



SEP 15 2006

Washington, D.C. 20201

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Review of TriSpan Health Services's Payments to Synergy Behavioral Health for Partial Hospitalization Services for the Period August 1, 2000, Through June 30, 2003 (A-06-04-00032)

Attached is an advance copy of our final report on TriSpan Health Services's (TriSpan) payments to Synergy Behavioral Health (Synergy) for partial hospitalization services for the period August 1, 2000, through June 30, 2003. We will issue this report to TriSpan, a fiscal intermediary, within 5 business days. This is one of a series of reports on Medicare partial hospitalization services provided by community mental health centers (CMHC).

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients instead of inpatient psychiatric care. Under the Medicare hospital outpatient prospective payment system, which was implemented in August 2000, CMHCs receive per diem payments for partial hospitalization services. Medicare may make additional payments, called outlier payments, if the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses.

Our objective was to determine whether TriSpan calculated Medicare outlier and per diem payments to Synergy in accordance with Medicare reimbursement requirements.

TriSpan did not calculate Medicare outlier and per diem payments to Synergy in accordance with Medicare reimbursement requirements. In calculating outlier payments, TriSpan:

- used incorrect cost report information to compute Synergy's cost-to-charge ratio and
- incorrectly entered the ratio in the outpatient provider-specific file within the claim-processing system.

In calculating per diem payments, TriSpan assigned the wrong geographic wage index factor to Synergy.

These errors occurred because TriSpan did not have adequate internal controls to prevent or detect the improper calculation and entry of the cost-to-charge ratio and the incorrect assignment of the geographic wage index factor. As a result, TriSpan overpaid Synergy \$8,193,433 for services between August 1, 2000, and June 30, 2003.

Medical reviewers conducted a separate review of the medical necessity of Synergy's partial hospitalization services (report number A-06-04-00076). The dates of service of the medical review (August 1, 2000, through December 31, 2002) and this audit (August 1, 2000, through June 30, 2003) overlap. However, the overpayments identified in this report do not duplicate those identified in the medical review.

We recommend that TriSpan:

- recover from Synergy improper outlier and per diem payments totaling \$8,193,433 (\$6,946,670 for services rendered between August 1, 2000, and December 31, 2002, and \$1,246,763 for services rendered between January 1, 2003, and June 30, 2003);
- review claims with dates of service subsequent to our audit period to ensure that they were paid in accordance with Medicare reimbursement requirements and make any necessary financial adjustments; and
- implement internal controls to ensure that future outlier and per diem payments are calculated with the correct cost-to-charge ratio, effective date, and wage index factor.

In its comments on our draft report, TriSpan did not agree with most of the findings, the cause, or the first and last recommendations. However, TriSpan agreed that by using the Medicare charges on a particular cost report worksheet, it computed a higher cost-to-charge ratio that resulted in larger outlier payments. TriSpan also agreed that it had assigned the wrong geographic wage index factor to Synergy. TriSpan did not fully address the second recommendation to review all claims subsequent to our audit period because TriSpan stated that it was limited to reviewing and adjusting the claims available on the system.

TriSpan's comments did not provide any additional information that would lead us to change the findings, cause, or recommendations included in the draft report.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414 or through e-mail at Gordon.Sato@oig.hhs.gov. Please refer to report number A-06-04-00032.

Attachment



SEP 18 2006

Office of Audit Services
1100 Commerce, Room 686
Dallas, TX 75242

Report Number: A-06-04-00032

Mr. William V. Morris III
Vice President, Government Programs
TriSpan Health Services
Medicare Part A Intermediary
1064 Flynt Drive
Flowood, Mississippi 39232-9570

Dear Mr. Morris:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of TriSpan Health Services's Payments to Synergy Behavioral Health for Partial Hospitalization Services for the Period August 1, 2000, Through June 30, 2003." A copy of this report will be forwarded to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. 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, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-06-04-00032 in all correspondence.

Sincerely yours,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Roger Perez
Regional Administrator (Acting)
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Atlanta, Georgia 30303-8909

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF TRISPAN HEALTH
SERVICES'S PAYMENTS TO
SYNERGY BEHAVIORAL HEALTH
FOR PARTIAL HOSPITALIZATION
SERVICES FOR THE PERIOD
AUGUST 1, 2000, THROUGH
JUNE 30, 2003**



Daniel R. Levinson
Inspector General

September 2006
A-06-04-00032

Office of Inspector General

<http://oig.hhs.gov>

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

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. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Partial hospitalization is an intensive outpatient program of psychiatric services that community mental health centers (CMHC) or hospitals may provide to patients in lieu of inpatient psychiatric care. Under the Medicare hospital outpatient prospective payment system, which was implemented in August 2000, providers receive per diem payments for partial hospitalization services. Medicare may make additional payments, called outlier payments, if the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses.

We conducted this audit because the Centers for Medicare & Medicaid Services raised concerns about excessive Medicare outlier payments to CMHCs. This review is part of a series of audits of payments to CMHCs.

OBJECTIVE

Our objective was to determine whether a fiscal intermediary, TriSpan Health Services (TriSpan), calculated Medicare outlier and per diem payments to Synergy Behavioral Health (Synergy) in accordance with Medicare reimbursement requirements.

SUMMARY OF FINDINGS

TriSpan did not calculate Medicare outlier and per diem payments to Synergy in accordance with Medicare reimbursement requirements. In calculating outlier payments, TriSpan:

- used incorrect cost report information to compute Synergy's cost-to-charge ratio and
- incorrectly entered the ratio in the outpatient provider-specific file within the claim-processing system.

In calculating per diem payments, TriSpan assigned the wrong geographic wage index factor to Synergy.

These errors occurred because TriSpan did not have adequate internal controls to prevent or detect the improper calculation and entry of the cost-to-charge ratio and the incorrect assignment of the geographic wage index factor. As a result, TriSpan overpaid Synergy \$8,193,433 for services between August 1, 2000, and June 30, 2003.

Medical reviewers conducted a separate review of the medical necessity of Synergy's partial hospitalization services.¹ The dates of service of the medical review (August 1, 2000, through December 31, 2002) and this audit (August 1, 2000, through June 30, 2003) overlap. However, the overpayments identified in this report do not duplicate those identified in the medical review.

¹"Medical Review of Synergy Behavioral Health's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2000" (A-06-04-00076, issued March 9, 2006).

RECOMMENDATIONS

We recommend that TriSpan:

- recover from Synergy improper outlier and per diem payments totaling \$8,193,433 (\$6,946,670 for services rendered between August 1, 2000, and December 31, 2002,² and \$1,246,763 for services rendered between January 1, 2003, and June 30, 2003);
- review claims with dates of service subsequent to our audit period to ensure that they were paid in accordance with Medicare reimbursement requirements and make any necessary financial adjustments; and
- implement internal controls to ensure that future outlier and per diem payments are calculated with the correct cost-to-charge ratio, effective date, and wage index factor.

TRISPAN COMMENTS

In its comments on our draft report, TriSpan did not agree with most of the findings, the cause, or the first and last recommendations. However, TriSpan agreed that by using the Medicare charges on a particular cost report worksheet, it computed a higher cost-to-charge ratio that resulted in larger outlier payments. TriSpan also agreed that it had assigned the wrong geographic wage index factor to Synergy. TriSpan did not fully address the second recommendation to review all claims subsequent to our audit period because TriSpan stated that it was limited to reviewing and adjusting the claims available on the system.

TriSpan's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

TriSpan's comments did not provide any additional information that would lead us to change the findings, cause, or recommendations included in the draft report.

²Action on this recommendation should be coordinated with the audit resolution on report number A-06-04-00076.

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B – TRISPAN COMMENTS

INTRODUCTION

BACKGROUND

We conducted this audit because the Centers for Medicare & Medicaid Services (CMS) raised concerns about excessive Medicare outlier payments to community mental health centers (CMHC). This review is part of a series of audits of payments to CMHCs.

Partial Hospitalization Program

Pursuant to section 1861(ff) of the Social Security Act, partial hospitalization is an intensive outpatient program of psychiatric services that CMHCs or hospitals may provide to individuals in lieu of inpatient psychiatric care. The program is designed to provide individuals who have mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment involving nurses, psychiatrists, psychologists, and social workers.

Pursuant to the Balanced Budget Act of 1997, Medicare pays for partial hospitalization services as part of the hospital outpatient prospective payment system (PPS), which was implemented in August 2000. Under the PPS, Medicare makes per diem payments to partial hospitalization providers. Medicare may make additional payments, called outlier payments, if the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses.

Medicare makes outlier payments when the provider's charges for the services, adjusted to cost, exceed a threshold amount that CMS establishes. Effective August 2000, CMS established the threshold amount at 2.5 times the per diem payment. Effective April 2002, CMS increased the threshold to 3.5 times the per diem payment and decreased it to 2.75 times the per diem payment effective January 2003. A change in the per diem amount will affect the threshold amount and, in turn, the outlier payment.

Cost-to-Charge Ratios

Medicare claims contain data on patient charges. To determine whether a claim qualifies for an outlier payment, Medicare fiscal intermediaries must convert billed charges to estimated costs using a cost-to-charge ratio. The use of a properly computed, provider-specific cost-to-charge ratio is essential to ensure that Medicare makes outlier payments only for cases that have extraordinarily high costs, not merely high charges. Intermediaries should calculate these ratios by dividing total patient-related costs by total charges as shown on the providers' Medicare cost reports.

Intermediary Responsibilities

CMS contracts with fiscal intermediaries for assistance in administering the partial hospitalization program, including:

- processing and paying claims from CMHCs,

- calculating initial cost-to-charge ratios based on fiscal year (FY) 1997 Medicare cost reports,
- computing outlier payment amounts,
- updating cost-to-charge ratios based on the most recent cost reports available,
- conducting audits of CMHCs' cost reports, and
- reviewing claims for medical necessity and reasonableness of services.

TriSpan Health Services

Blue Cross and Blue Shield of Mississippi, doing business as TriSpan Health Services (TriSpan), is a CMS-contracted Part A fiscal intermediary located in Jackson, Mississippi. TriSpan's Part A provider service area includes Louisiana, Mississippi, and Missouri.

TriSpan paid the 39 CMHCs in its service area approximately \$96.5 million for partial hospitalization services rendered from the inception of the outpatient PPS in August 2000 through June 2003. Of these payments, \$57.9 million (approximately 60 percent) represented outlier payments.

Synergy Behavioral Health

Synergy Rehab Services, Inc., is a Medicare-certified CMHC located in Baton Rouge, Louisiana. It operates under the business name of Synergy Behavioral Health (Synergy). TriSpan paid Synergy \$18,448,178 for services rendered from August 2000 through June 2003. Of these payments, \$14,634,289 (approximately 79 percent) represented outlier payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether TriSpan calculated Medicare outlier and per diem payments to Synergy in accordance with Medicare reimbursement requirements.

Scope

Our audit covered TriSpan's \$14,634,289 in outlier payments to Synergy for services rendered between August 1, 2000, and June 30, 2003. We reviewed the elements of the outlier payment calculation, which included the per diem payment calculation. During that analysis, we noted an error in the per diem calculation; therefore, we expanded our scope to include \$3,813,889 in per diem payments to Synergy for the same period.

We limited our internal control review to TriSpan's processes for calculating outlier and per diem payments. We did not perform detailed tests of internal controls because the objective of

our review did not require such testing. Medical reviewers examined a sample of Synergy's claims for medical necessity in a separate audit.¹ We did not review the medical necessity of the services in this audit.

We performed fieldwork at TriSpan in Jackson, Mississippi, and at Synergy in Baton Rouge, Louisiana.

Methodology

We reviewed the Balanced Budget Act of 1997, the Balanced Budget Refinement Act of 1999, the Code of Federal Regulations, the Federal Register, program memorandums, and Medicare manuals as they pertained to outlier and per diem payments for partial hospitalization services. We also interviewed officials of TriSpan, CMS, and Synergy.

From TriSpan, we obtained (1) Synergy's cost reports for the FYs that ended between March 31, 1999, and December 31, 2002; (2) documentation detailing the cost-to-charge ratio calculation; (3) information from the online system that identified the cost-to-charge ratio effective date and geographic wage index factor; and (4) summaries and details of provider statistical and reimbursement (PS&R) reports. We identified the cost report that TriSpan used to establish Synergy's cost-to-charge ratio.

We extracted detailed claim information from CMS's Standard Analytical File using the Data Extract System for partial hospitalization claims from August 1, 2000, to June 30, 2003. We reconciled these data to the PS&R reports from TriSpan.

We independently recomputed the payments as they appeared on the PS&R report. Specifically, for each claim, we recomputed the outlier and per diem payments from data in the Standard Analytical File. Therefore, we considered the net effect of all errors in computing the overpayment and did not rely on a statistical projection.

To establish the correct amount of outlier and per diem payments, we recomputed outlier payments for claims with dates of service after November 20, 2000, using the cost-to-charge ratio computed from appropriate data for FY 2000. We recomputed per diem payments using the Baton Rouge geographic wage index factor.

We conducted our review in accordance with generally accepted government auditing standards.

¹"Medical Review of Synergy Behavioral Health's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2000" (A-06-04-00076, issued March 9, 2006).

FINDINGS AND RECOMMENDATIONS

TriSpan did not calculate Medicare outlier and per diem payments to Synergy in accordance with Medicare reimbursement requirements. (See Appendix A for examples.) In calculating outlier payments, TriSpan:

- used incorrect cost report information to compute Synergy's cost-to-charge ratio and
- incorrectly entered the ratio in the outpatient provider-specific file within the claim-processing system.

In calculating per diem payments, TriSpan assigned the wrong geographic wage index factor to Synergy.

These errors occurred because TriSpan did not have adequate internal controls to prevent or detect the improper calculation and entry of the cost-to-charge ratio and the incorrect assignment of the geographic wage index factor. As a result, TriSpan overpaid Synergy \$8,193,433.

FEDERAL REQUIREMENTS

Establishing Cost-to-Charge Ratios

On September 8, 2000, CMS issued to fiscal intermediaries Program Memorandum A-00-63 (effective August 1, 2000) on how to compute outpatient PPS outlier payments. The memorandum required intermediaries to use FY 1997 cost reports to calculate a cost-to-charge ratio for each CMHC. However, for CMHCs that did not have 1997 cost reports, CMS required intermediaries to use the most recent cost report available. For CMHCs, like Synergy, that did not have a full-year cost report available, CMS required intermediaries to use the statewide cost-to-charge ratio currently in effect. In Synergy's case, the statewide ratio was 0.343.

CMS Program Memorandum A-00-63 also requires fiscal intermediaries to use provider-specific cost-to-charge ratios to convert providers' billed charges to costs when calculating outlier payments. As part of the computations, fiscal intermediaries compare converted cost figures with a prescribed threshold. Costs that are above that threshold qualify for outlier payments.

CMS Program Memorandum A-00-63 states that the cost-to-charge ratio can be computed using Form 2088-92, worksheet C, page 2.² Specifically, fiscal intermediaries are to calculate the cost-to-charge ratio by dividing costs from line 39.01, column 3, by charges from line 39.02, column 3. Worksheet instructions indicate that line 22 on worksheet D should contain a figure identical to that on line 39.02, worksheet C.

The outpatient provider-specific file within the claim-processing system contains the information, including the cost-to-charge ratio, effective date, and geographic wage index factor, that the pricing software needs to calculate outlier and per diem payments. Program Memorandum A-00-36 and the "Medicare Claims Processing Manual" (CMS Publication

²Worksheet C is entitled "Apportionment of Patient Service Costs."

100-04), section 50.1, explain how the outpatient provider-specific file must be updated. Section 50.1 provides:

FIs [fiscal intermediaries] must maintain the accuracy of the data, and update the file as changes occur in data element values An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Adjusting Payments To Reflect Geographic Wage Variations

Section 4523 of the Balanced Budget Act of 1997 requires per diem and outlier payments to be adjusted to reflect geographic differences in labor-related costs. Each year CMS publishes geographic wage index factors in the Federal Register.

Authority To Retroactively Adjust Outlier Payments

The “Medicare Financial Management Manual,” Chapter 3, section 90.1, states that providers remain liable for overpayments due to clerical or mathematical errors by the fiscal intermediary or by the provider in calculating reimbursement or charges. For payments under a PPS, Federal courts have upheld CMS’s policy of not revisiting those payments when there have been errors in the calculation of wage indexes, outlier thresholds, or other estimates on which national or regional PPS rates and adjustments depend. By contrast, overpayments to particular providers that result from clerical or mathematical errors by the intermediary or the provider do not affect national or regional PPS payments or adjustments and therefore are not governed by these decisions.

IMPROPER CALCULATION OF OUTLIER PAYMENTS

TriSpan did not calculate Medicare outlier payments to Synergy in accordance with Medicare reimbursement requirements. TriSpan initially assigned CMHCs the statewide cost-to-charge ratio on August 1, 2000. After CMS issued Program Memorandum A-00-63, TriSpan began calculating provider-specific cost-to-charge ratios and Synergy submitted its first full-year cost report. TriSpan used this cost report to establish Synergy’s provider-specific cost-to-charge ratio on November 20, 2000. When establishing the ratio, TriSpan made two errors.

TriSpan Used an Inaccurately Reported Figure To Calculate the Cost-to-Charge Ratio

TriSpan used the figure on line 22 of the cost report’s worksheet D, not line 39.02 of worksheet C, to calculate Synergy’s cost-to-charge ratio. Providers use worksheet C to apportion patient service costs and determine the allowable costs applicable to the Medicare program. Providers use worksheet D to calculate the reimbursement settlement. According to worksheet instructions, worksheet D, line 22, is identical to worksheet C, column 3, line 39.02, for CMHCs with cost-reporting periods ended prior to August 2000. However, in Synergy’s reports, the two figures differed because Synergy made an error in completing worksheet D. Even though CMS stated that fiscal intermediaries could use numbers from worksheet C to compute the cost-to-

charge ratio, TriSpan believed that either worksheet would provide the same number. However, in Synergy’s case, the numbers were not the same, and the numbers on worksheet C were the appropriate numbers to use in calculating the cost-to-charge ratio.

By using an inaccurate figure, TriSpan calculated Synergy’s cost-to-charge ratio as 1.342. By using the correct figure, i.e., that on worksheet C, we calculated a cost-to-charge ratio of 0.836. The use of the incorrect cost-to-charge ratio resulted in an overpayment of \$7,558,145 for the period August 1, 2000, through March 30, 2003.

TriSpan Incorrectly Entered the Cost-to-Charge Ratio in the Outpatient Provider-Specific File

On November 20, 2000, when establishing Synergy’s provider-specific cost-to-charge ratio, TriSpan did not change the effective date in the outpatient provider-specific file to November 20, 2000. TriSpan should have added an additional complete record showing the new cost-to-charge ratio and the date that the change was made. Instead, TriSpan changed the old record by updating only the cost-to-charge ratio and left the effective date as August 1, 2000.

Pursuant to Program Memorandum A-00-63, TriSpan should have used the statewide cost-to-charge ratio for claims with dates of service between August 1 and November 20, 2000. However, because TriSpan did not enter the effective date of the change, it paid more than 250 claims for services between August 1 and November 20, 2000, using the provider-specific ratio of 1.342 instead of the statewide ratio of 0.343. This error resulted in a \$427,621 overpayment.

IMPROPER CALCULATION OF PER DIEM PAYMENTS

Beginning August 1, 2000, TriSpan incorrectly assigned to Synergy the New Orleans geographic wage index factor instead of the Baton Rouge factor. Using the wrong wage index factor affects the per diem rate regardless of whether a particular claim also qualifies for an outlier payment.

By using the wrong wage index factor, TriSpan overpaid Synergy \$207,667 in per diem payments. The table below shows that for every day in each claim during our audit period, Synergy received \$4.64 to \$11.29 in additional per diem payments.

Comparison of New Orleans and Baton Rouge Per Diem Rates

Effective Dates	New Orleans	Baton Rouge	Difference
Aug.–Dec. 2000	\$191.14	\$186.50	\$4.64
Jan.–Mar. 2001	198.07	192.45	5.62
Apr. 2001–Mar. 2002	200.65	194.95	5.70
Apr.–Dec. 2002	199.99	188.70	11.29
Jan.–June 2003	226.29	215.46	10.83

INADEQUATE INTERNAL CONTROLS

TriSpan's internal controls did not prevent or detect the improper payments that we noted. TriSpan incorrectly used worksheet D rather than worksheet C of Synergy's cost report to calculate the cost-to-charge ratio. TriSpan believed that the Medicare charges on both worksheets were identical when, in fact, they were not.

TriSpan interpreted the "effective date" of the calculation to be the effective date of CMS Program Memorandum A-00-63, which was August 1, 2000. Therefore, even if TriSpan had entered a new and complete record, TriSpan still would have entered the cost-to-charge ratio's effective date as August 1, 2000, rather than November 20. Furthermore, according to TriSpan, Program Memorandum A-00-63 did not require that the provider's first full-year cost report be submitted by August 2000 to use a provider-specific ratio rather than the statewide cost-to-charge ratio.

The "Medicare Intermediary Manual" (CMS Publication 13-2), section 2901.3, requires fiscal intermediaries to ensure that Medicare pays neither more nor less than what is appropriate and to implement proper Medicare reimbursement policy. If TriSpan had more carefully reviewed the cost-to-charge ratio and per diem computations and followed CMS's guidance requiring a new, complete record when updating the cost-to-charge ratio, it would have prevented the payment errors. Moreover, given the amount of outlier payments relative to Synergy's total payments, we believe that more active monitoring of the outlier payment process by TriSpan would have detected the outlier errors. However, TriSpan officials thought that the program safeguard contractor was responsible for monitoring outlier payments.

OVERPAYMENTS

As a result of the errors, TriSpan overpaid Synergy \$8,193,433 for partial hospitalization claims with dates of service between August 1, 2000, and June 30, 2003.

As previously stated, medical reviewers conducted a separate medical review of Synergy's partial hospitalization services (report number A-06-04-00076). The dates of service of the medical review (August 1, 2000, through December 31, 2002) and this audit (August 1, 2000, through June 30, 2003) overlap. However, the overpayments identified in this report do not duplicate those identified in the medical review.

RECOMMENDATIONS

We recommend that TriSpan:

- recover from Synergy improper outlier and per diem payments totaling \$8,193,433 (\$6,946,670 for services rendered between August 1, 2000, and December 31, 2002,³ and \$1,246,763 for services rendered between January 1, 2003, and June 30, 2003);

³Action on this recommendation should be coordinated with the audit resolution on report number A-06-04-00076.

- review claims with dates of service subsequent to our audit period to ensure that they were paid in accordance with Medicare reimbursement requirements and make any necessary financial adjustments; and
- implement internal controls to ensure that future outlier and per diem payments are calculated with the correct cost-to-charge ratio, effective date, and wage index factor.

TRISPAN COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

TriSpan's written comments on our draft report are included in their entirety as Appendix B. In summary, TriSpan disagreed with most of the findings, the cause, and the first and last recommendations. However, TriSpan agreed that it had assigned an incorrect geographic wage index to Synergy. TriSpan did not fully address the second recommendation to review all claims subsequent to our audit period because TriSpan stated that it was limited to reviewing and adjusting the claims available on the Fiscal Intermediary Standard System.

TriSpan's comments did not provide any additional information that would lead us to change the findings, cause, or recommendations included in the draft report.

Use of Inaccurate Cost Report Figure

TriSpan Comments

TriSpan agreed that by using the Medicare charges on worksheet D instead of worksheet C, it had computed a higher cost-to-charge ratio that resulted in larger outlier payments. However, TriSpan disagreed that its calculation was improper. TriSpan stated that worksheet D should be acceptable because the charges should flow directly from worksheet C to worksheet D and because CMS's guidance at the time did not require the use of worksheet C. TriSpan asserted that this finding should be considered a provider error in the completion of the cost report.

Office of Inspector General Response

We agree that charges should flow directly from worksheet C to worksheet D. Therefore, according to worksheet instructions, the figures on the two worksheets should have been identical. However, because of an error in the completion of worksheet D by Synergy, the figures were different. TriSpan should have verified that the Medicare charges on the two worksheets were the same. Had TriSpan done so, it would have noticed the discrepancy and could have followed up with Synergy to determine the reason for the discrepancy. TriSpan thus could have avoided paying Synergy millions of dollars in error.

Incorrectly Entered Provider-Specific Ratio

TriSpan Comments

TriSpan disagreed that the use of August 1, 2000, as the effective date of the cost-to-charge ratio was incorrect. TriSpan asserted that it correctly used August 1, 2000, because Change Request 1310 stated that changes were effective then.

Office of Inspector General Response

Program Memorandum A-00-36 (issued on June 1, 2000) and the “Medicare Claims Processing Manual,” section 50.1, support our position that “effective date of the change” refers to the date of a change in the data element, not the effective date of Change Request 1310.

Inadequate Internal Controls

TriSpan Comments

TriSpan disagreed that it did not have adequate internal controls in place. TriSpan stated that it may have had some initial weaknesses in its procedural steps until it finalized and documented the approved policies and procedures for calculating cost-to-charge ratios. However, TriSpan stated that it did have internal controls in place based on the CMS guidance at that time. Additionally, TriSpan explained that with the implementation of any new payment system or policies, it takes time to fully develop procedures and quality assurance checks. TriSpan stated that it had recognized areas needing improvement and detailed several enhancements it had made.

Office of Inspector General Response

We acknowledge that TriSpan has enhanced its internal control procedures. However, during our audit, TriSpan’s controls did have weaknesses. TriSpan’s comments confirm that procedures were not fully in place when TriSpan calculated Synergy’s Medicare outlier and per diem payments.

Recovery of Overpayments

TriSpan Comments

TriSpan stated that CMS precluded it from making any adjustments to recover outlier payments. TriSpan recommended that we work directly with Synergy to collect the payments.

Office of Inspector General Response

We do not have authority to collect payments directly from a provider. Furthermore, the “Medicare Financial Management Manual,” Chapter 3, section 90.1, states that providers are liable if they receive an overpayment as a result of the fiscal intermediary’s mathematical or

clerical error in calculating reimbursement. We have added language to the report clarifying that retroactively adjusting outlier payments does not conflict with CMS's prospective-only policy with respect to PPS payments. Therefore, we continue to recommend that TriSpan recover the overpayments.

APPENDIXES

APPENDIX A

PER DIEM AND OUTLIER PAYMENT COMPUTATION EXAMPLES

	A	B	C	D	E	F
	Billed Charges	Cost-to-Charge Ratio	Charges Converted to Cost²	Per Diem Payment	Threshold (2.5 times the ambulatory procedure classification payment) ³	Outlier Payment (75 percent of the difference) ³
	Per PS&R¹		Col. A x Col. B	Number of Days in Claim x Per Diem	Col. D x 2.5	0.75 x [Col. C - Col. E]
Paid claim 1 with 5 dates of service beginning 10-1-01	\$6,250	1.342	\$8,387.50	\$1,003.25	\$2,508.13	\$4,409.53
Office of Inspector General calculation	\$6,250	0.836	\$5,225.00	\$974.75	\$2,436.88	\$2,091.09
Overpayment on claim 1				\$28.50		\$2,318.44
Paid claim 2 with 6 dates of service beginning 9-29-00	\$6,075	1.342	\$8,152.65	\$1,146.84	\$2,867.10	\$3,964.16
Office of Inspector General calculation	\$6,075	0.343	\$2,083.73	\$1,119.00	\$2,797.50	\$0
Overpayment on claim 2				\$27.84		\$3,964.16

¹The PS&R is the provider statistical and reimbursement report.

²TriSpan places a conversion factor of 0.981956 in the outlier calculation in accordance with the “Medicare Claims Processing Manual” (CMS Publication 100-04), section 50.5.

³The threshold rate of 2.5 and the outlier payment percentage of 0.75 were in effect for claims with dates of service from August 1, 2000, to March 31, 2002.

**TRISPAN**

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Amended

February 20, 2006

Mr. Gordon L. Sato
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Subject: Report Number A-06-04-00032
Response to Draft Findings of Financial Review of Synergy Behavioral Health's
Partial Hospitalization Services for the Period August 1, 2000, Through June 30,
2003

Dear Mr. Sato:

We have reviewed the draft findings and recommendations based on your financial review of Synergy Behavioral, provider number 19-4665, for the period of August 1, 2000, through June 30, 2003. We previously responded to draft findings, but have not received a formal response. Therefore, we recommend that open issues be resolved prior to issuing a final report. The open issues are summarized as follows:

- *We are precluded by CMS from making any adjustments for the purpose of recovering outlier payments.* We recommend that OIG work directly with the provider to collect the payments made to Synergy for outlier payments. Since we are not authorized to correct outlier payments, we ask that this recommendation be removed from the final report.
- *We disagree that the use of Worksheet D instead of Worksheet C to calculate the cost-to-charge ratio was improper* because CMS' instructions at the time did not require the use of Worksheet C. The charges should flow directly from Worksheet C to Worksheet D; however, the provider did not correctly complete their cost report. The final report should reflect this issue as a provider error in completion of their cost report.
- *We disagree that the use of August 1, 2000, as the effective date is incorrect.* CMS has indicated that our use of August 1, 2000, is correct. This is definitely not an error and should be removed from the final report.



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- *We disagree that we did not have adequate internal controls in place. We agree that some weaknesses in the review process resulted in the use of an incorrect wage index. Errors also occurred because of the provider's error in completing their cost report; however, we have internal controls in place that have continued to be refined as CMS has issued additional instructions.*

The following are our detailed responses and comments to the findings and recommendations identified in the draft report:

Finding 1: TriSpan did not calculate Medicare outliers and per diem payments to Synergy in accordance with Medicare reimbursement requirements. In calculating outlier payments, TriSpan:

- did not use the correct cost report information to determine the cost-to-charge ratio (CCR) and compute the outlier payments, and;
- incorrectly entered Synergy's provider specific rate in its claim-processing system.

Response: We disagree that TriSpan did not calculate Medicare outlier payments in accordance with Medicare reimbursement requirements. We used Worksheet D to obtain the cost and charges used to compute the initial cost to charge ratio for implementation of OPPS. The instructions in Change Request 1310 did not state that we *must* use Worksheet C to calculate the CCR; instead, these instructions state "the calculation can be made using Form CMS 2088-92, Worksheet C, page 2."

Furthermore, based on the cost reporting instructions in the Medicare Provider Reimbursement Manual Part II, the costs on Worksheet C should flow directly to Worksheet D. The cost reporting instructions state that CMHCs are "... to enter in the applicable column the cost of services provided from Worksheet C column 6, Line 39 on Worksheet D, Part I, Line 1." Therefore, our position is that Worksheet D should be an acceptable worksheet.

The charges on the cost report as submitted by the provider were different on Worksheet C versus Worksheet D. Thus, the provider did not correctly complete their Medicare cost report. Determination of actual charges and related rework of the Medicare cost report is a part of the provider's final settlement process that occurs at a later date. We agree that by utilizing the charges on Worksheet D

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instead of C, we computed a higher CCR that resulted in larger outlier payments, but we contend that our calculation of outlier payments was in accordance with Medicare requirements.

We disagree that we incorrectly entered the effective date on Synergy's outpatient provider specific file (OPSF). The provider's ratio was entered in the OPSF and effective for services on or after August 1, 2000. Change Request 1310, dated September 8, 2000, provides instructions for calculating the CCRs and states the changes are *effective August 1, 2000*. Therefore, *entries we made into the OPSF had an effective date of August 1, 2000*. Furthermore, Change Request 1310 did not specify that the first full year cost report had to be submitted by August 2000 for the original update to pay claims under OPPS. We received guidance from a CMS representative who stated, "August 1, 2000 was an appropriate date."

Additional instructions for calculating provider specific CCRs were issued in Change Request 2197, dated January 17, 2003. After receipt of Change Request 2197, we made changes to our procedures to incorporate the new requirements from CMS. We began computing the CCRs based on the latest tentatively settled or final settled full year cost reporting period. We made the CCR effective based on the date it was entered in the OPSF. Prior to issuance of Change Request 2197, however, we appropriately entered August 1, 2000, as the effective date for CCRs, based on CMS' instructions.

- Finding 2:** In calculating per diem payments, TriSpan assigned the wrong geographic area wage index factor to Synergy.
- Response:** We agree that the incorrect geographic area wage index was assigned to Synergy and used to calculate the APC payments.
- Finding 3:** These errors occurred because TriSpan did not have adequate internal controls to prevent or detect the improper calculation and entry of cost-to-charge ratio and the incorrect assignment of the geographic area wage index factor. As a result, TriSpan overpaid Synergy \$8,193,433.
- Response:** We do not agree that the errors occurred because TriSpan did not have adequate internal controls. We contend that the computed ratio was higher based on the incorrect cost report preparation by the provider. The calculation was correct, but the charges the provider reported on Worksheet D were different from Worksheet C. The entry of the ratio was made based on interpretation of the existing

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instructions at the time of implementation of OPPS. We maintain that internal controls were adequate related to the entry of the CCR.

We agree that weaknesses in the review process of the wage index data resulted in the incorrect APC payments; however, we believe we have adequate internal controls for entry of the wage data on the provider specific file.

Recommendations:

We recommend that TriSpan:

- recover from Synergy improper outlier and per diem payments totaling \$8,193,433 (6,946,670 for services rendered between August 1, 2000 and December 31, 2002, and \$1, 246,763 for services rendered between January 1, 2003 and June 30, 2003);
- review claims with dates of service subsequent to our audit period to ensure that they were paid in accordance with Medicare reimbursement requirements; and
- implement internal controls to ensure that future outlier and per diem payments are computed with the correct CCR and wage index factor.

Response:

Based on current regulations in section 412.116 of the Code of Federal Regulations (CFR), the outlier payments are considered "final payments." We recognize that Synergy received higher outlier payments because the CCR was computed using the charges the provider incorrectly reported on Worksheet D and utilization of the incorrect wage index factor. However, we are not authorized by CMS to recover and adjust claims to recover the outlier payments because of CCRs, adjustments made to cost or charges at the time of audit, or any other reason that may result in deemed improper outlier payments. A response we previously received from CMS states, "CMS will not allow intermediaries to make adjustments to claims to correct outlier payments at this time."

We have conducted a thorough review subsequent to the audit period of Synergy of all the entries made to the provider specific file to ensure the accuracy of the file. We have also made modifications to enhance our quality review of the provider specific file to ensure accuracy.

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We disagree that we do not have documented internal policies, procedures, and controls relating to CCR calculations and update of the wage index factor. We initially followed the instructions in Change Request 1310 to establish the CCRs used to compute outlier payments under OPPS. After receipt of the revised instructions in Change Request 2197 for updating of CCR on an ongoing basis, we developed procedures and identified processes to ensure effective implementation of the instructions. Upon completing the initial phase of the implementation of Change Request 2197, we focused on identifying the most effective way to compute and enter CCRs into the provider specific file as a result of a completed tentative settlement or final settlement. As we worked through the processes, we made modifications to our procedures based on the CMS instructions.

With the implementation of the instructions, initially we may have had some weaknesses in our procedural steps until we finalized and documented the approved policies and procedures for calculating the CCRs, but we did have internal controls in place based on the instructions at that time. With the implementation of any new payment system or policies, it takes time to fully develop procedures and quality assurance checks. We recognized and identified areas of improvement after the implementation of OPPS and the related calculation of CCRs. The following enhancements were made:

1. We modified and revised our procedures to enhance the quality of our work. For example, we revised the CCR computation form to include sign off by the individuals who compute, review, input, and verify the CCRs.
2. We also modified our calculations to include an automatic default to the statewide average when the CCR exceeds 1.0.
3. We have included the update of the CCRs as a part of a monthly monitoring and reporting activity.
4. We created a log to monitor timeliness for completing the CCRs based on the date the tentative settlement or final settlement is complete.
5. We developed a database for cost report activities that includes a feature that automatically generates an email to notify the Supervising Senior Reimbursement Auditor that a tentative or final settlement has been completed.

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6. We enhanced our process for overall update of the provider specific files. Each entry made by an Auditor is reviewed by the Supervisor.
7. We modified our acceptance process to include a review of the cost report to determine the accuracy of the worksheets, and a notification is sent to the provider in the absence of Worksheet C.

We believe we revised our procedures to include processes to avoid the areas of concern you identified in our early processes established with the implementation of OPSS and update of the CCRs.

Thank you for the opportunity to offer comments on the draft findings and recommendations.

In addition, on April 17, 1998, the Dallas Regional Office of OIG issued a report to TriSpan Health Services noting that outlier claims were paid incorrectly because the capital CCRs were not properly updated. We faxed a copy of the report the Atlanta Regional Office (RO) of CMS on March 13, 2001, to determine if the intermediary would be able to make any retroactive correction to outlier payments, based on the language in the manual instructions that outliers are prospective payments and may not be changed retroactively. A response was received from Brett James with CMS' Central Office on September 23, 2003, that the Office of General Counsel (OGC) had revised the original response from CMS RO and *TriSpan would not be able to recoup the overpayments for outliers*. Attached is a copy of the response from OGC. Office of Inspector General Note: The attachment has been redacted because it contained information which may be considered privileged/confidential.

Moreover, CMS issued a Joint Signature Memorandum (JSM) on April 22, 2002, that communicated that CMS was aware that some intermediaries may be using incorrect hospital specific data to compute outlier payments. CMS instructions in the memorandum stated, "We are not asking FIs to make any changes to settled cost reports. We are instructing FIs to ensure that the operating and capital cost-to-charge ratios in the current provider specific files are correct". A copy of the JSM is attached.

In summary, we followed the instructions in Change Requests 1310 and 2197 as these Change Requests were issued. As we are precluded by CMS from adjusting claims to recover outlier payments, we ask that OIG reconsider the recommendation of recovering outlier payments of \$8,193,433. We have completed our review and verification of the accuracy of OPSF entries. However, with respect to review and adjustment of claims, we are limited to the claims data available on the system. We are unable to review and adjust actual claims data that is older than that allowed by the Fiscal Intermediary Standard System (FISS). Again, because of current Medicare regulations, *no adjustments can be made for the purpose of recovering outlier*

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payments. As an alternative, we recommend that OIG work directly with the provider to collect the payments made to Synergy for outlier payments.

Based on the response from OGC and CMS Central Office, there is *no basis* for retroactively correcting outlier payments even if OIG has identified errors on prior CCR entries in the provider specific file. We can only ensure the current updates are correct for open cost reports. The time and costs associated with correcting errors on CCRs for paid claims would be significant. It would involve:

- 1) Requesting Arkansas system programming and CPU time to identify and re-run the claims as adjustments.
- 2) Identifying cost reports to reopen (reopening will be determined based on the aggregate reimbursement impact adjustments); and
- 3) Generating PS&Rs for all affected providers after the claims have been adjusted.

We believe that the calculation of the CCR and the update of the provider specific file should not be considered findings as a result of inadequate internal controls. The error in outlier payments occurred mainly because of the provider's error in completing their Medicare cost report. We appreciate any recommendations to our processes that we have not presently included in our revised procedures.

Sincerely,



Sheila B. Thomas, CPA
Director, Provider Reimbursement



DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

DATE: April 22, 2002

FROM: Director, Financial Services Group
Office of Financial Management

Deputy Director for Contractor Management
Center for Medicare Management

SUBJECT: Correct Calculation of Hospital Cost-to-Charge Ratios

TO: All Fiscal Intermediaries (FIs)

The Centers for Medicare & Medicaid Services (CMS) has learned that some FIs throughout the country may be using incorrect hospital specific charge data to compute cost outlier payments for hospitals. The result can be errors in outlier payment amounts. The intent of this memorandum is to bring the problem to your attention and request that you ensure that the cost-to-charge ratios are correctly calculated for all open hospital cost reports.

The problem appears to stem from intermediaries not reconciling inpatient Medicare charges from the Provider Statistical and Reimbursement (PS&R) report to the cost report. In addition, in some instances routine charges were not included in the as-filed cost reports because the providers and some FIs believed the revised CMS 2552-96 did not have data fields to include routine charge data. (There are data fields on the cost report to record this information.) As a result some FIs used the statewide averages listed in the annual Prospective Payment System (PPS) update in the Federal Register as their best alternative.¹ By using statewide averages, the FIs either over or under paid providers for outlier payments.

We are not asking you to make any changes to settled cost reports. We are instructing

¹The statewide averages are only used when the hospital's operating or capital cost-to-charge ratios fall outside parameters established by CMS in the annual update to the PPS payments.

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you to ensure that you calculated the operating and capital cost-to-charge ratios in the current provider specific file using the correct Medicare inpatient charges. This will require you to reconcile PS&R data to the charges on the cost report and/or ensure that the providers included charges on the as-filed cost report.

There will not be any additional funding allocated to accomplish this review. You should determine the effect on your current workload and make appropriate adjustments. If there is any impact on accomplishing the goals set forth in the Budget Performance Requirements (BPRs), then inform your regional office of any needed changes to accomplish the cost-to-charge ratio review. If you have any questions concerning this instruction, please contact Charlotte Benson at 410-786-3302 or Brett James at 410-786-9358.

/s/

Elizabeth Richter

/s/

Elizabeth Cusick

cc:

All RAs

All CCMOs

All ARAs for Financial Management

Nan Foster Reilly, Kansas City RO

Carol Plum, CMM