Elements of the Medicare Cost Report
For Rural Health Clinic and Federally Qualified Health Center Providers

Presented by
Provider Outreach and Education

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Disclaimer

This resource is not a legal document. This presentation was prepared as a tool to assist our providers. This presentation was current at the time it was created.

Although every reasonable effort has been made to assure accurate information, responsibility for correct claims submission lies with the provider of services. Reproduction of this material for profit is prohibited.
Medicare Cost Report

- Required annual submission to the MAC
- Contains the following information:
  - Facility characteristics
  - Utilization data
  - Cost and charges by cost center
  - Medicare settlement data
  - Financial statement data
- Maintained by CMS in HCRIS

Cost Reporting Period

- Select any annual period to report
- Cost reporting period consisting of one of the following:
  - 12 successive calendar months
  - 13 four-week periods with an additional day added to the last week or period
  - A reporting period which will vary from 52 to 53 weeks
Cost Report Due Date

- Due on or before the last day of the fifth month following the close of the cost reporting period
- Extensions granted only for extraordinary circumstances outside of a provider’s control
- Must be postmarked by the due date
- December 31, 2012 cost reports are due May 31, 2013

Cost Report Filing Tips

- Obtain PS&R from online PS&R system within 30 days of cost report due date
- All documents filed electronic with the exception of the cost report certification page
- Mail electronic file in the same package with the certification page
- Place check at top of package, if applicable
  - Identified with provider name, CCN (provider number), and FYE
- Include cover letter with cost report, including phone number of provider contact for questions
Physician Compensation

- Subject to instructions and regulations related to reasonable costs
  - The Provider Reimbursement Manual, 15-1
- Subject to desk review
  - Support for hours
  - Justification for unusually high compensation

Physician Compensation

- Limited to reasonableness for physicians who own the clinic
  - Determined by the use of The Bureau of Labor Statistics data by state and region
  - Based on hours worked
- Periodic time studies must be maintained in accordance with CMS Publication 15-1, section 2314
- If the physician owned clinic is a corporation, the compensation must be paid out within 75 days of the year end
Physician Compensation

- Productivity is not an allowable calculation basis for the determination of reasonable physician salaries
- Owner’s compensation includes compensation for all duties including:
  - Patient care,
  - Medical director, and
  - Administration
- Administrative time is reimbursed at the lower administrator rate

Owner’s Compensation

- All owners compensation is limited to reasonable amounts
  - Nurse Practitioners
  - Physician Assistants
- Compensation paid to family members in the operation of the clinic are subject to reasonableness
Home Office Costs

- The Medicare cost report should not be used as a home office cost report
- Consider the need to file a home office cost report to appropriately report shared administrative and general services
- Multiple facilities should not be reported as non-reimbursable
- CMS Publication 15-1, Chapter 10, Section 1000

Related Party Costs

- Related party costs should be self-disclosed via worksheet A-2-1
  - Only allow the actual cost of ownership for related party property; not the amount paid to the related party
- Related party- those with common ownership or control
- Make available adequate documentation to support the costs incurred by the related organization
**Costs and Documentation**

- **Non-reimbursable costs**
  - Areas operated within the RHC that either are not reimbursed by CMS or are reimbursed through Part B of the Medicare Program
  - Labs and x-rays should be reported as non-reimbursable cost centers

- **Provide “source” documentation**
  - Original invoice/receipt
  - Other documentation clearly showing the business purpose of the expense

- **Non-allowable costs**
  - Should be removed from the cost report via worksheet A-2 adjustment

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**Non-allowable Cost**

- RHC/FQHC providers are reimbursed under the reasonable cost regulations
  - Limit providers to the reasonable cost of services and deem certain services as non-allowable
- Non-allowable costs are items not related to patient care
- The value of donations to a provider of space, supplies or produce may not be imputed as costs on the Medicare cost report
  
Reporting Visits on the Cost Report

• Total visits that should be reported are face-to-face encounters with:
  ◦ Physician
  ◦ Physician Assistant
  ◦ Nurse Practitioner
  ◦ Visiting Nurse
  ◦ Clinical Psychologist
  ◦ Clinical Social Worker

• Total visits should include visits that:
  ◦ Take place in the clinic during RHC hours
  ◦ Home visits
  ◦ Skilled Nursing Facility visits

Reporting Visits on the Cost Report

• Total visits should not include:
  ◦ Inpatient hospital visits
  ◦ Visits for patients seen by staff nurses
  ◦ Injections or other procedures

• Total visits should be documented by the clinic
• An inaccurate amount of total visits reported can have an adverse effect on your reimbursement
Injection Costs

- Injection logs should contain
  - Patient Name
  - Date of Service
  - Health Insurance Claim (HIC) Number
- Legible
- Should not include Medicare Advantage patients
- Staff Time ratio
- Review the cost per injection
  - $200 per injection or more is not reasonable
- Total injection count should include all patients

Staff Time Ratio Calculation

- To calculate the Staff Time Ratio:
  1. Calculate Staff Time Per Shot (10 minutes/60 minutes) times Total Injections = Total Injection Time
  2. Determine total hours related to staff time. Hours should be for ALL salaries reported on Worksheet A, lines 1-12, column 7
  3. Divide Total Injection Time by Total Staff Time Hours to determine the staff time ratio
     - Example: 10/60 = .1667 X 1000 total injections = 166.7/10,400 total staff time hours = .0160289
Bad Debts

- The Medicare Bad Debt log should include the following for each claim:
  - Beneficiary Name
  - Date of Service
  - Health Insurance Claim (HIC) Number
  - Date of first bill
  - Medicaid number (or indigence indication)
  - Medicare Remittance Advice date
  - Write off date
  - Coinsurance and Deductible amounts
  - Any payments from other insurance or beneficiary
  - Total write off amount
- Log should calculate: Coinsurance + Deductible – Payments = Write Off Amount

Bad Debts

- Do not include Medicare Advantage/HMO patients
- Collection efforts for Medicare and non-Medicare beneficiaries should be the same
- Bad debts must be returned from the collection agency before they are eligible to be claimed
- Indigence determined by the provider should include a review of the patient’s income and expenses
  - Source documentation
- Bad debts reported should be reduced by recoveries of prior years’ debts
  - Recoveries should be claimed in the cost reporting year received
**Bad Debt Changes from PPACA**

- Patient Protection and Affordable Care Act
- Reduction to reimbursable bad debts:
  - Begins in Fiscal Year (FY) 2013
  - Medicare and dual eligible Medicare/Medicaid bad debt reimbursement
- 3 year reduction:
  - FY 2013- 12% reduction
  - FY 2014- 24% reduction
  - FY's thereafter- 35% reduction

**Amended Cost Reports**

- Accepted within 30 days from receipt
- Amended tentative settlements should be issued within 60 days
- Amended cost reports are generally accepted by Audit managers if the desk review process has not been started and the cost report has not been scoped
Amended Items

- If an amended cost report is not accepted and amended items such as Bad Debt listings are submitted, Cahaba GBA generally considers revisions if amended items are scoped for review and audit samples have not been selected.
- Otherwise, request a reopening to incorporate amended items if greater than $10,000.
- Recommend sending amended cost reports and items within 8 months from FYE.

Sequestration

- **Question:** How will the payments be calculated on the claims?
  - **Answer:** The reduction is taken from the calculated payment amount after the approved amount is determined and the deductible and coinsurance are applied.
  - **Example:** A provider bills a service with an approved amount of $100, and $50 is applied to the deductible. A balance of $50 remains. We normally would pay 80% of the approved amount after the deductible is met, which is $40 ($50 \times 80\% = \$40$). The patient is responsible for the remaining 20% coinsurance amount of $10 ($50 - $40 = \$10$). However, due to the sequestration reduction, 2% of the $40 calculated payment amount is not paid resulting in a payment of $39.20 instead of $40 ($40 \times 2\% = \$0.80$).
Website Resources

Cost Report Software Vendors

Low-Volume Hospitals
Criteria and Payment Adjustments for FY 2013

In order to receive a low-volume hospital payment adjustment for fiscal year (FY) 2013 consistent with the previously established procedures, the Centers for Medicare & Medicaid Services (CMS) is continuing to require a hospital to notify and provide documentation to its fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) that it meets the mileage criterion. For FY 2013, a hospital should notify of its request for low-volume hospital status in writing to its FI or MAC and provide documentation that it meets the mileage criterion on March 22, 2013, so that the applicable low-volume percentage increase can be applied to payments for its discharges occurring on or after October 1, 2012 (that is, the beginning of FY 2013).

A hospital that qualified for the low-volume payment adjustment in FY 2012 may continue to receive a low-volume payment adjustment in FY 2013, without notifying, if it continues to meet the Medicare discharge criterion based on the FY 2011 INPAR data shown in Table 5.1 of the Federal Register notice available on the CMS Web site (located on the distance criterion). However, the hospital must verify in writing to its FI or MAC that it continues to be more than 15 miles from any other "outlier designation [O]" hospital as of March 22, 2013.

Cost Report Filing

All Medicare-certified providers are required to submit Medicare cost reports annually. Use the following information to help you complete your report correctly:

- Cost Report Filing Checklists by Provider Type
- Cost Report Filing Instructions
- Address for Filing Cost Reports
- Cost Report Filing Software Vendors
- Cost Reporting Forms and Instructions
- Free Electronic Cost Report Software
- Medicare Cost Report Software
- No or Low Utilization Cost Report
- Cost Reporting Policies

File an Amended Cost Report

File an Amended Cost Report
Cost Report Receipt Status

If you need to confirm that your CMS has received your Medicare Cost Report, please allow 15 days for processing and then enter your 6-digit Part A provider number or the applicable cost report number. If your report was submitted at least 15 days ago and it is not showing as received, please send an email to OCHPMS@CMS.HHS.GOV, or call 1-800-368-1520, whichever method is available to you. Cost Report Receipt Status (including your claim number) and cost reporting period for this can be researched.

Page last updated: January 11, 2011

PS&R Home Page

Provider Statistical and Reimbursement Reports

The Provider Statistical Reimbursement (PS&R) System is a key tool for institutional healthcare providers: Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACOs), and CMS. The system establishes statistical and reimbursement data applicable to the processed and finalized Medicare Part A claims. These data are subject to various reports which are used by providers to improve Medicare cost reports, and by FIs and MACOs during the audit and settlement process. The PS&R is integral to the CMS system and is the primary tool used in cost reporting.

There are numerous reports that may be generated from the PS&R, but they are primarily grouped into two categories: Provider Summary Reports and Payment Reconciliation Reports. Provider Summary Reports contain data that can be used for cost reporting and data analysis, summarized by specific criteria. The Payment Reconciliation Reports also known as Delata Reports contain detailed claim-specific data that supports the Provider Summary reports.

PS&R users will not be able to generate their own Provider Summary reports using the PS&R Redesign user interface, although the reports are available for printing or importing using various methods. The Payment Reconciliation reports (Delata Reports) may be replicated by the provider using the user interface.
What’s New Article

- MM8278 – Applying Multiple Procedure Payment Reductions to Therapy Caps Amounts for Critical Access Hospital (CAH) Claims
  Posted May 6, 2013 in Part A

- MM8223 – Phase III Electronic Remittance Advice (ERA) Enrollment Operating Rules
  Posted May 6, 2013 in Part A/B

- MM8170 – Medicare System Update to Implement the Line Level National Provider Identifier (NPI) Editing for Sanctioned Critical Access Hospitals (CAHs) Method II Providers
  Posted May 6, 2013 in Part A

- Draft Local Coverage Determination (LCD) Open Meetings – 2013
  Posted May 6, 2013 in Part A/B

- Rural Health Clinics (RHC): Signature Requirements for Medical Records – Reminder
  Posted May 6, 2013 in Part A

- Probe Notification – Review of DRG 681 (Other Skin Subcutaneous Tissue and Breast Procedures)
  Posted May 6, 2013 in Part A


ForeSee Survey

We want to hear from you!

- Rate your Cahaba GBA website experience:
  - Quality of information
  - Freshness of content
  - Clarity of organization
  - Location of information
  - Consistency of speed
  - Overall satisfaction
Online Provider Portal

Eligibility Verification:
- Part A&B Entitlement
- ESRD
- Preventive Services
- Medicare Secondary
- Advantage Plan
- Home Health
- Hospice

Claim Status:
- Claim Number
- Date of Service
- Total Submitted Charges
- Status of Claim
- Amount Paid
- Deductible Amounts
- Adjustment Date

Questions?

Provider Contact Center
1-877-567-7271
Thank you for attending!

Please complete the electronic post-test and evaluation at the conclusion of the webinar

OR

Submit using the following links:

Post-test  http://listmgr.cahabagba.com/subscribe/survey?f=1491

Evaluation http://listmgr.cahabagba.com/subscribe/survey?f=1489