Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

BEVERLY MANOR OF MARGATE, A SKILLED NURSING FACILITY, BILLINGS FOR ANCILLARY MEDICAL SUPPLIES FOR THE PERIOD JANUARY 1, 1993 THROUGH DECEMBER 31, 1994

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS operating divisions.

JUNE GIBBS BROWN
Inspector General

JULY 1997
A-09-96-00090

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

CIN: A-09-96-00090

JUL 2 9 1997

MS. Jacqueline Anderson
General Manager
Medicare Program
Blue Cross of California
P.O. Box 9140
Oxnard, California 93031-9140

Dear Ms. Anderson:

This report provides you with the results of an Office of Inspector General (OIG) audit of Beverly Manor of Margate's (Beverly Manor) billings to Medicare for ancillary medical supplies and its associated costs as claimed on its Medicare cost reports for calendar years ended (CYE) December 31, 1993 and December 31, 1994. Beverly Manor is one of over 600 skilled nursing facilities (SNFs) in a national chain.

During this 2-year period, Beverly Manor billed Medicare about $158,000 for items identified as ancillary medical supplies (i.e., medical supplies not included in the patient's daily routine care) and $373,000 for items identified as ancillary pharmacy supplies. It claimed costs of about $151,000 for ancillary medical supplies and about $267,000 for the ancillary pharmacy supplies.

The objective of our review was to determine if unallowable charges had been billed to Medicare and if inappropriate costs had been claimed on the cost reports for ancillary medical supplies.

According to Medicare reimbursement rules, items and services that can be considered ancillary are limited to only those supplies and services that are directly identifiable to an individual patient, furnished at the direction of a physician because of special medical needs, and are either not reusable, represent **a** cost for each preparation, or are complex medical equipment.

Our review showed that Beverly Manor generally complied with Medicare's rules relating to the treatment of medical supplies as ancillary or routine, both as Medicare billings and as costs claimed on the cost reports. The percentages of errors we noted in our judgmental samples were very small.

However, from a review of the current master list used to classify each medical supply item as routine or ancillary, we noted 36 routine medical supply items that were classified as

ancillary (see list on page 8). The 36 items may not include all items on the master list that may be incorrect. According to Beverly Manor's home office, Beverly Health and Rehabilitation Services, Inc. (BH&RS), this master list is used by all facilities in the chain. Therefore, according to BH&RS staff, some incorrect classifications of items as ancillary occurred at all of BH&RS's SNFs to varying degrees.

We recommend that Blue Cross of California, the current fiscal intermediary (FI) for BH&RS, ensure that BH&RS:

- Reviews its master list to identify and correct all of its classifications of ancillary medical supplies that should be treated as routine.

In our draft report, we listed 56 routine items on BH&RS's master list that should not have been classified as ancillary. In its response to our draft report, BH&RS agreed with most of the items but did not agree with the treatment of some of the items. It provided additional material to support its position. After reviewing BH&RS's material and consulting with Blue Cross of California, we reduced the list to 36 items.

Aetna Life Insurance Company (Aetna), the FI for BH&RS during our audit period, did not comment on our draft report in its written response but did confirm during several telephone conversations that it agreed with the final OIG position. Aetna also notified us that it was terminating as a Medicare fee-for-service intermediary. Blue Cross of California has taken over as BH&RS's national intermediary as of June 1997. The BH&RS's and Aetna's responses are attached as appendices.

INTRODUCTION

Background

As part of the Department of Health and Human Services' efforts to combat fraud, waste, and abuse, the OIG, in partnership with the Health Care Financing Administration (HCFA) and the Administration on Aging, undertook an initiative called Operation Restore Trust. This project was designed to specifically target Medicare and Medicaid abuse and misuse in nursing home care, home health care, and durable medical equipment, three of the fastest growing areas in Medicare.

The OIG's audit of the Beverly Manor SNF was one of several conducted in a national review of ancillary medical supplies. States included in this review were California, Florida, Illinois, New York, and Texas. As part of this national review, we identified those SNFs with significantly higher medical supply costs than comparable SNFs.

We selected Beverly Manor for this review because, even though its medical supply costs were not excessive when compared with other SNFs of similar size in Florida, its pharmacy charges were greater than those at other comparable Florida SNFs.

Beverly Manor, located in Margate, Florida, is one of about 600 facilities in a chain of nursing homes owned by BH&RS. The BH&RS, which is headquartered in Fort Smith, Arkansas, prepared the cost reports and provided other financial and accounting services for Beverly Manor and other nursing homes in the chain. The BH&RS is one of several health care related subsidiaries of Beverly Enterprises, a New York Stock Exchange listed company. One of Beverly Manor's sources of pharmacy supplies and services, Pharmacy Corporation of America, was also a subsidiary of Beverly Enterprises.

Medicare generally reimburses SNFs on a reasonable cost basis as determined under principles established in the law and regulations. In order to determine their reasonable costs, providers are required to submit cost reports annually, with the reporting period based on the provider's fiscal accounting year. The SNFs are paid on an interim basis (based upon their billings to Medicare), and the cost report is used to arrive at a final settlement amount. Costs are classified on the cost report as either routine or ancillary.

Routine services are generally those services included by the provider in a daily service--sometimes referred to as the "room and board" charge. Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of certain equipment and facilities for which a separate charge is not customarily made.

According to Medicare rules, ". . . the following types of items and services. . . are always considered routine in an SNF for purposes of Medicare cost apportionment, even if customarily considered ancillary by an SNF:

"0 All general nursing services, including administration of oxygen and related medications. . . handfeeding, incontinency care, tray service, enemas, etc.

"o Items which are furnished routinely and relatively uniformly to all patients, e.g., patient gowns, paper tissues, water pitchers, basins, bed pans, deodorants, mouthwashes.

"0 Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities, e.g., alcohol, applicators, cotton balls, bandaids, antacid, aspirin,

(and other nonlegend drugs ordinarily kept on hand), suppositories, tongue depressors.

"0 Items which are utilized by individual patients but which are reusable and expected to be available in an institution providing an SNF level of care, e.g., ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, other durable medical equipment (DME) which does not meet the criteria for ancillary services in SNFs under §2203.2, and the requirements for recognition of ancillary charges under §2203....

"0 Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician...." (Provider Reimbursement Manual, section 2203.1)

Ancillary services are those services directly identifiable to individual patients, such as laboratory, radiology, drugs, medical supplies, and therapies. Section 2203.2 of the Provider Reimbursement Manual, effective during our audit period,' specified that certain items and services could be considered ancillary if they met each of the following three requirements:

"0 direct identifiable services to individual patients, and

"0 furnished at the direction of a physician because of specific medical needs, and

"0 one of the following:

- Not reusable - e.g., artificial limbs and organs, braces, intravenous fluids or solutions, oxygen (including medications), disposable catheters;

- Represent a cost for each preparation, e.g., catheters and related equipment, colostomy bags, drainage equipment, trays and tubing; or

- Complex medical equipment - e.g., ventilators, intermittent positive pressure

---

1 This section was revised effective March 1995. The phrase "furnished at the direction of a physician because of specific medical needs" (see above) was replaced by "not generally furnished to most patients." In addition, "support surfaces" was added as another option for the third requirement.

> breathing (IPPB) machines, nebulizers, suction pumps, continuous positive airway pressure (CPAP) devices, and bead beds such as air fluidized beds."

Medicare pays its portion of a provider's reasonable costs based upon an apportionment between program beneficiaries and other patients so that Medicare's share of the costs is based on services received by Medicare beneficiaries. For routine costs, Medicare's share is determined on the basis of a ratio of Medicare patient days to total patient days. For ancillary costs, Medicare's share is determined on the basis of the ratio of total covered beneficiary charges for ancillary services to total patient charges for such services.

Classifying costs as ancillary rather than as routine can result in higher Medicare reimbursement to SNFs because of two factors. First, SNFs generally have higher Medicare utilization for ancillary services than for routine services. That is, Medicare eligible patients generally receive more ancillary services than other patients but comprise a smaller portion of the total number of patients. Thus, Medicare's share of ancillary costs is usually greater than its share of routine costs. Second, Federal law (specifically, section 1888 of the Social Security Act) limits Medicare reimbursement for SNFs' routine costs to 112 percent of the mean operating costs of other similar SNFs. Thus, Medicare does not share in routine costs exceeding the Federal limit, unless the provider applies for and receives an exception or exemption from HCFA.

The HCFA administers the Medicare program and designates certain fiscal intermediaries to perform various functions, such as processing Medicare claims, performing audits, and providing consultative services to assist SNFs as providers. Aetna served as the fiscal intermediary for Beverly Manor during the 2-year period of our audit. As of June 1, 1997, Blue Cross of California has replaced Aetna as the Medicare intermediary.

Objective, Scope **and Methodology**

Our objective was to determine if unallowable charges had been billed to Medicare and if inappropriate costs had been claimed on the Medicare cost reports for ancillary medical supplies for the 2-year period ended December 31, 1994.

According to its audited cost reports, Beverly Manor billed Medicare $90,384 for ancillary medical supplies for CYE December 31, 1993 and $67,565 for CYE December 31, 1994 (a total of $157,949). It claimed $88,244 as Medicare costs for these supplies for CYE December 31, 1993 and $63,177 for CYE December 31, 1994 (a total of $151,421). Beverly Manor also billed Medicare $190,140 for ancillary pharmacy items for CYE

December 31, 1993 and $182,600 for CYE December 31, 1994 (a total of $372,740) and claimed $136,358 as costs for these items for CYE December 31, 1993 and $130,239 for CYE December 31, 1994 (a total of $266,597).

To accomplish our objective, we reviewed a judgmental sample of 129 medical supply line items billed to Medicare as ancillary medical supplies (totaling $3,375) and discussed billing procedures with Beverly Manor and BH&RS staff. We also reviewed 278 line items for pharmacy billings (totaling $6,735). To select the billings to review, we chose several Medicare patients and then reviewed all medical supply charges to Medicare for those patients.

In addition, we gained an understanding of Beverly Manor's accounting system, reconciled the amount claimed on the Medicare cost reports for ancillary medical supplies to the accounting records, and examined a judgmental sample of 96 ancillary medical supply line items that were treated as ancillary costs (totaling $19,425). For our judgmental sample of 96 line items; we selected invoices of those vendors that appeared to us to account for the most costs in each account.

Since Beverly Manor classified medical supplies according to the BH&RS master list, we reviewed the current master list to determine if it contained routine items that were classified as ancillary medical supplies chargeable to Medicare.

We relied on the FI's medical review staff to determine whether the sampled items were properly classified as ancillary using Medicare's guidelines. Because our samples were not random, we cannot project the results to the total billings or costs claimed.

Pharmacy Corporation of America supplied most of the pharmacy items to the individual SNFs in the chain and billed the home office directly. Invoices for the pharmacy items were kept at the home office. Accordingly, we did not review the pharmacy costs for Beverly Manor.

Prior to our review, Beverly Manor's cost report for CYE December 31, 1993 was audited by Aetna. In addition, Beverly Manor was part of a group of 50 SNFs selected by the FI for a special review of billing and claiming of costs for ancillary medical supplies. Aetna found that routine items had been inappropriately treated as ancillary medical supplies at Beverly Manor, both as Medicare charges and as costs for CYE December 31, 1993. As a result of those two reviews, the FI reduced the amount charged to Medicare for medical supplies by about 7 percent and the amount claimed by the provider for total medical supply costs by about 5 percent.

Our review was made in accordance with generally accepted government auditing standards. The fieldwork was performed at the Beverly Manor SNF in Margate, Florida during September 1996.

FINDINGS AND RECOMMENDATIONS

We found that Beverly Manor was generally in compliance with Medicare's rules relating to the billing and claiming of costs for ancillary medical supplies. The percentages of errors we noted in our judgmental samples were very small. However, we found that it had misclassified several routine medical supplies as ancillary in its current master list of items chargeable to Medicare.

Specifically, of the 129 line items (totaling $3,375) billed to Medicare as ancillary medical supplies that we examined, we found that all were properly classified. In addition, of the 278 pharmacy line items billed to Medicare that we examined, we found only about 1 percent (3 items) that were actually routine medical supplies and should not have been billed to Medicare. The inappropriate pharmacy billings totaled $42, less than 1 percent of the total amount we examined ($6,735).

Of the 96 line items that we examined that were claimed as costs for ancillary medical supplies (totaling $19,425), we found that 7.4 percent ($1,435) were improperly classified as ancillary. However, most of the inappropriate costs that we noted ($1,106 for newspaper advertisements for prospective medical supply staff and $99 for employee travel costs) were of a nonrecurring nature, did not consist of frequently purchased supplies, and may have been properly allowable, in part, as ancillary costs. The remaining inappropriate costs that we noted ($158 for non-sterile gloves and $72 for incontinent pads) represented only about 1 percent of the costs that we examined.

The entire amount of the recruitment and travel costs was directly charged as ancillary medical supplies. These costs related to the services of a central supply clerk, and only a portion of the costs should have been classified as ancillary medical supplies because only a portion of the central supply clerk's duties is related to ancillary supplies. According to BH&RS staff, these costs were classified as ancillary at the facility level, the home office does not have a policy to classify the entire amount of these types of costs as ancillary, and it was unaware that the entire amounts had been treated as ancillary.

We found that Beverly Manor's current master list for classifying items as ancillary or routine contained several routine medical supplies that were incorrectly classified as ancillary. The

following is a list of 36 routine items appearing on the master list that we identified that were classified as ancillary:

Abdominal Binder/Support
Absorbent Towels
Adjustable Appliance Belt
Amerigel Lotion
Applicators, Cotton Tip
Band-Aids, Various
Banish Liquid Deodorant
Bed Pads
Belt Adaptor
Betadine Swabsticks
Betadine Viscous Pad
Bite Stick, Disposable Plastic
Cairpad Incontinent Cover
Comfort Cushion
Composite Pad, Non-Sterile
Deodorizer, Germicide
Dispos-A-Bag
Enema Bag
Enema Bucket
Epiflex Heel/Elbow Protector
Gauze Bandages, Non-Sterile
Home Thermometer
Isolation Gown
Kerlix Bandages, Non-Sterile
Moisture Barrier Skin Ointment
Montgomery Strap
Positioning Pillow
Protective Barrier Wipes
Pumps, Feeding
Skin Barrier
Skin Cleanser
Skin Gel
Specimen Container
Thermometer
Tongue Depressors
Vinyl Gloves

The classification errors in the master list occurred because BH&RS had not fully updated its master list after the earlier FI medical supply review.

The classifications on the master list were developed by BH&RS and were used by all its SNFs in the chain, according to the billing and accounting staff at BH&RS. Thus, the incorrect classifications of these items probably occurred at varying degrees at the other SNFs in the chain.

Under Medicare's rules (see pages 3 and 4 of this report), items and services furnished routinely to all patients should always be considered as routine. In order to be classified as ancillary, the item or service must be directly identifiable to an individual patient, furnished at the direction of a physician because of special medical needs, and be either not reusable, represent a cost for each preparation, or be complex medical equipment. The items we noted did not meet the specific requirements for treatment as ancillary medical supplies.

Recommendation

We recommend that Blue Cross of California ensure that BH&RS:

- Reviews its master list to identify and correct all of its classifications of ancillary medical supplies that should be treated as routine.

BH&RS's Comments

The BH&RS generally agreed with our audit findings and recommendation. It concurred with our finding that recruitment and travel costs should not have been classified entirely as ancillary medical supplies. It noted that the recruitment costs should have been allocated between the medical supply cost center and the central supply cost center.

Regarding the list of items on its master list that we said should be classified as routine (56 items listed in our draft report), it took exception to the classification of some items and submitted pages from Blue Cross of California's Medicare Bulletin 406 to support its position. The BH&RS also noted that this bulletin provided that a particular item could be billable for one patient and non-billable for another. As an example, BH&RS claimed that an incontinency pad can be ancillary when the pad is specifically designed for and used with a special bed which qualified as ancillary under Medicare rules.

In the final section of its response, BH&RS listed the changes that it is implementing to reduce inaccurate billing or expense coding, such as improved communications with its new FI, a new automated ordering and billing process, and an expanded up-to-date ancillary revenue system.

The BH&RS response to the draft report included 85 pages of exhibits. The exhibits contained our draft report, illustrations of how we traced costs and billings, the Blue Cross of California Medicare Bulletin 406, and other material. The exhibits related primarily to issues that have been resolved. As a result, we have not included the exhibits in our final report.

FI's Comments

Aetna did not comment on our draft report in its written response but did confirm during several telephone conversations that it agreed with the OIG position on several separate issues, including that the recruitment costs for central supply staff should not have been charged entirely to ancillary medical supplies. Aetna said in its response that it was leaving the Medicare fee-for-service program but will continue to work with HCFA and the replacement contractor to resolve any outstanding items. Blue Cross of California has taken over as BH&RS's national intermediary as of June 1997.

OIG's Comments

We evaluated BH&RS's additional material and consulted with both Aetna and Blue Cross of California. As a result, we reduced the number of items from the master list that we classified as routine to 36.

Some of the items that BH&RS referenced on Medicare Bulletin 406 as similar to a medical supply it classified as ancillary, were classified as routine by Blue Cross of California. For example, BH&RS compared an abdominal binder/support to a Montgomery strap. Blue Cross of California classified the Montgomery strap as routine. As a result, we did not remove the abdominal binder/support from our list (see page 8 of this report).

The incontinency pad that BH&RS classified as ancillary because it was designed for and used with a specially approved bed was discussed with officials at Blue Cross of California and they determined that the incontinency pad should be classified as routine because incontinency care items are specifically mentioned as routine items under Medicare's rules.

Requested Response

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. To facilitate identification, please refer to the common identification number A-09-96-00090 in all correspondence relating to this report.

-- -- -- -- --

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

Sincerely yours,

Lawrence Frelot
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Elizabeth Abbott
Regional Administrator
Health Care Financing Administration
75 Hawthorne Street
San Francisco, California 94105

APPENDICES

April 24, 1997

Mr. Lawrence Frelot
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Region IX
50 United Nations Plaza
San Francisco, CA 94 102

Reference: CIN #A-09-96-00090

Dear Mr. Frelot:

Thank you for the opportunity to respond to Mr. Douglas Leonard's draft audit report on Beverly Manor of Mar-gate (Provider # 10-5505).

Office of Audit Services Note – Comments have been deleted at 'this point, including pages 2 and 3 of BH&RS's response, because they pertain to material not included in this report.

Office of Audit Services Note – Comments have been deleted at this point because they pertain to material not included in this report.

Notation ③ - This section will address Mr. Leonard's review of and findings on Medical Supplies costs. The detail audit data included as Exhibit I-B details the nature of the $1,435 (or 7% of the sampled items) that Mr. Leonard concludes should not have been reported in the Medical Supplies cost center. First, I concur that the costs incurred for recruitment of a Supply Clerk and Supply Clerk travel (amounting to $1,205 of the $1,435) should not be reported 100% in the Medical Supplies cost center. As these are allowable costs attributable to the operation of the Supply department, they are allocable between the Medical Supplies cost center and the Central Supply cost center. As seen from the data shown in Notation ②, 57% and 50% of allocable costs are attributable to the Medical Supplies cost center for FYE 12/31/93 and FYE 12/31/94, respectively. Accordingly, the potential misclassification of direct costs is reduced by over half.

Office of Audit Services Note – Comments have been deleted at this point because they pertain to material not included in this report.

As can be seen, many of the items on the Appendix A list can be traced directly to a comparable (or often exact) item on the Intermediary bulletin. This bulletin is distributed for the sole purpose of advising Providers as to proper coverage criteria (i.e., covered versus non-covered; billable versus non-billable). In this regard, it is important to note that a particular item can be a billable item for one patient and non-billable for

another. This statement is supported by the comment section for Skin Prep Pads on page 24 of the Intermediary bulletin. An example from Mr. Leonard's audit report relates to Cairpad incontinence pads (see the cover page of Exhibit I-B). When used for a specific patient, in conjunction with a specific care plan and/or product (such as the Clinitron wound care bed in this patient's case) the item meets the definition of an ancillary and is, therefore, billable.

Office of Audit Services Note – Comments have been deleted at this point because they pertain to material not included in this report.

As the final section of this response, I would like to present examples of actions/policies and/or procedures we have implemented or will be putting in place in the near future which should help to further reduce the occurrence of billings and/or expense codings which could be deemed inaccurate.

- **Communication With Intermediary** - As I'm sure you are aware, Aetna, our current Intermediary, is leaving service as a Medicare Intermediary. Throughout the fifteen (15) years that Aetna has been our Intermediary, we have maintained constant dialogue with the appropriate Billing/Claims review staff as well as the Audit/Reimbursement group. Blue Cross of California will take over as our National

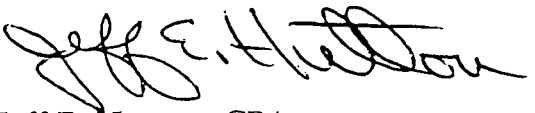
Intermediary in June of this year. However, we have already had numerous meetings, teleconferences, etc. to ensure that this communication process is continued. Appropriate Beverly Nursing and/or Billing personnel have attended Blue Cross sponsored provider workshops. Beverly arranged a coverage/billing issues review meeting between appropriate staff from Beverly, Aetna, and Blue Cross.

- **Establishment of a Corporate Procurement Department -** This has enabled us to negotiate consistent, cost-effective contracts with national vendors. Through automated ordering/billing process we are able to reduce clerical errors (of coding) and to more effectively ensure compliance with Medicare billing rationales.

- **Ancillary Revenue System -** We are developing an expanded, up-to-date ancillary revenue system which will enhance our ability to ensure compliance with coding and billing guidelines.

Again, thank you for the opportunity to present these comments and related data. If you have any questions relative to this material, please don't hesitate to call me at (50 1) **484-8667.**

Respectfully,



Jeff E. Hutton, CPA
Vice President - Reimbursement

JEH/cas

Enclosures

Aetna

Medicare Provider Audit/Reimbursement
501 Office Center Drive
Ft. Washington, PA 19034
215-643-7200

Medicare

215-540-1717
Fax: 215-540-9520

May 8, 1997

Mr. Lawrence Frelot,
Regional Inspector General for Audit Services
Office of Audit Services--Region IX
50 United Nations Plaza
San Francisco, CA 94102

Re: DRAFT AUDIT REPORT--A-09-96-0090
Beverly Manor of Margate-- lo-5505

Dear Mr. Frelot:

Aetna Inc has announced its decision to leave the Medicare fee for service program effective September 30, 1997.

Given the transition that is on going we will continue to work with the Health Care Financing Administration and the replacement contractor to resolve any outstanding items.

Sincerely,

Dennis J. Phipps, Manager
Provider Audit/Reimbursement Department
Aetna Inc