Ask Cahaba A: Elements of the Medicare Cost Report

Presented by
Provider Outreach and Education

May 24, 2016

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
  - Statistics for allocation
  - 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, 2015 cost reports are due May 31, 2016

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
- Checks are sent separately to the Lockbox
  - Identified with provider name, CCN (provider number), and Fiscal Year End (FYE)
- Include cover letter with cost report, including phone number of provider contact for questions
Cost Report Filing Tips

- The cost report must be on the correct version of the cost report software
- See CMS Publication 15-2, Section 130 for more information

InSite: My Financials
InSite: My Financials

Enter the following:
Fiscal Year End Format: MM/DD/YYYY
Type of Data
Contact Email Address
Purpose of Submission
InSite: My Financials
InSite: My Financials

Your documents have been submitted successfully
InSite Cost Report Submission Reminders

- Common A&R Mistakes
  - Users forget to hit “submit” after attaching files
  - Worksheet S requires original signature and must be mailed
  - Receipt date is when Worksheet S is received in our office

Mailing address

- Mailing address for cost reports, as-filed, amended and reopening
  Cahaba Audit & Reimbursement
  Post Office Box 9062
  Portland, ME 04104

- Overnight mail
  Cahaba Audit & Reimbursement
  2 Gannett Drive
  South Portland, ME 04106
Payments Mailing Address

- All payments should be mailed to the lockbox and include information regarding the provider number(s), name, and Fiscal Year End (FYE)

Cahaba Medicare Part A
Lockbox 6028
Post Office Box 7247
Philadelphia, PA 19170-6028

Website References for Hospitals

- We prepared the following to help providers locate the various pieces of information necessary to track reimbursement:
- We are not sending out information related to CMS directed updates, such as 10/1 updates for IPPS, 1/1 updates for OPPS, or when directed to update the SSI%. We will continue to send rate review letters for cost-to-charge ratios and pass-thru updates. The information that is updated per CMS direction for 10/01/XX or 01/01/XX each year is published by CMS on the CMS website or on the QualityNet.org website.
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html) - for FY2016 IPPS
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html) - for OPPS
- CR 9253 provided the IPPS FY2016 update factors. CMS will include the Change Request in the Transmittal Section for the given Federal Year for IPPS updates effective 10/01/XX. This is also the location for any updates or corrections to the CR.
  - [http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetHomepage&cid=1120143435363](http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetHomepage&cid=1120143435363)
Website Information Cont.

- For information on DSH, please follow this link:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

- Additionally, the IPPS acute providers can review the information in FISS through DRG Inquiry. The Inquiry Menu manual includes instructions for the DRG Inquiry screens in FISS. There are several screens that will include the various rates specific to each hospital. By entering the provider number, effective date, and a DRG, the screens will be populated with the specifics for the Hospital. DRG 386, for FY2016, has a weight of .9996 and is the closest to a weight of 1.000. This tool is only available to the Acute IPPS hospitals. Usually, someone in billing or patient accounts will have access to FISS and can get screen prints for you. The base rate is available from these screens in most cases.

- Please refer to this link for additional information:
  - http://www.cahabagba.com/part-a/education/educational-materials/
  Then, click the Inquiry Menu link in the middle of the page, in the FISS Reference Guide section.

Interim Payments

- It is the provider’s responsibility to keep track of interim payments received
- Please ensure you are maintaining this information
- Request for payments can be sent to PSR@anthem.com
3 week letters

- NGS, as part of their desk review process for hospitals, will send a letter giving the provider an opportunity to make changes/corrections to the original filed cost report prior to starting the desk review. 3 weeks is usually given to submit the new cost report and supporting information.
- We will generally not accept an amended cost report once the desk review has started.

Amended Cost Reports

- Accepted or rejected within 30 days from receipt
- Amended tentative settlements should be issued within 60 days
- Amended cost reports are generally accepted 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 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 Fiscal Year End (FYE).

Provider Contact Information

- All correspondence is sent to the contact information in our system of record STAR.
- To update contact information, an updated Form 855A must be submitted to Cahaba Provider Enrollment at:
  
  Cahaba Medicare Part
  Provider Enrollment
  Post Office Box 6168
  Indianapolis, IN 46206

  Email addresses can be updated in the 855 information for us to contact providers.
Payment Questions

- Questions regarding the provider remittance advice payments or withholding should be directed to the Provider Contact Center
  - 1-877-567-7271

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
- Do not include bad debts related to fee for service charges
- Collection efforts for Medicare beneficiaries should be at least as stringent as it is for non-Medicare
- 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 recoveries should be reported on a separate log and bad debts 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
Reopening

- Must be requested within 3 years of the original NPR
- Cahaba requires reimbursement impact of $10,000 or greater
- Ensure that support for the reopening and the reimbursement effect is submitted with the reopening requests

Reopening

- Reopening requests can be submitted via the InSite portal attention Lynn Watts or via email to Lynn.Watts@anthem.com

- Mail reopening request to:
  Cahaba
  Audit & Reimbursement
  Post Office Box 9062
  Portland, ME 04104
Hitech Payments

• **IMPORTANT:** Medicare Administrative Contractors (MACs), carriers and fiscal intermediaries will not be making these payments. CMS has contracted with a Payment File Development Contractor to make these payments.

• Have questions about your EHR incentive payment?
  ◦ **DON'T:** Call your MAC/carrier/fiscal intermediary with questions
  ◦ **DO:** Call the EHR Information Center
  ◦ 1-888-734-6433. TTY users should call 1-888-734-6563

Hitech for CAH providers

• Critical Access Hospital (CAH) providers must submit information for meaningful use to the MAC for review
  ◦ Please submit these to
    Sandra.Gittens@anthem.com
Provider Based Determinations (PBD)

- PBD are voluntary
- Complete the Provider based attestation statement checklist available on the Cahaba website
- Submit all supporting data with the attestation. Please see the CMS PBD checklist for further information on the supporting data required by CMS

http://www.cahabagba.com/part-a/enrollment/provider-based-status-determinations/

Provider Based Determination

- Please send via InSite or mail
  Cahaba
  Audit & Reimbursement
  Post Office Box 9062
  Portland, ME 04104
  or email
  Maria.Grindle@anthem.com
Cahaba 2016 Medicare Expo

Cahaba invites you to attend its 2016 Medicare Expo for providers, software vendors, billing services, and clearing houses

**Date:** June 29-30

**Where:** Cobb Galleria Centre
2 Galleria Parkway
Atlanta, GA 30339

**Registration Now Open**

Customer Satisfaction Survey

**Cahaba would like to hear from you!**

*Please take the ForeSee Survey and let us know how we can enhance your website navigation experience.*
MAC Satisfaction Indicator (MSI)

- Best way to share your opinions of our service directly to the Centers for Medicare and Medicaid Services (CMS)
- Takes about 10 minutes of your time
- To take the survey, go to https://cfigroup.qualtrics.com/SE/?SID=SV_bp9wfWbjvYXhiJ&MAC=JJ-Cahaba&MAC_BRNC=10

Thank you for attending!

Please complete the electronic evaluation at the conclusion of the webinar

Evaluation: http://listmgr.cahabagba.com/subscribe/survey?f=1761&x=c991f45f