

**Memorandum**

Date: SEP 02 1997

From: Regional Inspector General
for Audit Services, Region IV

Subject: Results of Audit of Medical Therapy Services Inc. Cost Reports
(Home Office and Its Four Providers) (CIN: A-04-96-02122)

To: Rose Crum-Johnson
Regional Administrator
Health Care Financing Administration, Region IV

This report provides you with the results of our audit of Medical Therapy Services Inc. (MTS), a chain of outpatient therapy clinics with a home office in Cedartown, Georgia. The objective of the audit was to determine whether costs claimed on the 1995 cost reports submitted by MTS and its subsidiary clinics were in accordance with Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Our review showed that the home office and the four clinics included \$761,849 of costs that did not meet Medicare reimbursement requirements:

- ▶ Three of the four clinics overestimated the amount of home office costs they could claim by \$562,828.
- ▶ The home office and a clinic included costs for a non-Medicare service area totaling \$67,254.
- ▶ Three clinics claimed other costs that were unreasonable or not incurred totaling \$58,911.
- ▶ Three of the clinics claimed related party transactions in excess of costs totaling \$50,512.
- ▶ Two clinics claimed bad debt expense for bad debts that they collected or could have collected totaling \$14,821.
- ▶ The home office cost report included unreasonable travel and maintenance expenses of \$7,523.

We believe the unallowable costs were incurred because the accounting and administrative controls need improvement. The provider recently changed ownership.

The new owner indicated that he may have emphasized managing the services aspect of the business rather than the record keeping and other administrative matters. The new owner was receptive to suggestions for improving the accounting and record keeping functions.

RECOMMENDATIONS

We recommend the Health Care Financing Administration (HCFA) instruct the cognizant fiscal intermediary for each of the providers to implement the financial adjustments totaling \$761,849 identified in this report.

On August 1, 1997, the Regional Administrator, HCFA Region IV, responded to a draft copy of this report. The Administrator stated that HCFA concurs with the findings and recommendation. A full copy of the Administrator's response is shown in the attachment.

BACKGROUND

The MTS is the home office (provider #11-8849) for four outpatient therapy clinics: M. Therapy Inc. (provider #11-6716), Cedartown Medical Therapy Clinic (provider #11-6640); Piedmont Medical Therapy Clinic (provider #01-6558); and Medical Therapy Inc. (provider #25-6528).

For Fiscal Year (FY) 1995, MTS reported home office costs totaling \$636,430. The four clinics claimed \$3,789,882 on their cost reports, which included estimated home office costs totaling \$1,109,977.

FISCAL INTERMEDIARY RESPONSIBILITIES

The HCFA contracts with fiscal intermediaries usually, large insurance companies, to assist them in administering the Medicare program. The intermediaries for the providers were:

<u>Provider</u>	<u>Intermediary</u>
Medical Therapy Services Inc.*	Blue Cross of Georgia
M Therapy	Blue Cross of Georgia
Cedartown Medical Therapy Clinic	Mutual of Omaha
Piedmont Medical Therapy Clinic	Mutual of Omaha
Medical Therapy Inc.	Blue Cross of Mississippi

* home office

The intermediaries are responsible for processing claims for payment, conducting medical reviews of the claims for medical necessity coverage, and conducting audits of cost reports submitted by Medicare provider organizations.

REGULATIONS

The Social Security Act provides for outpatient therapy (physical, speech and occupational) services to an individual who is under the care of a physician and has a (treatment) plan established and periodically reviewed by a physician. Payment for the services is governed by 42 Code of Federal Regulations (CFR) Part 413.9(a) which states that payments to providers of services must be based on the lesser of the reasonable cost of services covered under Medicare or the customary charges for such services. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans.

The home office submits a cost report to the intermediary. The home office costs, however, are reimbursed through the individual providers of service through allocations of the home office costs to the providers.

SCOPE

We conducted our review in accordance with generally accepted government auditing standards. The objective of the review was to determine whether costs claimed on the 1995 cost report for the home office and each of the provider clinics were in accordance with Medicare reimbursement requirements.

To accomplish our objectives, we: (1) interviewed provider auditors from the cognizant intermediaries; (2) reviewed intermediary working papers from prior audits; (3) reviewed policies and procedures employed by the home office; (4) reviewed the allocation methodology utilized in preparing the provider cost reports; (5) interviewed current key personnel, lease holders and past owners (6) reviewed supporting documentation for selected costs on each cost report and (7) reviewed the visits and revenue amounts shown on the cost report. Our audit objectives did not require an understanding or assessment of the auditee's internal control structure.

We conducted our field work at the auditee site in Cedartown, Georgia from September 1996 through January 1997.

RESULTS OF REVIEW

Our review showed that MTS and its four clinics overclaimed costs of providing services to Medicare beneficiaries by \$761,849. The most significant adjustments were for home office expenses (\$562,828) that were overestimated at the time the clinic cost reports were filed. Medicare regulations state that Medicare will reimburse providers for only the reasonable cost of providing services to Medicare beneficiaries. We are recommending that HCFA instruct MTS and its providers to make financial adjustments to the cost reports totaling \$761,849. The details of our findings are discussed below and scheduled by provider in the appendix to this report.

HOME OFFICE COSTS

The four clinics under MTS claimed estimated home office costs totaling \$1,109,977. Based on our review, the amount of home office costs considered allowable and allocable to the clinics was \$547,149. The amounts reported by the clinics overestimated home office costs by \$562,828.

The clinics are required to submit cost reports to the intermediaries within certain timeframes and the reports include a claim for home office costs. The home office cost report was not available at the time the clinic cost reports were filed. As a result, the clinics estimated \$1,109,977 of home office costs.

The home office cost report claimed costs of \$636,430. Our audit showed that \$7,523 of this total was unallowable. The remaining balance of \$628,907 was allocable to the four clinics and to a non-Medicare affiliate. After allocating the non-Medicare share of costs (\$81,758) the amount allocable to the clinics was \$547,149 or \$562,828 less than the total claimed by the clinics ($\$1,109,977 - \$547,149 = \$562,828$).

Unallowable Home Office Costs

The unallowable costs of \$7,523 included unreasonable entertainment expenses of \$1,943 for travel and lodgings of the owners to resort locations for seminars that could have been obtained locally and for hotel accommodations within 30 miles of their residence. Medicare regulations provide that costs must be reasonable, necessary and related to patient care. Specifically, Title 42 CFR 413.9 (c)(3) provides that provider costs for luxury items or services - items or services substantially in excess or more expensive than necessary - will not be allowable.

The remaining home office costs considered unallowable represented \$5,580 for repairs and maintenance expense that were undocumented. The payments were made to a spouse of the previous owner for repairs and improvement of the home office. The

payments weren't supported with invoices, description of work, or time records. Title 42 CFR 413.24 requires that costs be supported by adequate documentation.

Non-Medicare Home Office Costs

The home office cost report allocated \$60,351 to a non-Medicare company called Outpatient Rehabilitation Alliance (ORA), and in our opinion ORA should have been allocated \$81,758.

The MTS owners established ORA to utilize "down" time experienced by the MTS clinics' therapists. The MTS loaned ORA therapists. The ORA contracted with other Medicare providers to provide therapists to treat beneficiaries whose claims were billed to Medicare through the other providers. The therapy provider paid ORA for therapy services and included the amount on its Medicare cost report as operating expense.

The MTS clinics who loaned therapists to ORA removed the cost associated with ORA activity from their expenses. For example, if a therapist worked 80 percent of the time for the clinic and 20 percent for ORA, that ratio was applied to certain expenses incurred (salary and benefits) and charged to ORA. Travel associated with ORA activity was absorbed 100 percent by ORA.

An effort was made to allocate direct costs to ORA at the clinic level, and MTS allocated ORA \$60,351 of home office costs in the FY 95 home office cost report. However, we do not believe ORA was allocated a fair share of home office costs. Based on our review and the ratio of ORA costs to the costs of the other clinics, ORA should have been allocated home office costs of \$81,758. Thus, we are recommending an additional allocation to ORA of \$21,407 (\$81,758 - \$60,351).

RELATED PARTY COSTS

Our review showed that the home office and the clinics procured services from organizations that represented related parties to the owners of MTS. In such relationships, the providers are limited to actual costs of the related parties. Three of the four providers claimed reimbursement for payments to related parties that exceeded allowable costs by \$50,512.

The Medicare regulations state in Title 42 CFR 413.17 that costs of services furnished to a provider by parties related to the provider by common ownership or control are limited to the costs of the related party. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

Related to the provider means the provider to a significant extent is associated with or has control over the servicing organization. Common ownership exists if the provider possesses ownership or equity in the provider and the organization servicing the

provider. Control exists if the provider has the power, directly or indirectly, significantly to influence or direct the actions of the servicing organization.

The leases in question were arranged by the former MTS owners (brother and sister) in 1993 and 1994, and continued through 1995. The current owner is a son of one of the former owners. By direct family relationship, we believe the related parties established by the former owners continued with the current owner. The basis for considering the leases to be related party transactions is explained below.

Non-Medicare Provider

M Therapy claimed contract labor costs of \$35,156 for services rendered under contract by ORA, a non-Medicare therapy provider owned by the owners of MTS. Since ORA was a related party, M Therapy's cost should be limited to ORA's cost. The ORA billed M Therapy at its usual rate which was inflated to allow for a profit margin. The actual cost of the services was \$19,065 and this is the amount considered allowable. The billed services exceeded the costs by \$16,091.

K&D Leasing

The former MTS owners arranged leases for several of their clinics with K&D Leasing (K&D), another entity we found to be a related party. As a result, we consider \$17,855 paid to K&D and claimed by the providers to be unallowable, representing claims in excess of costs.

The K&D leased office space and equipment, under separate leases, with the home office, the Cedartown clinic, and Medical Therapy Inc. The former owners informed us that they arranged these leases with K&D to make the transactions "arms length." However, in doing so, we believe they exerted significant control over K&D.

To illustrate, K&D leased office space to Medical Therapy Inc., the clinic in Mississippi. The space in question was owned by Madison Development Inc. (Madison). The K&D signed a lease with Madison, then subleased the space to the clinic. However, we found no evidence to indicate that K&D was ever involved in the negotiations with Madison.

The K&D appeared to have little, if any, control over the lease arrangements. The K&D informed us that they were approached by MTS to become a party in the lease, apparently after all the arrangements were made by the former owners of MTS. Documentation indicates that the former MTS owners, doing business as Cartersville Retirement Center Inc. (CRC), made the lease arrangements with Madison.

In March 1993, Madison wrote to one of the former owners transmitting copies of the lease agreement and requesting their signature on the lease. Madison provided us the first page of a lease between Madison and CRC for the space to be used by the clinic. However, we don't know if this lease was executed. Five months later, the former owner, using CRC letterhead, wrote to Madison transmitting a lease between Madison and K&D and stating that if K&D ever defaults, CRC would honor its commitment. It appears that CRC made the lease arrangements with Madison then brought K&D in as a middle party between Madison and the clinic. The former owners could have leased directly with Madison, but chose to bring in K&D.

The former owners' (doing business as CRC) involvement in the lease arrangements from the onset shows that they exerted significant influence and control over K&D, making them a related party.

For the equipment leases, we found that the former owners ordered most of the equipment, and in some cases, paid for the equipment, and were then reimbursed by K&D. It appears MTS controlled all aspects of the equipment leases, and K&D merely paid the bills. The K&D was unable to adequately explain certain lease clauses, and could not provide documentation for all the equipment represented by the leases. In our opinion, MTS also had significant influence over the actions of K&D for the equipment leases.

A&M Leasing

The MTS also arranged leases with A&M Leasing (A&M) that represented related party transactions. The owners of A&M leased space and equipment to the Piedmont clinic and; doing business as Rimers Leasing, leased space to M Therapy.

In 1993, the former owners separately, or together, owned and operated Properties LTD. (PL) and McClure-Kimball Leasing (MKL). In February 1993, PL leased office space in a shopping center at \$500 per month, to be used for the Piedmont clinic. The PL then sublet the space to A&M for \$600 per month, who in turn leased the space to the clinic for \$3,500 per month.

We were informed that A&M's role was to renovate and equip the space making it suitable for the clinic. The A&M informed us that this cost \$105,000 and was part of the basis for the amount of the lease payments made by the clinic. We learned that A&M had little control over this arrangement or little real ownership or equity in the space or equipment.

We were told that MKL was responsible for the renovations and they purchased the furnishings and equipment for the clinic. The MKL then sold these leasehold assets to A&M for \$105,000. The A&M actually signed a promissory note with MKL for the \$105,000, in essence, MKL held common equity with A&M. Moreover, while we were

on site in December 1996, A&M informed us that the clinic had not paid them in over 4 months. Consequently, A&M had not made any payments to MKL, and MKL had not pressured them for the payments. The MTS owners provided the financing and exercised the control to arrange this lease, making A&M a related party.

As a result of this relationship, the providers claimed \$16,566 in excess of actual costs incurred. The \$16,566 includes \$12,000 claimed by M Therapy and \$4,566 claimed by the Piedmont clinic. The \$12,000 represents an adjusting journal entry posted to M Therapy's books to accrue lease payments due to Rimers Leasing. We determined that Rimers had recovered its costs prior to FY 1995, therefore none of the \$12,000 is considered allowable. The \$4,566 represents payments to A&M in excess of costs incurred to renovate and equip the Piedmont clinic.

NON-MEDICARE COSTS

The cost report for M Therapy included costs of \$45,847 for a non-Medicare company with common ownership. The non-Medicare company, ORA, was co-located with the M Therapy clinic. The records of both companies indicated that M Therapy (Medicare provider) absorbed most of the local administrative and operating expenses. We determined that office expenses totaling \$183,402 benefitted both M Therapy and ORA. We allocated 25 percent of these costs (\$45,847) to ORA based on number of staff and space. This \$45,847 was added to the ORA cost total used to allocate home office costs between the clinics and ORA.

BAD DEBT COSTS

The providers claimed Medicare reimbursement for unallowable bad debts totaling \$14,821. The bad debts included accounts that had been collected and accounts that could have been billed to third party payers such as Medicaid and a private insurance company.

- ▶ The Cedartown clinic cost report included \$8,336 for bad debt expenses that had been collected and \$2,330 that could have been billed to Medicaid but was not.

- ▶ Piedmont Medical Therapy included \$2,648 for one beneficiary that had a secondary insurance policy that had already paid on two claims. The clinic also claimed \$1,507 that had been collected.

Bad debts are amounts considered to be uncollectible from accounts receivable which were created in providing services. Criteria found in Section 413.80 of the Medicare regulations, and Part I, paragraphs 308 and 310 of the Provider Reimbursement Manual specify that in order for the provider to claim bad debts, the provider must make reasonable collection efforts and the debt must actually be uncollectible at the time it is

claimed as a bad debt. Moreover, this criteria also requires the provider to exercise sound business judgement when determining there was no likelihood of recovering the debt in the future. As shown in our review, the providers did not meet this criteria when determining the collectibility of the debt. Consequently, these claims are unallowable.

UNNECESSARY COSTS AND CLERICAL ERRORS

The cost reports included costs of \$58,911 that were unnecessary or claimed due to clerical error.

- ▶ The Cedartown cost report failed to include an expense account for employee fringe benefits (paid days off) that had a \$25,351 credit balance. Reported expenses should have been offset by this credit balance to determine the net expense balance. The cost report also included \$3,875 for repair and maintenance costs that was a duplicate claim. The costs were also claimed by the home office.
- ▶ The M Therapy cost report included \$9,872 for office lease costs which we considered duplicative of costs already incurred. The \$9,872 was for office space in Norcross, Georgia which housed another clinic of the owner. The owner closed the Norcross clinic in December 1994 when he purchased the MTS group. The owner explained that he had planned to move the MTS home office to this location but he later abandoned these plans. Since the home office functioned adequately in its current location, the Norcross location offered no benefit to the MTS operations. Thus, we consider the \$9,872 an unreasonable and unnecessary expense.
- ▶ The Piedmont clinic cost report included \$19,813 for the salary of an administrator who had resigned. The payments were ostensibly for the old administrator to train the new administrator. The payments covered 6 months; we allowed as reasonable 1 month to train the new administrator.

In order for claimed cost to be allowable, they must be reasonable and related to patient care. Part I, Section 2102.1 of the Provider Reimbursement Manual, and paragraph 413.9 of the Medicare regulations provide explicit criteria for determining the allowability of these costs. Paragraph 2102.1 states that in order for cost to be reasonable, the provider must seek to "minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service."

Paragraph 2103 further states the "prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he also seeks to economize by minimizing costs." Our audit showed the \$58,911 of claimed cost did not meet this criteria and was therefore unallowable.

**CONCLUSIONS AND
RECOMMENDATIONS**

The management of the administrative affairs of this chain of providers needs to be improved. We have discussed several possible improvements with the auditee regarding the accounting and record keeping functions. The owner was receptive to the suggested improvements.

We recommend HCFA instruct the appropriate intermediary to implement the adjustments for the unallowable amounts discussed above to each cost report.

RESPONSE

On August 1, 1997, the Regional Administrator, HCFA Region IV, responded to a draft copy of this report. The Administrator stated that HCFA concurs with the findings and will instruct the intermediaries involved to implement the adjustments to the cost reports for the unallowable amounts identified during the review.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG Office of Audit Services reports are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemption in the Act which the Department chooses to exercise. (See 45 CFR Part 5)


Charles J. Curtis

Attachment