Cost Reporting

Provider Audit and Reimbursement (PAAR)

As directed, a copy of the presentation is available for viewing or download on the Cahaba GBA website.
Topics of Discussion

• Cost report receipt, tips for filing cost report

• Amended Cost Reports

• Reopening Issues

• PS&R information

• Bad debts for Medicare cost reports
Topics of Discussion

• Cost Report Issues

• RAC Adjustments on PIP providers

• 2016 Hospital Wage Index and OMS review

• Questions
Contact Information

Debbie Scott – Audit Site Manager
Email – DeScott@Cahabagba.com
Phone- (423) 658-8323
Email Outlook- Fax: (205) 733-7432
PAAR on the Website

www.cahabagba.com/part-a/claims/provider-audit-and-reimbursement/
COST REPORT INFORMATION
Cost Report Receipt

Cost Reports:

To follow-up on the receipt, acceptance or settlement of Medicare Cost Reports, please send an email to:
CRINQAL@CAHABAGBA.COM
Cost Report Filing Tips

• All documents filed electronic with the exception of the cost report certification page

• CMS requires that we have an *Original signed cost report worksheet S page (as applicable to report type)*. Copies, scanned documents and email documents cannot be accepted for this requirement.

• Mail electronic file in the same package with certification page

• Place check at top of package, if applicable
Cost Report Filing Tips

• Obtain PS&R from online PS&R system within 30 days of cost report due date

• Review cost report reminder letter for any changes to filing requirements

• Include cover letter with cost report, including phone number of provider contact for questions

• Do not include passwords in the package with electronic media. Either send in a separate envelope or send the password via email to CRINQAL@cahabagba.com to ensure documents can be accessed
Cost Report Filing cont.

- Please ensure that all contact information including name, address and telephone numbers are current in our system. Letters are sent based on the contacts in the STAR system.
- If contact information has changed please visit our website to complete an updated 855A form for provider enrollment.
- If you experience cost report software issues you should contact your software vendor to help with these issues. Our staff is not able to correct or assist with software issues.
- See our website at www.cahabagba.com/part-a/claims/provider-audit-and-reimbursement/cost-report-filing/ for a list of approved vendors.
Cost Report Timing

• The MAC has 30 days from receipt of a cost report to determine if it will be accepted or rejected
• 60 days from acceptance to issue a tentative settlement
• 12 months from acceptance to issue the final NPR (Hospitals with DSH are still on hold) unless held for Audit
• If selected for Audit, the provider has 4-6 weeks to provide documentation before the entrance conference start date
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 by Audit Managers if the desk review process has not been started and cost report has not been scoped
Amended Items

• If amended cost report is not accepted and amended items such as DSH and Bad debt listings are submitted by provider, Cahaba will generally consider revisions if amended items are scoped for review and audit samples have not been selected

• Otherwise, the provider will need to request a reopening to incorporate amended items if greater than $10,000

• Suggest amended cost reports or amended items are sent within 8 months from FYE
Amended Issues

• We have noted issues with providers filing amended cost reports for the DSH calculation related to the Allina case. This issue has not been addressed by CMS and we have not been given approval to follow the decision. CMS may still appeal to the Supreme Court. These amended cost reports will not be accepted.
REOPENING POLICY
Reopening Policy

- Cahaba requires a $10,000 reimbursement impact in order to grant a reopening request.
- Threshold applies to each provider individually and not chain provider cost reports which total $10,000 or greater in the aggregate.
- Providers should always send a formal request letter with the reimbursement impact of the reopening.
- Our reopening process is paperless; therefore, we encourage providers to send reopening requests to the Reopenings@cahabagba.com inbox with electronic documents in order to ensure a more efficient reopening process.
Reopening Request

- Please send any passwords for supporting documentation within another email so that we can include it in our electronic workpaper process (EWP) documentation.
- It is extremely important that providers understand that complete supporting documentation must be submitted with the reopening request or the reopening may be denied.
- If you question whether to submit certain documentation, err on the side of too much rather than not enough documentation to support the reopening.
- If a consultant is submitting a reopening request, the provider should include a letter stating that we may deal with the consultant on the provider’s behalf and should send only one reopening request.
Reopening Request

• If you send a reopening request electronically, please follow up with an email to the Reopenings@Cahabagba.com email box if you do not receive a Notice of Reopening letter in a few weeks.

• Do NOT send in a check with your reopening request. Until the reopening is processed and a revised NPR issued we do not have a way to apply the check.
Reopening Requests

• CMS has become more strict with MACs about accepting new omitted costs, bad debts, and Medicaid eligible days not adjusted in a revised NPR. CMS is instructing contractors to limit subsequent reopenings to address only those items adjusted within the revised NPR.

• Providers must include any omitted costs, new bad debts, or Medicaid eligible days within 3 years of the original NPR. Contractors will not consider these in a subsequent reopening if an adjustment was not made specifically for items in the revised NPR.
Reopening Requests

• Reopening requests for issues that are in jurisdictionally valid appeal are generally denied because these items must be addressed through the administrative resolution process and involve the BCBSA and PRRB

• If you have already filed an issue within an appeal and the appeal is active, please do not request a separate reopening for the same issues. This can create a great deal of confusion as two separate audit staffs may be working on the request and could cause duplicate work to be completed by the MAC
Cost Report Appeals

• Cost report appeals should be sent to the association and a copy to Cahaba. You may send our copy to CRappeals@Cahabagba.com or via mail service to:

Cahaba GBA
Renee Rhone, Appeals Specialist
Post Office Box 1448
Birmingham, Alabama 35201-1448
PS&R ONLINE INFORMATION
PS&R Online Overview

- Live February 2009
- Used for all cost reports with fiscal year ends 01/31/09 and after
- FYEs prior to 01/31/09 use legacy, send email to PS&R@cahabagba.com requesting PS&R
- CMS Publication 100-06, Chapter 8, Section 10.1 eliminates the requirement for MAC to provide PS&R reports to providers unless “the provider cannot access the system and informs the contractor of this issue”
PS&R Redesign

• After 12/31/10 cost reports, there is no requirement for MACs to send PS&R reports to providers

• It is extremely important that providers have registered for the IACS system to access their PS&R’s and that they maintain their access.

• You may find information regarding the PS&R on our website at www.cahabagba.com/part-a/claims/provider-audit-and-reimbursement/provider-statistical-and-reimbursement-reports/
Online PS&R Access

• **First register in IACS**, at the following web link: [https://applications.cms.hhs.gov](https://applications.cms.hhs.gov)

• **Then you must establish access to PS&R** using the following URL: [https://psr-ui.cms.hhs.gov/psr-ui](https://psr-ui.cms.hhs.gov/psr-ui)

• Questions regarding IACS registration, contact External User Services (EUS) help desk at 866-484-8049, or EUSSupport@cgi.com.


• Information pertaining to the PS&R and registration requirements: [www.cms.hhs.gov/PSRR](http://www.cms.hhs.gov/PSRR)
Online PS&R Usage Tips

• Request paid date approximately 30-45 days prior to cost report due date

• A provider must sign on at least *every 60 days to avoid the User ID being revoked*

• First person to register from organization is designated as Security Official

• Security Official can approve users but cannot access the PS&R

• Chain providers must register each provider within the chain individually

• Cahaba cannot provide either the provider CMS ID or resend a password to the provider, nor identify the correct PTAN
PS&R Detail versus Summary

• Summary PS&R will be sent to the user’s inbox in the PS&R system when requested by the provider through the PS&R system.

• Summaries requested by Cahaba will be sent via our PS&R mailbox.

• When requesting any PS&R through the mailbox be specific, use the correct PTAN, type: Summary or detail or both, PDF or electronic or both. Dates are required.

• Ensure all subunits are noted along with any applicable splits.

• Detail PS&R will be burned to CD/DVD and sent via U.S.P.S.

• Please ensure we have mailing address to mail all detailed PS&R requests.
PS&R Request Information

• If you have a consultant requesting PS&R information we require a letter from the provider approving that the information can be sent to the consultant

• Legacy reports take longer. IACS is now archiving reports with claims that are 5 years or older; therefore, these reports will take longer to receive

• Do NOT email individuals with requests. All requests should come through the PS&R mailbox
PS&R Contact Information

• If you have any questions about PS&R that are not about the IACS registration or issues with the IACS system

• Email-  PS&R@CahabaGBA.com
BAD DEBT ISSUES
## Data Elements Required for Bad Debt Listings

An acceptable bad debt listing MUST include all the following elements to be allowed:

<table>
<thead>
<tr>
<th>Name of Beneficiary</th>
<th>Amount Deductible &amp; Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIC Number</td>
<td>Indigence Designation</td>
</tr>
<tr>
<td>Date of First Bill</td>
<td>Medicaid/Other payments/Recoveries</td>
</tr>
<tr>
<td>Date of Service</td>
<td>Medicaid Number</td>
</tr>
<tr>
<td>Amount of Write off</td>
<td>Date of Write-off</td>
</tr>
</tbody>
</table>


Bad Debt - Indigence

• CMS Publication 15-I, Section 312
  
  In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:
Bad Debts, CMS Pub 15-I, Section 312

- A. The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

- B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

- C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and

- D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures. (See §322 for bad debts under State Welfare Programs.)
Bad Debt Documentation Issues

• Proper indigence documentation
  CMS’ expectation when documenting indigence includes the patient’s application with analysis of Net Worth (Analysis of Asset to Liabilities), Verification of Income (Bank Statement, Copy of SSI checks)
  Determination of indigence must be made by provider and not a patient declaration

• Collection efforts are required for deceased Medicare beneficiaries including an Estate Search (Estate searches can be performed with an online service or documented call to probate court to determine if an estate has been filed with court)

  Sometimes Attorneys are used to perform Estate Research
  Written documentation of the search should be obtained
Other Issues- Bad Debts

• We have been seeing a significant amount of Medicare Advantage claims included in the bad debt listings
  • *Bad Debts relating to HMO plans are reimbursed as part of the capitation rates established by the Medicare Advantage plan and should not be included on the Medicare cost report.*

• Bad Debts relating to deductible & coinsurance for Fee Reimbursed services should not be included in providers’ bad debt listings. Examples such as OP Therapy and Ambulance services are not reimbursable bad debts
Other Issues Bad Debts

- Cross over listings do not have the HIC numbers on the listing
- Cross over bad debts are being claimed on denied Medicaid remits
- Collection efforts have not ceased as of the write off date
- There is not sufficient support of billing the beneficiary consistently for a minimum of 120 days
- The first bill is not being sent timely to the beneficiary. The date of the first bill should be within 45-60 days of the date of service or the Medicare remittance advice date
Bad Debt Reductions

• Legislation regarding reduction of bad debts, beginning fiscal year 2013
• Hospitals and non-dual beneficiaries in SNFs and Swing Beds, Medicare bad debt reimbursement is reduced by 35%
• ESRDs begin a 3 year reduction of bad debt reimbursement as follows
  Fiscal Year 2013 by 12%
  Fiscal Year 2014 by 24%
  Fiscal Years thereafter by 35%
Bad Debt Reductions Cont.

- CAHs, CMHCs, RHCs, FQHCs, COST BASED HMOs, HCCPs and CMPs and dual eligible beneficiaries in SNF and Swing Beds begin 3 year reduction of bad debt reimbursement as follows:
  - Fiscal Year 2013 by 12%
  - Fiscal Year 2014 by 24%
  - Fiscal Years thereafter by 35%
COST REPORT SPECIFIC ISSUES

Reasonable cost
Reasonable Costs Reimbursement

• All providers are required to properly report costs on the cost report, but CAH providers are focused on more often due their reimbursement of reasonable cost
• Providers should remember that all instructions in the Provider Reimbursement Manual 15-1 are applicable to their cost reports
• Providers are overstating advertising costs among other areas
• In order to be claimed, costs must be reasonable, necessary, and what a prudent buyer would expect
Issues Noted

• All step down allocations should follow the instructions
• If direct assignment of costs is utilized, it must be utilized for all cost centers not just select ones
• Providers are combining revenue producing cost centers. For example, each therapy needs a separate cost center and a separate A-8-3
ER Standby Costs

• Per CMS 42 CFR 415.60 the provider must have an annual allocation agreement that proportions the percentage of time for each category of services by physician:
  – Physician services to provider
  – Physician services to patients
  – Activities of the physician not paid by either Part A or Part B, such as research

This allocation must by supported by documentation of time spent in each category and the information has to be auditable by the intermediary/contractor
ER Standby Costs Cont.

- The provider should maintain time studies in accordance with CMS instructions
- To claim unmet guarantee, ER physician revenue must be available based on their billing as compared to the compensation guaranteed by the provider and that difference must be reasonable to be allowable
- ER contracts must be maintained on all ER physicians and physician time must be maintained.
Issues Noted by MACs on ER Standby Arrangements

• Providers are paying ER Physician Groups based on ER contracts written for 24 hours a day standby costs when ER physicians are at the facility a portion of that time seeing patients

• CMS only intended to pay for actual standby time as they realized that in a rural facility that doctors may be idle and they recognize that doctors are only able to bill professional services for a portion of their time at a CAH. For a CAH, the physician can be on standby but not on the hospital premises if they can be on-site within 30 minutes.
Issues Noted by MACs on ER Standby Costs

- Medicare only pays under Part A for actual standby costs. Therefore, the time physicians are seeing patients for professional services should be documented with time studies or other time allocation methods and should not be claimed as standby costs. If professional service time is not removed from standby costs, Medicare is reimbursing for standby at the same time as doctors are seeing and billing patients.
RAC ADJUSTMENTS

PIP Providers
Impact of RAC Adjustments for Providers Paid on PIP

- The bi-weekly PIP amount is paid at the established rate regardless of the Part A claim activity that occurs on the remittances.
- Part A claim activity for services paid under the PIP method is reflected on the remittances. This includes the calculated reimbursement amounts generated by the PIP claim activity. The calculated reimbursement amount for PIP claims is not what is actually paid to the provider on the remittance.
- The Part A claim activity (history) for claims paid under PIP in FISS should then be processed into the PS&R system. The bi-weekly PIP amount paid to the provider is not reflected in the PS&R system.
- Upon settlement of the cost report, the difference in the total calculated reimbursement for PIP claims and the total actual bi-weekly PIP amount would be incorporated in the total final settlement payable to/from the provider.
- Previously, adjustments to RAC claims only impacted the calculated reimbursement amounts for PIP claims and therefore would only impact payment to the provider when the cost report was settled.
RAC Adjustments on PIP Providers

- RAC adjustments to PIP claims actually began to also impact the net payment amount issued to the provider on each remittance. This is shown as an adjustment to the net payment amount on the remittance. These RAC adjustments to payments for PIP claims later also began to be accumulated on the PS&R. (Only for RAC; not for non-RAC claim adjustments).

- Conversely, if a provider wins claim appeals of RAC adjustments, the claim adjustments would be reversed and the provider should receive a refund on the remittance. These refunds for RAC adjustment reversals for PIP claims should also be included in the net amount of RAC adjustments to payments accumulated on the PS&R.

- RAC adjustments and reversals should continue to impact calculated reimbursement amounts for PIP claims. The bi-weekly PIP amount would continue at the established rate.
Cost Reporting for PIP Providers

• PIP payments for W/S E-1:
  Total bi-weekly PIP amount
  (PIP Payment Confirmations)
  +/- RAC adjustments that affected payments per
  the PS&R

• RAC adjustment amount is included on the PS&R in
  the field labeled “Actual Claim Payments for PIP”
  This field on the PS&R includes the total of both
  Operating Outlier payments +/- RAC adjustments
RAC Adjustments and Reversals Subsequent to Cost Report Settlement

• After settlement of the cost report, any RAC adjustments and reversals for PIP claims should continue to impact payment on individual remittances. Therefore, for PPS providers, there would not appear to be a material difference in the final reimbursement for these claims adjusted on the remittance and if they were processed thru the cost report. Cahaba’s policy is to not holdup a settlement or to initiate the reopening of cost reports for subsequent RAC adjustments or reversals. Providers could request a reopening to be considered by Cahaba if they determine the impact to reimbursement is material.
2016 WAGE INDEX AND OMS
2016 Wage Index and OMS

• OMS full survey occurs every 3 years, this year is a full survey. Survey’s were due July 1st.
• The Preliminary July Occupational Mix PUF and supplement can be found here:
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2016-Wage-Index-Home-Page.html
2016 Wage Index and OMS

• The tentative 2016 Hospital Wage Index time table has been released and will start earlier this year than in years past.
• Early October 2014 – Deadline for hospitals to request revisions to their Worksheet S-3 wage data and occupational mix data as included in the preliminary PUFs and to provide documentation to support the request
• Mid December 2014- Deadline for MACs to complete all desk reviews for hospital wage index data and transmit information
SSI Settlements

• Cost reports settlements are being completed on some of the cost reports previously on hold
QUESTIONS
Thank you!

Please complete your evaluation for this session