REVENUE TESTS

Regulation References: 42 CFR 413.20, 413.24, and 413.53

OBJECTIVES:

1. To evaluate the data accumulation system and the charging practice of the provider to ascertain that it results in an equitable basis for apportioning costs.
2. To ensure that the provider's charge structure is uniformly applied to all patients (all patients are billed the same rate for the same services and supplies and the charges are reasonably and consistently related to the cost of the services.)
3. To ascertain that all revenues are properly recorded and classified to revenue cost centers.
4. To determine the matching of revenue with cost is consistent.
5. To determine that charges to Medicare and all other patients are proper.

OTHER REFERENCES:

MIM-4, §3952.4

PRM-I, §§2202, 2203, 2205, 2302.6, 2302.8 and 2604.3

Cost Report Forms: Hospital:

HCFA-2552, Worksheet C
HCFA-2552, Worksheet D, Parts II and III
HCFA-2552, Worksheet D, Parts II, IV and V
HCFA-2552, Worksheet G-2
HCFA-2552, Worksheet G-3
HCFA-2552, Worksheet D-6

REVENUE TEST INDEX

HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

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RECONCILIATION OF REVENUES

1. If not done at desk review, reconcile the provider's patient care and other revenues as claimed on Worksheet C and Worksheet G-2 (Statement of Patient Revenues and Operating Expenses) of the cost report to the provider's working trial balance and to the financial statements. Explain any significant differences.

   If the provider is furnishing charity care, due to a change in the GAAP treatment, the audited financial statements will exclude charity and Worksheet C should include charity.

MATCHING OF COSTS AND REVENUES

2. Determine that a proper matching of costs and revenues was made, both for total and Medicare. This would include routine and ancillary care, for example, IVs where the revenue may be in pharmacy and the cost in medical supplies, and cost of pacemaker or orthopedic in medical supplies and the revenues in operating room.

   A. Review the groupings of revenue accounts for ancillary cost centers to determine whether charges for the accounts are being consistently matched with their corresponding expense accounts in order to ensure proper allocation of costs to the program.
   B. Where a significant variance in the year-to-year comparison of cost-to-charge ratios or an unusually high cost-to-charge ratio for any ancillary or outpatient cost center is revealed during desk review and is scoped for audit, perform the following procedures:

      1. Obtain an explanation from the provider.

      2. Perform appropriate tests to verify the provider's explanation.

         If the desk review exception pertains to a clinic cost center into which several clinics/departments were aggregated, verify whether each clinic/department generates patient charges. Investigate whether those clinics/departments that have no charges should be set up as non-reimbursable cost centers (for example, physician-directed clinics, WIC program, adult day care centers). In any event, clinics with no charges cannot be aggregated into the same cost center with clinics that generate patient charges (PRM-I, §2203).

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If the desk review exception pertains to observation beds, especially if the beds are located in the inpatient routine area, verify that the charges were correctly computed.

3. Determine from these tests whether the variance or high ratio has been satisfactorily explained. If not, perform further work to resolve the variance, or, if no explanation is adequate, propose an audit adjustment.

OUTPATIENT CLINICS

3. A. If separate general ledger accounts are not maintained for each clinic (see Exhibit 1, Item 7C), but the Tour of Plant (Exhibit 1, Item 2B) or the telephone directory discloses that the provider operates various specialty clinics perform the following steps.

1. Determine whether the provider maintains any records which identify the Medicare utilization and cost/charge relationship for each clinic. If so, perform step 2.

2. Determine if significant differences in the individual clinic cost/charge ratios coupled with differences in Medicare utilization cause a distortion in Medicare reimbursement for the clinics. If so, adjust the total and Medicare charges to reflect a uniform cost/charge relationship for the individual clinics.

B. Some clinics erroneously include ancillary services, such as radiology, in the same cost center as the clinic. It is important for correct Medicare reimbursement to ensure that the cost and charges for such ancillary services are recorded in the appropriate ancillary cost centers and not in the clinic cost center.

1. Inquire of the clinic's staff how clinic ancillary services are billed and whether they are properly recorded as ancillaries rather than as clinic services.

2. Select a sample of patient bills for clinic patients and determine, by reference to medical records, charge slips and revenue accumulations whether the ancillary charges are correctly recorded. The sample must include both Medicare and non-Medicare patients. Where this test reveals that ancillary charges (and cost) have been included in the clinic cost center, request that the provider

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identify the ancillary cost, total charges and Medicare charges. Verify this information and propose an appropriate adjustment.

C. The provider is only cost reimbursed through the cost report for provider-based clinics and not for physician-directed clinics, which would be reported as nonreimbursable cost centers. Additionally, care must be taken to treat physicians' private offices as nonreimbursable cost centers.

1. Ascertain through inquiry or inspection whether the clinic includes any physicians' private offices and ensure that they are treated as nonreimbursable cost centers.

2. Ascertain through inquiry or inspection whether the clinic is physician-directed or provider-based. A provider-based clinic would be responsible to the provider's board of directors. This would not be true of a physician-directed clinic. However, even if the clinic is under the direction of the provider's board of directors, determine whether the provider bills patients for the routine clinic visits.

   If the physicians bill a global charge (charge for physician patient care services as well as for the nonphysician personnel and other operating costs of the clinic) contact HCFA for guidance whether the clinic qualifies as hospital-based.

   If the clinic is physician-directed, ensure that it is treated as a nonreimbursable cost center.

CONSISTENCY OF PHYSICIAN CHARGES

4. Determine on a department-by-department basis whether the total charges include charges for both physician and provider services or only provider services. Use this information in Exhibit 16, the Provider Statistical and Reimbursement Report section, to determine whether the related Medicare charges need to be adjusted in the same manner.

   Note: If the hospital is using combined billing (one bill for provider and physician service charge) for non-Medicare patients only, the Medicare physician service charges may be added to the Medicare provider component charges (or the non-Medicare physician service charges may be subtracted from the total departmental charges) for cost apportionment purposes.

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For Medicare purposes, clinical laboratory services are treated as provider services and billing for physician services in conjunction with clinical laboratory services is not allowed. However, for non-Medicare purposes, separate billing may be made for physicians services in conjunction with clinical laboratory services. In order to ensure appropriate cost apportionment, Medicare charges and total charges for clinical laboratory services must represent charges for the same services and cost components regardless of how the billing was initially characterized.

Also, note that while combined charges may be used for cost apportionment purposes on a department-by-department basis, aggregate charges must be reduced to provider-component-only charges when making a comparison of the lesser of reasonable costs or customary charges.

PROVIDER'S CHARGE POLICY

5. Review the provider's charging policies and its procedures for updating charges.

   A. Determine that the provider uses the same charge structure for all patients, for like services. Consistency of charging among all classes of patients is essential to achieving accurate and acceptable cost apportionment. If consistent charge structures are not applied, Medicare's share of provider costs cannot be correctly determined. If the tests show that the provider did not use a consistent charge structure, disallow the Medicare reimbursement for that cost center(s) until the provider produces and substantiates revised total revenue on a consistent basis.

      1. Gain access to the provider's schedule of charges used in the period under audit.

      2. Determine if rate increases become effective to all patients on the same date.

         Note: Some third party payers require providers to obtain 30 days or more advance approval prior to implementation of a rate change. Accordingly, the timing of rate changes may not be uniform.

      3. Determine if the provider has any special charging arrangements or discounts (other than the regular schedule) with special groups, such as group practice prepayment plans or health maintenance organizations, inpatient, outpatient and other components that would affect the ratio of cost to charges (RCC) application. If so, determine if the

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revenues applicable to these arrangements should have been subject to "grossing up" for the purposes of the cost report so that the amounts are comparable to the revenues generated by the regular schedules of charges.

B. Determine the provider's policy with regard to charges for noncovered items. When testing the provider's procedures for revenue accumulation, verify that the provider has not included noncovered items as covered charges when billing Medicare. Where errors are noted, and your tests are based on a sample that is not statistically valid, you should consider expanding the sample to verify that the expanded sample is representative of the population. However, if in your judgment the amount sampled is representative of the population, then you do not need to expand the sample. The audit adjustments should reflect the population and not just the errors in the original or expanded sample. Propose an audit adjustment for the population difference, if determinable. Otherwise, disallow Medicare reimbursement for that cost center until the provider produces and substantiates revised Medicare revenue on a covered charges basis.

REVENUE TESTING

Select one preliminary sample of all patients and perform the following tests of provider procedures, to the extent possible, on the same sample to avoid duplication of work.

Where errors are noted, and your tests are based on a sample that is not statistically valid, you should consider expanding the sample to verify that the expanded sample is representative of the population. However, if in your judgment the amount sampled is representative of the population, then you do not need to expand the sample. The audit adjustments should reflect the population and not just the errors in the original or expanded sample. Propose an audit adjustment for the population difference, if determinable. If the audit adjustment is not determinable, require the provider to produce appropriate revised records. In the interim, depending on the extent of the deficiency, disallow some or all of the provider's claimed costs.

OVERALL REVENUE ACCUMULATION

6. Select a sample of charge slips or equivalent for review:

   A. Trace the data on the charge slips to the appropriate source documents.

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Note: The source documents may include patient registers, log books, ancillary daily reports of service, appointment books, patients' medical records, etc.

B. Trace the data from the appropriate source documents to the charge slips and patients' accounts to determine that each patient is being charged for all services rendered.

C. Trace individual patients' charges for room and board, drugs, supplies, and other special services to charge slips to determine that the charges have been properly identified to the revenue-producing departments initiating the charges.

Note: Ensure that special care surcharges are treated as special care and not ancillary.

REVENUE ACCUMULATION PROCEDURES

7. Test the accuracy and reliability of the provider's revenue accumulation procedures by selecting one day's revenue accumulation and performing the following audit procedures:

A. Test the clerical accuracy of the daily charge summary.
B. Trace a representative sample of charge slips to the revenue summary for the day selected as to the department charged and inpatient and outpatient classifications.

Note: Describe in the working papers how these representative samples were selected and the basis of evaluation. (See MIM-4, §4112.3.E.3.)

C. Trace a sample of the daily charge summary into the monthly accumulation of revenue and trace accumulation by department into the general ledger.

D. Trace a sample of total charges from the monthly accumulation into the accounts receivable control account in the general ledger.

E. Trace a sample of charges from patient accounts receivable to individual charge slips. Cross-check these charges with the medical records to ensure that they were authorized.

BILLING PROCEDURES

8. Sample the provider's billing and recording procedures by performing the following audit steps:

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A. Verify that charges billed to all patients agree with the patient ledger card, published charge master for that time period and, for Medicare patients, the PS&R report.

B. Ensure that patients have been charged the proper number of daily room charges. Count the day of admission or day of discharge, but not both.

Note: For patients transferred between provider components, the patient's location at the census-taking hour determines where to count and/or charge the patient.

C. Ensure that patients have been charged only for those ancillary services received as shown by medical records.

1. Test that all types of patients are charged the same charge for similar services.

2. Determine the provider's policy for handling Medicare charges for no-adjustment inpatient and outpatient claims. These are claims where no additional reimbursement is made, such as where a patient incurs charges for drug or supply items after the patient has been discharged. When the PS&R report does not handle these adjustments, the provider must maintain a log of these claims. This will always be done for PPS hospital inpatient late charges, which cannot be submitted as an adjustment bill. It will also be done for late charges for other services where the provider chooses not to submit an adjustment bill.

UNIFORM CHARGES

9. To determine that the provider is uniformly applying charges, perform the following tests:

A. Select samples of inpatient and outpatient, Medicare and non-Medicare patients and obtain the medical records and patient account records.

Verify that the patient charges shown on the account agree with the charge schedule (the medical record may be required to determine the actual test or procedure performed). Obtain explanations for any exceptions and determine if explanations are reasonable. Documentation by medical personnel indicating unusual circumstances should be referred to medical review.

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B. Sample patient billing forms or equivalent for review and determine that uniform charging practices are maintained, especially in those ancillary departments that reflect either exceptionally high Medicare utilization, or where departmental costs are significantly higher than the charges.

C. If provider charges do not appear uniform or there is a weighting factor for specific categories of patients, propose adjustments accordingly.