



January 5, 2004

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Report Number: A-04-03-01006

Mr. Hal Ziecheck
Chief Operations Officer
300 Pinellas Street
Clearwater, Florida 33756-3825

Dear Mr. Ziecheck:

The enclosed report provides the results of our ***Review of Outpatient Cardiac Rehabilitation Services – Morton Plant Hospital***. This review was in response to Centers for Medicare & Medicaid Services' request for Office of Inspector General assistance in determining whether outpatient cardiac rehabilitation programs meet the current requirements outlined in the Medicare Coverage Issues Manual (Section 35-25).

The overall objective of our review was to determine whether Medicare properly reimbursed Morton Plant Hospital (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 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.

Although physician supervision is assumed to be met in an outpatient hospital department and the Hospital designated a physician to supervise the services provided through its cardiac rehabilitation program and utilized an emergency response team to supervise at the outpatient rehabilitation center, we found no documentation to support physician supervision during exercise sessions. Further, contrary to current Medicare requirements, we did not find sufficient evidence in the medical records to indicate that the cardiac rehabilitation services were provided "incident to" the medical director's professional services. In addition, from our specific claims review for Medicare covered diagnoses, allowability, and documentation for the sample of 30 beneficiaries receiving outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital received \$4,426 in Medicare reimbursement for:

- services where the referring physician did not include a Medicare covered diagnosis on the prescription (2 beneficiaries);
- services where the diagnoses establishing the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (8 beneficiaries);
- services where at least one of the required Group 1 services was not provided (17 beneficiaries); and,
- inadequately documented outpatient cardiac rehabilitation services (9 beneficiaries).

We recommend that the Hospital: (1) work with First Coast to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services provided "incident to" a physician's professional service; (2) work with First Coast to establish the amount of repayment liability for services, identified as \$4,426, provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable; (3) implement controls to ensure that each beneficiary has a prescription from a physician that includes a Medicare covered diagnosis; (4) establish policies and procedures to ensure that at least one Group 1 service is provided during a Phase II session; and, (5) implement controls to ensure that medical record documentation is maintained to support Medicare outpatient cardiac rehabilitation services.

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (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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If you have any questions or comments about this report, please contact Don Czyzewski, Audit Manager, at 305-536-5309, extension 10. To facilitate identification, please refer to report number A-04-03-01006 in all correspondence relating to this report.

Sincerely,



Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:
Rose Crum-Johnson, Regional Administrator
Centers for Medicare & Medicaid Services, Region IV
61 Forsyth Street, S.W., Room 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT CARDIAC
REHABILITATION SERVICES –
MORTON PLANT HOSPITAL**



**JANUARY 2004
A-04-03-01006**

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 Morton Plant Hospital (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 calendar year (CY) 2001 were for Medicare covered diagnoses, were supported by adequate documentation, and were otherwise allowable for reimbursement.

RESULTS OF AUDIT

Although physician supervision is assumed to be met in an outpatient hospital department and the Hospital designated physicians to supervise the services provided through its cardiac rehabilitation program and utilized an emergency response team to supervise at the outpatient rehabilitation center, we found no documentation to support physician supervision during exercise sessions. Further, contrary to current Medicare requirements, we did not find sufficient evidence in the medical records to indicate that the cardiac rehabilitation services were provided "incident to" the medical director's professional services. In addition, from our specific claims review for Medicare covered diagnoses, allowability, and documentation for the sample of 30 beneficiaries receiving outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital received \$4,426 in Medicare reimbursement for:

- services where the referring physician did not include a Medicare covered diagnosis on the prescription (2 beneficiaries);
- services where the diagnoses establishing the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (8 beneficiaries);
- services where at least 1 of the required Group 1 services was not provided (17 beneficiaries); and

- inadequately documented outpatient cardiac rehabilitation services (9 beneficiaries).

It should be noted that the sample errors and Medicare payments are part of a larger statistical sample and will be included in a multistate projection of outpatient cardiac rehabilitation service claims not meeting Medicare coverage requirements. We attribute these questionable services to weaknesses in the Hospital's internal controls and oversight procedures. Existing controls did not ensure that beneficiaries had Medicare covered diagnoses supported by the referring physician's medical records; and that supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained. In addition, the Hospital's staff was not aware that at least one of the Group 1 services must be provided during a session.

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, First Coast Service Options, Inc. (First Coast), should make a determination as to the allowability of the Medicare claims and appropriate recovery action.

RECOMMENDATIONS

We recommend that the Hospital:

- work with First Coast to ensure that the Hospital's outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services provided "incident to" a physician's professional service;
- work with First Coast to establish the amount of repayment liability for services, identified as \$4,426, provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable;
- implement controls to ensure that each beneficiary has a prescription from a physician that includes a Medicare covered diagnosis;
- establish policies and procedures to ensure that at least one Group 1 service is provided during a Phase II session; and
- implement controls to ensure that medical record documentation is maintained to support Medicare outpatient cardiac rehabilitation services.

HOSPITAL'S COMMENTS

The Hospital agreed with our findings relating to claims with "stent" diagnosis and undocumented services. However, the Hospital believed that it complied with applicable Medicare regulations relating to direct physician supervision and services provided incident to physician services. The Hospital stated that a physician was designated to provide direct physician supervision at the Bardmoor Outpatient Center. The Hospital also respectfully disagreed with our findings relating to non-monitored services and stated that the current clear guidance indicates that CPT code 93797 is an

acceptable billing code, and it performed a limited examination for physician follow-up. In addition, the Hospital requested a list of the beneficiaries that we were unable to determine if the diagnosis of stable angina was established. The Hospital also requested, “that the report include a specific reference to the applicable regulation which requires the hospital to request an ordering physician who provides a valid initial diagnosis to supplement that diagnosis and validate it on a continuing basis.” In summary, the Hospital stated it would work with First Coast to ensure it is meeting the requirements.

OFFICE OF INSPECTOR GENERAL’S RESPONSE

In our report, we did not indicate the Hospital was not in compliance with the requirements, but that the Hospital should work with First Coast to ensure that the physician supervision provided specifically conforms to the requirements. With regards to services provided “incident to” a physician’s professional services, we acknowledge the medical director was involved in the care of each patient, and that a physician personally saw the patient when an untoward event occurred. However, we determined that each patient was not seen personally by a hospital physician during the course of treatment.

Regarding the sample results, the Hospital stated that it performed a limited examination on each beneficiary at each visit; however, if the results of that specific examination are not sent for physician follow-up to adjust medication or other treatment changes then a Group 1 service has not been provided. We acknowledge that the Hospital relied on the initial valid diagnoses it received from the referring physicians. However, for eight beneficiaries we could not determine whether the patients experienced stable angina.

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INTRODUCTION

BACKGROUND

Medicare Coverage

The Medicare program, established by title XVIII of the Social Security Act (Act), provides health insurance to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by CMS. 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 1 unit of service.

Cardiac rehabilitation is provided by non-physician 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 hospital 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 hospital 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 First Coast. For CY 2001, the Hospital provided outpatient cardiac rehabilitation services to 484 Medicare beneficiaries and received \$149,823 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 Hospital¹ 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

¹ The Hospital includes one hospital (Morton Plant Hospital) and one outpatient rehabilitation center (Bardmoor Outpatient Center). Outpatient cardiac rehabilitation services provided at these locations were billed under the Medicare provider number for the Hospital.

- 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, referring physician referrals and supporting medical records, and Medicare reimbursement data for 30 beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001 as part of a multistate statistical sample. Specifically, we reviewed the Hospital's outpatient cardiac rehabilitation procedures for and controls over physician supervision, cardiac rehabilitation staffing, availability of advanced cardiac life support equipment, and documentation of services provided and billed to Medicare.

The sample included 30 of 484 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 30 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 FI local medical review policy (LMRP) 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 sampled beneficiary, we obtained the CY 2001 Medicare outpatient cardiac rehabilitation paid claims and lines of service and compared this data to the Hospital's outpatient cardiac rehabilitation service documentation. We reviewed the medical records maintained by the cardiac rehabilitation program to determine whether services were provided "incident to" a physician's professional service. We also verified the accuracy of the diagnoses identified on the Medicare claims to each beneficiary's inpatient medical record, the referring physician's medical record and referral, and the Hospital's outpatient cardiac rehabilitation medical record. FI staff has not yet reviewed the medical records. In addition, we verified whether 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 the provider was currently complying with existing Medicare coverage requirements. We performed fieldwork at the Hospital's cardiac rehabilitation center located in Clearwater and Largo, Florida, and at our field office in Tallahassee, Florida during the period March through June 2003. The Hospital's comments on the draft report are included in their entirety as APPENDIX C to this report. A summary of the Hospital's comments and our response follow the Recommendations section.

RESULTS OF AUDIT

Although physician supervision is assumed to be met in an outpatient hospital department and the Hospital designated physicians to supervise the services provided through its cardiac rehabilitation program and utilized an emergency response team to supervise at the outpatient rehabilitation center, we found no documentation to support physician supervision during exercise sessions. Further, contrary to current Medicare requirements, we did not find sufficient evidence in the medical records to indicate that the cardiac rehabilitation services were provided "incident to" the medical director's professional services. In addition, from our specific claims review for Medicare covered diagnoses, allowability, and documentation for the sample of 30 beneficiaries receiving outpatient cardiac rehabilitation services during CY 2001, we determined that the Hospital received \$4,426 in Medicare reimbursement for:

- services where the referring physician did not include a Medicare covered diagnosis on the prescription (2 beneficiaries);
- services where the diagnoses establishing the patients' eligibility for cardiac rehabilitation may not have been supported by medical records (8 beneficiaries);
- services where at least 1 of the required Group 1 services was not provided (17 beneficiaries); and
- inadequately documented outpatient cardiac rehabilitation services (9 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.

The Hospital has two facilities providing outpatient cardiac rehabilitation services: one at the main campus in a separate building, and a second, Bardmoor Outpatient Center (Bardmoor) in Largo, Florida. On a day-to-day basis, the cardiac rehabilitation program was staffed and run by registered nurses and exercise physiologists. A registered nurse, who was advanced cardiac life support qualified, was on duty at any time the cardiac rehabilitation program was in session, and was responsible for the day-to-day supervision of the cardiac rehabilitation area at each facility.

Morton Plant Hospital. The Hospital's policies and procedures require the medical director be immediately available for consultation concerning patient management, however, no documentation existed in the cardiac rehabilitation program's medical records. The medical director informed us she designates another physician to assume her responsibilities when she is absent. The Hospital's policies and procedures for emergencies require the cardiac rehabilitation team to activate the emergency response team and notify the physician on site.

Bardmoor Outpatient Center. The Hospital did not have separate policies and procedures for Bardmoor. The Hospital officials informed us that at Bardmoor the medical director designates another physician to provide direct physician supervision to the cardiac rehabilitation exercise area when she is absent. In addition, Bardmoor utilized a "code blue" emergency response team of physicians to "supervise" outpatient cardiac rehabilitation services, however, no documentation existed in the cardiac rehabilitation program's medical records. The "code blue" team was responsible for responding to any medical emergency that occurred throughout the center, including the cardiac rehabilitation exercise area.

Cardiac rehabilitation staff believed that other physicians, located nearby the cardiac rehabilitation exercise areas, could respond to any medical emergency and, thus, were also available to "supervise" cardiac rehabilitation services.

Although Medicare policy provides that physician supervision is assumed to be met in an outpatient hospital department, we believe that the Hospital should work with First Coast to ensure that the physician supervision provided specifically conforms to 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 non-physician. However, during any course of treatment rendered by auxiliary personnel, the hospital 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.

While the hospital indicated that the cardiac rehabilitation services were provided “incident to” the medical director's professional services, we did not find sufficient evidence in the medical records. Specifically, we did not find documentation that the medical director personally saw the patient sufficiently often to assess the course of treatment. According to the Hospital's policies

and procedures, each patient referred to the Hospital's outpatient cardiac rehabilitation program attends an initial evaluation session conducted by a registered nurse to determine an individualized plan of care for exercise training, cardiac risk factor reduction education, and counseling. This session includes, among other services, a focused physical assessment of the patient's condition and symptoms since discharge from the hospital, and a functional capacity assessment. Based on this assessment the medical director (a physician) writes an individualized exercise prescription at a later date when the patient is not present. The medical director establishes an individualized exercise prescription for beneficiaries at both the main facility and the Bardmoor facility.

Patients generally attend the Phase II cardiac rehabilitation program 3 days per week. The cardiac rehabilitation staff prior to each exercise session does an ongoing assessment. This assessment includes a determination based on new onset of signs/symptoms, blood pressure, and heart rate and rhythm. In addition, according to the Hospital's policies and procedures, physicians (usually the referring physicians and the medical director), are contacted by the cardiac rehabilitation staff when a determination of the new onset of signs/symptoms was made during the ongoing assessments.

From our review of the Hospital's outpatient cardiac rehabilitation medical records, we found evidence the medical director established an individualized exercise prescription for patients in both facilities. In addition, we located evidence the referring physician was notified of an event requiring intervention. Although required under the "incident to" benefit, we could not find documentation to support that a hospital physician personally saw the patient sufficiently often to assess the course of treatment. Therefore, we believe that the Hospital's cardiac rehabilitation program should work with First Coast to ensure that the "incident to" provision conforms to the requirements.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

Medicare coverage considers cardiac rehabilitation services reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician, and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months; (2) have had coronary artery bypass graft surgery; and/or (3) have stable angina pectoris. Medicare only reimburses providers for Phase II outpatient cardiac rehabilitation services and allows one unit of service to be billed per cardiac rehabilitation session. In order for the session to be reimbursable, at least one of the following Group 1 services must be provided: (1) continuous ECG telemetric monitoring during exercise; (2) ECG rhythm strip with interpretation and physician's revision of exercise prescription; and/or (3) limited examination for physician follow up to adjust medication or other treatment changes. Documentation for these services must be maintained in the patients' medical records.

Our statistical sample of 30 of 484 Morton Plant Hospital Medicare beneficiaries, with claims for outpatient cardiac rehabilitation services amounting to \$8,355 during CY 2001, disclosed that Medicare claims for 24 beneficiaries contained 36 errors. Some beneficiaries had more than one type of error.

Categories of Errors

Medicare Covered Diagnoses. Medicare paid the Hospital for outpatient cardiac rehabilitation services with diagnoses establishing eligibility for cardiac rehabilitation, which did not appear to be supported by the notes in the beneficiaries' medical records. Of the 30 sampled beneficiaries, eligibility for 6 beneficiaries was based on the diagnosis of acute myocardial infarction; eligibility for 7 beneficiaries was based on the diagnosis of coronary artery bypass graft surgery; and eligibility for 14 beneficiaries was based on the diagnosis of stable angina, 2 beneficiaries had a non-covered Medicare diagnosis, and the medical records for 1 beneficiary were missing. For the 13 beneficiaries with diagnoses of acute myocardial infarction or coronary artery bypass graft surgery, medical records contained documentation to support the diagnoses. For the remaining 17 beneficiaries:

- for the 1 beneficiary with missing files, we were unable to determine whether the diagnoses on the claim was valid, and we question the reimbursement in the undocumented services section;
- the diagnosis on the prescription for 2 beneficiaries was “stent” which is not a valid Medicare diagnosis for the cardiac rehabilitation program. As a result, Medicare inappropriately paid \$489 to the Hospital for these 2 beneficiaries; and
- for the 14 beneficiaries with diagnoses of stable angina, the medical records for 8 did not appear to indicate that he/she continued to experience stable angina post-procedure. As a result, we believe that Medicare may have inappropriately paid \$1,254 to the Hospital for the cardiac rehabilitation services provided to these 8 beneficiaries.

Of these eight beneficiaries, five had been admitted to a hospital with a diagnosis of unstable² or stable angina,³ or congestive heart failure; one was seen in his physician's office for ischemic heart disease;⁴ and two did not have medical records available. Four of the beneficiaries who had been admitted to a hospital had cardiac procedures, such as stenting or valve replacement. Two beneficiaries did not undergo therapeutic cardiac procedures. After their discharge from the hospital or documented episodes of ischemic heart disease, their physician referred the beneficiaries to the outpatient cardiac rehabilitation program.

² Unstable angina is not a Medicare covered diagnosis for outpatient cardiac rehabilitation.

³ Stable angina was defined as a pain or discomfort in the chest or adjacent areas caused by insufficient blood flow to the heart muscle. This chest pain is relieved by rest or medication within a short period of time (usually 15 minutes). Chest pain of a longer duration or pain appearing with a lower level of effort than before, even at rest, should be considered unstable angina. Symptoms of stable angina included a feeling of tightness, heavy pressure, or squeezing or crushing chest pain that is under the breastbone or slightly to the left; is not clearly localized; may radiate to the shoulder, arm, jaw, neck, back, or other areas; may feel similar to indigestion; is precipitated by activity, stress, or exertion; lasts 1 to 15 minutes; and is usually relieved by rest and/or nitroglycerin. This information was obtained from the MEDLINEplus Medical Encyclopedia, identified at the U.S. National Library and National Institute for Health website (<http://www.nlm.nih.gov/medlineplus/ency/article/000198.htm>).

⁴ Ischemic heart disease results when the arteries that bring blood and oxygen to the heart, called coronary arteries, are blocked. Ischemic heart disease is a common cause of congestive heart failure. Patients with this diagnosis may at one time have had an acute heart attack, angina, or unstable angina. This information was obtained from the MEDLINEplus Medical Encyclopedia, identified at the U.S. National Library and National Institute for Health website (<http://www.nlm.nih.gov/medlineplus/>).

The Hospital's cardiac rehabilitation staff conducted an initial evaluation with each beneficiary and either identified the beneficiary's diagnosis or relied on a physician referral as documentation of a Medicare covered diagnosis. The Hospital's cardiac rehabilitation program staff did not maintain additional documentation indicating whether the angina symptoms continued to exist post-procedure, or to validate the diagnosis of stable angina.

To validate the diagnosis of stable angina, we obtained and reviewed the inpatient medical records as well as the medical records of the physicians who referred these eight beneficiaries for cardiac rehabilitation. The medical records covered the dates of the medical episode that prompted referring the patient through their completion of Phase II of the cardiac rehabilitation program. We were unable to determine if the beneficiaries continued to experience angina symptoms post-procedure and through their completion of Phase II of the cardiac rehabilitation program.

Non-Monitored Services. The Hospital billed for cardiac rehabilitation services for 17 beneficiaries when 1 of the 3 required Group 1 services were not rendered. In order for the visit to be reimbursable by Medicare, at least one of the Group 1 services must be provided. Group 1 services include the following: 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. The Hospital did an exercise session without telemetric monitoring. As a result, Medicare made inappropriate reimbursements of \$1,508 to the Hospital for the ineligible claims for 17 beneficiaries.

Undocumented Services. The Hospital was unable to locate any medical records for services provided to four beneficiaries or the documentation for specific dates of services for cardiac rehabilitation for five additional beneficiaries. Accordingly, Medicare made inappropriate reimbursements of \$1,175 to the Hospital for the unsupported claims for 9 beneficiaries.

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

Underlying Causes for Errors

Medicare Covered Diagnoses. The Hospital did not ensure referrals for beneficiaries with Medicare covered diagnoses were supported by medical documentation prior to providing cardiac rehabilitation services and billing Medicare. Specifically, the Hospital's procedures did not require the referring physicians to provide supporting medical documentation supporting the diagnosis used to justify Phase II cardiac rehabilitation services at Medicare expense. Further, the staff indicated they would not question the physician's diagnosis on the referral. In addition, the Hospital did not always review the referral to ensure a Medicare covered diagnosis was prescribed. During the audit period, the Hospital implemented procedures to ensure the diagnosis on the referral is a Medicare covered diagnosis.

Non-Monitored Services. The Hospital staff believed that billing for non-monitored services was valid based on their interpretation of the LMRP.

Undocumented Services. The Hospital’s internal controls did not ensure supporting documentation for Medicare billings and reimbursements for outpatient cardiac rehabilitation services was maintained.

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

RECOMMENDATIONS

We recommend that the Hospital:

- work with First Coast to ensure that the Hospital’s outpatient cardiac rehabilitation program is being conducted in accordance with the Medicare coverage requirements for direct physician supervision and for services provided “incident to” a physician’s professional service;
- work with First Coast to establish the amount of repayment liability for services, identified as \$4,426, provided to beneficiaries where medical documentation may not have supported Medicare covered diagnoses and for services not otherwise allowable;
- implement controls to ensure that each beneficiary has a prescription from a physician that includes a Medicare covered diagnosis;
- implement controls to ensure that medical record documentation is maintained to support Medicare outpatient cardiac rehabilitation services; and
- establish policies and procedures to ensure that at least 1 Group 1 service is provided during a Phase II session.

HOSPITAL’S COMMENTS

The Hospital agreed with our finding relating to claims with “stent” diagnosis and undocumented services. The Hospital, however, believes that it complied with applicable Medicare regulations relating to direct physician supervision, services provided incident to physician services and non-monitored services. In addition, the Hospital offered comments relating to Medicare covered diagnoses. In summary, the Hospital stated they would work with First Coast to ensure it is meeting the requirements.

Direct Physician Supervision - In written comments to the draft report, the Hospital stated that they respectfully disagree with our finding relating to documentation of a physician being immediately available for consultation. The Hospital stated, “we do not believe it is necessary to restate this requirement in each individual medical record.” With regard to the same physician

supervision requirement at the Bardmoor Outpatient Center, the Hospital stated that we incorrectly stated that there was no physician actually designated to provide direct physician supervision to the cardiac rehabilitation exercise area. The Hospital stated that when the medical director is “at one location, one of her partners is providing the physical coverage and supervision at the other location.” Although the Hospital has disagreed with our finding, in their written comments they concur with our recommendation and the Hospital stated they “will work with First Coast to ensure that we fully understand the nature of this requirement and comply with it.”

“Incident To” Physician Services - The Hospital also respectfully disagreed with our finding relating to “incident to” physician services. The Hospital stated that the definitions in Section 230.4 of the Hospital Manual and Section 3112.4 of the Intermediary Manual differ significantly from one another, and that the Hospital would appreciate clarification in the report as to which authoritative source takes precedence in this situation. The Hospital quoted the Intermediary Manual where it says, “The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.” The Hospital then stated that this sentence “would indicate that the Hospital is also considered to have met this definition based on the location of the service provided.” The Hospital also stated that during the course of treatment, the patient is personally seen by his attending physician, who is a member of the hospital’s medical staff, and thus a “hospital” physician. The Hospital stated that the records of these visits would be maintained by the attending physician and were not part of the records reviewed under the audit. The Hospital also noted that the medical director is closely involved in the treatment of each patient.

Non-Monitored Services - The Hospital also respectfully disagreed with our finding relating to non-monitored services. The Hospital stated that it would be contacting First Coast for additional clarification of the LMRP, but that the current clear guidance indicates that CPT code 93797 is an acceptable billing code for this service. The Hospital believed it is meeting the requirement for providing a Group 1 service by performing a limited examination for physician follow-up to adjust medication or other treatment changes. The Hospital stated, “If the results of this examination warrant, they are shared with the medical director and attending physician to adjust medication or to make other treatment changes.”

Medicare Covered Diagnoses - For the eight beneficiaries for whom we were unable to determine if the patient continued to experience angina symptoms post-procedure and through the completion of the cardiac rehabilitation program, the Hospital is requesting a listing of these patients. The Hospital is also requesting, “that the report include a specific reference to the applicable regulation which requires the hospital to request an ordering physician who provides a valid initial diagnosis to supplement that diagnosis and validate it on a continuing basis.”

OFFICE OF INSPECTOR GENERAL’S RESPONSE

Direct Physician Supervision - We acknowledge that the physician supervision requirement is generally assumed to be met when outpatient therapeutic services are performed on hospital premises. In addition, we agree that the Hospital had a medical director, physicians located nearby, and emergency procedures in place. In our report, we did not indicate the Hospital was

not in compliance with the requirements, but that the Hospital should work with First Coast to ensure that the physician supervision provided specifically conforms to the requirements. We revised the report on page five to indicate that another physician is designated at Bardmoor Outpatient Center when the medical director is not present.

“Incident To” Physician Services – As to clarification about which authoritative source takes precedence with regards to the definition of “incident to” physicians’ services, we acknowledge that definitions in Section 230.4 of the Hospital Manual and Section 3112.4 of the Intermediary Manual differ significantly from one another; however, the Medicare Coverage Issues Manual takes precedence over the Hospital Manual and the Intermediary Manual. Section 35-25 of the Medicare Coverage Issues Manual requires that each patient be under the care of a hospital physician, and Section 3112.4 of the Medicare Intermediary Manual requires that during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment. We acknowledge the medical director was involved in the care of each patient; however, she does not personally see each patient. In addition, we understand that the referring physician is notified when an untoward event occurred. However, during our review of patients with diagnoses of stable angina, we found that not all of the patients were personally seen by their referring physician during the course of the cardiac rehabilitation program. Therefore, we could not determine that each patient was seen personally by a hospital physician during the course of treatment as required by the Medicare requirements.

With regards to Section 3112.4 of the Intermediary Manual, the last sentence that the hospital quotes in its response is “The physician supervision requirement is generally assumed to be met where the services are performed on the hospital premises.” This sentence is related to requirements for “direct supervision” and not services “incident to” a physicians’ services.

Non-Monitored Services - We acknowledge that the Hospital is eligible for reimbursement of non-monitored services under CPT code 93797 when a Group 1 service has been provided. The Hospital has stated that it performed a limited examination on each beneficiary at each visit, but if the results of that specific examination are not sent for physician follow-up to adjust medication or other treatment changes then a Group 1 Service has not been provided. We did not question the non-monitored services that occurred at the beginning of the program since we determined the medical director (a physician) followed up on the examination and wrote a plan of care. The non-monitored services we questioned occurred near the end of the program as often as three times a week. In addition, we found 1 beneficiary with a diagnosis of stable angina had 23 exercise sessions without telemetric monitoring, and no evidence of physician follow-up in the Hospital’s or physician’s medical records.

Medicare Covered Diagnoses - We acknowledge the Hospital relied on the valid initial diagnoses it received from the referring physicians. We reviewed the referring physicians’ medical records and referrals, the Hospital’s outpatient cardiac rehabilitation records, and additional medical records for indications of stable angina. For eight beneficiaries we could not determine whether the patients experienced stable angina. Also, the Hospital requested the Medicare policy that would require them to obtain documentation of stable angina from the referring physician beyond the diagnosis on the prescription. The Medicare Coverage Issues

Manual states “Medicare coverage of cardiac rehabilitation programs are considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician and ... (3) have stable angina pectoris.” The Hospital would only be meeting one element of this three-part requirement if a doctor’s prescription were all that is necessary to enroll a new patient. Once the diagnosis was established, continued validation would not be required. In addition, the listing of eight beneficiaries requested by the Hospital will be provided under separate cover.

APPENDICES

APPENDIX A

STATISTICAL SAMPLE SUMMARY OF ERRORS

The following table summarizes the errors identified during testing of our statistically selected sample of 30 Medicare beneficiaries who received outpatient cardiac rehabilitation services from the Hospital during CY 2001. The total number of errors per diagnosis is greater than the total sample, as some beneficiaries had more than one type of error. The results from our sample will be included in a multistate estimate of Medicare errors for outpatient cardiac rehabilitation services that may not have met Medicare coverage requirements or were otherwise unallowable for payment.

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

Number of Sampled Beneficiaries With Diagnosis	Number of Sampled Beneficiaries With Errors	Medicare Covered Diagnosis	Beneficiaries Not Having Medical Documentation Supporting a Medicare Covered Diagnosis	No Cardiac Rehabilitation Supporting Documentation	Group 1 Service Not Provided	Total Errors Per Diagnosis
6	3	Myocardial Infarction	0	2	3	5
7	6	Coronary Artery Bypass Graft	0	0	6	6
14	12	Stable Angina	8	6	6	20
3	3	Non-covered or Missing Records	2	1	2	5
30	24	Total	10	9	17	36

APPENDIX B

SAMPLING AND UNIVERSE DATA AND METHODOLOGY

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

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

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

Universe	Population Value	Sample Size	Sample Value	Sampled Beneficiaries with Errors	Sample Errors Value
484	\$149,823	30	\$8,355	24	\$4,426



Morton Plant Hospital

P.O. Box 210, Clearwater, Florida 33757-0210 Phone: 727-462-7000

October 24, 2003

RECEIVED

OCT 29 2003

Office of Audit Svcs

Mr. Charles J. Curtis
Regional Inspector General for Audit Services
Region IV – Office of Inspector General
Department of Health and Human Services
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

RE: Audit Report Number: A-04-03-01006

Dear Mr. Curtis:

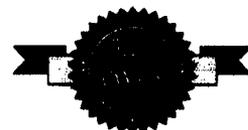
This letter is in response to your letter dated August 26, 2003, in which you requested our written comments to your office's draft report – "Review of Outpatient Cardiac Rehabilitation Services – Morton Plant Hospital, Clearwater, Florida." Our response covers each of the areas listed under the "Results of Audit" section of your report.

PHYSICIAN INVOLVEMENT IN OUTPATIENT CARDIAC REHABILITATION

Direct Physician Supervision

We respectfully disagree with the findings under the paragraph entitled "Morton Plant Hospital." The finding indicates that there was no documentation in the individual cardiac rehabilitation program's medical records to indicate that the Medical Director, a physician, was immediately available for consultation concerning patient management. The Hospital has a policy and procedure which clearly outlines this responsibility of the Medical Director. Under the circumstances, we do not believe it is necessary to restate this requirement in each individual medical record.

Additionally, the "Bardmoor Outpatient Center" paragraph of the report contains an incorrect statement. The report states that "[a]t Bardmoor, no physician was actually designated to provide direct physician supervision to the cardiac rehabilitation exercise area." The Medical Director for Morton Plant Hospital is also the physician designated to provide direct physician supervision to the Bardmoor cardiac rehabilitation exercise area. When she is physically at one location, one of her partners is providing the physical coverage and



supervision at the other location. Neither location operates if either the Medical Director or one of her partners is not physically at such location.

The report correctly notes that Medicare policy and applicable regulations provide that the physician supervision requirement is assumed to be met in an outpatient hospital department. We do not merely rely on the assumption, but, as required by applicable regulations, there is a physician present and on the premises of the location where the outpatient services are being provided. We are unclear as to the extent to which actual supervision must be reflected in the medical records and will work with First Coast to ensure that we fully understand the nature of this requirement and comply with it.

“Incident To” Physician Services

We respectfully disagree with the conclusions in this section of the report. The report states that “[a]lthough required under the “incident to” benefit, we could not find documentation to support that a hospital physician personally saw the patient sufficiently often to assess the course of treatment.”

The Medicare Coverage Issues Manual (Section 35-25) references both Section 230.4 of the Hospital Manual and Section 3112.4 of the Intermediary Manual as applicable to hospitals furnishing cardiac rehabilitation programs to outpatients in defining “incident to” services. Unfortunately, the two definitions included in these sections differ significantly from each other. We would appreciate clarification in the report as to which authoritative source takes precedence in this situation. We are under the assumption the Hospital Manual would take precedence as we are a hospital.

We reviewed the definition of “incident to” physicians’ services found in the CMS Hospital Manual under Section 230.4 Outpatient Therapeutic Services. It states:

“to be covered as incident to physicians’ services, the services and supplies must be furnished on a physician’s order by hospital personnel under hospital medical staff supervision in the hospital, or if outside the hospital, under the direct personal supervision of a physician who is treating the patient. There is no requirement that the physician who orders the hospital services be directly connected with the department which provides the services.”

This requirement was met by the hospital.

Section 3112.4 of the Intermediary Manual defines “incident to” in the following terms:

“The services and supplies must be furnished on a physician’s order by hospital personnel and under a physician’s supervision. 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 regimen. A hospital service or supply would not be considered incident to a physician’s service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of

that course of treatment. The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.”

The last sentence of this definition would indicate that the hospital is also considered to have met this definition based on the location of the service provided.

Additionally, during the course of treatment, the patient is being personally seen by his or her attending physician who wrote the order for treatment. This attending physician is a member of the hospital's medical staff and thus is a "hospital" physician. During these visits, the attending physician is assessing the course of the treatment and has the right to change the treatment regimen if necessary. This documentation would be maintained in a separate medical record in the practice office of the attending physician, and not duplicated in the records reviewed under the audit. In addition, the attending physician is also sent copies of the appropriate medical record documentation prepared during the cardiac rehabilitation sessions. Thus, a physician clearly is involved in the management of the course of treatment as required by the definition. Furthermore, the Medical Director is also closely involved in the assessment of the course of treatment as the Medical Director is reviewing the initial assessment, the patient's history & physical, the plan of care, the teaching plan, the exercise prescription, and the progress notes for each exercise session.

MEDICARE COVERED DIAGNOSES AND DOCUMENTATION

Medicare Covered Diagnoses

1 Beneficiary with missing file - We accept the proposed finding. Beginning in CY 2002, the patient's medical records were kept on site in the department to ensure all supporting documentation was maintained.

2 Beneficiaries with "Stent" diagnosis – We accept the proposed finding. The supporting documentation in the patients' medical records clearly indicated both beneficiaries had stable angina; however, we note that the prescription did not list this diagnosis. Procedures have been implemented to help ensure that all prescriptions list a valid diagnosis before services are rendered.

14 Beneficiaries with Stable Angina diagnosis –

For the 8 beneficiaries on which the auditors were unable to determine if the beneficiaries continued to experience angina symptoms post-procedure and through their completion of the cardiac rehabilitation program, we would appreciate a listing of the 8 specific beneficiaries so we may review the charts which are in question ourselves.

We are also requesting that the report include a specific reference to the applicable regulation which requires the hospital to request an ordering physician who provides a valid initial diagnosis to supplement that diagnosis and validate it on a continuing basis. Since the attending physician is routinely seeing the patient for follow-up care, and has the authority to change the treatment regimen, we believe there is the appropriate continued monitoring necessary.

Non-Monitored Services

We respectfully disagree with the findings in this section of the report. We will be contacting the Florida intermediary, First Coast, to obtain additional clarification of its Local Medical Review Policy (LMRP - L1420) on Cardiac Rehabilitation programs. The clear guidance in the LMRP indicates that both CPT code 93797 (services without continuous ECG monitoring) and CPT code 93798 (services with continuous ECG monitoring) are acceptable billing codes for this service. Although the 17 beneficiaries identified in the review were not on an ECG monitor for the duration of their entire treatment, we believe we were meeting the requirement for providing a Group 1 service by performing the third listed Group 1 service - a limited examination for physician follow-up to adjust medication or other treatment changes. This limited examination, which is performed on each beneficiary at each visit, is what is referred to as an "ongoing assessment" on page 6 of the report. In addition to performing the steps listed in the report - "review for new onset of signs/symptoms, blood pressure, heart rate and rhythm," the personnel also review the following: beneficiary's weight, blood sugar level, pulse, prescription changes since the last visit, symptoms which occurred post prior session, angina still stable, and congestive heart failure evident. If the results of this examination warrant, they are shared with the Medical Director and attending physician to adjust medication or to make other treatment changes.

Also, please note that in each case, the 17 beneficiaries identified in the review were billed with the appropriate CPT code (93797) for services without continuous ECG monitoring.

Undocumented Services

We accept the proposed findings in this section of the report. Beginning in CY 2002, the patient's medical records were retained on site in the department to ensure all supporting documentation was maintained.

Thank you for allowing us to respond in writing to the findings. We are taking the findings of this report very seriously and will make any changes necessary to comply with Medicare's requirements. We will be working with our intermediary, First Coast, to ensure we are meeting their requirements. If you should have any questions concerning our responses, please feel free to contact either myself at (727) 462-7101 or Robert Lynch, Director of Cardiology Services, at (727) 461-8173.

Sincerely,


Hal Ziecheck
Chief Operating Officer
Morton Plant Hospital

ACKNOWLEDGMENTS

This report was prepared under the direction of (RIGAS). Other principal Office of Audit Services staff who contributed include:

Don Czyzewski, *Audit Manager*

Kathy Lee, *Senior Auditor*

Mervyn Carrington, *Auditor in Charge*

John Christian Poole, *Auditor*

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