally respond to your report. Please do not hesitate to contact me at 413-447-2778 with any questions you may have.

Sincerely,



James Canino, Jr.
Compliance Officer

ACKNOWLEDGMENTS

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

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