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**Memorandum**

Date **AUG 12 2003**

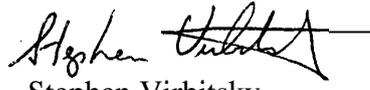
From Regional Inspector General for Audit Services

Subject Audit Report – REVIEW OF OUTPATIENT CARDIAC REHABILITATION SERVICES AT WASHINGTON ADVENTIST HOSPITAL, TAKOMA PARK, MARYLAND (Report Number A-03-03-00006)

To Sonia A. Madison  
Regional Administrator  
Centers for Medicare & Medicaid Services

Attached are two copies of the U. S. Department of Health and Human Services (HHS), Office of Inspector General's report entitled "Review of Outpatient Cardiac Rehabilitation Services at Washington Adventist Hospital, Takoma Park, Maryland." This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The objectives of our review were to ascertain whether Washington Adventist Hospital's (WAH) policies and procedures complied with Medicare requirements and whether Medicare properly reimbursed WAH for outpatient cardiac rehabilitation services. Should you have any questions or comments concerning the matters commented on in this report, please contact me or have your staff contact Eugene Berti, Audit Manager at 215-861-4474.

To facilitate identification, please refer to Report Number A-03-03-00006 in all correspondence relating to this report.

  
Stephen Virbitsky

Attachment



**DEPARTMENT OF HEALTH & HUMAN SERVICES  
OFFICE OF INSPECTOR GENERAL  
OFFICE OF AUDIT SERVICES  
150 S. INDEPENDENCE MALL WEST  
SUITE 316  
PHILADELPHIA, PENNSYLVANIA 19106-3499  
AUG 12 2003**

Report Number: A-03-03-00006

Kenneth B. DeStefano  
Vice President and General Counsel  
Adventist HealthCare  
1801 Research Boulevard, Suite 301  
Rockville, Maryland 20850

Dear Mr. DeStefano:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's report entitled "Review of Outpatient Cardiac Rehabilitation Services at Washington Adventist Hospital, Takoma Park, Maryland." This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The objectives of our review were to ascertain whether Washington Adventist Hospital's (WAH) policies and procedures complied with Medicare requirements and whether Medicare properly reimbursed WAH for outpatient cardiac rehabilitation services. Should you have any questions or comments concerning the matters commented on in this report, please direct them to the HHS official named below.

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To facilitate identification, please refer to Report Number A-03-03-00006 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a long horizontal flourish extending to the right.

Stephen Virbitsky  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Sonia Madison  
Regional Administrator  
Centers for Medicare & Medicaid Services, Region III  
Public Ledger Building, Suite 216  
150 S. Independence Mall West  
Philadelphia, PA 19106-3499

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT CARDIAC  
REHABILITATION SERVICES AT  
WASHINGTON ADVENTIST HOSPITAL,  
TAKOMA PARK, MARYLAND**



**AUGUST 2003  
A-03-03-00006**

# *Office of Inspector General*

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## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.



## **EXECUTIVE SUMMARY**

### **BACKGROUND**

This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the Administrator of the Centers for Medicare & Medicaid Services 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 Washington Adventist Hospital (WAH) for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

- Payments to WAH 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 AUDIT**

Even though physician supervision is assumed to be met in an outpatient hospital department, WAH contracted with a physician to supervise the services provided by its cardiac rehabilitation program. The physician's responsibilities included the approval of cardiac rehabilitation treatment plans and review of patients' medical records. However, our review disclosed that the physician was not in the exercise area during regularly scheduled exercise sessions, nor did he personally see the patients.

In addition, from our claims review for 29 sampled beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that WAH received Medicare payments of \$15,946 for:

- Services with diagnoses establishing the patients' eligibility for cardiac rehabilitation which may not have been supported by medical records (8 beneficiaries);
- Claims containing non-covered diagnoses codes (10 beneficiaries);
- Claims containing incorrect procedure codes (3 beneficiaries);
- Duplicate claims for a service for a single cardiac rehabilitation session (1 beneficiary);
- Services for which WAH's medical records did not contain a physician referral (1 beneficiary); and

Services for which the WAH's medical records did not contain electrocardiogram (ECG) strips (3 beneficiaries)'.<sup>1</sup>

The sample errors and Medicare payments are part of a larger statistical sample and will be included in the multi-state projection of outpatient cardiac rehabilitation service claims not meeting Medicare coverage requirements.

We attribute these exceptions to a lapse in WAH's internal controls and oversight procedures. Most notably, WAH did not consistently ensure that beneficiaries had a Medicare covered diagnosis supported by the referring physician's medical records and that supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained.

Our determinations regarding Medicare covered diagnosis were based solely on our review of medical record documentation. We believe that WAH's fiscal intermediary (FI), Mutual of Omaha (Mutual), should decide on the allowability of the Medicare claims and proper recovery action to be taken.

## **RECOMMENDATIONS**

We recommend that WAH:

- Work with Mutual to ensure that WAH'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;
- Work with Mutual to establish the amount of repayment liability, estimated to be \$15,946 for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable;
- Enforce existing policies to ensure that medical record documentation is obtained and maintained to support Medicare outpatient cardiac rehabilitation services; and
- Develop billing system edits to ensure only covered diagnosis codes and appropriate procedure codes are billed.

WAH concurred with our recommendations. Specifically, WAH supports the recommendations and will work with the FI to ensure that they are implemented. We summarized WAH's response along with our comments after the Recommendations section of the report. The full text of WAH's response is included as Appendix B to this report.

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<sup>1</sup> Although WAH could not provide ECG strips for services to three beneficiaries, Medicare only paid for one service to one beneficiary during our time period. Therefore, Appendix A only includes one error.

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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, 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 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. 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.
- 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. However since 1977, Maryland hospitals have operated under a waiver from Medicare's reimbursement methodology for hospital services. Under the waiver, Medicare reimburses Maryland hospitals on the basis of rates approved by the State's Health Services Cost Review Commission. The fiscal intermediary (FI) for Washington Adventist Hospital (WAH) is Mutual of Omaha (Mutual). For calendar year (CY) 2001, WAH provided outpatient cardiac rehabilitation services to 72 Medicare beneficiaries and received \$109,077 in Medicare reimbursement 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 WAH for outpatient cardiac rehabilitation services. Specifically, we determined whether:

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

- Payments to WAH 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 WAH's policies and procedures and interviewed WAH's staff to gain an understanding of its management of their outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services. Specifically, we reviewed WAH'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 to beneficiaries and billed to Medicare. In addition, we reviewed WAH's cardiac rehabilitation services documentation, hospital medical records, referring physician supporting medical records and referrals, and Medicare reimbursement data for a statistical sample of beneficiaries who received outpatient cardiac rehabilitation services from WAH during CY 2001.

We statistically selected 29 of 72 Medicare beneficiaries who received outpatient cardiac rehabilitation services from WAH during CY 2001. We reviewed all Medicare paid claims for cardiac rehabilitation services provided to these 29 beneficiaries during CY 2001.

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

## **Methodology**

We compared WAH's policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and identified any differences. We documented how WAH's provided direct physician supervision for cardiac rehabilitation services and verified that WAH'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 WAH'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 the beneficiary's hospital medical record, the referring physician's referral and medical record (for beneficiaries with angina or no readily identifiable Medicare covered diagnosis), and WAH's outpatient cardiac rehabilitation medical record. In addition, we verified that Medicare did not reimburse WAH beyond the maximum number of services allowed.

The medical records have not yet been reviewed by FI staff. In accordance with the intent of CMS' request for a nationwide analysis, we determined the extent that the provider was currently complying with existing Medicare coverage requirements.

We performed our fieldwork at WAH, Takoma Park, Maryland and the Philadelphia Regional Office between March and May 2003.

## **RESULTS OF AUDIT**

Even though physician supervision is assumed to be met in an outpatient hospital department, WAH contracted with a physician to supervise the services provided by its cardiac rehabilitation program. The physician's responsibilities included the approval of cardiac rehabilitation treatment plans and review of patients' medical records. However, our review disclosed that the physician was not in the exercise area during regularly scheduled exercise sessions, nor did he personally see the patients.

In addition, from our claims review for 29 sampled beneficiaries who received outpatient cardiac rehabilitation services during CY 2001, we determined that WAH received Medicare payments of \$15,946 for:

- Services with diagnoses establishing the patients' eligibility for cardiac rehabilitation which may not have been supported by medical records (8 beneficiaries);
- Claims containing non-covered diagnoses codes (10 beneficiaries);
- Claims containing incorrect procedure codes (3 beneficiaries);
- Duplicate claims for service for a single cardiac rehabilitation session (1 beneficiary);
- Services for which WAH's medical records did not contain a physician referral (1 beneficiary); and
- Services for which the WAH's medical records did not contain electrocardiogram (ECG) strips (3 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.

According to WAH cardiac rehabilitation center personnel, the medical director, a physician, is under contract to provide direct physician supervision to the cardiac rehabilitation center's exercise staff. The medical director's contract required that he "review records and reports of patient[s] ... to promote quality of patient care." However, neither the medical director's contract nor the cardiac rehabilitation program's policies and procedures require the medical director to be in the exercise area or immediately available during exercise hours. Rather, during

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<sup>2</sup> Although WAH could not provide ECG strips for services to three beneficiaries, Medicare only paid for one service to one beneficiary during our time period. Therefore, Appendix A only includes one error.

exercise hours, the medical director could be in the main hospital building visiting patients, or performing duties in his office or in one of the catheterization laboratories.

We determined that one of the registered nurses supervised the daily cardiac rehabilitation activities. In the event of an emergency, the cardiac rehabilitation center staff would call an emergency response team comprised of emergency department personnel and the medical director. The emergency department personnel were responsible for responding to any medical emergency that occurred throughout the hospital, including the cardiac rehabilitation center. If the cardiac rehabilitation staff called for the emergency team, the trained cardiac rehabilitation center staff would initiate advanced cardiac life saving techniques until the team's arrival.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe that WAH should work with Mutual to determine whether WAH's practices of contracting with a medical director and utilizing an emergency response team conforms with Medicare 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.

At WAH, the medical director approved the treatment plans and performed the bi-weekly reviews (rounds) of the patients' records. When a physician referred a patient to WAH's cardiac rehabilitation center, the center's registered nurses and/or exercise physiologist conducted a patient orientation. During the orientation, the registered nurse or the exercise physiologist discussed the patient's limitations by reviewing the referring physician recommendations, the patient's medical and exercise histories, patient education, and the benefits of exercise.

According to WAH's policies and procedures, the clinical staff and the medical director then develop and approve an exercise treatment plan. The policies further require that the medical director review patient progress and problems during patient rounds, scheduled twice per month. The policies and procedures, however, did not specifically require that the medical director personally see the beneficiaries. Although we observed that the medical director signed the treatment plans as evidence of his approval, the cardiac rehabilitation center staff did not provide documentation to support that the medical director personally saw the patients periodically and sufficiently often to assess the course of treatment, as required under the "incident to" benefit.

**[Emphasis added]**

Because WAH's policies required the medical director to review and approve the patients' treatments, but did not require the medical director to see the patient, we were not able to determine whether WAH's cardiac rehabilitation program met the requirements for providing

"incident to" services. Accordingly, we recommend that WAH coordinate with Mutual to ensure that WAH's cardiac rehabilitation program is operating in accordance with Medicare's requirements for "incident to" services.

## **MEDICARE COVERED DIAGNOSES AND DOCUMENTATION**

Medicare coverage policy 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 permits providers to bill for initial assessments, however, it does not explicitly state which procedure code the providers should use. Additionally, Medicare allows one unit of service to be billed per cardiac rehabilitation session and requires the provider to maintain documentation for these services in the patients' medical records.

Our statistical sample of 29 of 72 WAH Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to \$42,305 during CY 2001, disclosed that Medicare claims for 17 beneficiaries contained 24 errors. Some claims had more than one type of error. Errors related to: Medicare covered diagnoses; billing procedures; and documentation of services.

### **Categories of Errors**

#### **Medicare Covered Diagnoses**

For eight beneficiaries, WAH billed and received Medicare payments for outpatient cardiac rehabilitation services when the diagnoses used to establish the beneficiaries' eligibility may not have been supported by medical records. As shown in Appendix A, Table 1, we determined that sampled beneficiaries participated in the cardiac rehabilitation program based on the following Medicare covered diagnoses: myocardial infarction (8 beneficiaries); coronary artery bypass graft surgery (11 beneficiaries); and myocardial infarction and coronary artery bypass graft surgery (2 beneficiaries). Of the remaining eight beneficiaries, four beneficiaries participated in the cardiac rehabilitation program based on a diagnosis of angina, unspecified and four beneficiaries participated in the cardiac rehabilitation program without a Medicare covered diagnosis.

For the 21 beneficiaries with diagnoses of myocardial infarction, coronary artery bypass graft surgery, or both, medical records contained documentation to support the diagnoses. For the remaining eight beneficiaries, medical records did not contain any indication that the beneficiaries experienced stable angina after a cardiac procedure or treatment for a cardiac condition or had another Medicare covered diagnosis within one year prior to beginning the cardiac rehabilitation program.

Each of these eight beneficiaries received treatment at WAH for cardiac related symptoms such as chest pain and shortness of breath, but none of the eight beneficiaries' medical record

documentation contained the specific diagnosis "stable angina." According to the hospital records, seven of the eight beneficiaries underwent cardiac procedures such as catheterization, stenting, or angioplasty. The remaining beneficiary received drug therapy to treat his diagnoses of congestive heart failure and atrial fibrillation. After the procedures or treatment, the beneficiaries' physicians referred the patients to the outpatient cardiac rehabilitation program at WAH.

According to WAH's policies and procedures, the cardiac rehabilitation center staff conducts an initial assessment of each beneficiary and prepares a patient information sheet to record intake information including details of the patient's diagnosis. After the assessment, the cardiac rehabilitation center staff requests, as appropriate, the following documentation from the referring physician and/or the hospital: history and physical information; hospital discharge summary; most recent copy of exercise stress test/ECG; operative reports; and recent lipid profiles.

For the eight beneficiaries, we found that the documentation maintained by WAH did not sufficiently indicate whether the patients experienced angina symptoms post-procedure or had another Medicare covered diagnosis. Consequently, to validate a stable angina diagnosis or another Medicare covered diagnosis, we obtained and reviewed the hospital medical records as well as the referring physicians' medical records for these eight beneficiaries. The medical records covered the dates of the beneficiaries' hospital visit/stay through their completion of Phase II of the cardiac rehabilitation program.

For one of the eight beneficiaries, the medical records indicated that the beneficiary continued to experience chest pain post-procedure, but the medical records also included an unstable angina diagnosis mid-way through the cardiac rehabilitation program. For the remaining seven beneficiaries, our review of the medical records did not reveal any indications that the beneficiaries (1) experienced or continued to experience angina symptoms post-procedure and throughout their completion of Phase II of the cardiac rehabilitation program or (2) had another Medicare covered diagnosis within one year prior to beginning the cardiac rehabilitation program. As a result, Medicare may have inappropriately paid \$13,721 to WAH for the cardiac rehabilitation services provided to these eight beneficiaries.

## **Billing Procedures**

### **Non-Covered Diagnoses Codes**

For 10 of the 29 sampled beneficiaries (123 services), WAH included diagnoses codes other than the three diagnoses covered by Medicare. For example, WAH billed Medicare using the diagnosis code for "Aortic Valve Disorder." Our review of the beneficiary's medical record revealed, however, that the patient actually had suffered an acute myocardial infarction. Because the 10 beneficiaries medical records supported a Medicare covered diagnosis or we accounted for the dollars in another finding, there is no monetary effect for this error.

### **Incorrect Procedure Codes**

For three beneficiaries, WAH improperly billed, and subsequently received payment, for initial assessments using the procedure codes for cardiac rehabilitation services with or without continuous ECG monitoring. At WAH, the registered nurses or the exercise physiologist conducted the initial assessments that included patient interviews, documentation reviews, and patient orientation to the equipment and monitoring devices. The assessments did not actually include an outpatient cardiac rehabilitation service. WAH received \$409 for the incorrectly coded services.

### **Duplicate Billing**

WAH submitted duplicate bills for four services involving one beneficiary. Mutual did not determine the claims were duplicate and paid WAH \$269 for these duplicate charges.

### **Documentation of Services**

#### **Missing Referral**

WAH could not provide a physician referral for one beneficiary with 23 services. Similar to Medicare requirements, WAH's own procedures required that, upon beginning the cardiac rehabilitation program, all beneficiaries provide a referral from their physician. WAH was reimbursed \$1,547 for these services.

#### **Missing ECG Strips**

WAH did not provide support for continuous ECG monitoring for three beneficiaries (three services)<sup>3</sup>. For each exercise session at WAH, the beneficiary is attached to an ECG machine that monitors the patient's heart rate. After each session, the cardiac staff printed the ECG readings and affixed the readings in the patient's file. We observed that this can be a labor-intensive task and determined that the three missing ECGs represented an immaterial number of the total 843 services we reviewed. Although WAH could not provide the ECGs for these three services, we concluded that the patients received the services based on our review of additional documentation.

The results of our sample will be included in the 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.

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<sup>3</sup> The three beneficiaries received these three services in CY 2001, however, Mutual only paid for one service for one beneficiary during CY 2001. Therefore, Appendix A only includes one error.

## **Underlying Causes for Errors**

### **Medicare Covered Diagnoses**

WAH did not ensure that beneficiaries stated Medicare covered diagnoses were supported by medical documentation prior to providing cardiac rehabilitation services and billing Medicare. Although WAH cardiac rehabilitation center staff followed the center's policies and requested supporting documentation from the hospital and the referring physician, WAH could not compel either to produce the records. Without such documentation, the WAH could not ensure the patient's participation in the cardiac program was in compliance with Medicare requirements.

### **Billing Procedures**

#### **Non-Covered Diagnoses Codes**

WAH billed Medicare using non-covered diagnoses codes because different coders processed the claims throughout the exercise program. At WAH, the cardiac rehabilitation center billed claims for services monthly. The claims processed through the hospital's main billing system where one of many medical coders entered a diagnosis code, or codes, based on existing information acquired during the patients' initial admission to the outpatient program. Each coder may enter a different code based on his or her interpretation of the data. Furthermore, the hospital's billing system did not contain edits that would identify if a cardiac rehabilitation claim included non-covered Medicare diagnoses. Finally, during 2001, Mutual's payment system did not contain system edits that would have precluded payment for services with non-covered Medicare diagnoses.

#### **Incorrect Procedure Codes**

WAH's use of incorrect procedure codes likely occurred during the conversion process from the cardiac rehabilitation center's billing system to the hospital's billing system. When the WAH cardiac rehabilitation center staff entered the cardiac services, they had to choose from a series of services including assessment, exercise with monitoring, and exercise without monitoring. The staff could enter more than one choice. The hospital's main billing system then applied a procedure code for a cardiac rehabilitation service with continuous monitoring and the higher rate for an assessment service. However, because the patient did not participate in a monitored exercise session and the physician did not participate in the initial assessment, neither the code nor the higher rate is correct.

#### **Duplicate Billing**

A WAH billing official could not explain why four services were billed twice, however he agreed to contact Mutual to request an adjustment.

## **Documentation of Services**

For both the missing referral and the missing ECG strip, WAH merely could not locate the requested data. A WAH cardiac rehabilitation official stated that the information was likely misfiled in other beneficiaries' medical records.

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

## **RECOMMENDATIONS**

We recommend that WAH:

- Work with Mutual to ensure that WAH'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;
- Work with Mutual to establish the amount of repayment liability, estimated to be \$15,946 for services provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable;
- Enforce existing policies to ensure that medical record documentation is obtained and maintained to support Medicare outpatient cardiac rehabilitation services; and
- Develop billing system edits to ensure only covered diagnosis codes and appropriate procedure codes are billed.

## **WAH Response**

By letter dated July 14, 2003, WAH responded to our draft report. WAH stated that it supports the audit recommendations and will work with the FI to:

- ensure that the cardiac rehabilitation program continues to operate in accordance with Medicare coverage requirements;
- ascertain any repayment obligation [for services] to beneficiaries where medical documentation may not have supported Medicare coverage diagnoses;
- ensure that medical record documentation is appropriately maintained to support Medicare cardiac rehabilitation services; and
- ensure that only covered diagnosis codes and procedures are billed.

## **OIG Comments**

For the most part, W AH's corrective actions, when implemented, will address our concerns. W AH indicated that it would work with its FI to ensure that its cardiac rehabilitation program continues to operate in accordance with Medicare coverage requirements. However, as stated on page 5 of our report, we were not able to determine whether W AH's cardiac rehabilitation program met the requirements for providing "incident to" services. We believe that W AH, working with the FI, needs to determine if its cardiac rehabilitation, as implemented, meets Medicare coverage requirements.

APPENDIX A

STATISTICAL SAMPLE SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of our statistically selected sample of 29 Medicare beneficiaries who received outpatient cardiac rehabilitation services from WAH during CY 2001. The results of our sample will be included in the 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. Summary of Errors by Beneficiary Diagnosis and Type of Error

Sampled Beneficiaries with Diagnosis	Diagnosis	Sampled Beneficiaries with Errors	Diagnosis Errors		Billing Errors			Documentation Errors		Total Errors
			Beneficiaries without Documentation to Support Diagnosis	Non-Covered Diagnosis Codes	Incorrect Procedure Codes	Duplicate Billings	Missing Referral	Missing ECGs		
8	Myocardial Infarction (MI)	4	0	2	2	0	0	0	4	
11	Coronary Artery Bypass Graft (CABG)	4	0	3	0	1	1	0	5	
2	MI and CABG	1	0	1	0	0	0	0	1	
4	Angina, unspecified	4	4	3	0	0	0	1	8	
4	No Covered Diagnosis	4	4	1	1	0	0	0	6	
<b>29</b>		<b>17</b>	<b>8</b>	<b>10</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>24</b>	



Washington Adventist Hospital  
Shady Grove Adventist Hospital  
Hackettstown Community Hospital  
Kessler-Adventist Rehabilitation Hospital  
Potomac Ridge Behavioral Health  
Greater Washington Sleep Disorders Centers  
Adventist Senior Living Services  
Adventist Home Care Services

July 14, 2003

Stephen Virbitsky  
Regional Inspector General for Audit Services  
U.S. Department of Health and Human Services  
Office of Inspector General  
150 South Independence Mall West, Suite 316  
Philadelphia, Pennsylvania 19106-3400

SUBJECT: Report Number A-03-03-00006

Dear Mr. Virbitsky:

This letter is intended to respond to the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' draft report entitled "Review of Outpatient Cardiac Rehabilitation Services at Washington Adventist Hospital, Takoma Park, Maryland."

Washington Adventist Hospital supports the recommendations made by your office, and will work with our fiscal intermediary to:

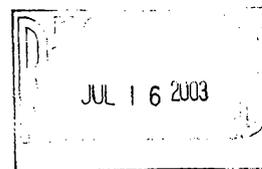
- ensure that our cardiac rehabilitation program continues to operate in accordance with the Medicare coverage requirements,
- ascertain any repayment obligation to beneficiaries where medical documentation may not have supported Medicare coverage diagnoses,
- ensure that medical record documentation is appropriately maintained to support Medicare cardiac rehabilitation services; and
- ensure that only covered diagnosis codes and procedure codes are billed.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'K. DeStefano'.

Kenneth B. DeStefano  
Vice President & General Counsel



## ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff that contributed includes:

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