# Memorandum

Date JUN 28 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of Rehability Health Services, Incorporated's Medicare Cost Report for the Outpatient Rehabilitation Facility Program in Texas for the Fiscal Year Ended September 30, 1998 (A-06-00-00051)

To Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

This memorandum is to alert you to the issuance on Friday, June 29, 2001, of our final report "Review of Rehability Health Services, Incorporated's Medicare Cost Report for Outpatient Rehabilitation Facility Program in Texas for the Fiscal Year Ended September 30, 1998." A copy of the report is attached. The objective of this audit was to determine whether selected costs in Rehability Health Services' (RHS) Fiscal Year (FY) 1998 Medicare cost report for its outpatient rehabilitation facility (ORF) operations in Texas (Rehability Center-Texas) met Medicare reimbursement requirements. For FY 1998, RHS reported Medicare costs of $6.9 million and received $5.5 million from the Medicare program for billed services provided in Texas. After yearend, RHS submitted the Medicare cost report showing $28.6 million of expenses allocated to all its rehabilitation activities including rehabilitation services provided to Medicare beneficiaries.

Based on our review of RHS' Medicare cost report, we questioned or determined to be unallowable $18.4 million of the $28.6 million of allocable expenses reported by RHS. The RHS did not provide documentation to support the costs claimed in its FY 1998 cost report, and certain clinic extension sites were not Medicare certified to provide ORF services to Medicare beneficiaries. Payroll expenses were questioned because salary and bonus expenses were not reconcilable to, or supported by, payroll registers, and documentation was not provided to support allocated expenses. Non-payroll expenses were unallowable because documentation was not provided, or costs were not supported, necessary, or patient related. The expenses for 7 of 25 RHS free-standing clinic extension sites were unallowable because the sites were not certified to provide services to Medicare beneficiaries. As a result, the RHS' Medicare cost report for FY 1998 was overstated by $18.4 million, which resulted in a material portion of the $5.5 million in Medicare payments to RHS not being reimbursable. We recommended that the parent company, Mariner Post-Acute Network (MPAN), which retained responsibility for RHS' Medicare liabilities, repay the

Federal Government for overpayments resulting from the questioned and unallowable costs. We will provide the results of our review to Mutual of Omaha Insurance Company, the fiscal intermediary, so that it can apply the appropriate adjustment during the settlement of RHS' Rehability Center-Texas Medicare cost report for FY 1998 and make a final determination on the amount of the $5.5 million which should be recovered.

Since the assets of RHS, a subsidiary of MPAN, were sold exclusive of Medicare accounts receivable, provider numbers, and liabilities; and RHS operations terminated effective July 1999, MPAN is responsible for RHS' Medicare liabilities. In its March 5, 2001 response to our draft report, MPAN stated it strongly disagreed with the Office of Inspector General (OIG) report findings.

The MPAN stated that OIG did not support final documentation to the costs being audited, and MPAN believed the difficulty in auditing caused OIG to conclude the data was unauditable. The MPAN indicated it believed that treating payroll expenses of more than $17 million as unallowable was an inappropriate remedy in light of the difficulties OIG encountered in accessing payroll data from RHS' accounting system. The MPAN noted that the audit was attempted during and after RHS' operations were shut down, and requested an additional opportunity to respond with documentation necessary to support the services.

As stated in the report, OIG questioned the allowability of Rehability Center-Texas' costs primarily because RHS and MPAN did not provide the documentation requested to support its expenses at any time during or subsequent to the audit. Although the home office's accounting system was complex, it did not allow for an individual provider's payroll register to be reconciled with the individual provider's general ledger. To compensate for the design of this accounting system, OIG used alternate methods to determine the allowability of payroll expenses allocated to Rehability Center-Texas. In addition, MPAN did not address the other conditions noted in our report. Therefore, we continue to believe that our findings and recommendations are valid, and in accordance with Medicare rules and regulations. The basis for our position is further discussed on page 8 of the attached report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414.

Attachment

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REVIEW OF REHABILITY HEALTH SERVICES, INCORPORATED'S MEDICARE COST REPORT FOR THE OUTPATIENT REHABILITATION FACILITY PROGRAM IN TEXAS FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 1998


JUNE 2001
A-06-00-00051

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

Common Identification Number: A-06-00-00051

Mr. Chris Winkle
Chairman, President and Chief Executive Officer
Mariner Post-Acute Network
One Ravina Drive, Suite 1500
Atlanta, Georgia 30346

Dear Mr. Winkle:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Rehability Health Services, Incorporated's Medicare Cost Report for the Outpatient Rehabilitation Facility Program in Texas for the Fiscal Year Ended September 30, 1998." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary. Final determination 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 (Public Law 90-23), 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.)

To facilitate identification, please refer to Common Identification Number A-06-00-00051 in all correspondence relating to this report.

Sincerely yours,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

James R. Farris, MD
Regional Administrator
Centers for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

## EXECUTIVE SUMMARY

### Background

The Medicare program reimburses outpatient rehabilitation facilities (ORF) for the lesser of reasonable costs or customary charges associated with providing outpatient rehabilitation services (physical therapy, occupational therapy, and speech pathology services). All payments to providers of services must be: (1) based on the reasonable cost of services covered under Medicare; and (2) related to the care of beneficiaries. Providers must maintain sufficient financial and statistical records for proper determination of costs payable under the program. Claims are submitted for services rendered and are reimbursed on an interim basis, based on submitted charges. At yearend, the ORF submits a cost report to the Medicare fiscal intermediary (FI) for final settlement.

Section 1861 of the Social Security Act (Act) includes a provision that the outpatient therapy services may be rendered at a facility (such as an ORF), a physical therapist's office, or an individual's home. Although there is no requirement that services be rendered on the ORF premises, providers must maintain a centralized location with adequate space, equipment, and staff to treat patients.

Medicare guidelines provide that services may be provided from multiple locations that the provider controls. This includes free-standing clinics operating from buildings or space that is owned or rented by the provider. The guidelines require providers to report the proposed addition of new extension locations or other sites, and State surveys are required for each outpatient physical therapy (OPT) primary site and for each OPT extension location where services are provided.

Rehability Health Services, Incorporated (RHS) operated numerous rehabilitation agencies throughout the nation, including one in Texas, during the Fiscal Year (FY) ended September 30, 1998. Effective July 1999, the assets of RHS, a subsidiary of Mariner Post-Acute Network (MPAN), were sold by MPAN, exclusive of Medicare accounts receivable, provider numbers, and liabilities, and RHS' operations were terminated nationwide. Thus, MPAN retained responsibility for Medicare liabilities. On January 18, 2000, MPAN and its affiliates (which included RHS) filed for Chapter 11 Bankruptcy.

### Objective

The objective of this audit was to determine whether selected costs in RHS' FY 1998 Medicare cost report for its ORF operations in Texas (Rehability Center-Texas) met Medicare reimbursement requirements.

For FY 1998, RHS reported Medicare costs of $6.9 million and received $5.5 million from the Medicare program for billed services provided in Texas. After yearend, RHS submitted its Rehability Center-Texas Medicare cost report for final settlement. The cost report included allocable expenses of $28.6 million.

**Summary of Findings**

Of the $28.6 million of allocable expenses reported in RHS' FY 1998 Medicare cost report, $18.4 million were questioned or unallowable primarily because RHS did not provide documentation to support the costs claimed in its FY 1998 cost report, and certain clinic extension sites were not Medicare certified to provide ORF services to Medicare beneficiaries.

We found:

- Payroll expenses of $17,200,680 were questioned because salary and bonus expenses were not reconcilable to, or supported by, payroll registers. The ledger was not reconcilable to the payroll registers because the payroll registers did not accurately reflect payments by RHS to its employees, and requested documentation was not provided to support expenses and allocations made to the RHS ledger. This included selected salary expenses tested totaling $689,572, which were unallowable because documentation was not provided to support the expenses, of which $150,475 also appeared to represent marketing activities that were not patient related. It was also noted that salary expenses for leave taken by staff shared with other companies were not allocated consistent with the salary allocation to each company.

- Non-payroll expenses totaling $574,027 were unallowable because: (1) documentation was not provided or did not support expenses; (2) expenses were in excess of supported amounts or were not incurred in FY 1998; or (3) expenses were not necessary and reasonable, patient related, or paid.

- Payroll and non-payroll expenses of $1,679,144 relating to 7 of 25 of RHS' free-standing ORF clinic extension sites were unallowable because the sites were not certified to provide services to Medicare beneficiaries. This amount includes $1,059,386, which was also questioned or unallowable as part of the other conditions discussed above and $619,758, which was unallowable solely for this condition.

As a result, RHS' cost report was overstated by $18.4 million, which resulted in a material portion of the $5.5 million in Medicare payments to RHS not being reimbursable. This occurred because RHS did not properly account for payments made to employees in its payroll registers, submit requested documentation, and/or submit applications to the Centers for Medicare and Medicaid Services (CMS)[1] or to the State survey agency for Medicare certification of all of its added free-standing ORF clinic extension sites.

[1] Formerly known as the Health Care Financing Administration (HCFA)

**Recommendation**

We recommended that MPAN, which retained responsibility for RHS' Medicare liabilities, repay the Federal Government for overpayments resulting from the questioned and unallowable allocable expenses. We will provide the FI, Mutual of Omaha, with the details of the $18.4 million claimed in questioned and unallowable expenses so it can apply the appropriate adjustments to RHS' Rehability Center-Texas FY 1998 Medicare cost report**,** recompute the costs of provider services, and determine the overpayment amount for final settlement of the cost report.

We did not recommend improvements in internal controls because RHS is no longer in operation and is no longer a provider in the Medicare program.

The MPAN strongly disagreed with the report's findings. It stated that OIG did not find documentation to support the costs being audited, and MPAN believed the difficulty in auditing caused OIG to conclude the data was unauditable. The MPAN indicated it believed that treating payroll expenses of more than $17 million as unallowable was an inappropriate remedy in light of the difficulties OIG encountered in accessing payroll data from RHS' accounting system. The MPAN noted that the audit was attempted during and after the Rehability operations were shut down, and requested an additional opportunity to respond with documentation necessary to support the services.

As stated in the report, OIG questioned or determined Rehability Center-Texas' costs were unallowable primarily because RHS and MPAN did not provide the documentation requested to support its expenses at any time during or subsequent to the audit. Although the home office's accounting system was complex, it did not allow for an individual provider's payroll register to be reconciled with the individual provider's general ledger. To compensate for the design of this accounting system, OIG used alternate methods to determine the allowability of payroll expenses allocated to Rehability Center-Texas. In addition, MPAN did not address the other conditions noted in our report. Therefore, we continue to believe that our findings and recommendations are valid. The MPAN's comments are included as Appendix A to this report.

## TABLE OF CONTENTS


INTRODUCTION ..... 1

BACKGROUND ..... 1
Certification Requirements for Extension Locations ..... 1
Medicare Reimbursement Requirements ..... 2
Rehability Health Services' Organization and Operations in Texas ..... 2

OBJECTIVE, SCOPE, AND METHODOLOGY ..... 3
Objective ..... 3
Scope and Methodology ..... 3

FINDINGS AND RECOMMENDATIONS ..... 5

Payroll Expenses and Supporting Documentation ..... 5
Non-Payroll Expenses ..... 7
Extension Locations ..... 7

CONCLUSION ..... 7

RECOMMENDATION ..... 8

MPAN COMMENTS AND OIG RESPONSE ..... 8

MPAN Comments ..... 8
OIG Response ..... 8

APPENDIX A
Auditee's Comments

# INTRODUCTION

## BACKGROUND

The Medicare program, established by Title XVIII of the Act, provides health insurance coverage to people age 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by CMS.

Section 1861(p) of the Act defines outpatient physical therapy services as "...physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency...to an individual as an outpatient." A rehabilitation agency is defined in section 120 of the CMS Outpatient Physical Therapy, Comprehensive Outpatient Rehabilitation Facility, and Community Mental Health Center Manual (the Manual) as a provider of outpatient physical therapy, occupational therapy, and/or speech pathology services. In recent years, the term "rehabilitation agency" has become synonymous with "outpatient rehabilitation facility" or ORF in the Medicare provider community.

### Certification Requirements for Extension Locations

Section 1861 of the Act includes a provision that the outpatient therapy services may be rendered at a facility (such as an ORF), a physical therapist's office, or an individual's home. Section 2298 of the CMS State Operations Manual states that OPT or outpatient speech pathology (OSP) providers may provide services from multiple locations that it controls. This includes free-standing clinics operating from buildings or space that are owned or rented by the provider. Section 2300 states that providers are required to report the proposed addition of a new extension location or other site. Section 2302 states that a survey is required for each OPT primary site, for each of the (multiple) locations controlled by the OPT provider and for each OPT extension location where services are provided (i.e., such as at nursing homes). A separate State survey report is completed for each surveyed OPT location in addition to the primary location. Failure to correct deficiencies noted as a result of a survey at any location will jeopardize the certification of the OPT provider in its entirety.

To add a clinic extension location, the Texas State survey agency required providers to submit an application consisting of three documents. One of these documents is form CMS-1856, Request for Certification in the Medicare and/or Medicaid Program to provide OPT and/or OSP services. The CMS officials informed us that added clinic extension locations for which Medicare certification applications had not been submitted and approved were not Medicare certified sites and costs associated with these sites were not reimbursable under the Medicare program.

## Medicare Reimbursement Requirements

The Medicare program reimburses ORFs for the lesser of reasonable costs or customary charges associated with providing outpatient physical therapy, occupational therapy, and speech pathology services. The regulations at 42 CFR 413 require that all payments to providers of services must be: (1) based on the reasonable cost of services covered under Medicare; and (2) related to the care of beneficiaries. This includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and costs. The provision for payment of reasonable cost of services is intended to meet the actual costs except in instances where they are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

The 42 CFR 413.24 states that providers receiving payment must provide adequate cost data. This must be based on their financial and statistical records, which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. Claims are submitted for services rendered and are reimbursed on an interim basis, based on submitted charges. After yearend, the ORF submits a cost report to the Medicare FI for final settlement.

Adequate cost information must be available in the provider's records to support the payments made for services furnished to beneficiaries. The Medicare guidelines and policies implementing this regulation are set forth in the CMS Provider Reimbursement Manual (PRM) 15-1. Section 2304 states that cost information must be current, accurate, and sufficient in detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records, and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, basis for apportioning costs, (etc.), which pertain to the determination of reasonable cost, capable of being audited. Section 2305 states that a short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. Section 2136.2 states that costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable.

## Rehability Health Services' Organization and Operations in Texas

The RHS Rehability Center-Texas operated under the same Medicare provider number since 1982; operated multiple extension sites throughout Texas; and was part of a large multi-level national chain organization. During FY 1998, Rehability Center-Texas' principal place of business was in Austin, Texas. It operated its primary ORF clinic in Austin, and had at least

25 free-standing ORF clinics located throughout Texas. Costs were also reported for Medicare patients served at more than 50 nursing homes and in the homes of patients that received services through approximately 12 home health agencies with which RHS conducted business.

The RHS was the wholly owned subsidiary of American Management Services, Inc., which was the wholly owned subsidiary of American Rehability Services, Inc. (ARS), the home office, which is a wholly owned subsidiary of MPAN. During the past few years, RHS had been involved in numerous corporate mergers and reorganizations. During FY 1998, RHS and its related owners' corporations went through multiple mergers, with the last merger in July 1998, making it a subsidiary of the newly formed parent corporation, MPAN.

During April 1999, MPAN officials signed an agreement with HealthSouth to sell RHS' assets, exclusive of Medicare accounts receivable, provider numbers, and liabilities, as well as the assets of 25 other Medicare ORF providers operating clinics in 18 States across the nation. Thus, MPAN retained responsibility for Medicare liabilities. The sale was closed on about June 30, 1999. Effective July 1, 1999, RHS voluntarily withdrew from participation in the Medicare program. On January 18, 2000, MPAN and its affiliates (which included RHS) filed for Chapter 11 Bankruptcy.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

The objective of this audit was to determine whether selected costs in RHS' FY 1998 Medicare cost report for its ORF operations in its Rehability Center-Texas met Medicare reimbursement requirements.

### Scope and Methodology

For FY 1998, RHS reported Medicare costs of $6,864,568 and received $5,488,556 from the Medicare program for billed services provided in Texas. After yearend, RHS submitted its Rehability Center-Texas Medicare cost report for final settlement. The cost report included allocable expenses of $28,597,777. The cost report also included a claim for reimbursable bad debts of $665,655. The allocable expenses were reconciled to RHS' working trial balance and general ledger. Our examinations included testing $18,584,883 of the reported allocable expenses, but did not include testing of home office expenses of $3,745,570, included in the allocable expenses, or testing of reimbursable bad debts claimed.

To meet the objectives of this audit, we:

- Examined applicable Medicare laws, regulations, policies, and guidelines;

- Interviewed FI auditors regarding prior years' audit findings for RHS's Medicare home office cost statement and Rehability Center-Texas cost reports;

- Reviewed RHS' Rehability Center-Texas FY 1998 cost report and reconciled cost report expenses to its working trial balance and general ledger account analyses (transaction detail reports);

- Attempted to reconcile RHS' Rehability Center-Texas (1) FY 1998 general ledger salary and bonus (payroll) accounts, totaling $17,200,680, to its payroll registers in total for the year, and (2) February 1998 general ledger payroll account transactions, net of accruals, totaling $1,398,967, to February 1998 payroll registers;

- Tested support for selected payroll transactions for payroll accounts and personnel who received salaries and bonuses totaling $689,572[1] during FY 1998;

- Reviewed $781,324 in non-payroll expenses (judgmentally selected) for accounts including facility rent, rent-nursing home, recruiting, advertising, automotive, employee welfare, contract services-therapist, contract services-other, contract services-medical director fee, supplies sold, property tax, audit and general accounting, and miscellaneous expense accounts which were tested for allowability in accordance with Medicare regulations and guidelines at 42 CFR 413 and PRM 15-1;

- Reviewed an additional $602,879 in non-payroll expenses associated with sites located in Texas that were not Medicare certified, and which were not duplicated in our review of $781,324 above; and

- Interviewed survey and certification officials from the CMS regional office in Dallas, Texas and Texas Department of Health (TDH) in Austin, Texas, and reviewed the records they provided to identify RHS extension sites that were Medicare certified.

Our audit did not include on-site verification of the actual activities conducted in RHS' numerous clinic and administrative offices in Texas because RHS was no longer in operation during our audit. For this reason, we did not evaluate the internal control structure for reliance but instead expanded our testing. We also relied on the completeness of RHS' general ledger

[1] Amount includes selected personnel's estimated gross salaries that were compiled by an ARS official.

transaction detail reports which were not reconciled to audited financial statements, but which did match the expenses reported in RHS' Rehability Center-Texas Medicare cost report. Our review was performed in accordance with generally accepted government auditing standards. The examinations of financial records were performed at RHS' administrative home office in Brentwood, Tennessee.

## FINDINGS AND RECOMMENDATIONS

Of the $28,597,777 of allocable expenses reported in RHS' FY 1998 Medicare cost report, $18,394,465 were questioned or unallowable primarily because RHS did not provide documentation to support the costs claimed in its FY 1998 cost report, and certain clinic extension sites were not Medicare certified to provide ORF services to Medicare beneficiaries.

We found:

- Payroll expenses of $17,200,680 were questioned because salary and bonus expenses were not reconcilable to, or supported by, payroll registers. The ledger was not reconcilable to the payroll registers because the payroll registers did not accurately reflect payments by RHS to its employees, and requested documentation was not provided to support expenses and allocations made to RHS' ledger. This included selected salary expenses tested totaling $689,572, which were unallowable because documentation was not provided to support the expenses, of which $150,475 also appeared to represent marketing activities that were not patient related. It was also noted that salary expenses for leave taken by staff shared with other companies were not allocated consistent with the salary allocation to each company.

- Non-payroll expenses totaling $574,027 were unallowable because: (1) documentation was not provided or did not support expenses; (2) expenses were in excess of supported amounts or were not incurred in FY 1998; or (3) expenses were not necessary and reasonable, patient related, or paid.

- Expenses of $1,679,144 relating to 7 of 25 of RHS' free-standing ORF clinic extension sites were unallowable because the sites were not certified to provide services to Medicare beneficiaries. This amount included $1,059,386, which was also questioned or unallowable as part of the other conditions discussed above, and $619,758, which was unallowable solely for this condition.

### Payroll Expenses and Supporting Documentation

The general ledger payroll salary and bonus expenses, totaling $17,200,680, were not reconcilable to RHS' payroll registers because the payroll registers did not accurately reflect

payments by RHS to its employees. The payroll register was: (1) missing persons whose salaries were included in the ledger support detail; and (2) included persons whose salaries were not shown in the ledger support detail. As a result, the payroll registers could not be relied on to test that RHS employees had been paid or to identify all RHS employees.

This discrepancy was further supported by statements made by RHS' home office officials. The RHS' general ledgers and payroll registers were maintained by ARS, its home office. According to ARS officials, ARS maintained payroll registers for other companies who shared some of the same employees with RHS. The salaries for employees were paid from the payroll register of the company where the employees were primarily assigned. Thus, RHS' payroll registers reflected payments to employees primarily assigned to RHS, including some who worked for other companies, and did not include some employees who worked for RHS, if they were primarily assigned to another company.

In further testing $689,572 of the $17,200,680 total payroll expenses, RHS did not provide requested documentation to support the allocation of selected salary and bonus payroll expenses. The requested documentation not provided included therapy logs, employee time sheets, personnel files, position descriptions, and other support for payments. These expenses were tested to determine whether allocations made to RHS' ledger were appropriately allocated to RHS, and supported by payments made to the employees. Thus, without this documentation verification, there was no assurance that: (1) the salary expenses claimed in RHS' cost report were appropriate; and (2) salary expenses of shared staff were not duplicated in the costs of other ARS companies that participated in the Medicare program or for which expenses were passed through in the form of home office expenses.

We also noted that $150,475 of the $689,572 tested appeared to represent marketing expenses that were not patient related, including expenses from two ledger accounts: Salary-Marketing and Salary-Territorial Management, and Bonus-Marketing. According to a former RHS Regional Director of Operations, these accounts included activities aimed at increasing the number of patients referred to RHS. Such activities are not considered to be patient related, and the expenses are not allowable or reimbursable under Medicare.

We also noted that salary expenses for leave were not always allocated to RHS in proportion to the time that the employee spent on activities benefiting RHS. For staff shared with other companies, the allocation of leave was not consistent with the allocation of the salary paid for regular hours worked. Instead, all of an employee's leave was charged to the company the employee was assigned to in the payroll registers. This indicates that salary expenses for leave were not appropriately allocated to RHS.

We concluded that payroll salary and bonus expenses were not: (1) reconcilable to; or (2) supported by payroll registers. In addition, we could not validate that the expenses allocated to RHS' ledgers were allowable because documentation was not provided. Thus, we are questioning the entire payroll salary and bonus expenses for FY 1998 totaling $17,200,680 and identifying as unallowable $689,572 included in the total payroll.

**Non-Payroll Expenses**

Non-payroll expenses totaling $574,027 were not supported or did not meet Medicare reimbursement requirements. These expenses were unallowable because: (1) documentation was not provided or did not support the expenses ($428,134); (2) expenses were in excess of supported amounts or were not incurred in FY 1998 ($75,395); or (3) expenses were not necessary and reasonable ($62,464), patient related ($7,384), or paid ($650).

**Extension Locations**

The examinations of added clinic extension sites showed that 7 of 25 RHS-controlled free-standing ORF clinic sites (extension locations) located in Texas were not Medicare certified to provide ORF services to Medicare beneficiaries. The seven clinics were located in South Austin, Corpus Christi, Dickinson, Houston, Killeen, Lubbock, and Sudan. The State survey agency officials at TDH confirmed that the seven sites were not Medicare certified during or prior to FY 1998. The general ledger expenses associated with the seven clinics, totaling $1,679,144 for FY 1998, were unallowable. This amount included $1,059,386, which was also questioned or unallowable as part of the other conditions discussed above, and $619,758, which was unallowable solely for this condition.

**CONCLUSION**

Medicare regulations and guidelines require that auditees maintain and provide adequate documentation to support expenses, and that costs claimed for reimbursement be reasonable and necessary in furnishing services to patients, patient related, and paid. Medicare guidelines in the CMS State Operations Manual require providers to report the proposed addition of new extension locations or other sites. The TDH and CMS require the submission of Medicare certification applications, reviewed by the State survey agency. Officials of CMS informed us that added clinic extension locations for which a certification application had not been submitted and approved, were not Medicare certified sites of RHS, and costs associated with these sites were not reimbursable under the Medicare program.

The above conditions resulted in RHS' FY 1998 Medicare cost report being overstated by $18,394,465 and a material portion of the $5,488,556 in Medicare payments made to RHS not being reimbursable. This occurred because RHS and the home office did not: (1) maintain RHS payroll registers reflecting payments made only to RHS' employees; (2) submit requested supporting documentation; and/or (3) submit applications to the Texas State survey agency prior to or during FY 1998 for Medicare certification of all its free-standing ORF clinic extension sites operating in FY 1998.

Since the assets of RHS, a subsidiary of MPAN, were sold, exclusive of Medicare accounts receivable, provider numbers, and liabilities, and its operations terminated effective July 1999, MPAN is responsible for any liabilities.

## RECOMMENDATION

We recommended that MPAN, which retained responsibility for RHS' Medicare liabilities, repay the Federal Government for overpayments resulting from the questioned and unallowable allocable expenses. We have provided the FI with the details of the $18,394,465 claimed in questioned and unallowable allocable expenses so it can apply the appropriate adjustments to RHS' Rehability Center-Texas 1998 Medicare cost report, recompute the costs of provider services based on the adjusted expenses, and determine the overpayment amount during the final settlement of the cost report.

We did not recommend improvements in internal controls because RHS is no longer in operation and is terminated from the Medicare program.

## MPAN COMMENTS AND OIG RESPONSE

### MPAN Comments

The MPAN strongly disagreed with the report's findings. The MPAN's response stated that OIG's report concluded that the costs claimed were significantly overstated because OIG did not find documentation to support the costs being audited. The MPAN stated that the accounting system was designed to separately track the salary of personnel who provided services in multiple locations. The MPAN believed it was the difficulty in auditing the system that caused OIG to conclude the data was not auditable. The MPAN indicated it believed that treating payroll expenses of more than $17 million as unallowable was an inappropriate remedy in light of the difficulties OIG encountered in accessing payroll data from RHS' accounting system.

The MPAN also noted that the audit was attempted during and after the RHS' operations were shut down, and requested an additional opportunity to respond with documentation necessary to support the services.

### OIG Response

As stated in the report, OIG questioned or determined Rehability Center-Texas' costs were unallowable primarily because RHS and MPAN did not provide requested support for expenses during or subsequent to the audit. Providers are required, by the regulations at 42 CFR 413, to provide adequate cost data that is based on an approved method of cost finding. With regard to payroll, the accounting system used by RHS' home office, although complex, did not allow for an individual provider's payroll register to be reconciled with the individual provider's general ledger that was maintained by the home office. As cited in the report, home office officials

stated that they maintained payroll registers for other companies, shared employees among companies, and each employee's salary was paid from the payroll register of the company where an employee was primarily assigned. To compensate for the design of this accounting system, OIG used alternate methods to validate the appropriateness of payroll expenses allocated to Rehability Center-Texas. In doing so, individual-specific timesheets, personnel records, and other supporting documentation were requested during the audit, and while the home office was still in operation. However, MPAN did not provide those records at any time during or subsequent to the completion of the audit. Thus, all payroll costs remain unsupported.

We also note that MPAN chose not to respond to additional findings in our report. These findings related to unallowable salary expenses ($689,572), non-payroll expenses ($574,027), and costs relating to clinic extension sites that were not Medicare certified to provide ORF services to Medicare beneficiaries ($1,679,144). Due to MPAN's nonresponsiveness, all conditions and recommendations in the report remain unchanged.

This final report includes our findings and recommendations as well as MPAN's comments. In accordance with OIG policy, the final report is made available to the public through our Internet site. The statutory or regulatory support for publishing a report on the Internet is the Electronic Freedom of Information Act Amendments of 1996 [Public Law 104-231].


***Gary W. Reicherzer***
***Vice President of Reimbursement***

March 5, 2001

Mr. Donald L. Dille
Regional Inspector General
Office of Audit Services
Department of Health & Human Services
1100 Commerce, Room 6B6
Dallas, Texas 75242

**RE: CIN A-06-00-00051**

Dear Mr. Dille:

We have reviewed the draft audit report on the Department's Review of Rehability Health Services, Inc's ("Rehability's") Medicare Cost Report for Outpatient Rehabilitation Facility Program in Texas for Fiscal Year 1998. We strongly disagree with its findings regarding service costs that were claimed by the provider on its Medicare Cost Report.

The report concludes that a significant part of the costs claimed in the cost report were significantly overstated, primarily because the Department could not support them by audit. According to the report, some supporting salary documentation was unavailable.

In July 1999 the assets of Rehability Health Services were sold by the parent company, Mariner Post-Acute Network ("Mariner"), and the operations were terminated. Within a few months after the sale and termination of operations, support services personnel for these operations were terminated as well. It was during and after this shut-down period that the Department attempted to audit the cost report.

Rehability operated Rehabilitation Programs across the nation and had a complex system to record and account for salaries and other expenses. As noted in the Department's draft report, Rehability provided services from multiple locations within the state, including services to nursing facilities on under arrangement and under assignment contracts as well as in freestanding clinics. The accounting system was designed to separately track the salaries of personnel who provided services in multiple locations. We believe that it was the difficulty in auditing this system that caused the Department to conclude that the data was not auditable and, therefore, not allowable. The result was a disallowance of all payroll expenses, more than $17 million.

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The services claimed by Rehability on its cost reports were provided in good faith to Medicare beneficiaries. A disallowance of all payroll expenses is an inappropriate remedy in light of the difficulties encountered by the audit team in accessing payroll data from the Rehability accounting system. As the Department is aware, Mariner filed for bankruptcy in January of 2000. One of Mariner's priorities in the bankruptcy has been the cessation and divestiture of non-performing assets, such as Rehability, so that Mariner can continue to exist as an on-going concern and thereby provide quality care to Medicare beneficiaries and other patients in post-acute facilities.

While the Company has an obligation to respond to audits, the extenuating circumstances in this instance suggest that the Company should be granted an additional opportunity to respond with whatever documentation is necessary to support these significant services. Please contact me directly if I can be of assistance in this regard.

Very truly yours,

MARINER POST-ACUTE NETWORK

Gary W. Reieherzer
Vice President of Reimbursement

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