



DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region II
Jacob K. Javits Federal Building
New York, New York 10278
(212) 264-4620

December 19, 2003

Our Reference: Report Number A-02-03-01016

Ms. Janice Stout
Vice President for Corporate Compliance and Regulatory Affairs
Robert Wood Johnson University Hospital Hamilton
One Hamilton Health Place
Hamilton, New Jersey 08690

Dear Ms. Stout:

Enclosed are two copies of the Office of Inspector General report entitled "Review of Outpatient Cardiac Rehabilitation Services at Robert Wood Johnson University Hospital Hamilton." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

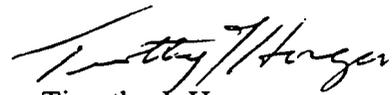
Final determinations as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe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

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Page 2 - Ms. Janice Stout

To facilitate identification, please refer to Report Number A-02-03-01016 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Timothy J. Horgan". The signature is fluid and cursive, with a large initial "T" and "H".

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Mr. James T. Kerr
Regional Administrator
Centers for Medicare & Medicaid Services, Region II
U.S. Department of Health and Human Services
26 Federal Plaza, Room 3811
New York, New York 10278

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT CARDIAC
REHABILITATION SERVICES AT
ROBERT WOOD JOHNSON
UNIVERSITY HOSPITAL HAMILTON**



**DECEMBER 2003
A-02-03-01016**

Office of Inspector General

<http://oig.hhs.gov>

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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.

Currently, CMS 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 Social Security Act]. Medicare coverage policy for cardiac rehabilitation services is found in section 35-25 of the Medicare Coverage Issues Manual. Under 42 Code of Federal Regulations 482.24(b), the hospital must maintain a medical record for each inpatient and outpatient.

Outpatient cardiac rehabilitation is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physicians, and have a documented Medicare covered diagnosis for cardiac rehabilitation. Services provided in connection with cardiac rehabilitation programs must be rendered under direct physician supervision and be incident to the professional services of a physician.

OBJECTIVE

The overall objective of our review was to determine whether Medicare properly reimbursed Robert Wood Johnson University Hospital Hamilton (Hamilton) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

- Hamilton’s policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, “incident to” services, and Medicare covered diagnoses.
- Payments to Hamilton 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

According to the Medicare Intermediary Manual (Intermediary Manual), Section 3112.4, the physician supervision requirement is generally assumed to be met for outpatient cardiac rehabilitation services provided on hospital premises. At Hamilton, there was no physician specifically designated to directly supervise the cardiac rehabilitation program. Instead, Hamilton relied on a house physician, the program exercise area’s proximity to the Cardiac and Emergency Departments, and emergency response procedures.

In addition, the Intermediary Manual, Section 3112.4, states that 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 a physician’s professional service in the course of diagnosis or treatment of an illness or injury. That is, during any course of treatment rendered by auxiliary personnel, a physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient’s progress and, where necessary, to change the treatment program. At Hamilton, we were unable to identify the physician professional services to which the cardiac rehabilitation services were provided “incident to.” There was no documentation to indicate that a hospital physician personally saw patients to assess their response to the program and update treatment plans.

Medicare reimbursed Hamilton \$29,236 for 1,926 cardiac rehabilitation services provided to 80 beneficiaries during CY 2001. Our analysis of the medical and billing records of 10 beneficiaries, who received 301 services totaling \$4,575 during CY 2001, showed that 36 services totaling \$548 for 8¹ beneficiaries did not meet Medicare criteria for reimbursement as follows:

- One service was not rendered for each of two beneficiaries (\$31).
- Four services were not documented for one beneficiary (\$60).
- Twenty-two services were rendered in excess of the physician’s prescribed number of sessions for two beneficiaries (\$336).
- Eight services unallowable for outpatient cardiac rehabilitation were rendered to seven beneficiaries (\$121).

We also found that the diagnosis codes for three beneficiaries on the Paid Claim Data file did not match the diagnosis codes in the patients’ records. Although the documented diagnosis codes did not match, the diagnoses documented in the patients’ records were Medicare covered diagnoses for cardiac rehabilitation services.

We attribute these questionable services to weaknesses in Hamilton’s internal controls and oversight procedures. Existing controls did not ensure that services billed were (1) actually rendered, (2) sufficiently documented within and supported by the medical records, (3) rendered in accordance with physician prescriptions and (4) allowable for reimbursement under cardiac rehabilitation requirements and that diagnoses were properly coded.

Our determinations regarding Medicare covered diagnoses were based solely on our review of the medical record documentation. The medical records have not been reviewed by Medicare Fiscal Intermediary (FI) staff. We believe that the Medicare FI,

¹ We identified six beneficiaries with multiple questionable services.

Riverbend Government Benefits Administrator, should determine appropriate recovery action.

The results of our review may be included in a nationwide roll-up report of all outpatient cardiac rehabilitation providers reviewed.

RECOMMENDATIONS

We recommend that Hamilton:

- Work with its Medicare FI to ensure that Hamilton’s outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirement for direct physician supervision and for services provided “incident to” a physician’s professional services.
- Work with its Medicare FI to establish the amount of repayment liability for services provided to beneficiaries that did not meet criteria for Medicare reimbursement.
- Strengthen internal controls and oversight activities to ensure that services claimed are allowable for reimbursement under Medicare outpatient cardiac rehabilitation requirements.

AUDITEE COMMENTS AND OIG RESPONSE

Hamilton, in its response dated November 7, 2003 (see Appendix B), provided a plan describing actions taken to improve its procedures for claiming outpatient cardiac rehabilitation services. Specifically, Hamilton has developed written policies to address its compliance with the “incident to” requirements and to strengthen internal controls for documentation and billing. The hospital has also installed a computerized documentation system and procedures for verifying the accuracy of coding and appropriateness of diagnoses billed. In addition, Hamilton has agreed to return overpaid reimbursements to the FI.

We reviewed all relevant comments made by Hamilton and believe that Hamilton should continue to work with the FI to determine whether the actions implemented by Hamilton ensure that its outpatient cardiac rehabilitation program is being conducted in accordance with Medicare requirements.

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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). CMS 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 (Coverage Issues Manual). Under Medicare, outpatient cardiac rehabilitation is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physicians, and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) have had coronary artery bypass graft surgery, and/or (3) have stable angina pectoris. Under 42 Code of Federal Regulations (CFR) 482.24(b), the hospital must maintain a medical record for each inpatient and outpatient. 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. According to the Medicare Intermediary Manual (Intermediary Manual), Section 3112.4, the physician supervision requirement is generally assumed to be met where the outpatient 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 Medicare FI for Robert Wood Johnson University Hospital Hamilton (Hamilton) is Riverbend Government Benefits Administrator. For Calendar Year (CY) 2001, Hamilton provided 1,926 outpatient cardiac rehabilitation services to 80 Medicare beneficiaries and received \$29,236 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 Hamilton for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

- Payments to Hamilton 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 and Methodology

To accomplish our audit objectives, we:

- Reviewed Hamilton's current policies and procedures and interviewed staff to gain an understanding of Hamilton's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services.
- Compared Hamilton's current policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and identified any differences.
- Documented how Hamilton's staff provided direct physician supervision for cardiac rehabilitation services and verified that Hamilton's cardiac rehabilitation program personnel were qualified in accordance with Medicare requirements.
- Verified the availability of advanced cardiac life support equipment in the cardiac rehabilitation exercise area.
- For 10 beneficiaries, reviewed all Medicare paid claims totaling \$4,575 for 301 cardiac rehabilitation services provided by Hamilton during CY 2001.
- For each of the 10 beneficiaries, compared reimbursement data and lines of service to Hamilton's outpatient cardiac rehabilitation service documentation.
- Reviewed the medical records maintained by the cardiac rehabilitation program to determine whether services were provided "incident to" a physician's professional service.
- Verified the accuracy of the diagnoses identified on the Medicare claims to the beneficiaries' inpatient medical record, physician referral and supporting medical records, and Hamilton's outpatient cardiac rehabilitation documentation. The Medicare FI medical review staff did not review the medical records.
- Verified that Medicare did not reimburse Hamilton beyond the maximum number of services allowed.

Our audit was conducted in accordance with generally accepted government auditing standards. 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 during March 2003 at Robert Wood Johnson University Hospital Hamilton, located in Hamilton, New Jersey.

RESULTS OF REVIEW

Although physician supervision is assumed to be met in an outpatient hospital department, we found that Hamilton did not designate a physician to directly supervise the services provided by its cardiac rehabilitation program. However, the cardiac exercise room is physically located within the hospital and in close proximity to the Cardiac and Emergency Departments, and a house physician was available to respond to emergencies within the cardiac exercise room during the program's operating hours.

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." There is no documentation to indicate that a hospital physician personally saw patients to assess their response to the program and update treatment plans.

Medicare reimbursed Hamilton \$29,236 for 1,926 cardiac rehabilitation services provided to 80 beneficiaries during CY 2001. Our analysis of the medical and billing records of 10 beneficiaries who received 301 services totaling \$4,575 during CY 2001 showed that 36 services totaling \$548 for 8¹ beneficiaries did not meet Medicare criteria for reimbursement as follows:

- One service was not performed for each of two beneficiaries (\$31).
- Four services were not documented for one beneficiary (\$60).
- Twenty-two services were rendered in excess of the physician's prescribed number of sessions for two beneficiaries (\$336).
- Eight services unallowable for outpatient cardiac rehabilitation were rendered to seven beneficiaries (\$121).

We also found that the diagnosis codes for three beneficiaries on the Paid Claim Data file did not match the diagnosis codes in the patients' records. Although the documented diagnosis codes did not match, the diagnoses documented in the patients' records were Medicare covered diagnoses for cardiac rehabilitation services.

The findings from our review of Medicare outpatient cardiac rehabilitation services are described in detail below.

¹ We identified six beneficiaries with multiple questionable services.

PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION

Direct Physician Supervision

According to the Coverage Issues Manual, Section 35-25(A), the requirements for outpatient cardiac rehabilitation state that direct supervision means that a physician must be in the exercise program area and immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require that a physician be physically present in the exercise room itself, provided the contractor does not determine that the physician is too remote from the patients' exercise area to be considered immediately available and accessible. Under the Intermediary Manual, Section 3112.4, the physician supervision requirement is generally assumed to be met where the outpatient services are performed on hospital premises.

On a day-to-day basis, Hamilton's cardiac rehabilitation program was staffed and run by registered nurses, exercise physiologists, and other support staff. A clinical coordinator, who was a registered nurse, was responsible for daily supervision of the cardiac rehabilitation area. There was no one physician specifically designated to directly supervise the cardiac rehabilitation program. However, the cardiac rehabilitation exercise room is physically located within the hospital and in close proximity to the Cardiac and Emergency Departments, and a house physician was available to respond to emergencies within the cardiac exercise room during the program's operating hours. In addition, Hamilton's written policies include procedures for managing emergency situations. Specifically, in the event of an emergency, a cardiopulmonary arrest "code 77" would be called to which an emergency response team would respond.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe that Hamilton should work with the Medicare FI to ensure that the outpatient cardiac rehabilitation program specifically conforms to the direct supervision requirements.

"Incident To" Physician Services

According to the Intermediary Manual, Section 3112.4, 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 a physician's professional service in the course of diagnosis or treatment of an illness or injury. The 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 and the patient's progress and, where necessary, to change the treatment program.

At Hamilton, we were unable to identify the physician professional services to which the cardiac rehabilitation services were provided "incident to". According to Hamilton's policies and procedures, each patient referred to the outpatient cardiac rehabilitation

program attended an initial assessment session conducted by the registered nurses. This session included, among other services, a focused physical assessment of the patient's condition and symptoms since discharge from the hospital, and a functional capacity assessment to help determine an individualized exercise prescription.

Based on the initial assessment, an individualized plan of care for exercise training that addresses the cardiac risk factor educational and counseling plan, psychosocial plan, discharge plan, and outcome measurement plan, was developed. Thereafter, the registered nurses performed ongoing assessments. These assessments included a determination based on new onset of signs/symptoms, blood pressure, and heart rate and rhythm. The cardiac rehabilitation staff contacted a physician, usually the referring physician, only if a significant issue arose during a session. Patients generally attended the Phase II cardiac rehabilitation program 3 days per week.

From our review of Hamilton's outpatient cardiac rehabilitation medical records, we were unable to locate evidence of any physician professional services rendered to the patients participating in the program. There was no documentation to indicate that a hospital physician personally saw patients to assess their response to the program and update treatment plans. Accordingly, we believe that Hamilton's cardiac rehabilitation program did not meet the requirements to provide an "incident to" service. Hamilton should work with the Medicare FI to ensure that the outpatient cardiac rehabilitation program specifically conforms to the "incident to" requirements.

MEDICARE COVERED DIAGNOSES AND CLAIMS REVIEW

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 analysis of the medical and billing records of 10 beneficiaries who received 301 cardiac rehabilitation services totaling \$4,575 during CY 2001 showed that 36 services totaling \$548 for 8 beneficiaries did not meet Medicare criteria for reimbursement. In addition, we found that the diagnosis codes for three beneficiaries on the Paid Claim Data file did not match the diagnosis codes in the patients' records. However, the documented diagnoses were also covered for Medicare outpatient cardiac rehabilitation reimbursement.

A summary of questionable services is contained in Appendix A of this report.

Services Not Performed

According to the Coverage Issues Manual, Section 35-25(A) and (E), Medicare will reimburse providers for Phase II outpatient cardiac rehabilitation services. Only one unit of service is billable per session. In order for the visit to be reimbursable, at least one Group 1 service must be performed.² However, not all the services need be performed at each visit.

We identified two services totaling \$31 for two beneficiaries that were not performed. For each beneficiary, Hamilton billed two sessions on the same date of service, December 7, 2001. In each case, the medical records supported only one session on that date of service. The records, and our review of the Paid Claims Data File for all Medicare beneficiaries serviced by the cardiac rehabilitation program, indicate that due to a clerical error, Hamilton double-billed sessions for a total of 11 patients, including the two reviewed beneficiaries, who received services on that same date of service. Hamilton's internal controls and oversight procedures did not ensure that services billed were actually performed.

Services Not Documented By Medical Records

According to the 42 CFR 482.24 (b) and (c), the hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

We identified four services totaling \$60 for one beneficiary for which the medical record did not contain documentation supporting the services billed. Hamilton's internal controls and oversight procedures did not ensure that supporting documentation for these outpatient cardiac rehabilitation services was maintained.

Services Exceeding the Physician's Prescription

According to the Coverage Issues Manual, Section 35-25(A) and (D), services may be considered reasonable and necessary for up to 36 sessions, based on a referral by the attending physician. Coverage for continued participation in cardiac exercise programs beyond 12 weeks are allowed only on a case-by-case basis with exit criteria taken into consideration.

We identified 22 services totaling \$336 for two beneficiaries for whom services were provided in excess of the physicians' prescriptions. Based on our review of the medical records, we were unable to determine whether the sessions rendered in excess of the

² A Group 1 service may consist of continuous ECG telemetric monitoring during exercise; ECG rhythm strip with interpretation and physician's revision of exercise prescription; and limited examination for physician follow-up to adjust medication or other treatment changes.

number of sessions prescribed by the physicians were justified. Although existing controls require a prescription for entry into the cardiac rehabilitation program, we noted nothing in Hamilton's written policies and procedures that addresses changes to the number of sessions prescribed. Hamilton's internal controls and oversight procedures did not ensure that services billed were rendered in accordance with physician prescriptions.

Services Not Allowable

According to the Coverage Issues Manual, Section 35-25(E), in order for a visit to be reimbursable, at least one Group 1 service must be performed. A Group 1 service may consist of continuous ECG telemetric monitoring during exercise; ECG rhythm strip with interpretation and physician's revision of exercise prescription; and limited examination for physician follow-up to adjust medication or other treatment changes. Not all the services need be performed at each visit. Also, a hospital may be reimbursed for Group 2 service, such as a new patient evaluation or stress test. A Group 2 service conducted by nonphysician personnel must be performed in conjunction with a rehabilitation session.

We identified eight services totaling \$121 provided to seven beneficiaries that did not qualify as a reimbursable service for cardiac rehabilitation. For each of the seven beneficiaries, the hospital was reimbursed for a new patient evaluation conducted by nonphysician personnel. These services were not performed in conjunction with a rehabilitation session. Hamilton cardiac rehabilitation staff misinterpreted the Medicare requirements for Group 2 services.

Medicare Covered Diagnoses

According to the Coverage Issues Manual section 35-25(A), 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; or (2) have had coronary bypass surgery; and/or (3) have stable angina pectoris.

Of the 10 beneficiaries reviewed, we found that 2 beneficiaries were eligible for cardiac rehabilitation based on a diagnosis of acute myocardial infarction, 2 beneficiaries were eligible based on a diagnosis of coronary bypass surgery, 2 had both myocardial infarction and coronary bypass surgery and 4 were eligible based on a diagnosis of stable angina.

We identified three beneficiaries in which the diagnosis codes on the Paid Claim Data file did not match the diagnosis codes in the patients' records. Although the documented diagnosis codes did not match the Paid Claim codes, the diagnoses documented in the patients' records were Medicare covered diagnoses for cardiac rehabilitation services. Therefore, there is no dollar impact for the three beneficiaries.

We attribute these questionable services to weaknesses in Hamilton's internal controls and oversight procedures. Existing controls did not ensure that services billed were

(1) actually rendered, (2) sufficiently documented within and supported by the medical records (3) rendered in accordance with physician prescriptions and (4) allowable for reimbursement under cardiac rehabilitation requirements and that diagnoses were properly coded.

The results of our review may be included in a nationwide roll-up report of all outpatient cardiac rehabilitation providers reviewed.

RECOMMENDATIONS

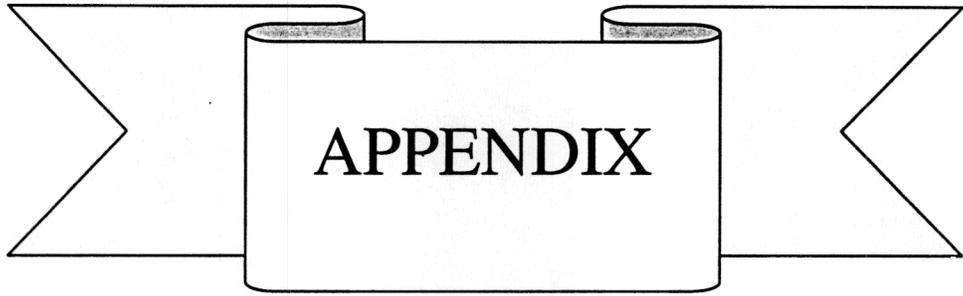
We recommend that Hamilton:

- Work with its Medicare FI to ensure that Hamilton's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare requirements for direct physician supervision and for services provided "incident to" a physician's professional services.
- Work with its Medicare FI to establish the amount of repayment liability for services provided to beneficiaries that did not meet criteria for Medicare reimbursement.
- Strengthen internal controls and oversight activities to ensure that services billed to Medicare are services actually rendered, sufficiently documented within and supported by the medical records, rendered in accordance with physician prescriptions and allowable for reimbursement under cardiac rehabilitation requirements.

AUDITEE COMMENTS AND OIG RESPONSE

Hamilton, in its response dated November 7, 2003 (see Appendix B), provided a plan describing actions taken to improve its procedures for claiming outpatient cardiac rehabilitation services. Specifically, Hamilton has developed written policies to address its compliance with the "incident to" requirements and to strengthen internal controls for documentation and billing. The hospital has also installed a computerized documentation system and procedures for verifying the accuracy of coding and appropriateness of diagnoses billed. In addition, Hamilton has agreed to return overpaid reimbursements to the FI.

We reviewed all relevant comments made by Hamilton and believe that Hamilton should continue to work with the FI to determine whether the actions implemented by Hamilton ensure that its outpatient cardiac rehabilitation program is being conducted in accordance with Medicare requirements.



SUMMARY OF QUESTIONABLE SERVICES

Total Medicare Reimbursement: \$29,235.58
 Total Services Provided: 1,926
 Total Beneficiaries: 80

Reviewed Medicare Reimbursement: \$4,574.78
 Reviewed Services Provided: 301
 Reviewed Beneficiaries: 10

Type of Questionable Service	Number of Beneficiaries with Questionable Services	Total Questioned Services	Total Reimbursement for Questionable Services
Services Not Performed	2	2	\$31
Services Not Documented by Medical Records	1	4	\$60
Services Exceeding the Physician Prescription	2	22	\$336
Services Not Allowable	7	8	\$121
Totals:	12³	36	\$548

³ We identified six beneficiaries with multiple questionable services.

ROBERT WOOD JOHNSON
UNIVERSITY HOSPITAL
HAMILTON

11/7/03

Timothy J. Hogan
Regional Inspector General for Audit Services
Dept. of Health & Human Services
Office of Inspector General
Office of Audit Services Region II
26 Federal Plaza 3900 A
Jacob K. Javits Federal Building
New York, NY 10278

WHS/OIG
OFFICE OF AUDIT
NEW YORK REGIONAL OFFICE

NOV 12 2003

RECEIVED

RE: Report Number A-02-03-01016

Dear Mr. Hogan:

The following is response to in your letter dated 10/8/03 regarding the Review of Outpatient Cardiac Rehabilitation Services provided to Medicare beneficiaries at Robert Wood Johnson University Hospital at Hamilton in 2001.

Our comments, action plan, and the status of that action plan to address each of the recommendations are summarized on the table below.

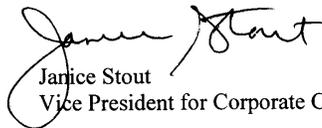
OIG Recommendations	RWJUHH Action Plan	Target Date	Date Completed
Plan services in compliance with "incident to" requirements	Develop written policy to notify ordering physician of each patient's cardiac rehab. schedule so that they are aware of when they can observe a patient's exercise session. Develop method and inservice staff.	Nov. 2003	11/6/03
	Develop written policy to give patients a copy of their cardiac rehab. notes to take to their physician office visit or fax copies to the physician prior to their physician office visit. Inservice staff.	Nov. 2003	11/6/03
	Develop written policy that all visits billed include a Group 1 service. Inservice staff.	Oct. 2003	11/6/03
	Negotiate contract with a cardiologist to provide supervision of cardiac rehab. Monitor compliance with the contract.	Oct. 2004	
Ascertain any repayment obligation	Return reimbursement due to FI per report from OIG.	Oct. 2003	10/13/03

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OIG Recommendations	RWJUH Action Plan	Target Date	Date Completed
Strengthen internal controls for documentation and billing	Install computerized online cardiac rehab. documentation system which provides for mandatory documentation fields and prompts for missing documentation.	-----	Feb. 2003
	Verify accuracy of coding and appropriateness of diagnoses of all cardiac rehab. cases prior to submission of abstract to Billing.	-----	April 2003
	Develop procedure for (a) reviewing at least 10% of cardiac rehab. cases before each case is closed to verify that all cardiac rehab. services billed have been documented and (b) notifying dept. director and Patient Accounts of undocumented services so that those charges are reversed. Inservice staff.	Nov. 2003	11/6/03

If there are any questions or additional information is needed, please call me at 609-584-6401.

Sincerely,



Janice Stout
Vice President for Corporate Compliance & Regulatory Affairs

cc: C. Stephenson, CEO
M. Long, Director - Rehab.Services