



DEPARTMENT OF HEALTH & HUMAN SERVICES

---

Office Of Inspector General  
Office Of Audit Services

Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza  
New York, NY 10278

January 9, 2004

Our Reference: Report Number A-02-03-01022

Mr. Kirk C. Tice  
President and Chief Executive Officer  
Robert Wood Johnson University Hospital Rahway  
865 Stone Street  
Rahway, New Jersey 07065

Dear Mr. Tice:

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

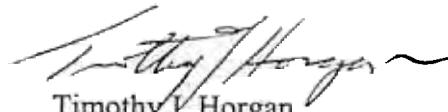
Final determinations as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Page 2 - Mr. Kirk C. Tice

To facilitate identification, please refer to Report Number A-02-03-01022 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Timothy J. Horgan", with a stylized flourish at the end.

Timothy J. Horgan  
Regional Inspector General  
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**

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

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT CARDIAC  
REHABILITATION SERVICES**

**AT**

**ROBERT WOOD JOHNSON  
UNIVERSITY HOSPITAL RAHWAY**



**JANUARY 2004  
A-02-03-01022**

# *Office of Inspector General*

<http://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

## *Office of Evaluation and Inspections*

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

## *Office of Investigations*

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees state Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

This review is part of a nationwide analysis of Medicare reimbursement for outpatient cardiac rehabilitation services. The analysis was requested by the Administrator of the Centers for Medicare & Medicaid Services (CMS) to determine the level of provider compliance with national Medicare outpatient cardiac rehabilitation policies.

Currently, CMS covers Phase II outpatient cardiac rehabilitation programs conducted in specialized, free-standing cardiac rehabilitation clinics and in outpatient hospital departments under the “incident to” benefit [section 1861(s)(2)(A) of the Social Security Act]. Medicare coverage policy for cardiac rehabilitation services is found in §35-25 of the Medicare Coverage Issues Manual. Under 42 Code of Federal Regulations §482.24(b), the hospital must maintain a medical record for each inpatient and outpatient.

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

### **OBJECTIVE**

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

- Rahway’s policies and procedures reflected Medicare cardiac rehabilitation coverage requirements for direct physician supervision, “incident to” services, and Medicare covered diagnoses.
- Payments to Rahway for outpatient cardiac rehabilitation services provided to Medicare beneficiaries during calendar year (CY) 2001 were for Medicare covered diagnoses, were supported by adequate documentation, and were otherwise allowable for reimbursement.

### **RESULTS OF REVIEW**

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

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

Medicare reimbursed Rahway \$18,187 for 1,151 cardiac rehabilitation services provided to 46 beneficiaries during CY 2001. Our analysis of the medical and billing records of 10 beneficiaries, who received 267 outpatient cardiac rehabilitation services totaling \$4,205 during CY 2001, showed that 45 services totaling \$693 for 8<sup>1</sup> beneficiaries did not meet Medicare criteria for reimbursement as follows:

- Twenty-three services for one beneficiary with a documented diagnosis not covered for outpatient cardiac rehabilitation reimbursement under Medicare (\$342).
- Four services were not provided for four beneficiaries (\$64).
- Ten services were rendered in excess of the number of prescribed sessions for one beneficiary (\$160).
- Eight services not allowed for outpatient cardiac rehabilitation reimbursement were provided to seven beneficiaries (\$127).

We attribute these questionable services to weaknesses in the hospital’s internal controls and oversight procedures, and misinterpretation of Medicare requirements. Existing controls and oversight procedures did not ensure that services were: 1) for actual Medicare covered outpatient cardiac rehabilitation diagnoses, 2) actually rendered, 3) rendered in accordance with the physician’s prescription and 4) allowable for reimbursement under cardiac rehabilitation requirements.

Our determinations regarding Medicare covered diagnoses were based solely on our review of the medical record documentation. Medicare Fiscal Intermediary (FI) staff have not reviewed the medical records. We believe that the Medicare FI, Riverbend Government Benefits Administrator, should determine appropriate recovery action.

---

<sup>1</sup> We identified four beneficiaries with multiple questionable services. Three beneficiaries had two categories of questionable services and one beneficiary had three questionable services.

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

## **RECOMMENDATIONS**

We recommend that Rahway:

- Work with its Medicare FI to ensure that Rahway’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 its Medicare FI to establish the amount of repayment liability for services provided to beneficiaries that did not meet criteria for Medicare reimbursement.
- Strengthen internal controls and oversight activities to ensure that services claimed are allowable for reimbursement under Medicare outpatient cardiac rehabilitation requirements.

## **AUDITEE COMMENTS AND OIG RESPONSE**

Rahway, in its response dated November 7, 2003 (see Appendix B), submitted a corrective action plan (with new policies attached) addressing our three recommendations. Specifically, Rahway indicated that written policies had been developed to address its compliance with the “incident to” requirements, and to strengthen internal controls for documentation and billing. Rahway agreed to return overpaid reimbursements identified in our report to the FI.

We reviewed all relevant comments made by Rahway and believe that the hospital should continue to work with the FI to determine whether the proposed corrective action plan ensures that its outpatient cardiac rehabilitation program is being conducted in accordance with Medicare requirements.

## TABLE OF CONTENTS

	<b>Page</b>
INTRODUCTION	1
BACKGROUND	1
<i>Medicare Coverage</i>	1
<i>Cardiac Rehabilitation Programs</i>	2
OBJECTIVE, SCOPE AND METHODOLOGY	2
<i>Objective</i>	2
<i>Scope and Methodology</i>	3
RESULTS OF REVIEW	4
PHYSICIAN INVOLVEMENT IN CARDIAC REHABILITATION	5
<i>Direct Physician Supervision</i>	5
<i>“Incident To” Physician Services</i>	5
MEDICARE COVERED DIAGNOSES AND CLAIMS REVIEW	6
<i>Medicare Covered Diagnoses</i>	7
<i>Services Not Provided</i>	7
<i>Services Exceeding the Physician’s Prescription</i>	8
<i>Services Not Allowed</i>	8
RECOMMENDATIONS	9
AUDITEE COMMENTS AND OIG RESPONSE	9
APPENDIX A – Summary Of Questionable Services	
APPENDIX B – Robert Wood Johnson University Hospital Rahway Comments to Draft Report	

# INTRODUCTION

## BACKGROUND

### *Medicare Coverage*

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

Medicare coverage policy for cardiac rehabilitation services is found in §35-25 of the Medicare Coverage Issues Manual (Coverage Issues Manual). Under Medicare, outpatient cardiac rehabilitation is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending 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. Under 42 Code of Federal Regulations §482.24(b), the hospital must maintain a medical record for each inpatient and outpatient. Services provided in connection with the cardiac rehabilitation program may be considered reasonable and necessary for up to 36 sessions, usually 3 sessions per week in a single 12-week period. Each cardiac rehabilitation session is considered to be one unit of service.

Cardiac rehabilitation is provided by nonphysician personnel, who are trained in both basic and advanced life support techniques and exercise therapy for coronary disease, under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise area and immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require a physician to be physically present in the exercise room itself. According to the Medicare Intermediary Manual (Intermediary Manual), §3112.4, the physician supervision requirement is generally assumed to be met where the outpatient services are performed on hospital premises.

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

## ***Cardiac Rehabilitation Programs***

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

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

Medicare reimburses outpatient hospital departments for cardiac rehabilitation services under the outpatient prospective payment system. Cardiac rehabilitation services are paid by a Medicare Fiscal Intermediary (Medicare FI) based on an ambulatory payment classification. The Medicare FI for Rahway is Riverbend Government Benefits Administrator. For Calendar Year (CY) 2001, Rahway provided 1,151 outpatient cardiac rehabilitation services to 46 Medicare beneficiaries and received \$18,187 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 Rahway for outpatient cardiac rehabilitation services.

Specifically, we determined whether:

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

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

### ***Scope and Methodology***

To accomplish our audit objectives, we:

- Reviewed Rahway's current policies and procedures and interviewed staff to gain an understanding of Rahway's management of its outpatient cardiac rehabilitation program and the billing procedures for cardiac rehabilitation services.
- Compared Rahway's current policies and procedures for outpatient cardiac rehabilitation to national Medicare coverage requirements and identified any differences.
- Documented how Rahway's staff provided direct physician supervision for cardiac rehabilitation services and verified that Rahway's cardiac rehabilitation program personnel were qualified in accordance with Medicare requirements.
- Verified the availability of advanced cardiac life support equipment in the cardiac rehabilitation exercise area.
- For 10 beneficiaries, reviewed all Medicare paid claims totaling \$4,205 for 267 cardiac rehabilitation services provided by Rahway during CY 2001.
- For each of the 10 beneficiaries, compared reimbursement data and lines of service to Rahway's outpatient cardiac rehabilitation service documentation.
- Reviewed the medical records maintained by the cardiac rehabilitation program to determine whether services were provided "incident to" a physician's professional service.
- Verified the accuracy of the diagnoses identified on the Medicare claims to the beneficiaries' inpatient medical records, physician referrals and supporting medical records and outpatient cardiac rehabilitation documentation. The Medicare FI medical review staff did not review the medical records.
- Verified that Medicare did not reimburse Rahway beyond the maximum number of services allowed.

Our audit was conducted in accordance with generally accepted government auditing standards. In accordance with the intent of CMS's request for a nationwide analysis, we determined the extent to which providers were currently complying with existing

Medicare coverage requirements. We performed fieldwork during April 2003 at Robert Wood Johnson University Hospital Rahway,<sup>1</sup> located in Rahway, New Jersey.

## **RESULTS OF REVIEW**

Although physician supervision is assumed to be met in an outpatient hospital department, we found that Rahway did not designate any one physician to directly supervise the services provided by its cardiac rehabilitation program. Instead, Rahway relied on a house physician, the program exercise area's proximity to the Cardiac and Emergency Departments, and the hospital's emergency response procedures.

In addition, contrary to current Medicare requirements, we could not identify the physician professional services to which the cardiac rehabilitation services were provided "incident to." There is no documentation to indicate that a hospital physician personally saw patients to assess their response to the program and update treatment plans.

Medicare reimbursed Rahway \$18,187 for 1,151 cardiac rehabilitation services provided to 46 beneficiaries during CY 2001. Our analysis of the medical and billing records of 10 beneficiaries, who received 267 outpatient cardiac rehabilitation services totaling \$4,205 during CY 2001, showed that 45 services totaling \$693 for 8 beneficiaries<sup>2</sup> did not meet Medicare criteria for reimbursement as follows:

- Twenty-three services for one beneficiary with a documented diagnosis not covered for outpatient cardiac rehabilitation reimbursement under Medicare (\$342).
- Four services were not provided for four beneficiaries (\$64).
- Ten services were rendered in excess of the number of prescribed sessions for one beneficiary (\$160).
- Eight services not allowed for outpatient cardiac rehabilitation reimbursement were provided to seven beneficiaries (\$127).

We attribute these questionable services to weaknesses in the hospital's internal controls and oversight procedures, and misinterpretation of Medicare requirements. Existing controls and oversight procedures did not ensure that services were: 1) for actual Medicare covered outpatient cardiac rehabilitation diagnoses, 2) actually rendered, 3) rendered in accordance with the physician's prescription and 4) allowable for reimbursement under cardiac rehabilitation requirements.

---

<sup>1</sup> Prior to October 7, 2003, the hospital was known as Rahway Memorial Hospital.

<sup>2</sup> We identified four beneficiaries with multiple categories of questionable services. Three beneficiaries had two questionable services and one beneficiary had three questionable services.

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

## **PHYSICIAN INVOLVEMENT IN CARDIAC REHABILITATION**

### ***Direct Physician Supervision***

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

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

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

### ***“Incident To” Physician Services***

According to the Intermediary Manual, §3112.4, in order to be covered under the “incident to” benefit in an outpatient hospital department, services must be furnished as an integral, although incidental part of a physician's professional service in the course of diagnosis or treatment of an illness or injury. The benefit does not require that a physician perform a personal professional service on each occasion of service by a 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 Rahway, we were unable to identify the physician professional services to which the cardiac rehabilitation services were provided “incident to.” According to the Rahway's

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

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

From our review of Rahway's outpatient cardiac rehabilitation medical records, we were unable to locate evidence of any physician professional services rendered to the patients. Although written policies and procedures indicate that the Medical Director's responsibilities included daily visits to the exercise area, there was no documentation to indicate that a hospital physician personally saw patients to assess their response to the program and update treatment plans. Accordingly, we believe that Rahway's cardiac rehabilitation program did not meet the requirements to provide an "incident to" service. Rahway should work with the Medicare FI to ensure that the outpatient cardiac rehabilitation program specifically conforms to the "incident to" requirements.

## **MEDICARE COVERED DIAGNOSES AND CLAIMS REVIEW**

Medicare coverage considers cardiac rehabilitation services reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician, and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months, (2) have had coronary artery bypass graft surgery, and/or (3) have stable angina pectoris. Medicare reimburses providers for Phase II outpatient cardiac rehabilitation services and allows one unit of service to be billed per cardiac rehabilitation session. Documentation for the services provided must be maintained in the patients' medical records.

Our analysis of the medical and billing records of 10 beneficiaries, who received 267 outpatient cardiac rehabilitation services totaling \$4,205 during CY 2001, showed that 45 services totaling \$693 for 8 beneficiaries did not meet Medicare criteria for reimbursement.

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

### ***Medicare Covered Diagnoses<sup>3</sup>***

According to the Coverage Issues Manual, §35-25(A), services are considered reasonable and necessary for patients who 1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months or 2) have had coronary artery bypass surgery and/or 3) have stable angina pectoris.

We identified 23 services totaling \$342 for 1 beneficiary with a documented diagnosis not covered for outpatient cardiac rehabilitation reimbursement under Medicare.<sup>4</sup> Approximately two weeks prior to starting the outpatient cardiac rehabilitation program, the patient was admitted to the hospital, and discharged three days later, with unstable angina. The medical records did not identify any procedures performed to stabilize the angina symptoms. Although the physician's referral, dated four days after the patient's discharge date, indicated stable angina as the diagnosis, the medical records suggested symptoms of constant chest pain and shortness of breath.<sup>5</sup> Rahway's internal controls and oversight procedures did not ensure that the patient had a Medicare covered diagnosis supported by medical records.

### ***Services Not Provided***

According to the Coverage Issues Manual, §35-25(A) and (E), Medicare will reimburse providers for outpatient cardiac rehabilitation services provided by the outpatient department of a hospital or a physician-directed clinic. A visit that includes one or more of a range of routine services is considered as one routine cardiac rehabilitation visit.

We identified 4 services totaling \$64 for four beneficiaries that were not performed. For each of three beneficiaries, the hospital was reimbursed for two sessions for the date of service billed to Medicare. However, the medical records supported only one session. For the fourth beneficiary, the hospital was reimbursed for a session that was neither supported by the medical records nor accounted for in the sequence of cardiac rehabilitation session reports. Rahway's internal controls and oversight procedures did not ensure that services billed were actually provided.

---

<sup>3</sup> Our determination regarding the Medicare covered diagnosis was based solely on our review of the medical records. Medicare FI staff have not reviewed the medical records.

<sup>4</sup> For one of these 23 services, Rahway received reimbursement, but did not provide the service.

<sup>5</sup> According to the MEDLINEplus Medical Encyclopedia found at the U.S. National Library and National Institute for Health website (<http://www.nlm.nih.gov/medlineplus/ency/article/000198.htm>), stable angina is defined as a pain or discomfort in the chest or adjacent areas ... 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.

### *Services Exceeding the Physician's Prescription*

According to the Coverage Issues Manual, §35-25(A) and §35-25 (D), services are considered reasonable and necessary for patients with a clear medical need who are referred by their physician.

We identified 10 services totaling \$160 for 1 beneficiary for whom services were provided in excess of the physician's prescription. Based on our review of the medical records, we were unable to determine whether the sessions rendered in excess of the number of sessions prescribed by the physician were justified. Although existing controls require a prescription for entry into the cardiac rehabilitation program, we noted nothing in the Hospital's written policies and procedures that addresses changes to the number of sessions prescribed. Rahway's internal controls and oversight procedures did not ensure that the services billed were rendered in accordance with the physician's prescription.

### *Services Not Allowed*

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

We identified 8 services totaling \$127 provided to 7 beneficiaries that did not qualify as a reimbursable service for cardiac rehabilitation. For each of the seven beneficiaries, the hospital was reimbursed for a new patient evaluation conducted by nonphysician personnel that was not performed in conjunction with a rehabilitation session. For one beneficiary, the hospital was also reimbursed for a body composition analysis, which is not separately allowable for Medicare reimbursement. We attribute this to a misinterpretation of the cardiac rehabilitation requirements.

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

## **RECOMMENDATIONS**

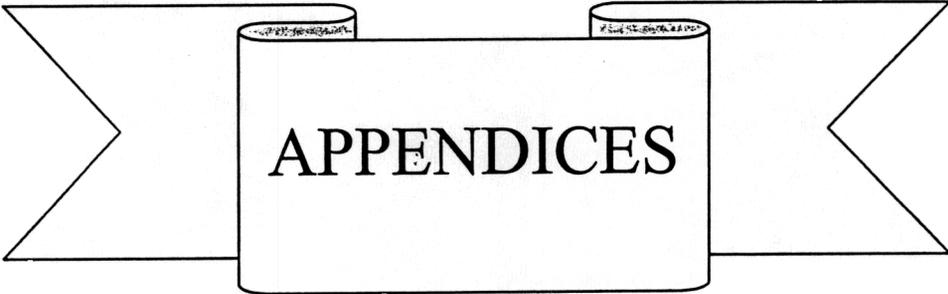
We recommend that Rahway:

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

## **AUDITEE COMMENTS AND OIG RESPONSE**

Rahway, in its response dated November 7, 2003 (see Appendix B), submitted a corrective action plan (with new policies attached) addressing our three recommendations. Specifically, Rahway indicated that written policies had been developed to address its compliance with the "incident to" requirements, and to strengthen internal controls for documentation and billing. Rahway agreed to return overpaid reimbursements identified in our report to the FI.

We reviewed all relevant comments made by Rahway and believe that the hospital should continue to work with the FI to determine whether the proposed corrective action plan ensures that its outpatient cardiac rehabilitation program is being conducted in accordance with Medicare requirements.



**APPENDICES**

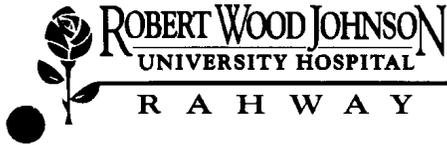
SUMMARY OF QUESTIONABLE SERVICES

Total Medicare Reimbursement: \$18,186.82  
 Total Services Provided: 1151  
 Total Beneficiaries: 46

Reviewed Medicare Reimbursement: \$4,204.73  
 Reviewed Services Provided: 267  
 Reviewed Beneficiaries: 10

Types of Questionable Services	Number of Beneficiaries with Questionable Services	Total Questionable Services	Total Reimbursement for Questionable Services
Medicare Covered Diagnoses	1	23	\$342
Services Not Provided	4	4	\$64
Services Exceeding the Physician's Prescription	1	10	\$160
Services Not Allowed	7	8	\$127
<b>Totals</b>	<b>13*</b>	<b>45</b>	<b>\$693</b>

\* We identified four beneficiaries with multiple questionable services. Three beneficiaries had two questionable services and one beneficiary had three questionable services.



November 7, 2003

Timothy J. Horgan  
Regional Inspector General for Audit Services  
Dept. of Health and Human Services  
Jacob K. Javits Federal Building  
New York, NY 10278

Dear Mr. Horgan,

Enclosed is Robert Wood Johnson University Hospital at Rahway's response to your report which was received on October 9, 2003 concerning Outpatient Cardiac Rehabilitation Services.

Included in the response is the hospital's action plan, target dates and attachments for your review.

If I can be of any further assistance please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Kirk C. Tice".

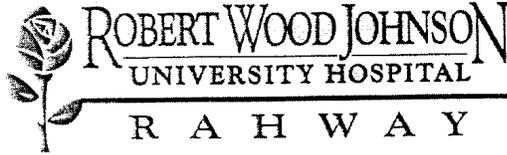
Kirk C. Tice  
President and CEO

Att.

Report: A-02-03-01022

10/03 OIG Recommendation Regarding Cardiac Rehabilitation Services at Robert Wood Johnson University Hospital at Rahway

OIG Recommendation	Action Plan	Target Date	Completion Date
Plan services in compliance with "incident to" requirements	1. Development of a written policy which details how and when the Medical Director assesses patients during exercising sessions. Exhibit A. Policy 107 ACS	October 2003	October 2003
	2. Continue to communicate progress reports to the referring physician. Exhibit B. Policy 814 ACS	October 2003	October 2003
	3. Revise existing enrollment policy to state the first exercise session occurs during initial enrollment. Exhibit C Policy 823 ACS	October 2003	October 2003
Ascertain any repayment obligation	Contact fiscal intermediary to return monies due to misinterpretation of standards	October 2003	November 2003
Strengthen internal controls for documentation and billing	Develop (2) distinct policies to manage billing from the charge entry point which is Cardiac Rehabilitation and Finance which submits the final bill. Each department will ensure all staff responsible for billing and finance will audit each case before completion of process. Exhibits D and E. Policy 210, 210.1 ACS	November 2003	November 2003



## POLICY AND PROCEDURE MANUAL

DEPT./SERV.: Ambulatory Cardiac Services	APPROVED: <i>[Signature]</i>	CODE NUMBER: 107 CROSS REF. NUMBER:
SUBJECT: <b>Medical Director – Role Responsibility</b>		

### POLICY:

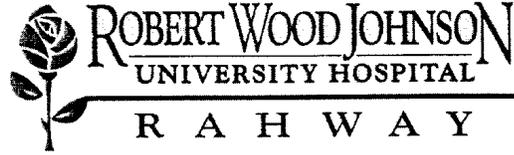
The medical direction of the Cardiac Rehabilitation Department shall be vested in the Medical Director of Cardiac Rehabilitation Services or his/her designee. The Medical Director's responsibility will be to evaluate each participant during exercise sessions.

### PROCEDURE:

- 1.0 In the absence of the Medical Director he/she shall provide for a qualified medical staff physician who is a member of the Department of Medicine and subdivision of Cardiology and has functional knowledge of Cardiac Rehabilitation Services.
- 2.0 The Medical Director is responsible for the review and approval of the exercise prescription which is developed by the Ambulatory Cardiac Services Nurse and/or Exercise Physiologist. All provision of therapy shall require medical prescription. Patient response and progress in therapy shall be documented on the progress report form and maintained in the permanent medical record.
- 3.0 Verbal or written consultation regarding the patient's response and/or progress in therapy shall be provided by the Ambulatory Cardiac Services Nurse to the Medical Director at regular intervals of at least every 30 days for participants in the Phase II monitored program and every 6 months for participants in the Phase IV maintenance program.
- 4.0 The Medical Director's assessment during an exercise session will be documented on the Progress Notes (see attachment A).

SUBJECT: Medical Director – Role Responsibility  
 REVISED: 5/89, 8/90, 8/94  
 SUPERCEDES: 11/03  
 DATE: 11/03  
 Admin/hughes/converte/ads/medrol.doc

PAGE: 1 of 1



**POLICY AND PROCEDURE MANUAL**

DEPT./SERV.: Ambulatory Cardiac Services	APPROVED: <i>[Signature]</i>	CODE NUMBER: 814 CROSS REF. NUMBER:
SUBJECT: <b>Progress Report</b>		

**POLICY:**

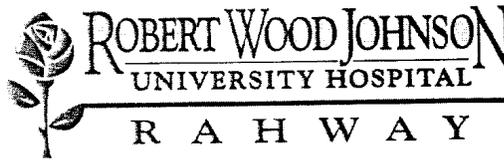
It is the policy of the Ambulatory Cardiac Services department that a cardiac rehabilitation patient progress report will be completed by the primary nurse at the completion of each four (4) week period of patient participation in the monitored program.

**PROCEDURE:**

- 1.0 The progress report will be reviewed by the Medical Director prior to its being forwarded to the referring physician.
- 2.0 Progress reports for the patient in the Maintenance phase of the program will be completed every six months and forwarded to the primary physician.

SUBJECT: Progress Reports  
 REVISED:  
 SUPERCEDES: 5/89, 4/92  
 DATE: 2/98





## POLICY AND PROCEDURE MANUAL

DEPT./SERV.: Ambulatory Cardiac Services	APPROVED: <i>[Signature]</i>	CODE NUMBER: CROSS REF. NUMBER: 823
SUBJECT: <b>Primary Nursing Assessment</b>		

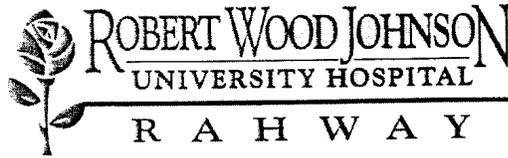
### POLICY:

A Registered Professional Nurse will assess all Ambulatory Cardiac Services patients prior to initiation of exercise therapy. This assessment is performed at the time of enrollment to the Cardiac Rehabilitation Program.

### PROCEDURE:

- 1.0 The primary nurse uses the Nursing History and Physical Examination form for initial client assessment. The assessment is comprised of the following:
  - 1.1 Present illness
  - 1.2 Past medical history and hospitalization
  - 1.3 Current medications and dosages
  - 1.4 Family history
  - 1.5 Review of systems
  - 1.6 Psychosocial aspects
  - 1.7 Cardiovascular physical assessment
- 2.0 The nurse will document nursing assessment based upon the data collected, physical examination of the client, subjective statements of client and family and past history.
- 3.0 The nurse will demonstrate to the patient how to put on a telemetry monitor.
  - 3.1 Patient will be shown all pieces of equipment and obtain a monitor write-out on each piece of equipment.
  - 3.2 Response to each exercise will be documented.
- 4.0 The nurse then signs his/her name and status on the progress notes that follows the health history and physical exam.

SUBJECT: Primary Nursing Assessment  
 REVISED: 11/03  
 SUPERCEDES: 3/92, 3/98, 2/00  
 DATE: 11/03  
 Admin.Hughes.Convert/ACS/pnapp.doc



## POLICY AND PROCEDURE MANUAL

DEPT./SERV.: Cardiac Rehab	APPROVED: <i>[Signature]</i>	CODE NUMBER: 210 CROSS REF. NUMBER:
SUBJECT: <b>Charging of Patients that participate in the Cardiac Rehabilitation Program</b>		

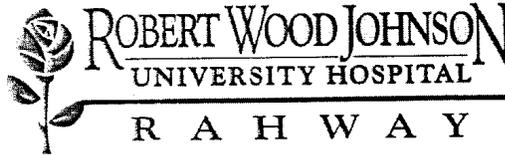
### Policy:

To post charges accurately and timely to all patient accounts.

### Procedures:

- 1.0 The Department Secretary will review the services rendered for each patient on a daily basis.
  - 1.1 Using the Invision charge entry screen, the daily charge will be entered on the patient account
  - 1.2 The charge entry should be completed on the same day the service is rendered. (see attached copy of the order entry screen).
  - 1.3 Charges entered on a daily basis until 3:00 classes. 4:00, 5:00 and 6:00 PM classes are entered on the following business day.
- 2.0 The IS department will send the departmental charge summary report (see attached copy of the report) to the department on a daily basis.
- 3.0 The coordinator will review the charges on the report daily, to insure that all of the charges are posted correctly, any discrepancies will be corrected immediately.
  - 3.1 Upon completion of the coordinator's review, the report should be initialed and a copy of the report will be maintained in the department for future auditing purposes.

SUBJECT: Charging Patients that participate in the Cardiac Rehabilitation Program  
 REVISED:  
 SUPERCEDES: 7/00  
 DATE: 11/03  
 U:masella/policy/charg pts for card Rehab.doc



## POLICY AND PROCEDURE MANUAL

DEPT./SERV.: Patient Accounting	APPROVED: <i>[Signature]</i>	CODE NUMBER: ACS 210.1 CROSS REF. NUMBER:
SUBJECT: <b>Audit of Cardiac Rehabilitation Patients</b>		

### Policy:

All Medicare monitored cardiac rehab patients will be audited by the Medicare outpatient billing staff, to insure compliance with the Medicare regulation regarding the number of visits billed and the medical necessity of the services being rendered.

### Procedure:

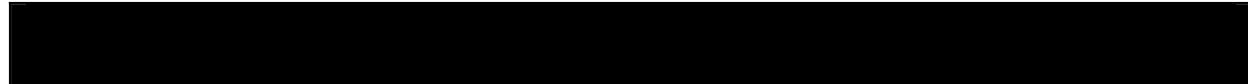
- 1.0 The first day of each month, the IS department will generate a report that lists the following information for all patients who had a cardiac rehab charge posted to their account in the prior month.
  - 1.1 Patient Account Number
  - 1.2 Patient Name
  - 1.3 Medical Record Number
  - 1.4 All insurance plan codes
  - 1.5 Number of visits charged for
- 2.0 A hard copy report will be given to the outpatient biller.
- 3.0 Upon receipt of the report, the outpatient biller will update the audit file with any new patients and update the following information on existing patients:
  - 3.1 Medical Record number
  - 3.2 Patient account number for each month
  - 3.3 Number of visits charged for each month
  - 3.4 Does the total number of visits charged for exceed 36
  - 3.5 The ICD-9 diagnosis codes
  - 3.6 Does the diagnosis code meet medical necessity criteria

SUBJECT: Audit of Cardiac Rehab Patient  
 REVISED:  
 SUPERCEDES: New  
 DATE: 11/03  
 U: Masella/policy/audit card rehab pt.doc

PAGE: 1 of 2

- 4.0 If any discrepancies are noted, they will be forwarded by e-mail to the Cardiac Rehabilitation Department Coordinator with a copy to the Patient Accounting Director, Ambulatory Services Manager and Director.
- 5.0 Upon receipt of any discrepancies, the Cardiac Rehab Coordinator will make the appropriate adjustments to the patient's account within three days of receipt of the e-mail. This timeframe must be adhered to so that when the bill drops the information is correct.
- 6.0 Upon receipt of the UB-92, the number of visits for each patient is verified against the log and adjustments are made to the log as required. A notification will be made in the log for any corrections as needed after the review.
- 7.0 By the 10<sup>th</sup> day following the close of the quarter (i.e. April, July, October, January) a copy of the log should be distributed to the Corporate Compliance Chairperson who will incorporate it into the Corporate Compliance meeting agenda. The results of the audit will also be shared with the Board of Director's Legal Audit Committee.

SUBJECT: Audit of Cardiac Rehab Patient  
REVISED:  
SUPERCEDES: New  
DATE: 11/03  
U: Masella/policy/audit card rehab pt.doc



This report was prepared under the direction of Timothy J. Horgan, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff that contributed include:

**NEW YORK**

James P. Edert, *Audit Manager*

Evelyn Diaz, *Senior Auditor*

Christine Duncan, *Auditor*

Rohan Ramdeholl, *Auditor*

**MADISON, WI**

Marc Gustafson, *Senior Auditor*

**HEADQUARTERS**

Eileen Bechkes, *Audit Manager*

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