

HOSPITAL FULL PROFESSIONAL DESK REVIEW PROGRAM

Non-PPS Hospital - complete if Medicare cost-based reimbursement is greater than \$1.5 million.

PPS Hospitals with cost-based subproviders - complete if Medicare cost-based reimbursement is greater than \$1.5 million, or if the operating outlier cost to charge ratio has increased or decreased by more than 30% for cost reports beginning on or after January 1, 2003.

PPS Hospitals with no cost-based subproviders - complete if TOPS payment is greater than \$500,000, or if the operating outlier cost to charge ratio has increased or decreased by more than 30% for cost reports beginning on or after January 1, 2003.

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Exhibit 1	Uniform Desk Review Summary of Issues

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<u>Module A - Cost Report Acceptability and Cost Report Reimbursement Questionnaire</u>					
1. Cost Report Acceptability Resolve any outstanding issues resulting from acceptability of the Medicare cost report. 2. Cost Report Reimbursement Questionnaire Review the required sections of Form CMS-339 for any questions that require further development. Identify those issues and actions taken and reference supporting workpapers. NOTE: This review of supporting documentation submitted with Form CMS-339 will look at compliance with Medicare principles of reimbursement.					
<u>Module B - Working Trial Balance</u>					
1. Review the working trial balance for the following: a. Are total expenses on the working trial balance reconcilable to the total expenses on the audited financial statements and Worksheet A? b. Are the revenues on Worksheet C reconcilable to the total revenues on the working trial balance and the audited financial statements? 2. Review for significant variances where the provider submitted a schedule grouping the working trial balance expense accounts to agree with Worksheet A:					

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a. Test comparison of expense account amounts in the working trial balance between the current and prior year for reasonableness and consistency (optional). b. Scan general ledger expense account groupings into cost report cost centers with prior years for reasonableness and consistency. c. Scan the grouping of accounts for the current year to identify general service (a.k.a. over-head), nonreimbursable, routine, ancillary, and outpatient service accounts that appear to have been improperly classified on W/S A. Some examples of improper groupings are: (1) inclusion of general service accounts such as admitting, billing, or nursing administration in the Psychiatric Supprovider cost center (2) inappropriate combination of several distinct revenue producing departments such as clinics, or operating room, recovery room, and anesthesia into one cost center, and (3) inclusion of nonallowable advertising expense account in Psychiatric Subprovider and Kidney Acquisition cost center. NOTE: The intermediary cannot <u>require</u> the provider to <u>submit</u> such a grouping, although the provider should have one available for audit.					
3a. If the submitted working trial balance includes sub-accounts, review the expense accounts that are grouped into the cost-based sub-provider, organ acquisition, paramedical education and outpatient (for pre-OPPS cost					

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reports and CAHs only) cost centers, where applicable, to determine whether general service costs (e.g., dietary, medical records, billing, admitting) were included in those accounts. If so, refer for further investigation. b. If a detailed working trial balance was not submitted with the cost report, review the Permanent File and prior years' workpapers to determine whether direct assignment of general service costs to the units mentioned in Substep a. has been reviewed in the past. If not, refer for further investigation. 4. Review the grouping of revenue accounts into the cost centers on Worksheet C to determine whether revenue was classified in accordance with the expense groupings in Step 2.					
<u>Module C - General Audit Areas</u> 1. Does the correspondence file contain any significant items that may impact Program reimbursement in the current year? 2a. Do the points for future audit indicate items that may require further review? b. Have major prior year adjustments, or repeat adjustments been considered on the current year's cost report? c. Have prior year management letter items been considered on the current year cost report?					

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3. Where applicable, ensure that the correct limits and rates are used for: a. RCEs (not applicable to CAHs) b. TEFRA inpatient target amount c. Respiratory Therapy Limits (only for CAHs) d. Physical Therapy Limits (only for CAHs) e. Occupational Therapy Limits (only for CAHs) f. Speech Pathology Limits (only for CAHs) g. RHC rate per visit limit h. Provider-based HHA limits and per beneficiary limits (not applicable for cost reporting periods beginning on or after 10/1/00) i. Ambulance rates j. SNF Swing Bed rates k. Cost to payment ratios for TOPs 4. Ensure proper treatment of CRNA costs, where applicable. 5. Review W/S A-8-4 for proper completion (only for CAHs). 6. Where loans have been made during the period to finance the acquisitions of facilities, capital stock, mergers or consolidations, evaluate whether adjustments to interest expense have been made in accordance with 42 CFR 413.153(d). 7. Verify that each subprovider shown in the cost report received approval from CMS to be excluded from PPS.					

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Module D - ADR/Cost Report Comparison					
1. Review the ADR comparison for a change in the number of beds during the period. (This change may have an effect on the IME/DSH calculations.)					
2. Review the ADR comparisons of cost centers with the prior year on Worksheet A for any variances that exceed parameters. This may indicate major changes in the nature of the cost centers or may reflect a comparable change in the revenue for the cost center.					
3. Review the ADR comparative analysis of Worksheet A-6 reclassification of expenses for variances exceeding parameters. Are the reclassifications of expenses consistent and comparable in nature and amount? Review the documentation accompanying the cost report for those variant expense reclassifications.					
4. Review the ADR comparison of Worksheet A-7, Part III. Have capital-related interest, insurance and taxes been reclassified from Line 90 to Lines 1 through 4 (for PPS hospitals) and from A&G to capital-related costs (for other providers)? (Review Worksheets A-6 and A-7.)					
NOTE: For cost reporting periods beginning on or after October 1, 2001, PPS hospitals paid at 100 percent federal are no longer required to complete this worksheet.					

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5. Review the ADR comparison for Worksheet A-8 adjustments between years for variances exceeding parameters. Review supporting documentation. Are the bases for adjustments on Worksheet A-8 consistent between years? Note: A provider may not change from a cost basis to a revenue adjustment.					
6. Have all other income items been offset on Worksheet A-8, where appropriate?					
7a. Review the ADR comparison of the order of allocation on Worksheet B-1 with prior year for exceptions.					
b. Review the ADR comparison of statistical bases on Worksheet B-1 with the prior year for exceptions. If bases are different because the provider received approval to use the simplified cost allocation methodology (PRM-II, Section 3617), consider the response to step 7.c. before annotating an exception.					
c. Are any of the bases different from the CMS recommended bases as detailed on Worksheet B-1 and in PRM-II, Section 3617? If yes, review the permanent file or correspondence file for approval of changes. NOTE: The provider <u>must</u> use the bases listed in PRM-II, Section 3617 if it uses the simplified cost allocation methodology.					

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d. Verify that if the provider elected the simplified cost allocation in the prior year, this methodology was used for the current year, unless it was already used for three (3) consecutive years prior to the current year. NOTE: The provider may elect to use the more simplified statistical basis with the understanding that this election is for a minimum of three (3) years, with no exceptions.					
e. Review the ADR comparison of statistics on Worksheet B-1 with the prior year for the following (on a column-by-column basis): (1) Variances that exceed parameters. (2) Columns in which all lines are identical with prior year. This may show the statistics used do not reflect the current year.					
8. Scan the current year's Worksheet B-1 to determine whether there are any illogical distributions of statistics (for example, 50 percent of medical records statistics on the clinic line and 25 percent on the Adults and Pediatrics line), lack of statistics on non-reimbursable cost center lines, etc.					
9. Review the ADR comparison of directly assigned capital-related costs on Worksheet B Part II and III for any variances exceeding parameters.					

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10. Review the ADR comparison of charges on Worksheet C with the prior year and resolve any variances that exceed parameters. Refer to CMS Pub. 15-1, Section 2314, for possible overhead adjustment where contracted services are only furnished to Medicare beneficiaries under arrangements.					
11. Review the ADR comparison of cost/charge ratios on Worksheet C with the prior year and resolve any variances that exceed parameters.					
12. Scan the current year's Worksheet C to determine whether any of the cost/charge ratios are unusually high (i.e. significantly higher than the ratios of most of the other cost centers.) Note that there are reimbursement implications if these high cost to charge ratios pertain to outpatient cost centers at CAHs and for pre-OPPS cost reports or ancillary cost centers with high excluded unit's Medicare utilization. In TEFRA hospitals there are reimbursement implications associated with high cost to charge ratios in any ancillary cost center. Cost to charge ratios also impact the outlier payments and TOPs payments.					

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Module E - Financial Statements and Reports					
1. Do the footnotes to the audited financial statements indicate any significant changes in accounting principles or other changes that may materially impact Program reimbursement? Have these changes been reflected in the documentation supporting Form CMS-339? Significant changes might include: a. Change in inventory valuation policy. b. Change in capitalization policy noted. c. Corporate restructuring or reorganization activities. d. Charity Service. e. Advance Refunding of Debt. f. Capitalized leases. g. Pensions/Deferred compensation. h. Affiliations. i. Closing of facilities. j. Contingencies. k. Self-insurance.					
2. Do the audited financial statements contain a qualified or disclaimer of opinion? If yes, review for impact on reimbursement caused by the effect of the qualifications or adverse opinion rendered by the provider's auditors on the financial statements.					
3. Do the audited financial statements show construction in progress changes that may indicate that an area was opened during the current year? If yes, does the cost report show start-up costs?					

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Module F - Capital					
1. For PPS capital hospitals, a. Review Worksheet L to ensure that it was properly completed. All capital costs are still to be considered for review and are subject to adjustment because of their effect on outpatient costs and other cost-based reimbursement areas, i.e., excluded units.					
2 For non-PPS hospitals, a. If the Permanent File or prior years' working papers indicate problems between book and Medicare depreciation, consider the need for review in the current year. b. If the current year's depreciation changed due to appraisal (see Form CMS-339), review the submitted appraisal report and summary for compliance with PRM-I, Section 134. c. If assets have been relifed (see Form CMS-339), review the submitted listing of assets to determine whether additional review is necessary. d. Where new leases and/or amendments to existing leases have been entered into (see Form CMS-339), review the lease agreements					

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to determine whether additional review is necessary to ensure that virtual purchase leases, capitalized leases, leases with related organizations, or leases of space not related to patient care have been properly reported. e. Review audited financial statements and Form CMS-339 for disclosure on changes in capitalization policies and major changes in fixed asset balances. f. Ensure all capital related costs such as interest, insurance and allowable property taxes which were reclassified from A&G to capital cost centers were appropriate. (See also ADR comparison of capital costs reclassified from Line 90, in step 4 of Module D, ADR/Cost Report Comparison).					
<u>Module G - Interest Expense</u> 1. Interest should be reviewed for significant variances with possible referrals to audit. Some areas of concern are: a. Offset of interest income b. Interest during construction (must be capitalized in accordance with CMS Pub. 15-1, Section 206) c. Funded depreciation and bond sinking funds. Did the provider borrow during the period without using available funded depreciation?					

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d. Borrowings from motherhouse e. Interfund borrowings f. Borrowings from related organizations g. Bond defeasance h. Interest expense on overpayments paid by the provider to the Medicare program or on borrowings to make payment to the Medicare program are <u>not</u> includable in allowable cost.					
<u>Module H - Start-Up Costs</u> 1a. Where information is available about new providers or facilities that indicates the possibility of start-up costs, consider referring for further review. b. Where the provider has withdrawn from the program, review the treatment of unamortized start-up cost.					
<u>Module I - Graduate Medical Education / Indirect Medical Education</u> 1. Review GME per-resident amounts to ensure that they were properly updated. NOTE 1: For cost reporting periods beginning on or after 10/1/93 through 9/30/95, the per-resident amount for non-primary care and OB/GYN programs was not updated. This created two different per-resident amounts (primary and non-primary programs) for all future years even though both of these amounts are updated now using the same update factor.					

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NOTE 2: For cost reporting periods beginning between October 1, 2000 and September 30, 2005, the national weighted average per-resident amount (PRA) that is updated for inflation and locality will be compared to the provider's primary care and nonprimary care PRAs separately and the PRAs will be adjusted in accordance with the directive in 42 CFR 413.86(e)(4) depending on where they fall in relation to the established floor and ceiling. (See also the FR, Vol. 65, No. 148, dated August 1, 2000, pgs. 47091 and 47193 and Program Memorandum A-01-38 dated March 21, 2001). 2. The Balanced Budget Act of 1997 imposed a limit on the number of allopathic and osteopathic interns and residents (IR) a hospital can include in its full time equivalent (FTE) count for direct and indirect graduate medical education payment. Residents in dentistry and podiatry are exempt from the limit. a. Ensure that the appropriate GME/IME FTE caps and the prior years' FTE counts used in the calculation of the rolling average were reported on W/S E-3 Part IV and W/S E Part A of the current year's cost report. NOTE: The prior years' FTEs used to compute the current year's rolling average must be adjusted fo the "cap" but not for the prior year's rolling average.					

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3. Determine the level of additional review required to properly settle the cost report if GME or IME payments are being claimed and meet the following criteria: a. IME or GME payment exceeds \$200,000, and b. The IME or GME payment in the current year increased 15 percent or more over the prior year IME or GME payment. If these thresholds are not met, no further review is required. You may skip step 4. NOTE: You can scope this area for review even if thresholds are not exceeded.					
4. If these thresholds are exceeded then consider the following examples of issues in determining if further review is necessary: a. Material adjustments to GME/IME during prior year reviews. b. Material variance in beds identified in step 1 of Module E (ADR/Cost Comparison) that impact IME payments. c. Material change in Interns and Residents reported on W/S S-3 Part I.					
5. Document your decision to further review or not review GME/IME.					

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<u>Module J - Nursing and Allied Health</u> <u>Educational Activities</u> 1. If Nursing School or Allied Health (i.e., paramedical) education costs were reported on W/S A, calculate the total Medicare reimbursement for these programs by adding lines 11.01, 14 and 15 of W/S E Part A, line 1.07 of W/S E Part B, and lines 28 and 29 of W/S E-3 Part III. However, if W/S D Part III and W/S D part IV show that the passthrough amounts on those W/S E lines include CRNA and/or graduate medical education costs, compute the Nursing School/Allied Health reimbursement using information on W/S D Part III and add line 11.01 of W/S E Part A. If the total Medicare reimbursement for the Nursing School/Allied Health programs exceeds \$200,000, and it increased 15 percent or more over the prior year complete steps 2 through 6. Otherwise, further review is not required. 2. Ensure that each paramedical education program is included in a separate cost center on W/S A. 3. Review the working trial balance for tuition income and ensure that it was offset on W/S A-8.					

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4. Review the support for other W/S A-8 adjustments (see item 14 of the Acceptability Checklist) that affect nursing school and paramedical education costs to ensure proper handling.					
5. If additional payment for nursing/allied health programs related to services provided to Medicare+Choice (managed care) enrollees was reported on W/S E Part A, Line 11.01 effective with the portion of a cost reporting period beginning in calendar year 2000 (i.e., January 1, 2000), determine whether the provider qualifies for such additional payment and if so, whether the amount was properly computed (see 42 CFR 413.87).					
6. Determine if further review is necessary and document the reason for your decision.					
<u>Module K - Disproportionate Share (DSH)</u>					
1. Supplemental Security Income (SSI) percentage. Is the latest SSI percentage obtained from CMS used?					
2. If DSH reimbursement is being claimed, use the following criteria to determine the level of additional review required to properly settle the cost report:					

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a. DSH reimbursement claimed exceeds \$200,000, and b. The amount claimed increased by 15 or more percent over the prior year DSH reimbursement. If these thresholds are not met, further review is not required. You may skip step 3.					
3. Examples of issues to consider in determining if further review is necessary: a. Material variance in beds identified in step 1 of Module D (ADR/Cost Comparison) if final bed count falls in close proximity to the DSH bed thresholds of 100 and 500 (only for discharges prior to April 1, 2001); b. Material adjustments to Medicaid days during the prior year reviews; c. Inclusion of ineligible days in prior year cost reports; e.g. general assistance, charity care, etc. d. Were Labor Room days and/or excluded unit days included in total and Medicaid days in prior year cost reports? e. Were Employee Discount days and/or Observation Bed days included in the total days used to calculate the DSH percentage in prior year cost reports?					
4. Document the reason for your decision to review or not review DSH.					

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<u>Module L - Organ Acquisition Costs</u>					
1. If the provider completed W/S D-6 for kidney, heart, liver, lung, pancreas after 7/1/99 if done in conjunction with kidney, or intestinal transplants on or after 10/1/01 check whether appropriate CMS certification was obtained. If the provider is not certified for the type of organ transplant, the related W/S D-6 must not be completed.					
2. For certified organ transplant providers:					
a. If net organ acquisition Medicare cost reported on W/S D-6 Part III, column 1, line 61 exceeds \$200,000, and there is a 15 percent or more increase over the prior year, complete step 3 below. Perform a separate analysis for each type of organ acquisition (i.e., kidney, heart, etc.).					
b. If these thresholds are not met, no further review is required. You may skip steps 3 and 4.					
3. Review the organ acquisition Worksheet D-6 on the cost report.					
a. Review the ADR comparison of routine and ancillary organ acquisition costs with the prior year and if material, consider for further review.					
b. Review the ADR comparison of revenue and statistics for organs sold with the prior year and if material, consider for further review.					

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c. Review the amount of W/S D-6 Part III, line 58 for the current year to determine whether it appears logical for the number of organs sold or transplanted into non-Medicare patients. If revenue per organ is significantly lower than the cost per organ or the amount at which the provider purchased similar organ, consider further review.					
4. Determine if further review is necessary and document the reason for your decision.					
<u>Module M - Bad Debts</u>					
1. Does the detailed bad debt listing submitted with the cost report agree with the bad debts reported on the cost report.					
2. If bad debt reimbursement is being claimed, use the following criteria to determine the level of review required: If the amount claimed is less than 5 percent of the total deductibles and coinsurance or less than 15 percent increase over prior year allowable bad debts, you can allow with no further review (perform inpatient and outpatient analysis separately). Otherwise, complete steps 3 through 7.					
3. Determine if the bad debt listing contains the following information: ● Name of beneficiary ● HIC number ● Date of discharge					

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● Date of first bill to beneficiary after discharge ● Medicare payment date ● Amount of write-off ● Date of write-off ● Amount of deductible / coinsurance Request this information from the provider if it has not been included on the bad debt listing.					
4. Scan the bad debt listing to identify accounts written off sooner than 120 days from the date of the first bill. If any of those identified do not show a Medicaid number, consider further review to determine if the patient is indigent.					
5. If the listing shows bad debts for patients who are eligible for Medicaid (see Form CMS-339, Exh. 5, column 4), review the state's Medicaid reimbursement policy for Medicare deductible/coinsurance for dual eligible/QMB recipients:					
a. If the state reimburses up to the Medicare rate, then there should be no bad debt amount for these patients.					
b. If the state reimburses less than the Medicare rate, then there may be a bad debt for Medicare deductible/coinsurance.					
6. Examples of other items to consider in determining if further review is necessary:					

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a. Material adjustments to bad debts during prior year reviews. b. Does additional documentation need to be requested for patients deemed indigent by the provider? c. Does it appear that the provider offset prior year recoveries against the current year Medicare bad debts? d. Is there any indication that secondary payors were billed and paid? 7. Document the reason for your decision to review or not review bad debts.					
<u>Module N - ESRD</u> (Perform on cost reports not subject to review under Section 4558 of BBA-97) 1. Ensure that the correct composite rates are used on Supplemental Worksheet I-3, Column 6 (where the provider has received an exception, identify the reason for the exception and ensure proper adjustment to the limit). 2. Ensure that patient weeks are used for CAPD and CCPD home program, columns 1 & 4 on lines 9 & 10 of Worksheet I-4. <u>Module N(1) - High Percentage of ESRD Beneficiary Discharges Adjustment</u> (This Section has been added by RGBA) 1. If the provider completed W/S E Part A Lines 5 through 5.06, check whether the detailed					

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ESRD listing submitted with the cost report agrees with the total ESRD discharges and days reported on the submitted cost report. 2. Ensure that the correct average cost per dialysis treatment is reported on W/S E Part A Line 5.05. 3. Determine the level of additional review required to properly settle the cost report if the high percentage ESRD adjustment is being claimed and meet the following criteria: a. High percentage ESRD payment exceeds \$200,000, and b. The high percentage ESRD payment in the current year increased 15 percent or more over the prior year high percentage ESRD payment. If these thresholds are not met, no further review is required. NOTE: You can scope this area for review even if thresholds are not exceeded. 4. Document your decision to further review or not review the high percentage ESRD payment.					
Module O - Home Office Costs 1. Reconcile the home office cost included in the cost report with the amount allocated to the provider via the home office cost statement.					

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2. If a copy of the home office cost statement has not been furnished, delete the home office cost out of the cost report.					
<u>Module P - Settlement Data</u> 1. For cost reporting periods ending before 11/30/95, update settlement data on the cost report to the most current PS&R report. For cost reporting periods ending on or after 11/30/95, ascertain what method (identified in Form CMS-339) the provider used to file the cost report. Review the settlement data documentation accordingly. NOTE: Update settlement data in accordance with Section 90 of Pub. 100-06. Complete step 1 during the desk review if the provider is not going to be audited. 2. Scan the settlement worksheets for unusual items. Adjust as necessary. 3. Remove protested items reported on the following worksheets: ● W/S E Part A, line 30 ● W/S E Part B, line 36 ● W/S E-2, line 22 ● W/S E-3 Part I, line 21 ● W/S E-3 Part III, line 59, column 2 ● W/S H-7 Part II, line 27 ● W/S J-3, line 29 ● W/S M-3, line 27					

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<u>Module Q - Permanent File</u>					
1. Update the permanent file using information submitted with the cost report or obtained during the desk review.					
<u>Module R - Fraud and Abuse</u>					
1. Watch for recurring incidents of the provider including cost disallowed in prior years and not declared as protested item(s) on the settlement summary and accompanying schedules.					

Auditor: _____ Date Completed: _____

Supervisor: _____ Date Review Completed: _____