Surviving a Cardiac Rehab Audit

Michele Parr, MS, CCEP, FAACVPR
No financial disclosures that would be considered a conflict of interest.
What is an Audit?

Audit - an official inspection of an individual’s or organization’s accounts, typically by an independent body.
Registration, Billing and Documentation of the CR/PR Patient

We receive the referral with the diagnosis on it
Patient registers for the service with that diagnosis
Someone codes the diagnosis (ICD-10)
Staff enters charges daily or as needed (CPT code)
Documentation and treatment occurs daily
Bill is created on a UB-04 document and sent in to CMS for payment.
Where Can Errors Occur in the Billing Process?

✓ We receive the referral with the diagnosis on it
✓ Patient registers for the service with that diagnosis
✓ Someone codes the diagnosis (ICD-10)
✓ Staff enters charges daily or as needed (CPT code)
✓ Documentation and treatment occurs daily
✓ Bill is created on a UB-04 document and sent in to CMS for payment.
How Do I Know My Program or Charts Are Getting Audited?

Your compliance department will receive a letter requesting additional documentation for specific claims. If you have communicated well with your compliance department and those who receive these letters, then they should send this letter to you. This letter will state why you are being reviewed such as “selected for review due to a service-specific targeted medical review” and what documentation is needed.
Who it’s from

What patient

Our purpose: Better health begins here.

Our mission: We help people live better lives through better health. • Our vision: We will be our region’s first choice for health and wellness.
What to send in:

- Dates of service

Documenting supporting medical necessity for pulmonary rehabilitation and the conditions of coverage in the Code of Federal Regulations (42CFR 410.27)

A copy of the individualized treatment plan

Documentation that the physician was immediately available for each monitored session billed

Documentation of the actual In/Out times for each session billed

Nurse’s and other ancillary notes

Progress notes to show the participation of the supervising physician in the course of treatment

Lab reports (if applicable)

Imaging tests

Therapy notes

Other diagnostic reports including pulmonary function studies that indicate post-bronchodilator values representing a patient with moderate to severe chronic obstructive pulmonary disease

Itemized supply or medication lists for all items billed for these dates of service

Please submit all documentation as required in the LCD or NCD, in this case 42CFR 410.27.

If you question the legibility of your signature, you may submit a signature log or an attestation statement in your ADR response.

A copy of an advanced beneficiary notice (ABN) if issued.

Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a handwritten or an electronic signature. Stamp signatures are not acceptable. Patient identification, date of service, and provider of the service should be clearly identified on the submitted documentation. The documentation you submit in response to this request should comply with these requirements. This may require you to contact the hospital or other facility where you provided the service and obtain your signed progress notes, plan of care, discharge summary, etc.

If the signature requirements are not met, the reviewer will conduct a review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated.

Medical records may be submitted on compact discs (CDs) or digital video disks (DVDs) to Palmetto GBA. You must use the correct file format of tagged image file format (TIFF) or portable document format (PDF), which may be saved to your CD/DVD.
<table>
<thead>
<tr>
<th>Reimb No.</th>
<th>Provider Name</th>
<th>Amount</th>
<th>Date</th>
<th>Admit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>042</td>
<td>CARDIAC REHAB</td>
<td>167.00</td>
<td>09/03/2015</td>
<td>05/04/2015</td>
</tr>
<tr>
<td>043</td>
<td>CARDIAC REHAB</td>
<td>167.00</td>
<td>05/04/2015</td>
<td>05/04/2015</td>
</tr>
</tbody>
</table>

Our mission: We help people live better lives through better health.  •  Our vision: We will be our region's first choice for health and wellness.
Date: April 21, 2017
Project ID: Y4P0446-CR1

ATTENTION: COMPLIANCE
WACCAMAW COMMUNITY HOSPITAL
ATTN: BUSINESS OFFICE
PO BOX 421718
GEORGETOWN, SC 29442

NPI/PROVIDER #: 1972503910
Phone: (843) 527-7078
Fax: Not in PECOS or NPPES

Request Type & Purpose: Initial Request
Subject: Additional Documentation Required

Dear Medicare Physician/Provider/Supplier:

The Centers for Medicare & Medicaid Services (CMS) through the Medicare fee-for-service (FFS) Medical Review program, carries out the task of requesting, receiving and reviewing medical records through its Medicare Contractors. The Supplemental Medical Review Contractor (SMRC), Strategic Health Solutions, LLC (Strategic), is a specialty review contractor for CMS. The SMRC reviews selected Medicare A, B and DME claims to identify possible improperly paid claims. For more information regarding the SMRC, please visit https://strategichs.com/smrc/

Reason for Selection
The SMRC is conducting medical review based on the analysis of CMS claims data and one or more of your Medicare claims has been selected for review. Additional information about this project can be found on the website at https://strategichs.com/smrc/

Action: Medical Records Required
Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the SMRC. Providing medical records of Medicare patients to the SMRC does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified in the SMRC Additional Request for

1 Social Security Act Sections 1833 [42 USC §1395 (c)] and 1815 [42 USC § 1395g(a)]; 42 CFR 405.980-986

Why the audit and what to do

Who it’s from
Documentation (ADR) letter, which is attached. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please be sure that the service does not invoice the SMRC or CMS.

When: Medical Record Submission Due Date
Please provide the requested information by June 05, 2017. A response is still required by the ADR due date even if you are unable to locate the requested information. Please note, you may request an extension to submit the requested documentation, if your request is made by June 05, 2017.

Consequences
If you fail to send the requested documentation or contact the SMRC by the ADR due date, your Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

Instructions
Please see the ADR letter on the following pages for specific information and instructions relating to returning requested documents for the claims selected for review.

Submission Methods
Documentation may be submitted via postal mail, fax, encrypted CD or via the Electronic Submission of Medical Documentation (esMD) mechanism. Please notify the SMRC if you intend to submit via esMD. For more information about esMD, see https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/esMD.

Please see the SMRC website at https://strategies.com/smrc/documentation-requests/ for specific information and instructions relating to returning requested documents for the claims selected for review.

Questions
If you have any questions, please contact Customer Service at 888.963.5527.

Sincerely,

Jill Nikolaisen
Director, Division of Medical Review and Education
Provider Compliance Group
Center for Program Integrity

Attachments/Supplementary Information
SMRC ADR Letter
Date: April 21, 2017
Reference ID: Y4F0446-CR1

ATTENTION: COMPLIANCE  
WACCAMAW COMMUNITY HOSPITAL  
ATTN: BUSINESS OFFICE  
PO BOX 421718  
GEORGETOWN, SC 29442

NPI/PROVIDER #: 1972503910  
Phone: (843) 527-7070  
Fax: Not in PECOS or NPPES

Request Type & Purpose: New Request, Post-Payment Claim Review  
Subject: Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce improper payment of Medicare claims. As part of our effort to accomplish this goal, CMS has retained StrategicHealthSolutions, LLC (Strategic) as the Supplemental Medical Review Contractor (SMRC) to conduct a medical record review of selected Part A and Part B claims. Additional information regarding this contract can be found at: https://strategic.cms.gov/smrc.

Reason for Selection:  
CMS has directed this review. In 2014, CMS expanded cardiac rehabilitation coverage to include stable, chronic heart failure with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II or IV symptoms despite being on optimal heart failure therapy for at least 6 weeks. The SMRC is conducting medical review based on the analysis of national claims data which will help determine compliance with all coverage requirements. For information about Medicare coverage requirements for cardiac rehabilitation services, refer to the Medicare National Coverage Determinations

Why the audit?

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1 Social Security Act Sections 1833 [42 USC § 1395l(a)] and 1815 [42 USC § 1395g(a)]; 42 CFR 405.980-986

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Our purpose: Better health begins here.  
Tidelands HEALTH  
Our mission: We help people live better lives through better health.  
Our vision: We will be our region's first choice for health and wellness.
Required documents


The expansion of coverage constitutes new and material evidence that establishes good cause for reopening the claim. Providing additional documentation for each claim is authorized by CMS and is being requested.

**Action: Medical Records Required**

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providing medical records of Medicare patients to the SMRC does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request.

Please submit the following supporting information for each claim requested in the following sequence:

- Copy of the claim bill
- Documentation to support one or more of the following conditions:
  - Acute myocardial infarction within the preceding 12 months
  - Coronary artery bypass surgery
  - Current stable angina pectoris
  - Heart valve repair or replacement
  - Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
  - Heart or heart-lung transplant
  - Stable, chronic heart failure with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II or IV symptoms despite being on optimal heart failure therapy for at least 6 weeks
  - Physician-prescribed exercise plan each day cardiac rehabilitation items and services are furnished
  - Physician order
  - Cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program
  - Psychosocial assessment
  - Outcomes assessment

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Our purpose: Better health begins here.

Our mission: We help people live better lives through better health.

Our vision: We will be our region’s first choice for health and wellness.
Individualized treatment plan detailing how components are utilized for each patient, including but not limited to the following:

- Description of the individual's diagnosis
- Type, amount, frequency, and duration of the items and services furnished under the plan
- Goals set for the individual under the plan
- Signatures/credentials of professionals providing services
- Copies of any patient notices given (e.g., Advance Beneficiary Notice of Noncoverage)
- Any abbreviation keys or acronym keys used
- Any other documentation to support services

When:
Please provide the requested documentation by June 05, 2017. A response is still required by June 08, 2017, even if you are unable to locate the requested information. Please note, you may request an extension to submit the requested documentation, if your request is made by June 05, 2017.

When the review is completed, you will receive a review results letter after a medical record review finding has been made. The results letter will stipulate if any underpayment(s) or overpayment(s) were identified. In addition, your claims may be subject to extrapolation in keeping with the Centers for Medicare and Medicaid Services (CMS) Internet-Only Manual (IOM). Publication (Pub.) 100-08, Chapter 8, Section 6.4.1.14 - Determining When Statistical Sampling May Be Used.

Consequences:
If the provider/supplier fails to send the requested documentation or contact Strategic by June 05, 2017, the provider/supplier’s Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

Instructions:
- Strategic does not reimburse the cost associated with copying of medical records from any setting. When records are requested, the expense of supplying medical records is a part of the administrative costs of doing business with Medicare. Therefore, invoices from record retention centers and copying agencies are not eligible for reimbursement.
- Refer to the ADR Claim List for selected claims.
- A copy of this request letter should be affixed to the documentation submitted.
Importance of sending in legible signatures

- All documentation should be submitted within 45 days of the date of this notice.
- Please refer to the Submission Methods section of this letter for additional information on document preparation and available submission methods.

Note:
- Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a legible handwritten or electronic signature.
- Stamp signatures are not acceptable. Beneficiary identification, date of service, and provider of the service(s) should be clearly identified on the submitted documentation. Documentation submitted in response to this request shall comply with these requirements.
- This may require providers to contact the hospital or other facility where services were provided to obtain signed progress notes, plan of care, discharge summary, etc., that may be used to support Medicare payment.
- If signature requirements are not met, the reviewer will conduct the medical review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that medical necessity for the service(s) billed has not been substantiated.
- Strategic recommends that providers review their documentation prior to submission and ensure that all medical record entries and orders are signed appropriately. For documentation with a missing or illegible signature, a signature log or signature attestation may be submitted additionally as part of the ADR response. For detailed guidance regarding Medicare signature requirements, refer to the Medicare Program Integrity Manual, Publication 100-08, Chapter 3 and Section 3.3.2.4.

Submission Methods:
Providers/suppliers may submit the documentation in any of the following ways:
- Via postal mail to:
  StrategicHealthSolutions, LLC
  4211 South 102nd Street
  Omaha, NE 68127
  ATTN: Supplemental Medical Review Contract
  Project ID: Y4P0448-CR1
- Via fax to: 855.219.1799
- Via Electronic Submission of Medical Documentation (esMD):
Point of Contact Information:
It may be necessary for Strategic to contact your organization regarding the claims provided to Strategic. Please provide a primary and secondary Point of Contact (POC) for your organization in the space provided below.

<table>
<thead>
<tr>
<th>POC</th>
<th>Name</th>
<th>Telephone</th>
<th>Facsimile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
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<td></td>
</tr>
</tbody>
</table>

ADR Claim List:
- Prepare documents/records in the order of the requested information listed on the enclosed ADR letter.
- Do not staple any pages together in the record. Paper clips and rubber bands are acceptable to keep the records organized, if necessary.
- Ensure all submitted pages are complete, legible, and include both sides of the page and edges where applicable.
- Bundle records for each claim sample separately. Each record should be its own file regardless of the size and/or submission method including faxes.
- Attach a copy of the ADR Claim Sample List to the front of each record. Clearly identify the corresponding sample claim from the list by circling or marking an (X) next to the Sample ID and beneficiary name.

The following claims have been selected for post-payment review of the cardiac rehabilitation services. Please send the requested documentation listed on the ADR for each claim.

<table>
<thead>
<tr>
<th>Case Sample ID</th>
<th>Beneficiary Name</th>
<th>Date of Birth</th>
<th>Claim Number</th>
<th>Claim From Date</th>
<th>Claim To Date</th>
</tr>
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<tr>
<td></td>
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<td>04/04/2016</td>
<td>04/14/2016</td>
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<td></td>
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<td></td>
<td>12/19/2016</td>
<td>12/28/2016</td>
</tr>
</tbody>
</table>
Submitting Your Documentation

Once you receive the ADR you need to prepare the chart to submit by the date deadline.
Set aside time to focus.
Do one chart at a time.
Follow directions very carefully.
Complete all required forms that come with the ADR.
Put the documents in order as the request states.

Tip - Assign headers to each page before each required section. This allows the reviewer to find the information easier.
Copy of the claim bill

Get this from your billing office
Documentation to support one or more of the following Conditions

- Acute MI within the preceding 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- Heart or heart-lung transplant
- Stable, chronic heart failure with left ventricular ejection fraction of 35% or less and NYHA class II – IV symptoms despite being on optimal heart failure therapy for at least 6 weeks.
Ensure the diagnosis codes are correct and are in the LCD when you admit a patient and send them to register.

If not, that claim will get denied on the “front end” or the “back end”

Ensure you have the medical record documents that support the actual diagnosis.
Physician prescribed exercise plan each day cardiac rehabilitation items and services are furnished.

Must have an exercise prescription that includes frequency, intensity, duration, modality and progression and it must be signed by a physician (signature legible).
Physician order

Referral order that includes the diagnosis (ensure this dx is approved and on the LCD).

Signed by the physician (legible).

NP or PA orders HAVE to have a co-signature from a physician.
Cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program.

Submit your ITP that highlights what type of intervention or education you did. Education sheet, etc.
Psychosocial assessment

Patient Health Questionnaire-9 (PHQ-9)
Hospital Anxiety and Depression Scale (HADS)
Single Factor Measures Depression Beck Depression Inventory-2 (BDI-2)
Centers for Epidemiological Studies-Depression Inventory (CES-D)
Psychosocial Risk Factor Survey (PRFS)

**key point**-we know that PGBA just doesn’t want the score. They want to see an interpretation of this within our scope of practice. They want social / family support noted and any home barriers noted as well.
Example of Interpretation letter for PHQ-9

Cardiopulmonary Rehabilitation
Tidelands Health/Waccamaw Community Hospital

Dear Dr.,

Your patient_____________DOB_____________ was given a mental health survey, called PHQ-9 which asks patients to respond to questions regarding signs and symptoms of depression. Following this letter is the tally sheet which shows the areas of concern for this patient. This patient scored _______.

- A score of 0—4 suggests the patient may not need treatment for depression.
- A score of 5—14 may indicate some signs of depression and functional impairment.
- A score of 15 or higher indicates significant symptoms of depression which may warrant treatment with medications or referral to specialist.

This patient currently is/is not prescribed medication for depression, anxiety, other psychological conditions. These medications are __________________________.

This patient currently sees/does not see a mental health professional on a regular basis.

On initial assessment of this patient:
- The patient voiced concern regarding depression _______
- Staff observed nervous/anxious/depressed behavior _______
- Family or friend expressed concern regarding patient mental, emotional, psychological health _______
- No problems noted, coping well with present treatment _______

Comments: ____________________________________________

Plan for patient to attend stress management classes, exercise regularly, maintain current medication regimen, maintain healthy diet and get adequate rest and sleep to optimize mental and physical health.

Please use this assessment information for consideration of any addition to or change in current treatment of this patient.

Thank you for your help in optimizing the medical care of this patient.

Sincerely;

Cardiopulmonary Rehabilitation
Tidelands Health/Waccamaw Community Hospital
Outcomes assessment signed by the physician

Some use the ITP.

We have a separate page for outcomes that includes a place for an interpretation and the medical director signs off on it.
Individualized treatment plan detailing how components are utilized for each patient including but not limited to the following: description of the individual's diagnosis type, amount, frequency and duration of the items and services furnished under the plan goals set for the individual under the plan.

This ITP MUST be signed by the medical director prior to or on the day the patient starts and every 30 days or less thereafter.
Signatures / credentials of professionals providing services.

Copies of patient notices given (ex. ABN for non coverage).

Any abbreviation keys or acronym keys used.
Any other documentation to support services
daily exercise sessions
-note who was the supervising physician and the on call physician for emergencies
-rhythm interpretation if billing for EKG
-in and out times for each session billed
nurses notes, et al. (PGBA requests are a little different).
September 06, 2017

WACCAMAW COMMUNITY HOSPITAL
ATTN: BUSINESS OFFICE
PO BOX 421718
GEORGETOWN, SC 29442
Letter ID: Y4P0446-CR1

Subject: Review Results Letter

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) has retained StrategicHealthSolutions, LLC (Strategic) as the Supplemental Medical Review Contractor (SMRC) to conduct medical record review of selected Part A and Part B claims. Additional information regarding this contract can be found at: https://strategichs.com/smrcl/

CMS has directed this review. In 2014, CMS expanded cardiac rehabilitation coverage to include stable, chronic heart failure with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II or IV symptoms despite being on optimal heart failure therapy for at least 6 weeks. The SMRC is conducting medical review based on the analysis of national claims data which will help determine compliance with all coverage requirements. For information about Medicare coverage requirements for cardiac rehabilitation services, refer to the Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 20.10 available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Medicare-Clinical-AdvisoryUpdates/nnc1031_Part1.pdf on the CMS website. This constituted new and material evidence that established good cause for reopening as required under 42 CFR 405.900(b).

The documentation for this medical review project was requested by Strategic in an Additional Documentation Request (ADR) letter. Based on a review of the medical record documentation and billing information, Strategic has made a no findings determination for the claim(s) listed in the enclosure. No further action is needed on your part.

[APPROVED stamp]
August 29, 2017

Waccamaw Community Hospital
607 Black River Road
Georgetown, SC 29442-4203

Beneficiary Contact Information
1-800-MEDICARE
or
1-800-633-4227

Medicare Number of Beneficiary:

Re: Appeal # 1-6525706101
MEDICARE APPEAL DECISION

Dear

This letter is to inform you of the decision on your Medicare appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you requested an appeal for the outpatient hospital ASC services provided by Waccamaw Community Hospital. Palmetto GBA - JM Part A Appeals was contracted by Medicare to review your appeal.

The appeal decision is unfavorable.

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Dates of Service</th>
<th>Claim Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim #1</td>
<td>02/01/2017 - 02/27/2017</td>
<td>Unfavorable</td>
</tr>
</tbody>
</table>

More information on the decision is provided below. If you disagree with the decision, you may appeal to a Qualified Independent Contractor (QIC). Your appeal of this decision must be made in writing and received by the QIC within 180 days of receipt of this letter. You are presumed to have received this decision five days from the date of the letter unless there is evidence to show otherwise. However, if you do not wish to appeal this decision, you are not required to take any action. For more information on how to appeal this decision, see the section at the end of this letter titled, “Important Information about Your Appeal Rights.”

A copy of this letter was also sent to the other parties of this appeal.

Summary of the Facts – Claim # 1 of 1

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Our mission: We help people live better lives through better health.

Our vision: We will be our region’s first choice for health and wellness.
Reason for denial

A claim was submitted for 11 other therapeutic services.
An initial determination on this claim was made on March 23, 2017.
The 11 physician services for outpatient cardiac rehabilitation with continuous electrocardiographic monitoring, per session, were denied as the diagnosis code submitted did not support the medical necessity of the services as outlined in Palmetto GBA’s Local Coverage Determination.
On July 13, 2017 we received a request for a redetermination.
The following documents were submitted with the request: a redetermination request letter, explanation of benefits, Local Coverage Determination (LCD): Cardiac Rehabilitation (L34412), UB-04, office visit records, summary report, physician referral form, exercise prescription, universal medication form, individualized treatment plan, outcomes report, patient depression questionnaire, patient health questionnaire, health survey records, patient orientation/education topics, cardiac rehabilitation assessment and plan, activity survey index, progress report, discharge summary report, fat intake questionnaire, and nutrition history.

Decision

We have determined that the above claim is not covered by Medicare. We have also determined that Waccamaw Community Hospital is responsible for payment for this service.

Explanation of the Decision

According to the documentation submitted, the beneficiary was referred for outpatient cardiac rehabilitation services due to congestive heart failure classified as New York Heart Association (NYHA) II to IV with left ventricular ejection fraction 25 percent. The medical records supported a covered indication for the outpatient cardiac rehabilitation services in accordance with Palmetto GBA Local Coverage Determination (LCD): Cardiac Rehabilitation (L34412).

The documentation submitted for the outpatient cardiac rehabilitation services included: an individualized treatment plan review and signed by the physician every 30 days, exercise prescription, cardiac risk factor modification, psychosocial assessment, and outcomes assessment. However, the documentation did not include cardiac rehabilitation session records specifying the exercises performed and electrocardiographic (EKG) monitoring strips for the services on February 1, 2017 through February 27, 2017. As outlined in LCD L34412, there should be a record of the intervention performed and description notation of the exercise provided. If EKG monitoring is provided, a representative strip should be documented.

The documentation did not support physician supervision for the cardiac rehabilitation services. LCD L34412 states that the supervising physician must possess all of the following: expertise in the management of individuals with cardiac pathophysiology; cardiopulmonary training in basic life support or advanced cardiac life support; and a license to practice medicine in the state in which the cardiac rehabilitation program is offered. The supervising physician must be immediately available at all times while cardiac rehabilitation services are being rendered. This does not require that a physician be physically present in the exercise room itself but must be...
immediately available and accessible at all times.

The medical records submitted did not contain all required components for the outpatient cardiac rehabilitation services, including the cardiac rehabilitation session records with electrocardiographic monitoring strips and documentation of physician supervision. Therefore, payment cannot be allowed for the 11 physician services for outpatient cardiac rehabilitation, with continuous electrocardiographic monitoring, per session, on February 1, 2017 through February 27, 2017, as the Medicare coverage requirements were not met.

When a redetermination request is made for Part B services billed on a Part A claim, all documentation to support the services being appealed must be included with the request for redetermination. It is the provider’s responsibility to submit complete documentation to substantiate that the services were rendered, ordered, and reasonable and necessary. Refer to Title 42 Code of Federal Regulations (CFR) Section 424.5 (a) (6).

Who is Responsible for the Bill?

After determining that the item or service will not be covered by Medicare, we must determine who is financially liable for the denied item or service. When an item or service is denied under §1862(a)(1), §1862(a)(2), or §1879(g) of the Social Security Act (the Act), we must determine if the beneficiary and the provider or supplier either knew or could reasonably be expected to know that the item or service would not be covered. This is known as the limitation on liability provision of §1879 of the Act.

If the beneficiary was informed by their provider or supplier in writing in advance of receiving the item or service that Medicare may not make payment (through receipt of an Advance Beneficiary Notice of Noncoverage (ABN)), the beneficiary may be responsible for the cost of the denied item or service. If the provider or supplier knew or could reasonably be expected to know the item or service would not be covered, but the beneficiary did not have such knowledge, then the provider or supplier may be responsible for the cost of the denied item or service.

There is no evidence to indicate that the provider notified the beneficiary in advance that the item or service would not be covered by Medicare. Therefore, we have determined that the beneficiary did not know and could not reasonably have been expected to know that the item or service would not be covered.

In addition, we have determined that the provider either knew or could reasonably be expected to know that the item or service would not be covered. This decision was made based on the coverage limitations provided in the ‘Explanation of the Decision’ section in this letter.

Since the provider has been determined to have had knowledge of the non-covered item or service, the provider is liable for the cost. The provider may not bill the beneficiary for the cost of the denied item or service, and must refund any monies collected from the beneficiary.

Additional Information for the Beneficiary

The beneficiary is not responsible for the charges billed by Waccamaw Community Hospital, except for any charges for services never covered by Medicare. If the beneficiary has paid for the services, they may be entitled to a refund. To get this refund, the beneficiary will need to contact
File an appeal

Reconsideration Request Form

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11, & 12, but to help us serve you better, please include a copy of the redetermination notice with your request.

C2C Solutions Inc.
Medicare Part A Eust
P.O. Box 45305
Jacksonville, Fl. 32232-3505

1. Name of Beneficiary: __________________________

2a. Medicare Number: __________________________

2b. Claim Number (ICN / DCN, if available): ______________

3. Provider Name:

4. Person Appealing: ☐ Beneficiary ☐ Provider of Service ☐ Representative

5. Address of the Person Appealing: __________________________

5a. Telephone Number of the Person Appealing: ______________

5b. Email Address of the Person Appealing:

6. Item or service you wish to appeal: __________________________

7. Date of the service: From __________ To __________

8. Does this appeal involve an overpayment? ☐ Yes ☐ No

*Please include a copy of the demand letter with your request.

9. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary.)

10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:

☐ Medical Records ☐ Office Records/Progress Notes

☐ Copy of the Claim ☐ Treatment Plan ☐ Certificate of Medical Necessity

11. Name of Person Appealing: __________________________

12. Signature of Person Appealing: __________________________ Date: ______________

Contractor Number: 11501