DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

APR 17 2003

Report Number: A-04-02-02017

Mr. Steve Short
Chief Financial Officer
Tampa General Hospital
Davis Island
P.O. Box 1289
Tampa, Florida 33601-1289

Dear Mr. Short:

Enclosed are two copies of the United States Department of Health and Human Services, Office of Inspector General, Office of Audit Services' final report entitled *Audit of Medicare Costs for Organ Acquisitions at Tampa General Hospital.*

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official. 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.

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To facilitate identification, please refer to the report number (A-04-02-02017) in all correspondence relating to this report. If you have any questions, please contact me or have your staff contact Peter Barbera at (404) 562-7758.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:

Wilma Cooper
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicare Operations, Region IV
61 Forsyth Street, S.W., Suite 4T20
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Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

AUDIT OF MEDICARE COSTS FOR ORGAN ACQUISITIONS AT TAMPA GENERAL HOSPITAL

JANET REHNQUIST
Inspector General

APRIL 2003
A-04-02-02017

Notices

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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.

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Mr. Steve Short
Chief Financial Officer
Tampa General Hospital
Davis Island
P.O. Box 1289
Tampa, Florida 33601-1289

Dear Mr. Short:

This final report provides you with the results of our *Review of Medicare Costs for Organ Acquisitions at Tampa General Hospital*. The objective of our review was to determine if the costs claimed by the hospital were properly stated in accordance with the Medicare reimbursement criteria.

Our review focused on the organ acquisition costs claimed by the Tampa General Hospital (TGH) totaling $7,001,918 on the Medicare cost report for fiscal year (FY) ending September 30, 1999.

EXECUTIVE SUMMARY

The Medicare reimbursement for organ acquisition costs in FY 1999 was overstated by $1,459,070. The majority of the excess reimbursement was the cumulative result of TGH overstating the direct costs for kidney and liver acquisition and understating the direct costs for heart acquisitions on the cost report.

The hospital's accounting and cost reporting practices contributed to the excess Medicare reimbursement including:

- the use of improper methods for reporting the average costs of organ acquisitions;
- the improper allocation of employee benefits;
- the improper allocation of transplant office costs to the heart acquisition cost center; and
- the unsupported claim for provider based physician compensation.

The TGH's procedures were not adequate to ensure that organ acquisition costs were properly assigned to all users and properly reported to Medicare. As a result, errors occurred in the accounting and recording of financial data for certified transplant center activities.

Appendix A includes adjustments to the cost report that we feel need to be made to more fairly report the organ acquisition costs allocable to Medicare. We are recommending that TGH file an amended cost report for FY 1999 to incorporate these adjustments and reduce its claim for Medicare reimbursement by $1,459,070. We also recommend that TGH establish procedures and accounting controls to assure the proper reporting of organ acquisition costs allocated to Medicare. In addition, we recommend that TGH review its cost reports for subsequent years and file amended cost reports as necessary to ensure that the cost reports are free of the types of errors identified during our audit.

In responding to our draft report, TGH disagrees with most of our findings. We have included an excerpt of TGH's responses after each finding and the entire response is included as Appendix B.

BACKGROUND

The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS). Medicare was established by Social Security Amendments in 1965 known as Title XVIII of the Social Security Act. Medicare provides health insurance coverage for people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage.

Federal criteria found in Section 1881(d) of Title XVIII of the Social Security Act provides for coverage of medical services related to organ donation for transplant surgery. In Title 42 of the Code of Federal Regulations (CFR) section 409.18, identifies specific medical services related to organ donation reimbursed by the Medicare program. The CMS reimburses organ acquisition services as a pass through cost on the Medicare cost report.

A Medicare cost report is required by CMS to be submitted from healthcare providers on an annual basis in order to make a proper determination of amounts payable under the Medicare program. The cost report summarizes the provider's financial records and statistical data to determine the proper costs payable under the Medicare program. An audit of the Medicare cost report is conducted to verify and test the accuracy of cost data that affects the provider's Medicare reimbursement. Cost claimed for reimbursement must be reasonable, as well as allowable according to the Medicare regulations.

The TGH, as a Medicare Part A provider, received reimbursement for organ acquisition services from the Medicare program. At the end of each Medicare accounting period, TGH filed a cost report claiming reimbursement from Medicare. The TGH reconciled its costs to the Medicare payments received during the year from Medicare. The TGH's cost report divided its costs into three groups: general service costs centers, impatient routine service cost centers, and ancillary services cost centers. General service costs are also known as overhead costs because the costs benefit TGH's patient services as a whole. Inpatient routine cost centers are the boarding costs of inpatient services. Ancillary service cost centers are those costs that are identifiable to a particular hospital service. Organ acquisition costs are reported under the ancillary group of cost centers.

To establish a standardized method of reporting, CMS has assigned line numbers on the cost report for each class of costs. The CMS has established line 83 on which a hospital reports kidney acquisition costs, line 84 for liver acquisition costs, and line 85 for heart acquisition costs. In order for the organ acquisition costs reported on lines 83, 84, and 85 to be allowable for reimbursement, the costs must meet the requirements set forth in the CFR for the Medicare program as well as CMS's program instructions.

Medical services related to organ donation reimbursed by the Medicare program are identified in 42 CFR 409.18. The Provider Reimbursement Manual (PRM), Part I, Sections 2770 to 2775 contain instructions explaining how Medicare pays for services provided a Medicare patient receiving an organ transplant. The PRM, Part II, Section 3610 provides instructions on completing the cost report's Worksheet A, Lines 83, 84, and 85 for organ acquisition costs.

The PRM, Part I, Section 2304 addresses the adequacy of cost information and the availability of records of providers. The PRM, Part I, Section 2182.3E states the provider must maintain adequate documentation to support the total hours for provider services rendered by physicians to permit application of the reasonable compensation equivalency (RCE) limits. Instructions on the proper preparation of cost report Worksheet A-6 (Reclassifications) are presented in the PRM, Part II, Section 3611. Worksheet A-8 (Adjustments to Expenses) instructions are contained in the PRM, Part II, Section 3613. Worksheets B and B-1 (Cost Allocation-General Service Costs and Cost Allocation-Statistical Basis) instructions are presented in PRM, Part II, Section 3617.

The TGH's kidney transplant center was certified on 5/31/88, its heart transplant center was certified on 8/19/88, and its liver transplant center was certified on 8/3/99.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine if the costs claimed by TGH for organ acquisition were properly stated in accordance with the Medicare reimbursement criteria. Our audit covered direct and indirect organ acquisition costs claimed by TGH on its Medicare cost report for FY 1999.

To accomplish our objective, we reviewed:

- federal regulations related to organ acquisition costs;
- TGH's FY 1999 cost report and related working papers furnished by the TGH's Medicare fiscal intermediary (FI), First Coast Service Options (FCSO); and
- TGH's accounting records for FY 1999.

At the hospital, we reviewed supporting documents for the entries in the organ transplant fee expense accounts and for TGH calculations of average cost per organ transplant. We also reviewed entries affecting organ acquisition cost centers on the Worksheets (A-6), (A-8), and (A-8-2) of the Medicare cost report.

We conducted our audit in accordance with generally accepted government auditing standards and Office of Audit Services Audit Policies and Procedures. The audit was conducted from April 2002 through November 2002. Site work was performed at TGH and the Tampa, Florida office of FCSO.

We limited consideration of the internal control structure to those controls concerning the recognition of revenues and expenses reported on the Medicare cost report and the preparation of the Medicare cost report. Our review did not require an understanding or assessment of TGH's complete internal control structure.

RESULTS

The Medicare reimbursement for organ acquisition costs in FY 1999 was overstated by $1,459,070. The majority of the excess reimbursement was the cumulative result of TGH overstating the direct costs for kidney and liver acquisition and understating the direct costs for heart acquisitions on the cost report.

The TGH's record keeping procedures were not adequate to ensure that organ acquisition costs were properly assigned to all users and properly reported to Medicare. The hospital's procedures included:

- the use of improper methods for reporting the average costs of organ acquisitions;
- the improper allocation of employee benefits;
- the improper allocation of transplant office costs to the heart acquisition cost center; and
- the unsupported claim for provider based physician compensation through the provider component hours claimed.

As a result, errors occurred in the accounting and recording of financial data for certified transplant center activities and some costs were improperly allocated to Medicare.

Appendix A includes adjustments to the cost report that we feel need to be made to more fairly report the organ acquisition costs allocable to Medicare. We are recommending that TGH file an amended cost report for FY 1999 to incorporate these adjustments and reduce its claim for Medicare reimbursement by $1,459,070. We also recommend that TGH establish procedures and accounting controls to assure the proper reporting of organ acquisition costs allocated to Medicare. In addition, we recommend that TGH review its cost reports for subsequent years and file amended cost reports as necessary to ensure that the cost reports are free of the types of errors identified during our audit.

The following findings provide more details on the results of our review. The Medicare reimbursement effect of each finding is not separately reported because all the findings were incorporated into the cost report together in order to determine a cumulative reimbursement effect.

Methods of Reporting Average Costs of Organ Acquisitions Need Improvement

The methods TGH used to report the costs of organ acquisition were based on estimates and in some instances were unsupported. As a result, the total organ acquisition costs reported for each organ acquisition cost center were inaccurately reported on Worksheet A of the cost report. The inaccuracies ranged from a $102,439 increase to a $2,181,772 decrease in reported costs.

The TGH is a certified transplant center for the kidney, heart and liver. Costs are reported separately for each organ acquisition cost center following the criteria established in the PRM.

The PRM I 2771 C states that costs are recovered on an interim basis using the average cost per organ acquisition or standard acquisition charge…" but "… on a final basis through the filing of a Medicare cost report at the end of the facility's fiscal period." Regarding the costs claimed, PRM I 2304 states that the provider's cost information "… must be current, accurate, and in sufficient detail."

The TGH did not properly maintain the average cost associated for transplants, as well as, an organ acquisition charge for each type of organ as stated in PRM I 2771 and PRM II 3625.4. The methods used by TGH for reporting costs on the Medicare cost report did not accurately reflect the total average costs per organ acquisition. The average cost per liver calculation did not include cost accruals and the hospital used data that was 2 years old (FY 1997). The average

cost per heart calculation also excluded cost accruals and was based on partial cost data, which was used to project the FY 1999 total. Finally, we were provided no supporting documentation to determine how the average cost per kidney was calculated.

We recalculated the average cost per organ using TGH's actual cost data for the cost report year. Based on our review, we believe the total acquisition costs on Worksheet A are overstated for the kidney and liver cost centers and understated for the heart cost center. We are recommending adjustments to decrease the kidney cost center by $2,181,772, the liver cost center by $6,729, and the non-certified liver cost center by $34,897. We also recommend the costs claimed in the heart cost center be increased by $102,439.

Auditee's Comments

The TGH contends that proper methods were used in reporting total organ acquisition costs and the reason for the inaccuracies related to the use of cost estimates. For future cost reporting periods, TGH has revised its procedures for determining the amount of organ acquisition costs. The TGH will request a reopening of the FY 1999 Medicare cost report to more accurately reflect organ acquisition expense.

OAS Response

We agree that cost estimates may be used during the cost reporting period. However, the cost estimates should be revised to actual costs prior to filing a cost report with Medicare. We also agree with TGH that a request for a reopening is necessary to correct the organ acquisition cost centers expenses reported in the as filed cost report for FY 1999.

Employee Benefits Not Properly Allocated

The TGH improperly reported certain employee benefit costs resulting in an improper allocation to Medicare.

The PRM II 3617 explains that Worksheets B, Part I, and B-1 were "…. designed to accommodate the stepdown method of cost finding." PRM II 3617 further requires, "There can be no deviation of the prescribed statistics and it must be utilized for all the following cost centers. … Employee Benefits … Salaries …." The PRM II 3617 also states, "The provider can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the intermediary, in writing, 90 days prior to the end of that reporting period. The intermediary has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or should demonstrate simplification in maintaining the changed statistics."

Contrary to these guidelines TGH improperly made an employee benefits reclassification consisting of a direct allocation of benefits from the A&G cost center to numerous other cost centers. Instead, TGH should have reclassified these costs only to the Employee Benefits cost

center. This would have allowed for the proper allocation of these costs based on salary through the step-down method on Worksheet B-1.

The TGH reclassification involved an expense related to employee retirement and an expense related to employee benefits. The retirement portion of the reclassification was allocated based on salary by department, while the benefits portion was allocated by flex cash payments by department. The TGH reclassification was improper for two reasons, first it was a direct assignment of cost that should have been allocated through cost findings and, second, the allocation methodologies were not approved by its FI prior to usage.

The reclassification by TGH should be modified to move employee benefits from the A&G cost center to the Employee Benefits cost center, which will allow for the allocation of the benefits by gross salary.

Auditee's Comments

The TGH contends that the methodology used to determine cost finding for employee benefits is in accordance with prescribed regulations and has been accepted by the FI. These employee benefits consisted of flex benefits expense and "other" employee benefits. The hospital's direct allocation of flex benefits more accurately identified the costs incurred in each department and was in accordance with PRM I Section 2307. Moreover, the assertion that this allocation method was without prior approval is unsubstantiated.

The hospital's treatment of "other" employee benefits has no impact on reimbursement, when compared to OAS's recommended method. The TGH contends for future cost report periods, it will continue to directly assign the flex benefits and the methodology suggested by OAS will be used for "other" employee benefits.

OAS Response

Contrary to TGH's contention, TGH was not in compliance with PRM I 2307. The hospital did not provide evidence that it had applied in writing or that its FI had approved in writing the direct assignment of employee benefits. The PRM I Section 2307 states that alternatives to cost finding may be used where appropriate after obtaining FI approval. In order for TGH to be in compliance with the regulation, it should have made a written request to the FI and submitted reasonable justification for approval of the change no later than 90 days prior to the beginning of the cost reporting period. Since TGH did not demonstrate that it had obtained proper approval for its allocation methods, we do not consider TGH to be in compliance with the CMS reporting requirements of PRM I 2307. As such, we believe TGH should stop directly assigning the flex benefits and reflect the change in their FY 1999 cost report, as well as all future cost reports.

We agree that the "other" employee benefits reimbursement effect would be the same under either TGH's method or CMS's methodology. However, in the absence of evidence indicating the awareness and approval by the FI of its allocation methods, TGH is not entitled to the option

of direct assignment. We believe that the change should be reflected in the FY 1999 cost report, as well as all future cost reports. Thus we believe our recommended adjustment is warranted.

Transplant Office Costs Not Properly Reported

The TGH did not properly allocate costs of the transplant office to the three cost centers under the transplant office. Instead, the costs were reported only in the heart acquisition cost center. This resulted in an inequitable allocation of transplant office costs to Medicare.

The transplant office provides administrative services to all transplant cost centers. Its office manager stated that one employee was a coordinator for liver transplants and another employee was responsible for billing/paperwork for all three organ acquisition cost centers. Yet the salary and other expenses related to the transplant office were reported only in the heart acquisition cost center.

For FY 1999, some of the salary and other expenses of the transplant office should be allocated to the kidney, certified liver, and non-certified liver acquisition cost centers. Based on our review, we believe 1.33 full time equivalents (FTE) are related to the liver acquisition cost center and .33 FTE is related to the kidney acquisition cost center. Using these ratios, we are recommending a cost report reclassification entry to allocate an equitable share of the transplant office costs to the kidney, certified liver, and non- certified liver acquisition cost centers.

We are recommending adjustments to increase the kidney acquisition cost center salary by $15,152 and other by $3,937; the certified liver cost center salary by $9,869 and other by $2,564; and the non-certified liver cost center salary by $51,200 and other by $13,304. A corresponding adjustment is recommended to decrease the heart acquisition cost center salary by $76,221 and other by $19,805.

Auditee's Comments

The TGH agrees that a portion of the salary and other expenses of the transplant office should be allocated to the kidney, liver and non-certified liver acquisition cost centers. However, the effect to Medicare reimbursement and any inequities in the allocation are minimal in relation to total organ acquisition costs. The hospital will reclassify portions of the transplant office costs as suggested in the report for future cost reports.

OAS Response

We disagree with TGH's proposed solution to only make future adjustments regarding this cost reporting issue. Since the FY 1999 cost report has to be reopened and revised making this adjustment will further provide for a more accurate allocation of costs to Medicare.

Provider Based Physician Compensation Not Supported

The TGH claimed $58,920 of provider based physician costs in the organ acquisition cost centers. However, TGH could not provide adequate support to justify the costs claimed. In lieu of adequate documentation we consider the costs to be unallowable.

According to PRM I 2182.3E, providers must, "…maintain the data and information used to allocate physician compensation in a form that permits validation by the intermediary and the carrier." Adequate documentation must be maintained to support the total hours for provider services rendered by physicians to permit application of the RCE limits.

According to PRM I 1102.3I, providers must complete Exhibit 2 to the Provider Cost Report Reimbursement Questionnaire (CMS 339) to support the claim for reimbursement of provider based physician costs. Exhibit 2 reflects "physicians' hours of service providing a breakdown between the professional and the provider component for intermediary and carrier use." The TGH did not complete and include Exhibit 2 as part of the FY 1999 cost report.

Initially TGH charged $109,083 of these costs to the organ acquisition cost centers, but made a $50,163 reduction in costs claimed, resulting in a net cost claimed of $58,920. The $58,920 represented 1248 provider hours of time spent in the organ acquisition cost centers by two physicians. However, TGH did not provide the necessary support for this time. Thus, we consider the claim to be unsupported and unallowable.

Auditee's Comments

The hospital contends that adequate data was provided to justify the costs claimed for provider based physician costs in the organ acquisition cost centers. It supplied the physician contracts and time studies. The time studies were consistent with what was furnished in the prior year cost reports. The hospital notes that for future cost report periods, the medical directors are required to submit monthly timesheets, rather than preparing a time study that only reflects an average week for the year. The hospital also notes that the submission of the physicians' time studies in lieu of CMS Form 339, Exhibit 2 has been acceptable to the FI.

OAS Response

We disagree with the hospital's contention that adequate data was provided to support the costs claimed. Only one time study reflecting a 1 week period was provided and it was dated well after the cost report period. Moreover, the physician contracts require a minimum amount of hours to be devoted for the provision of medical director services. Such a contract term should

be supported by more than an untimely portrayal of a typical work week that does not permit validation as required by PRM I 2182.3E.

Medicare Overpayments

At our request, TGH's FI processed the cost report adjustments shown in Appendix A. Based on the FI's computations, TGH was overpaid $1,459,070 for the FY ended September 30, 1999.

Auditee's Comments

The TGH contends the total amount of the error identified by OAS was incorrect, and states that the overstatement of organ acquisition costs was $1,162,339.

Regarding its accounting system, TGH cites an excerpt from the Government Auditing Standards, and contends that it has accounting system controls in place to comply with the cited standard. The TGH also contends that the errors noted in the organ acquisition costs claimed were caused by the use of estimates and not through the use of improper methods as stated in the draft report.

OIG's Response

We disagree with TGH's opinion of the overpayment amount because the TGH amount does not include all of our recommended adjustments.

We believe TGH has accounting controls in place, however its procedures for assigning and reporting costs to Medicare need improvement.

CONCLUSIONS AND RECOMMENDATIONS

The TGH did not properly report its organ acquisition costs in the FY 1999 cost report. As a result, TGH's Medicare reimbursement was overstated by $1,459,070.

We are recommending that TGH file an amended cost report for FY 1999 to incorporate the adjustments included in Appendix A and reduce its claim for Medicare reimbursement by $1,459,070. We also recommend that TGH establish procedures and accounting controls to assure the proper reporting of organ acquisition costs allocated to Medicare. In addition, we recommend that TGH review its cost reports for subsequent years and file amended cost reports as necessary to ensure that the cost reports are free of the types of errors identified during our audit. We will be forwarding a copy of our report to the Medicare FI.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Tampa General Hospital
FY 1999 Cost Report Adjustments

This appendix presents the cost report details pertaining to our recommended adjustments. To aid the Medicare fiscal intermediary officials in making the corrections the adjustments are presented in the cost report format.

Description	Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
W/S A-6 Reclassifications						
Employee Benefits	35.01	1	0	0	0	PRM II 3617
Employee Benefits	35.01	3	0	5	5	
Employee Benefits	35.01	5	0	21,735,536	21,735,536	
Employee Benefits	35.01	7	0	5	5	
Employee Benefits	35.01	9	0	348,564	348,564	
Admin & Gen Corp	35.02	1	0	0	0	
Admin & Gen Corp	35.02	7	0	6.01	6.01	
Admin & Gen Corp	35.02	9	0	1,069,126	1,069,126	
Central Activities	35.03	1	0	0	0	
Central Activities	35.03	7	0	6.02	6.02	
Central Activities	35.03	9	0	834,848	834,848	
Admin & Gen Reha	35.04	1	0	0	0	
Admin & Gen Reha	35.04	7	0	6.04	6.04	
Admin & Gen Reha	35.04	9	0	104,036	104,036	
Operation of Plant	35.05	1	0	0	0	
Operation of Plant	35.05	7	0	8.00	8.00	
Operation of Plant	35.05	9	0	433,377	433,377	
Laundry & Linen	35.06	1	0	0	0	
Laundry & Linen	35.06	7	0	9.00	9.00	
Laundry & Linen	35.06	9	0	22,761	22,761	
Housekeeping	35.07	1	0	0	0	
Housekeeping	35.07	7	0	10.00	10.00	
Housekeeping	35.07	9	0	879,155	879,155	
Dietary	35.08	1	0	0	0	
Dietary	35.08	7	0	11.00	11.00	
Dietary	35.08	9	0	532,112	532,112	
Nursing Admin	35.09	1	0	0	0	
Nursing Admin	35.09	7	0	14.00	14.00	
Nursing Admin	35.09	9	0	148,239	148,239	
Central Services	35.10	1	0	0	0	
Central Services	35.10	7	0	15.00	15.00	
Central Services	35.10	9	0	510,247	510,247	
Pharmacy	35.11	1	0	0	0	
Pharmacy	35.11	7	0	16.00	16.00	
Pharmacy	35.11	9	0	611,415	611,415	
Med Records	35.12	1	0	0	0	
Med Records	35.12	7	0	17.00	17.00	
Med Records	35.12	9	0	675,448	675,448	
Social Service	35.13	1	0	0	0	
Social Service	35.13	7	0	18.00	18.00	
Social Service	35.13	9	0	193,291	193,291	
Central Transport	35.14	1	0	0	0	
Central Transport	35.14	7	0	19.00	19.00	
Central Transport	35.14	9	0	183,330	183,330	
Paramed Ed Prgm	35.15	1	0	0	0	
Paramed Ed Prgm	35.15	7	0	24.00	24.00	
Paramed Ed Prgm	35.15	9	0	28,819	28,819	

Tampa General Hospital
FY 1999 Cost Report Adjustments

Description	Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
W/S A-6 Reclassifications (continued)						
Adults & Peds	35.16	1	0	0	0	
Adults & Peds	35.16	7	0	25.00	25.00	
Adults & Peds	35.16	9	0	3,665,891	3,665,891	
ICU	35.17	1	0	0	0	
ICU	35.17	7	0	26.00	26.00	
ICU	35.17	9	0	873,996	873,996	
CCU	35.18	1	0	0	0	
CCU	35.18	7	0	27.00	27.00	
CCU	35.18	9	0	419,289	419,289	
Burn ICU	35.19	1	0	0	0	
Burn ICU	35.19	7	0	28.00	28.00	
Burn ICU	35.19	9	0	159,856	159,856	
Surgical ICU	35.20	1	0	0	0	
Surgical ICU	35.20	7	0	29.00	29.00	
Surgical ICU	35.20	9	0	417,259	417,259	
Pediatric ICU	35.21	1	0	0	0	
Pediatric ICU	35.21	7	0	30.00	30.00	
Pediatric ICU	35.21	9	0	172,824	172,824	
Neonatal ICU	35.22	1	0	0	0	
Neonatal ICU	35.22	7	0	30.01	30.01	
Neonatal ICU	35.22	9	0	553,363	553,363	
Subprovider	35.23	1	0	0	0	
Subprovider	35.23	7	0	31.00	31.00	
Subprovider	35.23	9	0	651,335	651,335	
Subprovider 2	35.24	1	0	0	0	
Subprovider 2	35.24	7	0	31.01	31.01	
Subprovider 2	35.24	9	0	164,398	164,398	
Nursery	35.25	1	0	0	0	
Nursery	35.25	7	0	33.00	33.00	
Nursery	35.25	9	0	91,801	91,801	
Skilled Nurs Fac	35.26	1	0	0	0	
Skilled Nurs Fac	35.26	7	0	34.00	34.00	
Skilled Nurs Fac	35.26	9	0	193,795	193,795	
Operating Room	35.27	1	0	0	0	
Operating Room	35.27	7	0	37.00	37.00	
Operating Room	35.27	9	0	1,387,687	1,387,687	
Recovery Room	35.28	1	0	0	0	
Recovery Room	35.28	7	0	38.00	38.00	
Recovery Room	35.28	9	0	207,227	207,227	
Delivery Room	35.29	1	0	0	0	
Delivery Room	35.29	7	0	39.00	39.00	
Delivery Room	35.29	9	0	419,840	419,840	
Anesthesiology	35.30	1	0	0	0	
Anesthesiology	35.30	7	0	40.00	40.00	
Anesthesiology	35.30	9	0	73,025	73,025	
Radiology Diag	35.31	1	0	0	0	
Radiology Diag	35.31	7	0	41.00	41.00	
Radiology Diag	35.31	9	0	658,197	658,197	
Radiology Thera	35.32	1	0	0	0	

Tampa General Hospital
FY 1999 Cost Report Adjustments

W/S A-6 Reclassifications (continued)

Description	Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
Radiology Thera	35.32	7	0	42.00	42.00	
Radiology Thera	35.32	9	0	32,011	32,011	
Radioisotope	35.33	1	0	0	0	
Radioisotope	35.33	7	0	43.00	43.00	
Radioisotope	35.33	9	0	34,406	34,406	
Laboratory	35.34	1	0	0	0	
Laboratory	35.34	7	0	44.00	44.00	
Laboratory	35.34	9	0	700,508	700,508	
Pathology	35.35	1	0	0	0	
Pathology	35.35	7	0	44.01	44.01	
Pathology	35.35	9	0	64,028	64,028	
Respiratory Thera	35.36	1	0	0	0	
Respiratory Thera	35.36	7	0	49.00	49.00	
Respiratory Thera	35.36	9	0	678,610	678,610	
Pulmonary Funct	35.37	1	0	0	0	
Pulmonary Funct	35.37	7	0	49.01	49.01	
Pulmonary Funct	35.37	9	0	19,319	19,319	
Physical Therapy	35.38	1	0	0	0	
Physical Therapy	35.38	7	0	50.00	50.00	
Physical Therapy	35.38	9	0	212,634	212,634	
Physical Ther Reha	35.39	1	0	0	0	
Physical Ther Reha	35.39	7	0	50.01	50.01	
Physical Ther Reha	35.39	9	0	150,032	150,032	
Occupational Thera	35.40	1	0	0	0	
Occupational Thera	35.40	7	0	51.00	51.00	
Occupational Thera	35.40	9	0	84,438	84,438	
Occup Thera Rehab	35.41	1	0	0	0	
Occup Thera Rehab	35.41	7	0	51.01	51.01	
Occup Thera Rehab	35.41	9	0	120,018	120,018	
Speech Path Rehab	35.42	1	0	0	0	
Speech Path Rehab	35.42	7	0	52.01	52.01	
Speech Path Rehab	35.42	9	0	71,927	71,927	
Patient Supp Serv	35.43	1	0	0	0	
Patient Supp Serv	35.43	7	0	52.02	52.02	
Patient Supp Serv	35.43	9	0	76,959	76,959	
Electrocardiology	35.44	1	0	0	0	
Electrocardiology	35.44	7	0	53.00	53.00	
Electrocardiology	35.44	9	0	143,490	143,490	
Electroencephalogr	35.45	1	0	0	0	
Electroencephalogr	35.45	7	0	54.00	54.00	
Electroencephalogr	35.45	9	0	74,055	74,055	
Renal Dialysis	35.46	1	0	0	0	
Renal Dialysis	35.46	7	0	57.00	57.00	
Renal Dialysis	35.46	9	0	85,413	85,413	
Cardiac Perfusion	35.47	1	0	0	0	
Cardiac Perfusion	35.47	7	0	59.00	59.00	
Cardiac Perfusion	35.47	9	0	93,284	93,284	
Closed Cath Labs	35.48	1	0	0	0	
Closed Cath Labs	35.48	7	0	59.01	59.01	

Tampa General Hospital
FY 1999 Cost Report Adjustments

Description	Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
W/S A-6 Reclassifications (continued)						
Closed Cath Labs	35.48	9	0	205,969	205,969	
Gastro Intestinal	35.49	1	0	0	0	
Gastro Intestinal	35.49	7	0	59.02	59.02	
Gastro Intestinal	35.49	9	0	80,040	80,040	
Clinic	35.50	1	0	0	0	
Clinic	35.50	7	0	60.00	60.00	
Clinic	35.50	9	0	696,156	696,156	
Emergency	35.51	1	0	0	0	
Emergency	35.51	7	0	61.00	61.00	
Emergency	35.51	9	0	950,207	950,207	
23 Hr Observation	35.52	1	0	0	0	
23 Hr Observation	35.52	7	0	62.01	62.01	
23 Hr Observation	35.52	9	0	86,370	86,370	
Ambulance Serv	35.53	1	0	0	0	
Ambulance Serv	35.53	7	0	65.00	65.00	
Ambulance Serv	35.53	9	0	169,573	169,573	
Heart Acquisition	35.54	1	0	0	0	
Heart Acquisition	35.54	7	0	85.00	85.00	
Heart Acquisition	35.54	9	0	82,971	82,971	
Physicians Priv Off	35.55	1	0	0	0	
Physicians Priv Off	35.55	7	0	98.00	98.00	
Physicians Priv Off	35.55	9	0	4,035	4,035	
TGH Healthplan	35.56	1	0	0	0	
TGH Healthplan	35.56	7	0	100.01	100.01	
TGH Healthplan	35.56	9	0	72,140	72,140	
OccupationalHealth	35.57	1	0	0	0	
OccupationalHealth	35.57	7	0	100.02	100.02	
OccupationalHealth	35.57	9	0	30,397	30,397	
Pharmacy Studies	35.58	1	0	0	0	
Pharmacy Studies	35.58	7	0	100.04	100.04	
Pharmacy Studies	35.58	9	0	31,993	31,993	
W/S I-1						
Renal Dialysis	14	1	169,137	-85,413	83,724	

To revise the provider's pre-cost report reclassification of employee benefit expenses from a direct allocation to an indirect allocation through the Worksheet B-1 cost allocation step-down process. Employee benefit expenses originally in the A & G cost center and reclassified to various cost centers directly will now be reclassified to the Employee Benefits cost center for indirect allocation.

Liver Acquisition	35.01	1	0	P	P	PRM II 3611
Liver Acquisition	35.01	3	0	84	84	
Liver Acquisition	35.01	4	0	9,869	9,869	
Liver Acquisition	35.01	5	0	2,564	2,564	
Heart Acquisition	35.01	7	0	85	85	
Heart Acquisition	35.01	8	0	76,221	76,221	
Heart Acquisition	35.01	9	0	19,805	19,805	
Non Certified Liver	35.02	1	0	P	P	
Non Certified Liver	35.02	3	0	100.07	100.07	
Non Certified Liver	35.02	4	0	51,200	51,200	

Tampa General Hospital
FY 1999 Cost Report Adjustments

Description	Line No.	Column	As Filed	Adjustment	As Adjusted	Regulations
W/S A-6 Reclassifications (continued)						
Non Certified Liver	35.02	5	0	13,304	13,304	
Kidney Acquisition	35.03	1	0	P	P	
Kidney Acquisition	35.03	3	0	83	83	
Kidney Acquisition	35.03	4	0	15,152	15,152	
Kidney Acquisition	35.03	5	0	3,937	3,937	

To reclassify some of the salary and other expenses from the heart acquisition cost center to the kidney, certified liver, and non certified liver acquisition cost centers based on discussion with the transplant office manager of the duties of employees in the transplant office.

W/S A-8 Adjustments						
Kidney Acquisition	49.05	1	0	A	A	PRM I 2771
Kidney Acquisition	49.05	2	0	(2,181,771)	(2,181,771)	PRM II 3610
Kidney Acquisition	49.05	4	0	83	83	PRM I 2304
Liver Acquisition	49.06	1	0	A	A	
Liver Acquisition	49.06	2	0	(6,729)	(6,729)	
Liver Acquisition	49.06	4	0	84	84	
Non Certified Liver	49.07	1	0	A	A	
Non Certified Liver	49.07	2	0	(34,897)	(34,987)	
Non Certified Liver	49.07	4	0	100.07	100.07	
Heart Acquisition	49.08	1	0	A	A	
Heart Acquisition	49.08	2	0	102,440	102,440	
Heart Acquisition	49.08	4	0	85	85	

To adjust the organ acquisition cost to actual cost. Provider's average cost per organ calculations are incorrect, not adequately supported, and were multiplied by the number of transplants completed for a total cost amount.

W/S A-8-2 Adjustments						
Heart Acquisition	20	4	0	109,083	109,083	42 CFR 415.55
Heart Acquisition	20	5	109,083	(109,083)	0	42 CFR 415.60
Heart Acquisition	20	6	98,200	81,800	180,000	PRM I 2182.3E
Heart Acquisition	20	7	1,248	(1,248)	0	

To remove the provider based physician compensation since the provider did not adequately support the provider hours. To correct the RCE limit to the amount updated 5/5/97.

Tampa General Hospital

March 20, 2003

Mr. Charles J. Curtis
Regional Inspector General for Audit Services, Region IV
Department of Health & Human Services
Office of Inspector General, Office of Audit Services
61 Forsyth Street, S.W., Room 3T41
Atlanta, Georgia 30303-8909

Re: Report Number: A-04-02-02017

Dear Mr. Curtis:

We are submitting our formal response to the draft report dated February 13, 2003 and entitled *Review of Medicare Costs for Organ Acquisitions at Tampa General Hospital.* The findings in this draft report relate to the review by the Office of Inspector General, Office of Audit Services (OIG) to determine if the organ acquisition costs claimed by Tampa General Hospital (TGH) in its FY 1999 Medicare cost report were properly stated in accordance with Medicare reimbursement criteria. According to this report, TGH overstated Medicare reimbursement for organ acquisition costs by $874,876. The factors identified in the report that contributed to the excess Medicare reimbursement include the following:

- using improper methods of reporting the average costs of organ acquisitions;
- the improper allocation of employee benefits;
- the improper allocation of transplant office costs to the heart acquisition cost center;
- improperly writing off donor charges on cost report worksheet A-8; and
- claiming unsupportable provider based physician compensation through the provider component hours claimed.

Improper Methods of Reporting Average Costs of Organ Acquisitions

The OIG contends in its report that the methods TGH used to report the direct costs related to organ acquisition were not in accordance with program guidelines. As a result, the total costs reported for each organ acquisition cost center was inaccurately reported on Worksheet A of the cost report. These inaccuracies ranged from a $102,439 understatement to a $2,181,772 overstatement of organ acquisition costs.

We contend that proper methods were used in reporting total organ acquisition costs and that the reason for the inaccuracies related to the use of estimates. As stated in 42 CFR §413.24(a), cost data must be based on the accrual basis of accounting meaning that an expense is reported in the period in which it is incurred, regardless of when it is paid. Therefore, in order to properly capture all of the costs incurred for the period, estimates were used to accrue amounts related to invoices not yet received by the close of the fiscal year. These amounts related to organ acquisition costs such as fees for physician services, organs acquired from organ procurement organizations (OPO), transportation costs of organs, recipient registration fees, surgeon's fees for excising cadaveric organs, and tissue typing services from independent laboratories. An accrual for the outstanding invoices was estimated as the difference between the total expense per the general ledger and the average acquisition cost per transplant estimated from previous years' data applied to current year transplants.

As the amount of organ acquisition costs was based on estimates using the accrual basis of accounting, variances to actual cost are inherent. During the review, the OIG had the benefit of analyzing cost data more than two years after fiscal year end in determining its average cost per organ for all services that related to FY 1999. This information was not available during FY 1999 before the close of the accounting year. We stress that only the cost for the kidney acquisition cost center was materially different as compared to actual organ acquisition costs. The reason for the difference related to the use of an estimated average cost per kidney transplant and not from the use of an improper method. The other organ acquisition cost centers were either understated or immaterially overstated.

For future cost reporting periods, we have revised our procedures for determining the amount of organ acquisition costs. In addition to recording expense related to actual claims paid during the year, the accrued expenses for invoices not yet received by the close of the fiscal year are validated against billing statements and other correspondence from vendors associated with organ acquisition costs. These revised procedures will significantly improve the accuracy of estimates used to determine organ acquisition costs. Based upon careful review of the information now available, TGH will request a reopening of the FY 1999 Medicare cost report to more accurately reflect organ acquisition expense. Details of these and other adjustments to be included in the reopening are summarized later in this response.

The OIG cites PRM II 3625.4, which states that the provider should "compute the average cost of organ acquisition by dividing the total cost of organ acquisition (including the inpatient routine service costs and the inpatient ancillary service costs applicable to organ acquisition) by the total number of organs transplanted into all patients and furnished to others. If the average cost cannot be determined in the manner described, then use the appropriate standard organ acquisition charge in lieu of the average cost."

The OIG's citation of the above paragraph should be removed from the draft report as it relates to the completion of Worksheet D-6 and therefore, has no relation to the determination of the amount of direct organ acquisition costs reported on Worksheet A. Also, the paragraph in this citation is no longer applicable to the fiscal year being reviewed. This paragraph relates to the determination of organ acquisition cost for non-Medicare patients to be reported as "Revenue for Organs Sold" on lines 67 through 74 of Worksheet D-6, Part IV, which was discontinued for cost reporting periods beginning on or after September 15, 1997.

Employee Benefits Not Properly Allocated

The OIG contends that TGH improperly reported certain employee benefit costs resulting in an inequitable allocation to Medicare. Specifically, the OIG asserts that TGH erroneously direct allocated (1) flex benefits from the A&G cost center to numerous other cost centers based upon flex cash payments, and (2) certain employee retirement expenses based upon salaries. The OIG concludes that TGH's reclassification was improper for two reasons: first, it was a direct assignment of cost that should have been allocated through cost findings; and second, the allocation methodologies were not approved by its fiscal intermediary (FI) prior to usage.

We contend that the methodology used to determine cost finding for employee benefits is in accordance with prescribed regulations and has been accepted by the FI. As stated in 42 CFR §413.24(b)(1), cost finding is the determination of costs by the allocation of direct costs and the proration of indirect costs. The methodology used for the FY 1999 Medicare cost report included reclassifying employee benefits expenses from the Administrative & General cost center to the benefiting cost centers for presentation on Worksheet A, Column 3. These employee benefits expense consisted of flex benefits expense and "other" employee benefits such as payroll taxes, retirement benefits, and worker's compensation

insurance. TGH directly allocated the portion related to flex benefits expense based upon the year-end payroll report of actual flex benefits used by department. This direct allocation more accurately identified the flex benefits incurred for each department rather than using a percentage of gross salaries statistic for cost finding and was in accordance with PRM 2307. If the flex benefits costs were reclassified to the Employee Benefits cost center, as suggested in the draft report, this would create an inequitable allocation to those departments that contain salaried personnel who did not participate in the flex benefits program. Moreover, the assertion that this allocation method was without prior approval is unsubstantiated. TGH has been directly allocating its flex benefits in this manner consistent with prior years and the Intermediary has previously accepted this allocation. In fact, there is no adjustment on the FY 1999 audited cost report asserting that this was an unapproved allocation methodology. Thus, TGH's direct allocation of flex benefits is in compliance with PRM 2307.

All "other" employee benefits expenses were reclassified on Worksheet A based upon the percentage of gross salaries, similar to the allocation of the Employee Benefits cost center on Worksheet B, Part I. TGH's treatment of these costs in this manner has no impact on reimbursement. Since the original TGH reclassification for "other" employee benefits would otherwise be allocated based upon the same statistic (percentage of gross salaries) as the Employee Benefits cost center on Worksheet B, Part I, there would not be an inequitable allocation to Medicare as stated in the draft report. Furthermore, this reclassification recommended by the OIG would not affect the accumulated cost statistic utilized to allocate administrative and general cost on Worksheet B, Part I and does not result in additional inherent inaccuracies. In essence, the same allocation would only shift from Worksheet A, Column 3 to Worksheet B, Part I, Column 5.

For future cost reporting periods, we continue to directly allocate flex benefits expense based upon the flex benefits report for presentation of expenses on Worksheet A, Column 3 as accepted by the FI in previous years. All "other" employee benefits are reclassified from the Administrative & General cost center to the Employee Benefits cost center for cost finding on Worksheet B, Part I using percentage of gross salaries as the allocation statistic as recommended in the OIG draft report.

Transplant Office Costs Not Properly Reported

The OIG contends that TGH failed to properly allocate costs of the transplant office to the three cost centers under the transplant office. Instead, the costs were reported only in the heart acquisition cost center. The OIG further contends that this resulted in an inequitable allocation of transplant office costs to Medicare.

We agree with the OIG that a portion of the salary and other expenses of the transplant office should also be allocated to the kidney, certified liver, and non-certified liver acquisition cost centers. However, since the amounts identified are not significant in relation to total organ acquisition costs and are also reclassified to other organ acquisition cost centers, the effect to Medicare reimbursement and any inequities in the allocation are minimal.

For future cost reporting periods, the portions of the salary and other expenses of the transplant office are reclassified to the benefiting organ acquisition cost centers based upon the methodology described in the draft report.

Donor Charges Improperly Reported

The OIG contends that TGH improperly reduced the expenses of each of the organ acquisition cost centers by donor charges through an A-8 adjustment. And, as a result, the OIG concluded that TGH's expense totals in each cost center were reported at less than actual expenses, which would result in lower reimbursement. The OIG concluded that the treatment of donor charges were improper on two counts: they do not represent actual revenue received, nor do they represent actual costs. The OIG recommends that these Worksheet A-8 adjustments be reversed.

TGH included the donor charges on its general ledger as additional organ acquisition costs. As such, they were included on Worksheet A. Since donor charges are reimbursed through the organ acquisition costs in the Medicare cost report, the charges had to be removed from Worksheet A. The only method to remove these charges from Worksheet A was through a Worksheet A-8 adjustment. This Worksheet A-8 adjustment was correct as it caused the cost report to accurately reflect TGH's organ acquisition costs. In fact, if these donor charges were not removed from expense on Worksheet A, the amount claimed for organ acquisition costs would be overstated. Therefore, the expense totals for organ acquisition were not reported at less than actual expense as stated in the draft report. As such, the Worksheet A-8 adjustment should not be reversed. In sum, we agree with the OIG that the donor charges do not represent actual revenue received nor do they represent actual costs. Since the donor charges are identified in the general ledger as an expense and consequently reported in Worksheet A, Column 3, the amounts had to be removed. Therefore, the Worksheet A-8 adjustment prepared by TGH to remove the non-allowable cost represented by the donor charges was correct.

Provider Based Physician Compensation Not Supported

The OIG states that TGH could not provide any support to justify the costs claimed for provider based physician costs in the organ acquisition cost centers. The OIG further contends that adequate documentation was not provided to support the total hours for provider services rendered by physicians to permit application of RCE limits. The OIG, citing PRM I 1102.31, states that TGH did not complete and include Exhibits 2, 3, 3A, 4, and 4A of the Provider Cost
Report Reimbursement Questionnaire (CMS 339) with the submitted FY 1999 Medicare cost report.

We contend that adequate data was provided to justify the costs claimed for provider based physician costs in the organ acquisition cost centers. The professional and provider components related to physician compensation are defined in PRM I 2108.1. The professional component is defined as "that part of the physician's activities which is directly related to the medical care of the individual patient. It represents remuneration for the identifiable medical services by the physician, which contribute to the diagnosis of the patient's condition or to his treatment." The amount attributed to professional services is reimbursed under Part B and not through the Medicare cost report.

The provider component is defined as "the portion of the physician's activities representing services which are not directly related to an identifiable part of the medical care of the individual patient. Provider services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physician's provider service activities." The amount attributable to provider services is reimbursed under Part A through the Medicare cost report subject to Reasonable Compensation Equivalent (RCE) limits.

During the OIG's review, we provided copies of the contract agreements for medical directors included in the organ acquisition cost centers. It is important to note that these physicians are not employees of TGH, but merely contracted from other organizations to provide medical director services for the transplant programs. These contract agreements for physicians who specialized in organ transplant ranged from $20,000 to $30,000 annually. The specific duties related to providing medical director services were explicitly defined in the contract agreements, which included the following:

- Rendering Director services in a manner which assures efficient provision of quality and cost effective patient care and services;
- Leading the outcomes management process for physicians and facilitate Medical Staff participation;
- Providing immediate consultation with community and university physicians regarding urgent patient care issues by Director or Director's designee;
- Coordinating Medical Staff participation in CME, education of HCT, and development of community and patient education materials;
- Working with Risk Management, Quality Improvement and Utilization Review to resolve patient and Medical Staff concerns in a timely manner;
- Participating in all medical staff and Hospital meetings and committees as may be designated by the Chief Medical Officer;
- Working with the Chief Medical Officer and Managed Care Department to market health care services;
- Assisting the Chief Medical Officer in assuring that appropriate medical coverage of patients occurs during emergency situations that may be created by natural disasters such as hurricanes or flooding. The Medical Directors will provide such coverage if unable to otherwise arrange; and
- Working collaboratively with the Project Line Manager.

The OIG states that TGH failed to furnish the necessary time spent in administrative duties, and therefore no time will be allowed as provider component hours. We contend that the specific duties identified in the medical director services contracts do not include activities directly related to an identifiable part of the medical care of an individual patient as defined in PRM I 2801.1. Also, any remuneration for the identifiable medical services by the physician, which contribute to the diagnosis of the patient's condition or to his treatment, was not reimbursed through the medical director services contracts. Each contract agreement explicitly stated that compensation was for the provision of medical director services and each director shall separately bill patients or payors for patient care services rendered.

We also note that each contract was explicit regarding the minimum amount of hours each physician was to devote for the provision of medical director services. In addition, we provided copies of time studies that were signed by each physician documenting the amount of hours spent providing medical director services during an average week for FY 1999. These time studies were consistent with prior year cost reports and have been previously accepted by the FI as adequate documentation. The FI field audit for this cost reporting period did not include adjustments to provider component hours reported on Worksheet A-8-2. The time studies were also submitted with CMS 339 in lieu of Exhibit 2 and have been accepted by the FI. Exhibits 3, 3A, 4,and 4A of CMS 339 were not submitted with the Medicare cost report because these exhibits were not applicable to TGH. These exhibits relate to the computation of allowable availability service costs and allowable unmet guarantee amounts for emergency department physicians.

For future cost reporting periods, the medical directors are required to submit monthly timesheets rather than preparing a one-week time study. Even though the previous time study was accepted by the FI as adequate documentation, the monthly timesheets will provide more accurate information regarding the amount of hours spent performing administrative duties.

Conclusion

Amount of Reimbursement

The total amount of the error identified by the OIG report is not accurate. As described in the section of the draft report titled "Improper Methods of Reporting Average Costs of Organ Acquisition"; the OIG correctly reduced the amount of direct organ acquisition costs based upon its review of actual claims data. The amounts adjusted for each organ acquisition cost center, however, should be combined with the reversal of the OIG's Worksheet A-8 adjustment that erroneously removed costs associated with donor charges to determine the net overstatement. As shown in the table below, the net overstatement of organ acquisition costs was $1,162,339 versus $2,120,959 as reported in the draft report.

	Kidney	Liver	Heart	Non-Certified Liver	Total
Worksheet A, Col 7 (Filed)	$6,872,136	$217,592	$1,329,066	$1,320,569	$9,739,363
Adjust Cost to Actual Invoices	(2,181,772)	(6,729)	102,439	(34,897)	(2,120,959)
Reverse Adjustment for Donor Charges	729,938	37,027	191,655	0	958,620
Net Effect of Adjustments	(1,451,834)	30,298	294,094	(34,897)	(1,162,339)
Worksheet A, Col 7 (Revised)	$5,420,302	$247,890	$1,623,160	$1,285,672	$8,577,024

For future cost reporting periods, the donor charges are adjusted to a "Deductions from Revenue" account to be reported under Net Patient Revenue on the financial statements. Therefore, the donor charges are not included as expense on Worksheet A, and this adjustment is no longer applicable to future cost reporting periods.

Accounting Systems

The OIG concludes in the draft report that TGH lacked sufficient controls in its accounting system to ensure that the fiscal data for the certified transplant center operations contained no errors. We provide an excerpt from the *Government Auditing Standards*, which states that: "because of inherent limitations in any internal control structure, errors or irregularities may nevertheless occur and not be detected." It is our understanding that internal control over financial reporting is designed to reduce the risk that material misstatements may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We believe that the controls TGH has in place meet these goals.

We agree that utilizing information available after fiscal year end would yield more accurate results. However, we also contend that the variances related to the organ acquisition costs were the result of using estimates (which are generally accepted under the accrual basis of accounting) and not by the use of improper methods as stated in the draft report. We have taken the appropriate steps to ensure that these estimates are more appropriately determined and based upon current information. These steps include updating the average cost per transplant using current information and validating the accrued expenses

against billing statements and other correspondence from vendors associated with organ acquisition costs. We further contend that the methods used by TGH to report costs claimed in the Medicare cost report were based upon prescribed guidelines, applied consistently from prior year cost reports, and previously accepted by the Medicare fiscal intermediary. We also contend that adjustments were appropriately supported and adequate documentation was provided to substantiate the costs reported. Based upon the OIG review and the information now available, we concur, in part, with the OIG recommendation to reopen the FY 1999 Medicare cost report to request the following adjustments:

- Adjust the amount of direct organ acquisition costs included on Worksheet A for kidney (net decrease of $1,451,834), liver (net increase of $30,298), heart (net increase of $294,094), and non-certified liver (net decrease of $34,897).
- Reclassify a portion of the salary and other expenses of the transplant office included on Worksheet A for kidney (increase of $19,089), liver (increase of $12,433), non-certified liver (increase of $64,504) and heart (decrease of $96,026).

If you should have any questions or comments, please call me at (813) 844-4805.

Sincerely,

Steve Short
Chief Financial Officer
Tampa General Hospital

ACKNOWLEDGMENTS

This report was prepared under the direction of Charles J. Curtis, Regional Inspector General for Audit Services, Region IV. Other principal Office of Audit Services staff who contributed include:

Pete Barbera, *Audit Manager*
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