DZA

DINGUS, ZARECOR & ASSOCIATES PLLC

Hot Topics!

Presented by:

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What is a Cost Report?

- A costing system

- Product costing and profitability
  - Products are services
  - Methodology is defined by CMS

What is the purpose of a Medicare Cost Report?

- Informational
- Determination of Medicare's share of costs
- Determination of cost settlement

Costing System

- Routine costs per day
  - Acute care
  - ICU
  - CCU
  - Nursery
  - NICU
  - Rehabilitation
  - Psychiatric
- Rural health clinic cost per encounter or visit
- All others are cost per charge

Routine Example

Direct ICU costs		$	1,000,000
Allocated support costs			650,000
Total ICU costs		**$**	**1,650,000**
ICU days			500
Cost per day formula	=	$	1,650,000/500
Cost per day		$	3,300

Ancillary Example

Direct laboratory costs		$	1,000,000
Allocated support costs			650,000
Total laboratory costs		**$**	**1,650,000**
Total laboratory charges		$	2,500,000
Cost to charge formula	=	$	1,650/2,500
Cost-to-charge ratio			0.660000

How Much Does Medicare Pay?

- Medicare pays its portion of cost
- Cost report calculates cost to charge ratio
- Medicare charges times cost to charge ratio = Medicare cost

Laboratory cost center			
			CCR
Total cost / Total revenue	1,650,000 / 2,500,000	=	0.660000
Medicare charge	875,000		
Times CCR	0.660000		
Equals Medicare cost	577,500		

How Much Does Medicare Pay?

- Medicare pays its portion of cost
- Medicare charges to total charges equals percentage
- This percent = percent of that department's cost to be reimbursed

Laboratory cost center

			Cost %
Medicare charge	875,000	=	35%
Total revenue	2,500,000		
Total cost	1,650,000		
Times cost %	0.350000		
Equals Medicare cost	577,500		

How Much Does Medicare Pay?

- Medicare pays an interim rate when you bill
  - Average cost-per day
    - Inpatient
    - Swing
  - Average cost-to-charge—Outpatient

- Settles based on routine rate and department CCR

Inpatient Per-diem

- Assume the cost per day of $3,300
- Assume Medicare days of 200
- Assume this D-3 (cost of 493,065)

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,360,176		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.915692	71,180	65,179	50.00
53.00	05300	ANESTHESIOLOGY	0.062328	21,763	1,356	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.328276	301,853	99,091	54.00
60.00	06000	LABORATORY	0.360222	516,584	186,085	60.00
66.00	06600	PHYSICAL THERAPY	0.529272	85,371	45,184	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.101497	283,499	28,774	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.077869	865,516	67,397	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.434352	0	0	90.00
91.00	09100	EMERGENCY	0.296498	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.931892	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,145,766	493,066	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,145,766		202.00

Inpatient Per-diem

- Interim rate is ancillary divided by days added to routine cost per-day
- $493,066/200 = $2,465.33
- Add routine cost = $5,765.33
- Inflate by 1% and round down = $5,822

What's Medicare Pay

- Inpatient days = 4
- Other services:
  - Operation charge $5,000 at .915692 CCR
  - Laboratory charge $500 at .360222

- Routine cost-per day = $3,300
- Interim rate = $5,822

What's Medicare Pay?

A. Interim Rate

Days	4
Interim rate	5,822
Interim payment	23,288

B. Cost Report

			From MCR		Cost
Routine		4	3,300		13,200
Surgery	$	5,000	0.915692		4,578
Laboratory	$	500	0.360222		180
				$	17,958

What's Medicare Pay?

- Settlement

Interim rate	$	23,288
Cost report		17,958
Settlement	$	(5,330)

Cost-based

- Inpatient services
- Most outpatient services
- Technical portion of provider-based clinics
- Rural health clinics (including the physician cost)
  - April 2021 – rate caps which can limit cost-based reimbursement
- CRNA (if qualified for pass-through)
- Medicaid (depending on the state)

Not Cost-based

- Ambulance (with exceptions)
- Assisted living facilities / nursing homes
- Dialysis (unless inpatient only)
- Durable medical equipment (DME)
- Home health agencies
- Hospices
- Non provider-based clinics
- Physician costs
- Professional component of provider-based clinics

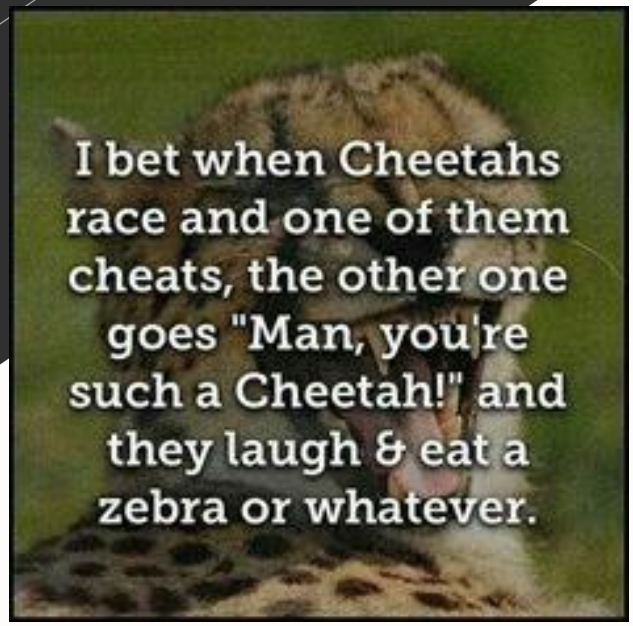
Department description	CMS #	Total allowable expenses	Percentage of total cost reimbursed	Reimbursed expenses
Overhead departments:				
Hospital building	1.00	400,000	**50%**	200,000
Employee benefits	4.00	2,500,000	**52%**	1,300,000
Administrative & general	5.00	3,000,000	**45%**	1,350,000
Operation of plant	7.00	800,000	**49%**	392,000
Laundry & linen service	8.00	100,000	**68%**	68,000
Housekeeping	9.00	150,000	**59%**	88,500
Dietary	10.00	120,000	**77%**	92,400
Cafeteria	11.00	200,000	**62%**	124,000
Nursing administration	13.00	120,000	**70%**	84,000
Central services & supply	14.00	15,000	**68%**	10,200
Pharmacy	15.00	150,000	**70%**	105,000
Medical records	16.00	400,000	**56%**	224,000
Revenue producing:				
Acute care	30.00	2,800,000	**77%**	2,156,000
Operating room	50.00	700,000	**45%**	315,000
Anesthesiology	53.00	400,000	**49%**	196,000
Radiology	54.00	2,000,000	**53%**	1,060,000
Laboratory	60.00	1,500,000	**43%**	645,000
Respiratory therapy	65.00	100,000	**77%**	77,000
Electrocardiology	69.00	50,000	**65%**	32,500
Medical supplies (billable)	71.00	180,000	**68%**	122,400
Drugs	73.00	500,000	**65%**	325,000
Emergency room	91.00	1,750,000	**49%**	857,500
Home health	101.00	1,000,000	**0%**	-
NonReimburseable:				
Physicians' Private Offices	192.00	-	**0%**	-
Hospital based physician fees	A-8	2,000,000	**0%**	-
Other	A-8	200,000	**0%**	-
		21,135,000	**46%**	9,824,500

Cost-based Percentages – Support

- Depends on the percentage of support cost allocated to various departments
- Simple example:
  - Acute care is 77% cost-based
  - Dietary is 100% allocated to acute care
  - Dietary's cost-based percentage is 77%

Cost-based Percentages – Support

- Slightly less simple example:
  - Acute care is 77% cost-based
  - Nursing home is 0% cost-based
  - 80% of meals go to the nursing home
  - 20% of meals go to acute care
  - Therefore, 80% of meals are not cost-based and 20% are 77% cost-based
  - Dietary is 15.4% cost-based (20% * 77% + 80%*0)



Patient days

Patient Days are Important

- Used to calculate the acute care per-diem

  $$\frac{\text{Cost}}{\text{Days}}$$

- Small variances have large effects
- Includes:
  - Acute care
  - ICU
  - Observation
  - Swing bed (skilled only, more to come)

Patient Days

- 50% of the per-diem calculation
  - Cost-based reimbursement is high in this department
- Base for Medicaid utilization

Counting Patient Days

- Discharge/admitting/medical records/actual count/charge count
- DZA recommends: accrual basis
- Reconcile reports
- Overstating of days decreases per-diem and, therefore, reimbursement

Counting Days: Example

	Original	Duplicate	Revised
Days count	900	(100)	800
Medicare days	475		475
Inpatient costs	2,250,000		2,250,000
Per-diem	2,500.00		2,812.50
Medicare reimbursement	1,187,500	**148,438**	1,335,938
Medicare percentage	53%		59%

Common Acute Care Issues

- Swing bed days included in acute care count
- Observation patients included in count
- Hospice days not tracked separately
- LDR days not tracked separately
- Days do not reconcile to billed days
- Test patients (included in summary reports)
- Excel spreadsheet does not foot

Recommendations

- Detail vs. summary reports
- Reconcile monthly/quarterly
- Use only one name for test patients

CAH Swing Beds

- Skilled swing bed days (SNF) –
  - A Medicare beneficiary in a swing bed and Medicare is picking up the bill
  - A Medicare Advantage beneficiary in a swing bed and the Medicare Advantage company is picking up the bill

- Non-skilled swing bed days (NF)
  - **EVERYTHING ELSE**

CAH Swing Beds

- Issue: skilled vs. non-skilled level of care
- Medicare pays cost
- Medicaid pays prospectively
- Non-Medicare days “carved out”

CAH Swing Beds: the Calculation

- Example swing bed "carve out"

Acute care cost	$ 2,000,000
State swing bed rate	$ 299.64
Acute care days	1,200
Medicare days	900
Swing bed days	400
Medicare days	300
Medicare advantage days	25
Other payors	75

CAH Swing Beds

	No NF days	Some NF Days	All NF Days
Swing NF days	-	50	75
Swing NF rate	$ 299.64	$ 250.00	$ 250.00
Swing NF costs	$ -	$ 12,500	$ 18,750
Total costs	$ 2,000,000	$ 2,000,000	$ 2,000,000
less swing NF (carve out)	-	(12,500)	(18,750)
Total cost for calculation	$ 2,000,000	$ 1,987,500	$ 1,981,250
Total days	1,600	1,600	1,600
less NF days	-	(50)	(75)
Days for calculation	1,600	1,550	1,525
Per diem	$ 1,250	$ 1,282	$ 1,299
Medicare days	1,200	1,200	1,200
Medicare cost	$ 1,500,000	$ 1,538,400	$ 1,558,800
Increase over no NF days	**$ -**	**$ 38,400**	**$ 58,800**

Common Swing Bed Issues

- Difference between swing bed days reported on PS&R and internal statistics
- Days counted as Medicare after skilled portion of stay
- Patients reflected as Medicare after benefits exhausted
- Swing bed charges billed under hospital provider number
- Started as skilled but did not meet qualification
- Split billing Medicare at year end
- Remember – corrections at desk review requires additional support

WHENEVER I SEE AN OLD LADY SLIP AND FALL ON A WET SIDEWALK, MY FIRST INSTINCT IS TO LAUGH. BUT THEN I THINK, WHAT IF I WAS AN ANT, AND SHE FELL ON ME. THEN IT WOULDN'T SEEM QUITE SO FUNNY.

- JACK HANDEY -

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Expenses

General Ledger to Cost Report

- How costs are recorded on your general ledger affects your cost report
- Most costs by department
- Some costs by type
- Some departments grouped
- Total expenses must reconcile to the financial statements

Direct Cost Assignment

- Payroll should be assigned through time cards, **not** time studies

- Ensure staff working in multiple departments understand how each cost center is defined

Salary Reporting, also important

- How are the “home” departments defined?
- Time tracking
  - Acute care vs. ER nursing time
  - Labor and delivery vs. post delivery vs. nursery
  - Therapist performs therapy for home health and hospital
  - Nurses calling swing bed time “nursing home”
  - Diagnostic costs in RHC
  - Diagnostic services with several cost centers (think xray separate from CT), but shared staff, shared space

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Overhead departments:				
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Other	A-8	200,000	**0%**	-
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High Cost, High Medicare Utilization

- Examples:
  - Blood
    - Separate costs
    - If using GL for revenue, separate revenue
  - Implantables
    - Separate costs
    - If using GL for revenue, separate revenue
  - Chemotherapy
    - Separate costs
    - Separate revenue on GL even if revenue code report
    - Separate Medicare and Medicaid revenues
  - Wound care

Wound Care

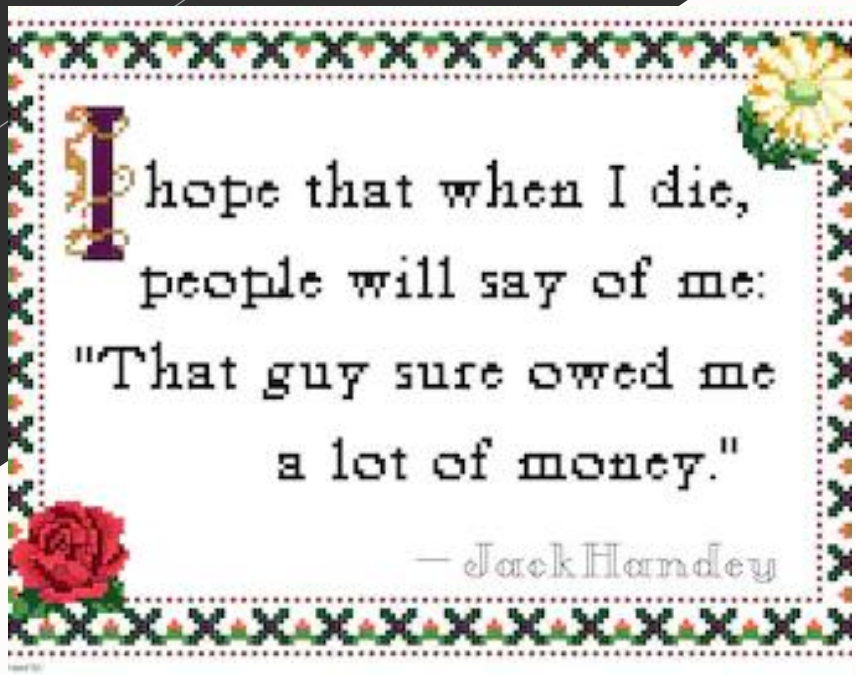
- Location
- Nurse cost
- Surgical debridement
- Supplies
  - Billed using 636 not a supply code
  - Separately track cost (like EpiFix)
  - Separately track associated revenues
    - Total
    - Medicare
    - Medicaid (if any)
- Often 100% Medicare

340B

- Contracted—make sure this is removed via an A8 (not a nonallowable cost center
- Internal use—art of the pharmacy cost
  - Do not group with contracted 340B

Therapy Caps

- Reasonable cost defined, in this instance
- Idaho, assume FY started 12.1.22
  - PT—$95.92
  - OT—$90.90
  - ST—$87.36
  - RT—$75.34



Allocation Methods

Building

- Square feet
  - Get count right
  - Walls or no walls
  - One building or many
  - All captured the same

- Tip: remeasure and use your cost-based spreadsheet

Movable Equipment

- Square feet
- By department

Benefits

- Salaries
- FTEs
- Direct assign what you can (actual)

- Tip: look at B, I for how much is going to your RHC

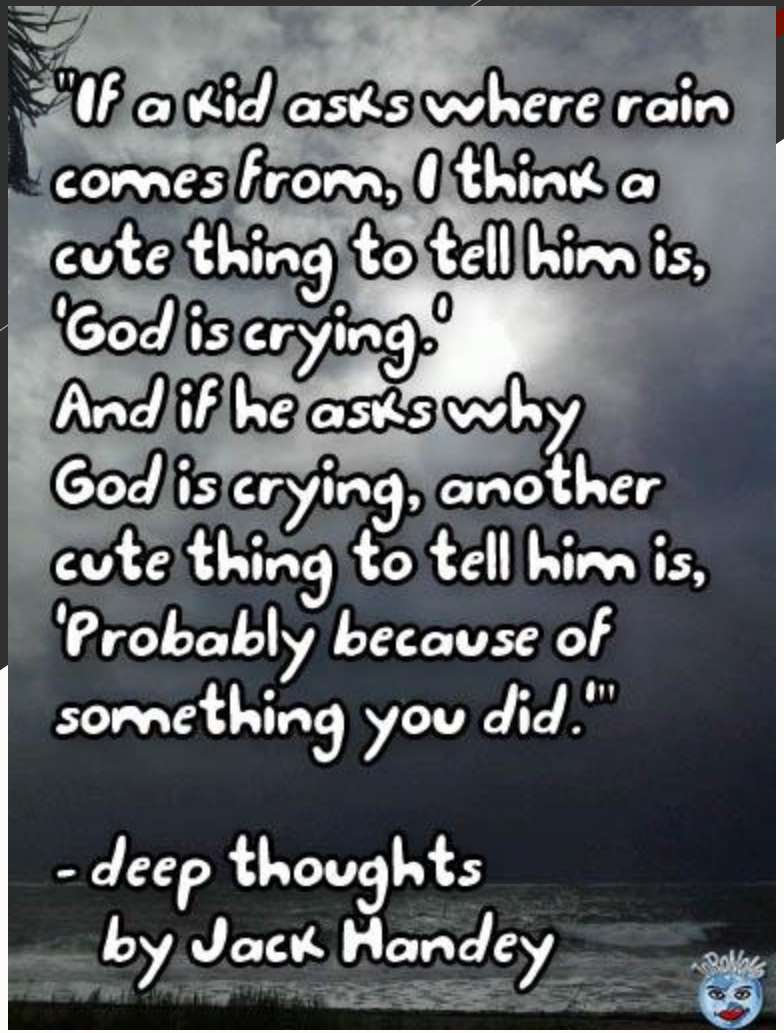
Benefits: the Example

Department description	CMS #	Percentage of total cost reimbursed	Salaries	FTEs	Salaries %	FTEs %	CB% Salaries	CB% FTEs
Overhead departments:								
Administrative & general	5.00	**45%**	2,278,000	33.90	20%	26%	9%	12%
Operation of plant	7.00	**49%**	288,000	4.70	3%	4%	1%	2%
Laundry & linen service	8.00	**68%**	24,000	0.70	0%	1%	0%	0%
Housekeeping	9.00	**59%**	297,000	7.40	3%	6%	2%	3%
Dietary	10.00	**77%**	341,000	7.20	3%	5%	2%	4%
Nursing administration	13.00	**70%**	232,000	4.10	2%	3%	1%	2%
Central services & supply	14.00	**68%**	113,000	1.90	1%	1%	1%	1%
Pharmacy	15.00	**70%**	144,000	1.30	1%	1%	1%	1%
Medical records	16.00	**56%**	196,000	3.90	2%	3%	1%	2%
Revenue producing:					0%	0%	0%	0%
Acute care	30.00	**77%**	1,605,000	15.30	14%	12%	11%	9%
Operating room	50.00	**45%**	329,000	2.20	3%	2%	1%	1%
Radiology	54.00	**53%**	644,000	6.60	6%	5%	3%	3%
Laboratory	60.00	**43%**	383,000	5.80	3%	4%	1%	2%
Respiratory therapy	65.00	**77%**	194,000	2.40	2%	2%	1%	1%
Physical therapy	66.00	**55%**	527,000	6.00	5%	5%	3%	2%
Rural health clinic	88.00	**29%**	2,196,000	18.60	19%	14%	6%	4%
Emergency room	91.00	**49%**	1,081,000	4.20	9%	3%	5%	2%
Home health	101.00	**0%**	480,000	5.40	4%	4%	0%	0%
NonReimburseable:					0%	0%	0%	0%
Physicians' Private Offices	192.00	**0%**	39,000	0.80	0%	1%	0%	0%
		0%	11,391,000	132	100%	100%	49%	50%

Benefits	**3,417,300**	**1,669,743**	**1,718,019**
Increase			**$ 48,276**

Time Studies

- Housekeeping
- Laundry
- Medical records
- Maintenance


"If a kid asks where rain comes from, I think a cute thing to tell him is, 'God is crying.'
And if he asks why God is crying, another cute thing to tell him is, 'Probably because of something you did.'"
- deep thoughts by Jack Handey

RHC Caps

New RHC Caps

- All RHCs now capped
- Base
  - 2020 cost report for some
  - Statutory rate for others

- Medicare could be paying less than cost
- Medicaid is most certainly paying less than cost
  - **ahem, IHA let's talk

Am I Over or Under the Cap?

- Review allocations
- Review provider mix
- Am I still the right type of clinic?
- Did I get a productivity waiver due to COVID-19?

RHC Analysis

	Cost	Cost/ Encounter	Cost/ Productivity
Direct costs	$ 2,932,665	$ 258.29	$ 151.11
Building	81,290	7.16	4.19
Movable equipment	63,945	5.63	3.29
Benefits	336,691	29.65	17.35
Administration	685,597	60.38	35.33
Maitenance and utilities	190,106	16.74	9.80
Laundry	81	0.01	0.00
Housekeeing	96,073	8.46	4.95
Cafeteria	117,903	10.38	6.07
Nurse administration	-	-	-
Central supply	41,359	3.64	2.13
Medical records	36,506	3.22	1.88
Total	$ 4,582,216	$ 403.58	$ 236.10
Encounters		11,354	19,408
Cap	**$385**		

Where to Start?

- First look at productivity issue and staffing
  - Are FTEs accurate?
  - What is the scheduling sequence?
  - Is it one practitioner more than another?

		Base	Visits	Productivity	Over/ (Under)
Mary Jane, MD	1.00	4,200	3,500	4,200	(700)
John Doe, MD	1.00	4,200	1,100	4,200	(3,100)
Martin van Nostrand, MD	1.00	4,200	500	4,200	(3,700)
Monica Quartermaine, DO	0.61	4,200	1,621	2,562	(941)
	3.61		6,721	15,162	(8,441)
Midlevels	1.79	2,100	4,146	3,759	387
Locums			487	487	-
Totals			11,354	19,408	(8,054)

Where to Start?

- Second research direct costs

	Cost	Cost/ Encounter	Cost/ Productivity
Practitioner salary	$ 1,573,760	$ 138.61	$ 81.09
Clinic manager	80,165	7.06	4.13
Nurse salaries	595,562	52.45	30.69
Contracted nursing	164,671	14.50	8.48
Contracted practitioners	76,956	6.78	3.97
Benefits	175,121	15.42	9.02
Maintenance	14,656	1.29	0.76
Supplies	191,471	16.86	9.87
Other	60,303	5.31	3.11
Total	$ 2,932,665	$ 258.29	$ 151.11
Encounters		11,354	97,034

Direct Costs

- Diagnostic costs
  - Laboratory
  - Radiology
  - EKG, not an all-inclusive list
- Dual ER coverage
- Medical director or administrative duties
- Directly assigned support cost (review in conjunction with next step)
  - Persons (like billing, or reception)
  - Software costs
  - Telephone same as say lab?
  - Licensing direct here, grouped for hospital?

Scrutinize Support Allocations

	Cost	Cost/ Encounter	Cost/ Productivity
Direct costs	$ 2,932,665	$ 258.29	$ 151.11
Building	81,290	7.16	4.19
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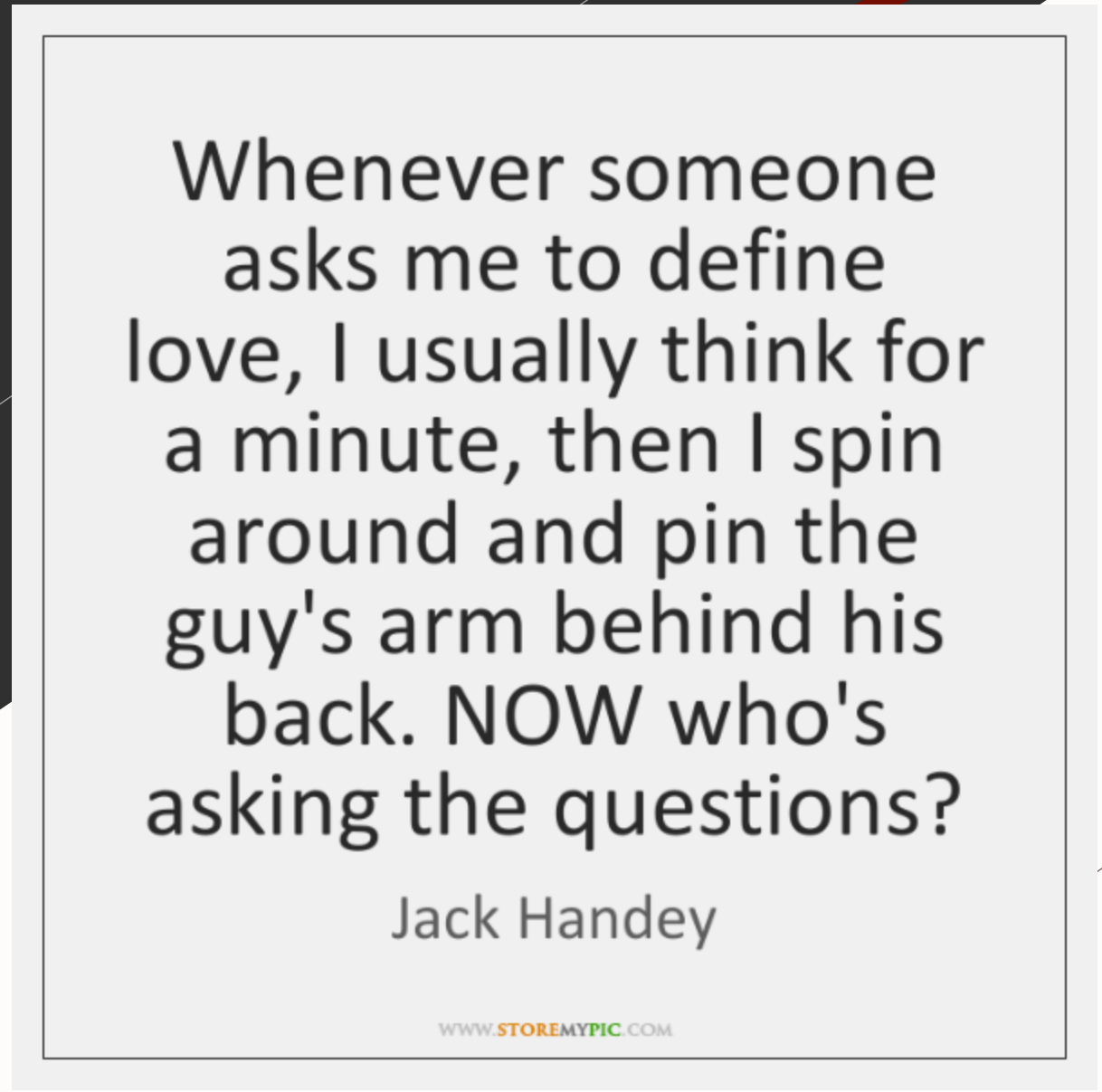
Vaccines

- Still important
- Challenge the status quo for staffing estimates
- Take care in detail provided

More Than One RHCs

- We can combine under one cap
  - Grandfathered with grandfathered
- Analyze first


Whenever someone asks me to define love, I usually think for a minute, then I spin around and pin the guy's arm behind his back. NOW who's asking the questions?
Jack Handey
WWW.STOREMYPIC.COM

Medicare Bad Debts

- Medicare deductibles and/or coinsurance:
  - Hospital services only (not physician)
  - RHCs
- Paid at 65% of the amount claimed
- Excludes:
  - Noncovered services
  - Fee schedule services
  - Co-pays
  - Professional fees
    - Method II billing
- High audit probability

Medicare Bad Debts

- Three types:
  - Reasonable collection efforts
  - Medicaid secondary payor (crossovers)
  - Written off under indigent care
    - Clarification from a couple years ago that charity care is not allowable, but indigent care is

Reasonable Collection Effort

- Deemed uncollectible using the hospital's normal collection efforts
- Treated similarly to other payors and billed with the intention of receiving payment for at least 120 days:
  - 120 days from date the bill was first sent to beneficiary to date it was deemed uncollectible and written off of the hospital's books
    - 120 days starts over after each payment
- Sound business judgment established there was no likelihood of recovery at any time in the future
- Must have auditable support
  - Including the 120 days collection efforts

Must Bill Patient Within Set Time Frame

- Bad debts are to be “worthless” to be claimed and paid by Medicare
- Must bill patient within 120 days of the latest of these:
  - Date of Medicare RA
  - Date of the secondary payor’s RA
  - Date of noncoverage by secondary payor

Recommended Steps

- Update your Medicare bad debt policy to reflect the 120 day rules
  - Starts over each time a patient makes a payment
  - Amount of time from RA to patient
- Devise a way in the patient detail to prove these dates
  - They are both 120 day rules, so figure out a way not to get confused on which we are talking about

Collection Agencies

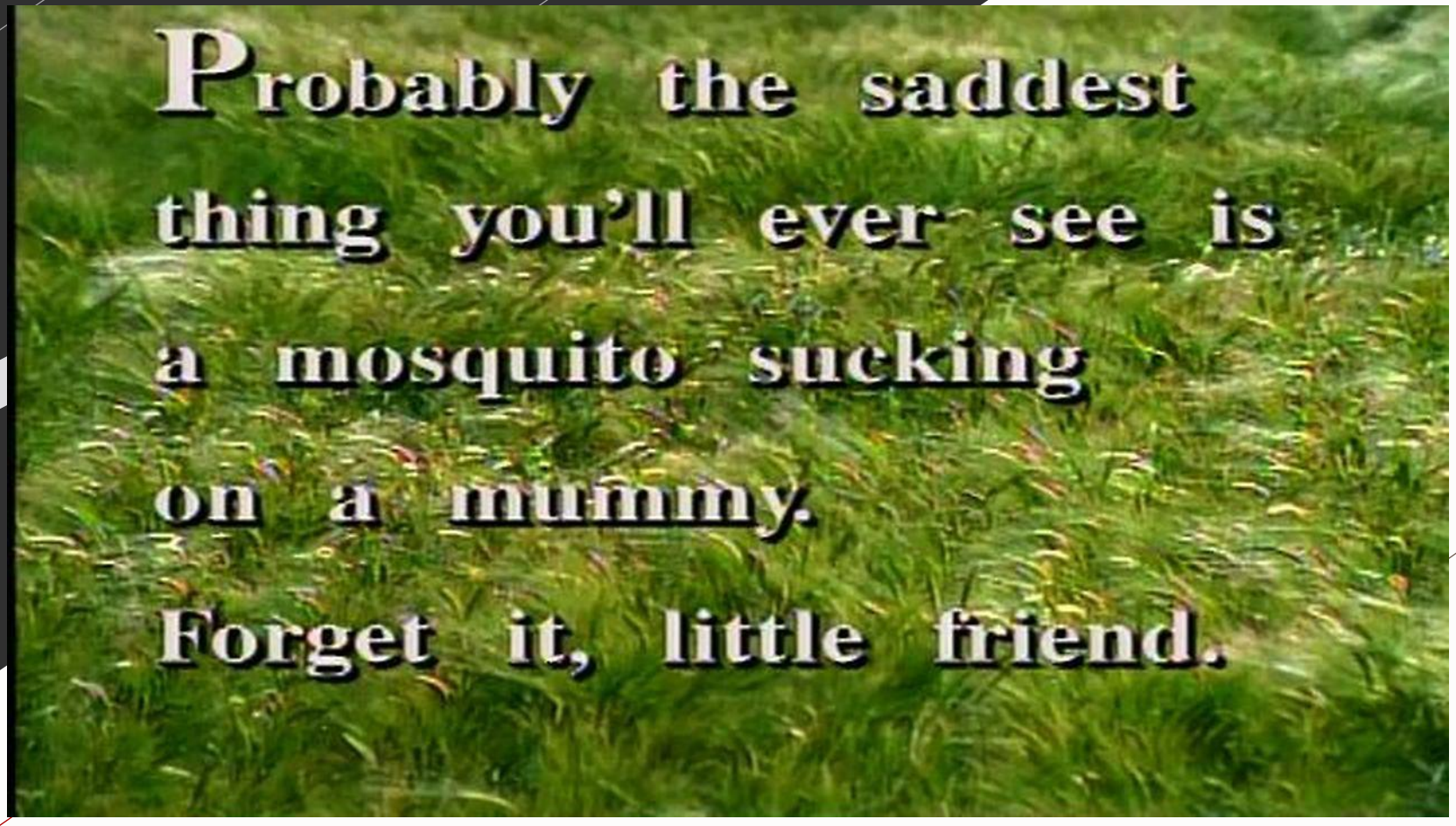
- Treat Medicare the same as other payors
  - Can pull back differing amounts, but not just all Medicare
- Collection agencies must be trying to collect (reasonable collection efforts apply here!!)
  - Must be able to prove collection efforts
  - No reasonable collection effort – collection agency expense now not allowable
- The 120 day rule also applies to them

Recommended Steps

- Update your collection agency contracts to include:
  - Collection efforts for Medicare and non-Medicare are conducted in the same manner
  - Accounts will not be pulled back until at least 120 days after the last payment
  - Collection efforts will be with the intent to collect
- Request a copy of their collection policy to share with Medicare

Crossovers

- Type of indigent bad debt:
  - Medicaid is responsible for payment of deductible and coinsurance
  - Must be billed and denied by Medicaid
  - Not subject to the 120-day rule
- Can claim partial and full writeoffs
- Auditable support
  - Copy of Medicaid RA


Probably the saddest
thing you'll ever see is
a mosquito sucking
on a mummy.
Forget it, little friend.

Medicare Bad Debt – Indigent Care

- Type of indigent bad debt:
  - Written off under the hospital's indigent care policy
  - This is often overlooked by hospitals
  - Not subject to the 120-day rule
- Can claim partial and full writeoffs
- Auditable support
  - Are you following your indigent policy?
  - Do you have copies of patient data?
  - Is there support that it was approved?

Indigent Care versus Charity Care

- Medicare pays for bad debts
- Medicare sees charity as a discount not a bad debt
  - Charity “allowance” is noted as “reductions of charges”
  - Bad debts are amounts “uncollectible from accounts and notes receivable”

Indigent Care Requires an Asset Test

- CMS Publication 15-1 §312
  - Medicare defines “should” as “must”
  - Provider **should** take into account a patient’s total resources…an analysis of assets”
    - “only those convertible to cash and unnecessary for the patient's daily living”
    - Retroactive
  - Other requirements (not changed)
    - Must be determined by provider
    - No one else is legally responsible
    - Patient’s file should contain the documentation supporting the claim of indigency (who determined and documents used)

Conflicting Rules?

- If your current financial assistance application requires an asset test:
  - Rename charity “indigent” applications
  - Rename charity policies as “indigent” policies
- If your current charity application does NOT require an asset test:
  - Devise a separate indigent care policy/Medicare bad debt policy or update wording as optional
- In both cases:
  - Devise wording in the patient detail that says “indigent bad debt”
  - Ensure all are in a bad debt account on the general ledger.
- Student loan forgiveness program

Other Rules

- Must write off in the same manner as other payors
- Must be returned from collections
  - Must have actual collection effort by agency
    - Do you have proof?
- Must be supported by auditable evidence
- Must be claimed in the year it is written off (or returned from collections)

Same Method as Other Payors

- Issue: collection on $50-$1,600 Medicare coinsurance or deductible compared to $10,000 self-pay amount
- Sent to collections
- Payment schedule
- Called back from collections

Medicare: the Same Strategies

- Call back from collections based on amount
- Call back based on account activity (120-180 days of no activity)
- Max amount of time to collect on an account (above is better, of course)

Documentation Issues

- Date written off not in cost report year
- Date written off missing
- Reasonable collection effort for fewer than 120 days (after last payment)
- Not billed to Medicaid
- Includes coinsurance for physicians (Method II issues)
- Error rate extrapolated
  - Over 35%

Recommendations

- Track throughout the year
- Use identifier in system
- Keep back-up data
- Separate spreadsheets
- Use excel formulas
- Devise return from collection plan to optimize collections and payment on Medicare bad debts
- Have formal policies (and follow them)

Recommendations

- Indigent care should be reflected as indigent bad debt
  - In the patient ledger
  - On the general ledger
  - On the application
  - On the policy
- Medicare bad debt should be reflected as bad debt
  - In the patient ledger
  - On the general ledger
- Add asset test to policy
  - Remember liquidatable assets not necessary for their daily living

Exhibit 2A – Medicare Bad Debts

- Separate exhibit for each type (regular, indigent, crossover) and by IP/OP/RHC
- Columns:
  1. Last name
  2. First name
  3. Date of service from
  4. Date of service to
  5. Patient account/control number
  6. Medicare number
  7. Medicaid number (if crossover)
  8. Deemed indigent - “Y” for indigent but not crossover; “N” for all other
  9. Medicare remittance advice date
  10. Medicaid remittance advice date; “AD” if using alternative documentation
  11. Date remittance advice was received from secondary payer
  12. Amount for which the beneficiary is responsible
      1. Type “QMB” for a qualified Medicare beneficiary
      2. For Medicaid crossovers, the amount of state required cost-sharing

Exhibit 2A – Medicare Bad Debts

- Columns continued

13. Date bill first sent to beneficiary; if QMB type “QMB”
14. A/R writeoff date
15. Sent to collection agency Y/N – if Y return date
16. Date all collection efforts ceased (internal and external)
17. Date written off as a Medicare bad debt (date should match patient detail)
18. Recoveries for amounts previously claimed
19. Fiscal year the item in 18, if any, applies
20. Medicare deductible
21. Medicare coinsurance
22. Partial payments
23. Allowable Medicare bad debt amount
24. Informational comments: “Wow, was this a lot of work!”

Supporting Exhibit	Medicare Bad Debt Listing
Provider Name	
Provider Number (CCN)	
Subprovider CCN	
FYB	
FYE	
Inpatient / Outpatient	IP
Prepared By	
Date Prepared	
Total Column 23	$0.00
Total Dual Eligible	$0.00

Patient Name - Last	Patient Name - First	Date of Service: From	Date of Service: To	Patient Account Number	MBI or HICN	Medicaid Number	Deemed Indigent	Medicare Remittance Advice Date	Medicaid Remittance Advice Date
1	2	3	4	5	6	7	8	9	10

Secondary Payer RA Received Date	Beneficiary Responsibility Amount	Date First Bill Sent to Bene	A/R Write Off Date	Sent to Collection Agency (Y/N)	Return from Collection Agency Date	Collection Effort Ceased Date	Medicare Write Off Date	Recoveries Only: Amount Received	Recoveries Only: MCR FYE Date	Medicare Deductible Amount	Medicare Coinsurance Amount	Current Year Payments Received Amount	Allowable Bad Debts Amount	Comments
11	12	13	14	15a	15	16	17	18	19	20	21	22	23	24

The other day I got out my can-opener and was opening a can of worms when I thought, What am I doing?!

-Jack Handey

allauthor

PS&R

PS&R

- What is a PS&R?

  - Summary of Medicare paid charges and payments
    - Based on DATES OF SERVICE
    - Paid claims only

Report Types

- 110 – Inpatient
  - 118 – Inpatient Medicare managed care (shadow billing)
- 180 – Swing
- 710 – Rural health clinic
  - 71S – RHC preventative care
- 850 – Outpatient
  - 855 – Outpatient professional fees

PS&R

- **How to read:**
  - Significant dates
  - Types of reports
  - Medicare days
  - Charges
  - Gross reimbursement
  - Deductibles and coinsurance
  - Net reimbursement

Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 03/29/17
Report Run Date: 03/29/17
Provider FYE: 12/31
Provider Number: [redacted]

PROVIDER SUMMARY REPORT
INPATIENT - PART A

Report #: OD44203
Report Type: 110

	SERVICES FOR PERIOD 01/01/15 - 12/31/15	SERVICES FOR PERIOD 01/01/16 - 12/31/16	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
STATISTIC SECTION				
DISCHARGES	52	44		
MEDICARE DAYS	152	135		
CLAIMS	52	44		

CHARGE SECTION

***** ACCOMMODATION CHARGES *****

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0120	ROOM-BOARD/SEMI	113	$101,926.00	99	$98,598.00				
0200	INTENSIVE CARE or (ICU)	39	$60,606.00	36	$58,194.00				
TOTAL ACCOMMODATIONS		**152**	**$162,532.00**	**135**	**$156,792.00**				

***** ANCILLARY CHARGES *****

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0250	PHARMACY	2,806	$26,291.68	3,707	$25,590.89				
0255	DRUGS/INCIDENT RAD	1	$95.00	1	$95.00				
0258	IV SOLUTIONS	104	$2,392.00	46	$1,046.50				
0260	IV THERAPY	1	$156.00	2	$161.00				
0270	MED-SUR SUPPLIES	3,602	$42,977.40	3,151	$34,545.05				
0272	STERILE SUPPLY	0	$0.00	1	$11.50				
0300	LABORATORY or (LAB)	456	$24,158.00	372	$22,520.00				
0301	LAB/CHEMISTRY	0	$0.00	8	$712.00				
0320	DX X-RAY	16	$4,718.00	7	$2,421.00				
0350	CT SCAN	1	$2,394.00	12	$4,161.00				
0360	OR SERVICES	1	$81.00	0	$0.00				
0381	BLOOD/PKD RED	2	$634.00	0	$0.00				
0390	BLOOD/STOR-PROC	1	$82.00	2	$951.00				

Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 03/29/17
Report Run Date: 03/29/17
Provider FYE: 12/31
Provider Number: [redacted]

PROVIDER SUMMARY REPORT
INPATIENT - PART A

		SERVICES FOR PERIOD 01/01/15 - 12/31/15		SERVICES FOR PERIOD 01/01/16 - 12/31/16		SERVICES FOR PERIOD No Data Requested		SERVICES FOR PERIOD No Data Requested	
REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0391	BLOOD/ADMIN	1	$371.00	1	$854.00				
0402	ULTRASOUND	1	$581.00	1	$581.00				
0410	RESPIRATORY SVC	64	$5,052.00	53	$5,953.00				
0420	PHYSICAL THERP/15 MIN	10	$1,218.00	16	$2,042.00				
0424	PHYS THERP/EVAL/15 MIN	12	$1,740.00	8	$1,160.00				
0430	OCCUPATION THER/15 MIN	3	$372.00	2	$428.00				
0434	OCCUP THERP/EVAL/15 MIN	4	$552.00	3	$414.00				
0440	SPEECH PATHOL/15 MIN	0	$0.00	5	$880.00				
0444	SPEECH PATH/EVAL/15 MIN	0	$0.00	4	$652.00				
0610	MRT	1	$1,978.00	0	$0.00				
0611	MRI - BRAIN	0	$0.00	1	$1,978.00				
0730	EKG/ECG	8	$600.00	7	$756.00				
0732	TELEMETRY	3	$489.00	0	$0.00				
0920	OTHER DX SVS	1	$54.00	2	$108.00				
0921	PERI VASCUL LAB	2	$1,141.00	0	$0.00				
0940	OTHER RX SVS	0	$0.00	1	$178.00				
TOTAL ANCILLARY		7,101	$118,127.08	7,413	$108,198.94				
TOTAL COVERED CHARGES			$280,659.08		$264,990.94				

REIMBURSEMENT SECTION

OPERATING

HOSPITAL SPECIFIC	$0.00	$0.00		
FEDERAL SPECIFIC	$0.00	$0.00		
OUTLIER	$0.00	$0.00		

Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 03/29/17
Report Run Date: 03/29/17
Provider FYE: 12/31
Provider Number: [redacted]

PROVIDER SUMMARY REPORT
INPATIENT - PART A

	SERVICES FOR PERIOD 01/01/15 - 12/31/15	SERVICES FOR PERIOD 01/01/16 - 12/31/16	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
DEVICE CREDIT	$0.00	$0.00		
CASH DEDUCTIBLE	$59,991.88	$48,888.00		
BLOOD DEDUCTIBLE	$634.00	$0.00		
COINSURANCE	$0.00	$0.00		
NET MSP PAYMENTS	$0.00	$0.00		
PIONEER REDUCTION	$0.00	$0.00		
SEQUESTRATION	$4,087.80	$3,909.46		
MSP PASS THRU RECONCILIATION	$0.00	$0.00		
OTHER ADJUSTMENTS	$0.00	$0.00		
NET REIMBURSEMENT	**$200,302.32**	**$191,563.54**		

ADDITIONAL INFORMATION SECTION

CALCULATED NET REIMB FOR PIP	$0.00	$0.00		
PIP PAYMENTS DUE TO ADD-ONS	$0.00	$0.00		
PIP IMPACTS DUE TO RAC	$0.00	$0.00		
ACTUAL CLAIM PAYMENTS FOR PIP	$0.00	$0.00		
CLAIM INTEREST PAYMENTS	$0.00	$0.00		
IRF PENALTY AMOUNT	$0.00	$0.00		
LTCH SHORT STAY OUTLIER PAYMENTS	$0.00	$0.00		
CAP FED-SPECIFIC @ 100%	$0.00	$0.00		
CAP OUTLIER @ 100%	$0.00	$0.00		
DISCHARGES	52	44		
DRG/CMG WEIGHT	0.0000	0.0000		
WEIGHT/DISCHARGES	0.0000	0.0000		
DISCHARGE FRACTION	0	0		

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 03/29/17
Report Run Date: 03/29/17
Provider FYE: 12/31
Provider Number: [redacted]

PROVIDER SUMMARY REPORT
CRITICAL ACCESS HOSPITAL

Report #: OD44203
Report Type: 850

	SERVICES FOR PERIOD 01/01/15 - 12/31/15	SERVICES FOR PERIOD 01/01/16 - 12/31/16	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
STATISTIC SECTION				
CLAIMS	4,582	4,727		

CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0250	PHARMACY	3,484	$53,150.58	1,865	$21,431.44				
0255	DRUGS/INCIDENT RAD	150	$14,250.00	115	$10,925.00				
0258	IV SOLUTIONS	425	$4,830.00	239	$2,725.50				
0260	IV THERAPY	1,619	$189,827.38	1,206	$107,739.60				
0270	MED-SUR SUPPLIES	6,369	$111,152.35	5,317	$88,930.82				
0272	STERILE SUPPLY	93	$1,585.00	76	$1,248.00				
0279	SUPPLY/OTHER	42	$2,142.00	28	$1,428.00				
0300	LABORATORY or (LAB)	13,032	$712,004.35	12,062	$676,588.00				
0301	LAB/CHEMISTRY	0	$0.00	691	$61,166.00				
0305	LAB/HEMATOLOGY	1	$40.00	1	$40.00				
0310	PATHOLOGY LAB or (PATH LA	73	$18,791.00	47	$10,137.00				
0320	DX X-RAY	862	$253,176.00	872	$252,561.00				
0343	NUC MED/DX RADIOPHARM	5	$1,925.00	16	$5,249.65				
0350	CT SCAN	375	$587,632.00	389	$550,345.00				
0360	OR SERVICES	24	$2,018.00	66	$67,138.00				
0370	ANESTHESIA	0	$0.00	4	$1,261.00				
0379	ANESTHE/OTHER	325	$35,252.00	308	$34,366.00				
0381	BLOOD/PKD RED	0	$0.00	0	$0.00				
0390	BLOOD/STOR-PROC	0	$0.00	24	$7,608.00				
0391	BLOOD/ADMIN	10	$7,886.00	17	$18,718.00				
0392	Unknown	17	$5,389.00	7	$2,219.00				

Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 03/29/17
Report Run Date: 03/29/17
Provider FYE: 12/31
Provider Number: [redacted]

PROVIDER SUMMARY REPORT
CRITICAL ACCESS HOSPITAL

Report #: OD44203
Report Type: 850

REV CODE	DESCRIPTION	SERVICES FOR PERIOD 01/01/15 - 12/31/15 UNITS	SERVICES FOR PERIOD 01/01/15 - 12/31/15 CHARGES	SERVICES FOR PERIOD 01/01/16 - 12/31/16 UNITS	SERVICES FOR PERIOD 01/01/16 - 12/31/16 CHARGES	SERVICES FOR PERIOD No Data Requested UNITS	SERVICES FOR PERIOD No Data Requested CHARGES	SERVICES FOR PERIOD No Data Requested UNITS	SERVICES FOR PERIOD No Data Requested CHARGES
0920	OTHER DX SVS	5	$270.00	0	$0.00				
0921	PERI VASCUL LAB	60	$37,001.00	59	$36,633.00				
0940	OTHER RX SVS	13	$1,804.00	13	$2,314.00				
0972	PRO FEE/RAD/DX	0	$0.00	0	$0.00				
0975	PRO FEE/OR	0	$0.00	0	$0.00				
0981	PRO FEE/ER	0	$0.00	0	$0.00				
0983	PRO FEE/CLINIC	0	$0.00	0	$140.00				
0985	PRO FEE/EKG	0	$0.00	0	$0.00				
TOTAL COVERED CHARGES		35,136	$3,387,800.97	32,800	$3,681,579.98				

REIMBURSEMENT SECTION

GROSS REIMBURSEMENT	$1,969,196.76	$1,974,204.73		
LESS				
CASH DEDUCTIBLE	$28,820.75	$31,962.78		
BLOOD DEDUCTIBLE	$0.00	$0.00		
COINSURANCE	$520,696.01	$576,345.89		
NET MSP PAYMENTS	$1,354.98	$3,572.60		
PIONEER REDUCTION	$0.00	$0.00		
SEQUESTRATION	$28,391.71	$27,292.96	$0.00	$0.00
REBILLING ADJUSTMENT	$0.00	$0.00		
NET REIMBURSEMENT	$1,389,933.31	$1,335,030.50		

ADDITIONAL INFORMATION SECTION

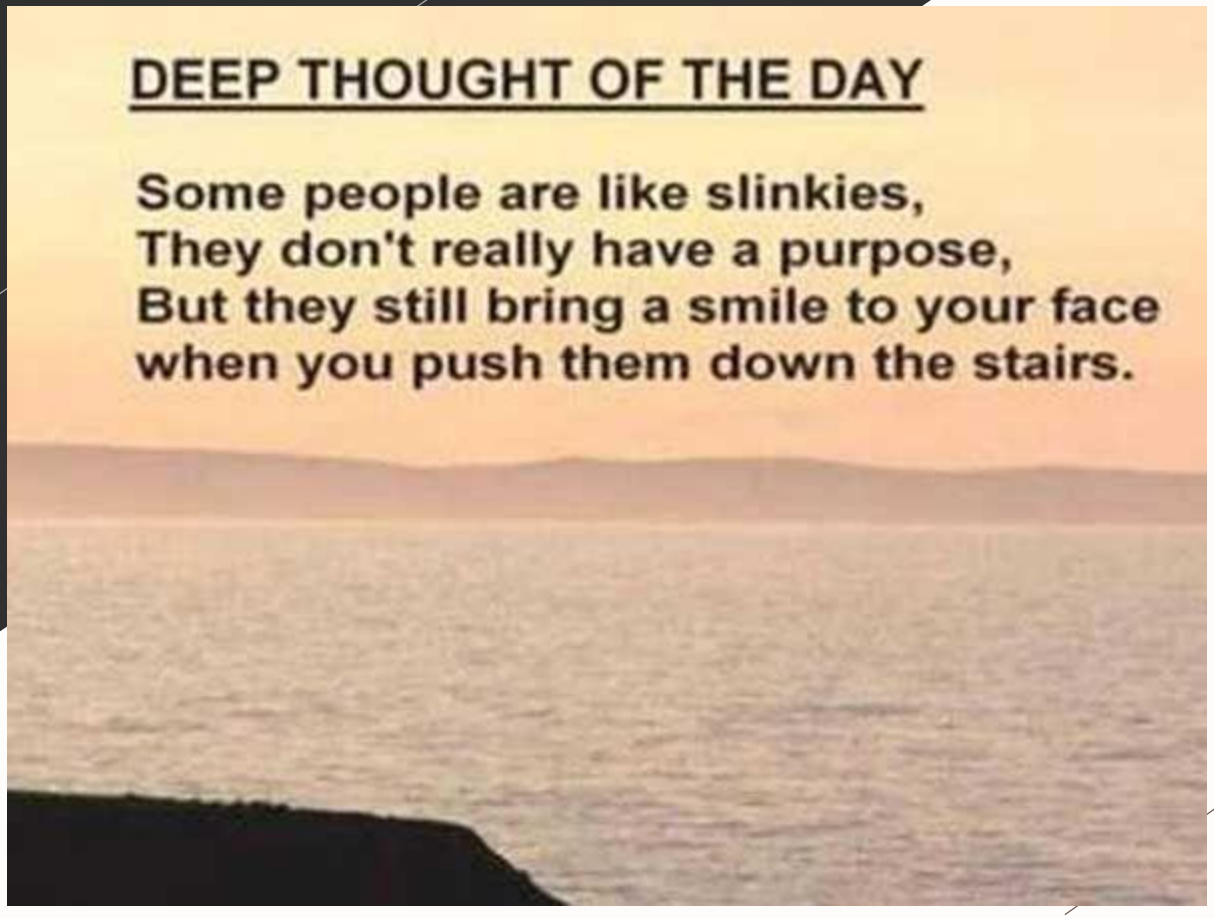
CLAIM INTEREST PAYMENTS	$0.05	$23.14		

PS&R Recommendations

- Reconcile inpatient and swing-bed days to census
- Compare RHC visits to census
- Medicare Advantage claims
- Investigate revenue codes on PS&R but not on revenue code report
- Professional or outpatient revenue codes billed as inpatient
  - CRNA is inpatient and outpatient
  - Method II is outpatient only
- RHC revenue codes billed as outpatient
- Ambulance charges on cost-based report type (or vice versa)
  - 85C – Ambulance cost reimbursed
  - 85Z – Ambulance fee schedule

PS&R Recommendations

- CRNA exemption:
  - Revenue code 964 CRNA, report 850 outpatient
  - Revenue code 370 Anesthesia, report 850 outpatient
- CRNA without exemption:
  - Revenue code 964 CRNA, report 855 outpatient professional fees
  - No revenue code 370
- Professional revenue codes for Method II billing:
  - Professional revenue codes 96X, 97X, or 98X will be on report 855, not 850
  - Facility revenue code 510 will be on report 850


DEEP THOUGHT OF THE DAY
Some people are like slinkies,
They don't really have a purpose,
But they still bring a smile to your face
when you push them down the stairs.

DZA

DINGUS, ZARECOR & ASSOCIATES

Contact Information

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