Cost Reporting for Patient Access and Patient Financial Services

Presented by:
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What is the purpose of a Medicare Cost Report?

- Informational
- Determination of Medicare’s share of costs
- Determination of cost settlement
## Medicare Cost Report – Summary

<table>
<thead>
<tr>
<th>Worksheet</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Information, settlement, days, discharges, observation hours, wage index, old 339</td>
</tr>
<tr>
<td>A</td>
<td>Cost by department</td>
</tr>
<tr>
<td>B</td>
<td>Allocation of support (overhead) costs</td>
</tr>
<tr>
<td>C</td>
<td>Charges by department, calculation of the cost to charge ratio</td>
</tr>
<tr>
<td>D</td>
<td>Determination of Medicare’s costs, including Medicare bad debts</td>
</tr>
<tr>
<td>E</td>
<td>Medicare settlement, EHR calculation</td>
</tr>
<tr>
<td>G</td>
<td>Financial statements</td>
</tr>
<tr>
<td>H</td>
<td>Home health</td>
</tr>
<tr>
<td>I</td>
<td>Renal Dialysis</td>
</tr>
<tr>
<td>K</td>
<td>Hospice</td>
</tr>
<tr>
<td>M</td>
<td>Rural health clinic</td>
</tr>
</tbody>
</table>
# Medicare Cost Report – Summary

(Continued)

<table>
<thead>
<tr>
<th>Worksheet</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Days used to calculate per-day cost</td>
</tr>
<tr>
<td>A</td>
<td>Allowable costs used to calculate cost-charge-ratio and per-day cost</td>
</tr>
<tr>
<td>B</td>
<td>Support costs allocated to revenue producing departments</td>
</tr>
<tr>
<td>C</td>
<td>Charges used to calculate cost-charge-ratio</td>
</tr>
<tr>
<td>D</td>
<td>Process claims summary report used to calculate Medicare’s portion of cost</td>
</tr>
<tr>
<td>E</td>
<td>Settlement calculated</td>
</tr>
</tbody>
</table>
S Series Worksheets

✓ Purpose: To report the statistics and general information of the hospital.

✓ Goal: To properly capture patient days used in calculating cost per day.

✓ Process: Utilizing internal statistics and PS&R data.
Worksheet S-3 – Statistical Data

- Set up beds
  - Set up vs. licensed beds

- Bed days available

- CAH patient hours
  - 96 hour rule
Worksheet S-3 – Statistical Data

• Patient days
  ▪ Medicare (Title XVIII)
    • Report HMO separately
  ▪ Medicaid (Title XIX)
    • Report HMO separately
  ▪ Total

• Labor and delivery days by payor

• Observation hours/days
Counting Patient Days

- Accrual basis
- Discharge/admitting/medical records/actual count/charge count
  - Which is more accurate?

Tip: Reconcile reports

- Overstating of days decreases per-diem and, therefore, reimbursement
Why Total Patient Days is Important

• It’s the denominator for:
  • PPS –
    ▪ DSH
    ▪ GME
    ▪ EHR
  • CAH
    ▪ Inpatient rate
    ▪ EHR
Why Total Patient Days is Important

- Goal – not to overstate total days
- Example:
  - Medicare pays its portion of cost
  - Medicare days = 1,000
  - Total days = 2,000
  - Cost = $5,000,000
  - Medicare pays 50% of allowable cost ($2,500,000)
  - Total days = 2,200
  - Medicare’s share = 45% or $2,250,000
  - Therefore, 200 days means $250,000 in this example
Worksheet S-3, Part I – Patient Days

• Total acute care days
  ▪ Acute care days
  ▪ Possibly ICU (may be a separate cost center)
  ▪ NICU
  ▪ PICU
  ▪ CCU
  ▪ Observation bed equivalent days
  ▪ Swing bed **SNF** days (CAH)
Excluded Days

• Labor and delivery days (LDR days)
  ▪ Mother in labor at midnight – should not be included in count
    *(typically they are included if a room charge is generated)*
    • Must be counted

▪ **Exceptions:**
  • Admitted prior to actual labor
  • Discharged the next day
Excluded Days (Continued)

- Hospice days (CAH specific)
  - Identify separately
  - Count as swing bed NF days
    *(admit to swing bed program)*
Common Acute Care Issues

• Hospice days not tracked separately
• LDR days not tracked separately
• Observation patients included in count
• Excel spreadsheet does not foot –
  ▪ Hidden cells
  ▪ Missing adjacent numbers
  ▪ Includes adjacent numbers
  ▪ Random number generation
• Beginning and end of year cut off
Medicare HMO Days

• Medicare Advantage claims

• Medicare eligible claims

• Must be billed to Medicare as no-pay
   Condition Code 04
   TOB 11x (not 110)
   PS&R report type 118

• Benefits:
   Only these claims will be added to EHR incentive calculation
   Compliance (DSH and low-volume hospitals)
Common Observation Day Issues

• Observation patients counted as inpatient and included in acute care count

• Observation patients counted in ER and cost report preparer not informed

• Observation charges billed using revenue code 720 in L&D included in observation count

• All hours counted for each block of hours charged
Observation Issues the Calculation

- Observation hours/24 = equivalent days
- Example:
  - Observation hours = 6,000 (250 days)
  - Observation in ER = 1,200 (50 days)
  - Acute care days = 8,000
  - Acute care costs = $10,625,000
  - Medicare days = 6,400
Observation Issues the Calculation (Continued)

- $13,612,500/8,250 = $1,650 per day
- $13,612,500/8,300 = $1,640 per day
- Remember Medicare days = 6,400
- Difference in per-diem = $10 per day ($1,650 less $1,640)
- $64,000 reimbursement effect ($10 times 6,400 Medicare days)
CAH Swing Beds

- Skilled vs. non-skilled level of care

- Skilled = Medicare (*and Medicare Advantage*)

- Medicare pays cost

- Medicaid pays prospectively

- Non Medicare days “carved out”
CAH Swing Beds (Continued)

• Skilled swing bed days –
  ▪ 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
  ▪ EVERYTHING ELSE
CAH Swing Beds (Continued)

- Example swing bed “carve out”
- Acute care cost = $2,000,000
- State swing bed rate = $200
- Acute care days = 1,200
  - Medicare days = 900
- Swing bed days = 400
  - Medicare days = 300
  - Medicare advantage days = 25
  - Other payors = 75
- Total days for calculation = 1,525 vs. 1,600
  - 1,200 acute days plus either 325 Medicare or 400 all swing
CAH Swing Beds (Continued)

Swing NF days not identified:

- **Cost**: $2,000,000
- **Days**: 1,600
- **Cost per day**: $1,250

Medicare days 1,200

Medicare cost  $1,500,000
## CAH Swing Beds (Continued)

### All Swing NF days identified:

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swing NF days</td>
<td>75</td>
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<tr>
<td>Swing NF rate</td>
<td>200</td>
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<tr>
<td>Swing NF costs</td>
<td>$15,000</td>
</tr>
<tr>
<td>Cost</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Less Swing NF costs</td>
<td>(15,000)</td>
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<tr>
<td>Cost for calculation</td>
<td>$1,985,000</td>
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<tr>
<td>Days</td>
<td>1,525</td>
</tr>
<tr>
<td>Cost per day (rounded)</td>
<td>$1,302</td>
</tr>
<tr>
<td>Medicare days</td>
<td>1,200</td>
</tr>
<tr>
<td>Medicare cost</td>
<td>$1,562,400</td>
</tr>
<tr>
<td>Increase in reimbursement</td>
<td>$62,400</td>
</tr>
</tbody>
</table>
## CAH Swing Beds (Continued)

### 50 of the 75 Swing NF days identified:

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swing NF days</td>
<td>50</td>
</tr>
<tr>
<td>Swing NF rate</td>
<td>200</td>
</tr>
<tr>
<td>Swing NF costs</td>
<td>$10,000</td>
</tr>
<tr>
<td>Cost</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Less Swing NF costs</td>
<td>-(10,000)</td>
</tr>
<tr>
<td>Cost for calculation</td>
<td>$1,990,000</td>
</tr>
<tr>
<td>Days</td>
<td>1,550</td>
</tr>
<tr>
<td>Cost per day (rounded)</td>
<td>$1,284</td>
</tr>
<tr>
<td>Medicare days</td>
<td>1,200</td>
</tr>
<tr>
<td>Medicare cost</td>
<td>$1,540,800</td>
</tr>
</tbody>
</table>

Cost of 25 day NF error: $21,600
Tip: Verify all swing bed days by payor

- Patients change payor status after admission
- To correct at desk review requires additional support
Common Swing-Bed Issues

• More swing-bed days reported on PS&R than 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 didn’t meet qualifications
• Non Medicare swing beds called Medicare to cost report preparer – usually with much conviction
CAH Skilled Swing Beds Defined

- Skilled swing bed days –
  - 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
  - EVERYTHING ELSE
Other Worksheet S’s

• S-3, Parts II and III – Wage Index (not applicable to CAHs)

• S-3, Part IV – Wage related costs
  - This schedule was on the CMS Form 339

• S-3, Part V – Contract labor and benefits
Other Worksheet S’s  (Continued)

- S-4: Home health
- S-5: Renal dialysis
- S-7: SNF
- S-8: RHC and FQHC
- S-9: Hospice
- S-10: Uncompensated and indigent care
S Series - Summary

✓ Report accurately
✓ 50% of the acute care formula
✓ Affects EHR calculation
✓ Affects DSH calculation
✓ Internal review of information = easy money
✓ Questions?
Worksheet A Series

✓ Purpose: To report the departmental expenses of the hospital

✓ Goal: To match expenses to charges (and Medicare)

✓ Process: Utilize hospital departmental data and care location
Worksheet A Series

1. **Starts with costs directly from trial balance**
   a. Salaries - column 1
   b. All other expenses – column 2

2. **Total** – column 3
   - Must reconcile to financial statements

3. **Reclassifications** – column 4

4. **Reclassified trial balance** – column 5
   - Must reconcile to column 3

5. **Adjustments** - column 6

6. **Total** = net expenses for allocation – column 7
Worksheet A (Continued)

• Grouped in specific order:
  - **General support cost centers (overhead)**
    - Capital (lines 1-3)
      - Old forms were line numbers 1-4
      - Eliminated the “old capital” cost center
    - Other overhead departments (lines 4-23)
  - **Revenue producing**
    - Inpatient departments (lines 30-46)
    - Ancillary departments (lines 50-76)
    - Outpatient services (lines 88-92)
    - Other reimbursable cost centers (lines 94-101)
  - **Special purpose and non-reimbursable cost centers** (line 105-194)
Worksheet A-6 – Reclassifications

✓ **Purpose:**

- To match costs and revenues
- To match Medicare requirements
- Move an expense from one cost center to another
  - Increases will equal decreases
A-6 Examples

• **Example:**
  - To reclassify chargeable supplies:
    - 71.0 Medical supplies charged to patients $60,000
    - 50.0 Operating room $(20,000)
    - 69.0 EKG $(20,000)
    - 91.0 ER $(20,000)
Worksheet A-8 – Adjustments

✓ **Purpose:**
  - To adjust trial balance to reflect Medicare allowable expenses.

**Basis:**
  - Expense adjustments – “A”
  - Revenue offset – “B”
Examples:

- Cost recoveries or revenue offsets (any miscellaneous revenue)
- Investment income
- Nonallowable expenses:
  - Patient telephones or televisions
  - Lobbying expense
  - Physician recruitment (unless administrative or RHC)
Common Issues: Miscellaneous Revenue

- Collection agency expenses netted with contractual adjustments

- Uncollected interest charged on patient accounts written off to bad debt
Interest on Patient Accounts – the example

- Interest charged = $100,000
- Collected = $20,000
- Administration cost-based percentage = 40%

<table>
<thead>
<tr>
<th></th>
<th>Charges Reversed</th>
<th>Uncollected Charged to Bad Debt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges reported</td>
<td>$20,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Cost of offset</td>
<td>$(8,000)</td>
<td>$(40,000)</td>
</tr>
<tr>
<td>Revenue received</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>Net gain/(loss)</td>
<td>$12,000</td>
<td>$(20,000)</td>
</tr>
</tbody>
</table>
B Series Worksheets

✓ Purpose: Allocate support (overhead) cost to revenue producing and non-allowable departments

✓ Goal: Match overhead use by department

✓ Process: Step-down approach
Worksheet B Series – Overview

- **B, Part I**– total cost allocation
- **B, Part II**– capital cost allocation
- **B-1**– allocation statistical basis
- **B-2**– post stepdown adjustments
Worksheet B-1 – Statistical Basis

• Used to calculate allocated overhead costs on B, Part I & II

• Uses allocation statistic specific to each overhead department

• Overhead allocated (stepped down) to:
  ▪ Revenue producing
  ▪ Non-allowable
Overhead Departments

- Building costs
- Moveable equipment costs
- Employee benefits
- Communications
- Information technology (IT)
- Admitting
- Purchasing
- Business office
- Other administrative
- Maintenance
- Plant

- Laundry
- Housekeeping
- Dietary
- Cafeteria
- Nursing administration
- Medical records
- Social services
- Activities
- CRNA
- Resident training costs
Overhead Strategies

• Review current allocations:
  ▪ Does allocated costs match department’s utilization?
  ▪ Is there a more accurate method?
  ▪ Does that department really take up that much space?
Common Overhead (OH) Issues

• Directly-assigned OH Costs
  ▪ Admitting
  ▪ Patient billing
  ▪ Medical records
  ▪ Insurance
  ▪ Nurse administration
  ▪ Housekeeping or maintenance directly assigned to medical office buildings

• Avoid double-allocation
Administration Costs

• Fragmented departments:
  ▪ Communications: number of phones
  ▪ Information technology: number of computer terminals or workstations
  ▪ Admissions: gross revenue or number of admits
  ▪ Purchasing: supplies expenses or requisitions
  ▪ Business office (patient accounting): gross revenue
  ▪ All other: accumulated cost
Time Studies

• In case you are preparing a time study

• OR think your facility would benefit from one...
Time Studies (Continued)

• At least one full week per month

• A full work week (e.g. 7 days)

• Equally distributed among the months (e.g. 3 months use 1\textsuperscript{st} week; 3 months use 2\textsuperscript{nd} week; etc.)

• No two consecutive months may use the same week

• Contemporaneous with the costs

• Provider specific
Time Studies  (Continued)

• Designate one responsible person

• Must be prepared accurately and consistently

• Preparers must understand how each “cost center” is defined
  - The cost report preparer and/or CFO should provide guidance
  - The one responsible person should then review/monitor
C Series Worksheets

- **Purpose:** Calculate cost-to-charge ratio
- **Goal:** Match revenues to costs
- **Process:** Internal revenue by revenue code report
Gross Revenues

• Reports gross hospital revenues

• Calculates the cost-to-charge ratio
  ▪ 50% of the cost-to-charge ratio
    • Expenses = numerator
    • Charges = denominator

• Higher expenses, higher cost-to-charge ratio

• Higher revenues, lower cost-to-charge ratio
Gross Revenues  (Continued)

• Remember the matching principle:
  ▪ Charges matched to costs
  ▪ Costs match with their charges
  ▪ Medicare charges matched to costs
  ▪ Medicare charges matched to total charges

• General ledger matches the first two
• Revenue code report helps match the other two
Cost-to-Charge-Ratio Calculation

- Medicare charges times cost-to-charge ratio = Medicare cost

\[
\text{Laboratory cost center} \\
\begin{array}{crl}
\text{Total cost} & 319,541 \\
\text{Total revenue} & 650,000 \\
\text{Medicare charge} & 200,000 \\
\text{Times CCR} & 0.491602 \\
\end{array} \quad \frac{\text{CCR}}{=} \quad 0.491602 \\
\text{Medicare cost} & 98,320
\]
Department Breakout

- **Routine** – cost per day: calculated at D-1
- **Ancillary** – cost-to-charge ratio
- **Non-allowable** – eliminated
- **Home Health, hospice, and ambulance**
  - Paid prospectively, CCR calculated
- **RHC** –
  - Paid cost per visit: calculated at M-3
  - CCR calculated
Computation of Charges

- Revenue by revenue code report
  - Reconcile to general ledger
  - By revenue code and by department
  - Use to match revenue codes to the correct department versus using the general ledger
  - Remove professional charges
### Revenue Code Report - Example

**General Hospital**  
Worksheet C  
December 31, 2012

<table>
<thead>
<tr>
<th>CMS #</th>
<th>Code</th>
<th>Description</th>
<th>Depart #</th>
<th>Depart Name</th>
<th>IP Amount</th>
<th>OP Amount</th>
<th>Total</th>
<th>N/A IP</th>
<th>N/A OP</th>
<th>IP Revenue</th>
<th>OP Revenue</th>
<th>Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>320</td>
<td>Diagnostic Xray</td>
<td>4100</td>
<td>Radiology</td>
<td>130,000</td>
<td>110,000</td>
<td>240,000</td>
<td></td>
<td></td>
<td>130,000</td>
<td>110,000</td>
<td>240,000</td>
</tr>
<tr>
<td>54</td>
<td>401</td>
<td>Diag Mammography</td>
<td>4200</td>
<td>Mammography</td>
<td>-</td>
<td>40,000</td>
<td>40,000</td>
<td></td>
<td></td>
<td></td>
<td>40,000</td>
<td>40,000</td>
</tr>
<tr>
<td>54</td>
<td>402</td>
<td>Ultrasound</td>
<td>4100</td>
<td>Radiology</td>
<td>50,000</td>
<td>25,000</td>
<td>75,000</td>
<td></td>
<td></td>
<td>50,000</td>
<td>25,000</td>
<td>75,000</td>
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<tr>
<td>54</td>
<td>921</td>
<td>Peri Vascul Lab</td>
<td>4100</td>
<td>Radiology</td>
<td>20,000</td>
<td>25,000</td>
<td>45,000</td>
<td></td>
<td></td>
<td>20,000</td>
<td>25,000</td>
<td>45,000</td>
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<tr>
<td>54</td>
<td>972</td>
<td>Pro fee/rad</td>
<td>4100</td>
<td>Radiology</td>
<td>40,000</td>
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<td>80,000</td>
<td>(40,000)</td>
<td>(40,000)</td>
<td>(40,000)</td>
<td>(40,000)</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>240,000</td>
<td>240,000</td>
<td>480,000</td>
<td>(40,000)</td>
<td>(40,000)</td>
<td>200,000</td>
<td>200,000</td>
<td>400,000</td>
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<tr>
<td>60</td>
<td>300</td>
<td>Laboratory</td>
<td>4300</td>
<td>Laboratory</td>
<td>50,000</td>
<td>600,000</td>
<td>650,000</td>
<td></td>
<td></td>
<td>50,000</td>
<td>600,000</td>
<td>650,000</td>
</tr>
</tbody>
</table>
Supplies

• Types of supplies:
  - Medical supplies not separately charged
  - Medical supplies charged to a patient using 27X
  - Implantables (typically charged using 275, 276, 278, and 624)
Supplies (Continued)

• One revenue code, many departments
• Two options
  ▪ Reclass costs (may or may not be that easy)
  ▪ Split the Medicare revenue based on department
One Revenue Code, Many Departments

• Other offenders:
  ▪ IV therapy
  ▪ Blood administration
  ▪ Infusions
  ▪ Chemo (and chemo drugs)
  ▪ Treatment room
  ▪ Clinic (510)
Computation of Charges

- Strive for a one to one relationship (1 revenue code = 1 cost center)

- Option: be able to track the charge by the department
Common Issues with Gross Revenue

- Using one revenue code in several locations
- Providing services in several locations and not tracking revenue codes to those locations
- Billing implantables using the wrong revenue code
Provider Based Clinic Revenue

• Typically four types of revenues
  ▪ Hospital services tracked back to clinic
  ▪ Global clinic charges
  ▪ Professional clinic charges
  ▪ Technical clinic charges
Provider Based Clinic Revenue

• Hospital services must be removed first

• Method II split charges to Medicare

• Global charge billed to other payors

• Must make the two match on cost report
  ▪ Basis for split (Medicare)
    • Set amount per charge
    • Percentage of charge
Provider Based Clinic Revenue

(Continued)

- Example:
  - 99213 standard charge
    - Professional = $100
    - Technical = $25
    - Total = $125
  - Medicare billed 75 patients
  - Blue cross billed 75 patients
  - Clinic also billed $10,000 hospital professional charges (revenue code 983)
### Provider Based Clinic Revenue

**Example:**

<table>
<thead>
<tr>
<th>Revenue code</th>
<th>%</th>
<th>Medicare</th>
<th>Other</th>
<th>Hospital</th>
<th>Total</th>
<th>Medicare</th>
<th>Other</th>
<th>Total</th>
<th>Revenue code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional charge</td>
<td>44%</td>
<td>7,500</td>
<td>16,875</td>
<td>10,000</td>
<td>34,375</td>
<td>7,500</td>
<td>16,875</td>
<td>24,375</td>
<td>983</td>
</tr>
<tr>
<td>Technical charge</td>
<td>56%</td>
<td>9,375</td>
<td></td>
<td></td>
<td>9,375</td>
<td>9,375</td>
<td></td>
<td>9,375</td>
<td>510</td>
</tr>
<tr>
<td>Total gross charge</td>
<td></td>
<td>16,875</td>
<td>16,875</td>
<td>10,000</td>
<td>43,750</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revenue code</th>
<th>Medicare</th>
<th>Other</th>
<th>Total</th>
<th>Revenue code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional charge</td>
<td>44%</td>
<td>7,500</td>
<td>16,875</td>
<td>983</td>
</tr>
<tr>
<td>Technical charge</td>
<td>56%</td>
<td>9,375</td>
<td></td>
<td>510</td>
</tr>
<tr>
<td>Total gross charge</td>
<td></td>
<td>16,875</td>
<td>16,875</td>
<td>33,750</td>
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</table>
### Provider Based Clinic Revenue

(Continued)

**Example:**

<table>
<thead>
<tr>
<th></th>
<th>With Hospital</th>
<th>Hospital Omitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total charge imputed</td>
<td>24,306</td>
<td>18,750</td>
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<tr>
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<td>Per patient</td>
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</table>
CRNA Pass-through

• Elect annually prior to January 1 (exemption is on a calendar year)

• Less than 800 procedures requiring anesthesia and less than 2,080 productive CRNA hours

• Nearly all that qualify should elect CRNA exemption
CRNA Pass-through (Continued)

- Pass-through basics
  - IP & OP services
  - Billed on the UB
  - Technical portion = 370
  - Professional portion = 964

- Payment cost settled on cost report
- Interim payment
  - Part of routine rates
  - At outpatient interim rate percentage
Method II Billing

- **Out**patient professional services

- If the CAH bills the physicians’ charges, it must bill this method
  - *Exception:* CRNA pass-through

- 115% of facility fee schedule (professional component):
  - Patient not charged 15% on their portion

- 101% of cost (technical component)

- Both technical and professional components are billed on the UB04

- Change: election stays in effect
  - New facilities must request 30 days before the end of their fiscal year
Purpose: Calculate Medicare cost

Goal: Match Medicare charges with internal charges by revenue code

Process: Summary of processed claims data applied to per-diem and cost-to-charge ratios
What is a PS&R?

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

- Significant dates
- Types of reports
- Medicare days
- Charges
- Gross reimbursement
- Deductibles and Coinsurance
- Net reimbursement
## STATISTIC SECTION

### CLAIMS

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## CHARGE SECTION

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## REIMBURSEMENT SECTION

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## PROVIDER SUMMARY REPORT
### CRITICAL ACCESS HOSPITAL

**Program ID:** REDESIGN  
**Paid Dates:** 02/01/08 THRU 02/09/12  
**Report Run Date:** 02/09/12  
**Provider FYE:** 12/31  
**Provider Number:** [Redacted]

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<th>SERVICES FOR PERIOD</th>
<th>SERVICES FOR PERIOD</th>
<th>SERVICES FOR PERIOD</th>
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<tbody>
<tr>
<td></td>
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<td>01/01/12 - 12/31/12</td>
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### ADDITIONAL INFORMATION SECTION

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Worksheet D-1

• Purpose:
  - Calculation of Medicare’s share of routine cost (inpatient)
  - Add acute ancillary costs to arrive at total Medicare inpatient cost
  - Calculation of Medicare swing (SNF) routine cost
Worksheet D-1 (Continued)

• Calculation of Routine Costs
  - Total costs from B, Col 26 for acute
  - Carve out cost related to Swing-NF days
  - Remaining costs are related to acute, swing SNF and observation
## Acute Per-diem Calculation

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<th>Value</th>
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<tr>
<td>Total acute days</td>
<td>1,500</td>
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<tr>
<td>Swing bed SNF</td>
<td>250</td>
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<td>Swing bed NF</td>
<td>50</td>
</tr>
<tr>
<td>Observation days</td>
<td>65</td>
</tr>
<tr>
<td>Total days</td>
<td>1,865</td>
</tr>
<tr>
<td>Total days less NF</td>
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</tr>
<tr>
<td>NF days</td>
<td>50</td>
</tr>
<tr>
<td>State NF rate</td>
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<tr>
<td>NF Costs</td>
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<tr>
<td>Acute costs</td>
<td>3,250,000</td>
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<tr>
<td>Less NF costs</td>
<td>(10,000)</td>
</tr>
<tr>
<td>Adjusted acute cost</td>
<td>3,240,000</td>
</tr>
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</table>

\[
\text{Adjusted acute cost} = \frac{\text{Acute costs}}{\text{NF days}} = \frac{3,240,000}{1,815} = \$1,785.12
\]
Worksheet D-3

• Calculation of inpatient and swing bed ancillary costs:
  - Column 1 – CCRs (from Worksheet C)
  - Column 2 – Inpatient charges (from PS&R)
  - Column 3 – Calculation of cost (Col. 1 x Col. 2)

• Two worksheets:
  - Acute
  - Swing
## INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

**Period**

From: 10/1/2010
to: 9/30/2011

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Ratio of Cost To Charges</th>
<th>Hospital Charges</th>
<th>Inpatient Program Costs (col. 1 x col. 2)</th>
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</thead>
<tbody>
<tr>
<td><strong>INPATIENT ROUTINE SERVICE COST CENTERS</strong></td>
<td></td>
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<tr>
<td>30.00 3000 ADULTS &amp; PEDIATRICS</td>
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<td><strong>ANCILLARY SERVICE COST CENTERS</strong></td>
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<td>50.00 5000 OPERATING ROOM</td>
<td>0.774957</td>
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<td>54.00 5400 RADIOLOGY-DIAGNOSTIC</td>
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<td>60.00 6000 LABORATORY</td>
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<td>66.00 6600 PHYSICAL THERAPY</td>
<td>0.529268</td>
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<td>71.00 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td>
<td>1.094567</td>
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<td>73.00 7300 DRUGS CHARGED TO PATIENTS</td>
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<td><strong>OUTPATIENT SERVICE COST CENTERS</strong></td>
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<td>88.00 8800 RURAL HEALTH CLINIC</td>
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<td>91.00 9100 EMERGENCY</td>
<td>0.461273</td>
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<td>92.00 9200 OBSERVATION BEDS (NON-DISTINCT PART)</td>
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<td>200.00 Total (sum of lines 50-94 and 96-98)</td>
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<td>201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)</td>
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<td>202.00 Net Charges (line 200 minus line 201)</td>
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<td>135,000</td>
<td>202.00</td>
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**CCN:** 131300

**Hospital:** Title XVIII

**Worksheet D-3**
• **Calculation of outpatient Medicare cost:**
  - Column 1 – CCRs (from Worksheet C)
  - Column 2 – PPS outpatient charges (from PS&R)
  - Column 3 – Cost based outpatient charges
  - Column 4 – Cost charges not subject to deductibles and coinsurance
  - Column 5, 6, 7 – respective costs

• **Rate setting:**
  - Total of columns 6+7 / columns 3+4 = Medicare rate for next year
Interim Rates

- Rates are set from filed Medicare cost reports
- Separate rates for IP, swing bed, and OP
- Actual reimbursement is calculated at year end and settled based on cost to charge ratios
- Intermediaries always round rates down
### Routine (Acute and ICU):

<table>
<thead>
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<th>Description</th>
<th>Line/Column</th>
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<tr>
<td>Total Medicare Inpatient Costs</td>
<td>D-1, Line 49</td>
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<tr>
<td>Total Medicare Days (includes Inpatient and ICU)</td>
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<td>Acute per-diem</td>
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### Swing Bed:

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<tr>
<td>Medicare Swing Bed Routine Cost</td>
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<td>Medicare Swing Bed Ancillary Cost</td>
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<td>Total Medicare Swing Bed Cost</td>
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<td>Medicare Swing-Bed Days</td>
<td>E-2, Line 5</td>
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**Swing bed on E-2 includes the 101%**

### Outpatient

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<tr>
<td>Total Medicare Charges</td>
<td>D, Parts V &amp; VI, Line 202, col 3</td>
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<td>Cost to Charge Ratio</td>
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**Outpatient rate**

### RHC #1:

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<td>Cost per Visit</td>
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Worksheets E

✓ Purpose: Calculate Medicare settlement
✓ Goal: Match payments with services
✓ Process: Summary of processed claims data and lump sum payments
Medicare Bad Debts

• Medicare deductibles and/or coinsurance:
  ▪ Hospital services only (not physician)
  ▪ RHCs

• 100% CAHs, 70% PPS
  ▪ Okay, it’s dropping to 65%...

• Excludes professional charges and any other fee schedule payments:
  ▪ Method II billing
Medicare Bad Debts (Continued)

• Three types:
  1. Reasonable collection efforts
  2. Medicaid secondary payor (crossovers)
  3. Written off under charity care policy (indigent)
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
  ▪ Collection agencies strategy

• Sound business judgment established that there was no likelihood of recovery at any time in the future
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

Tip: Can claim partial and full write-offs
Medicare Bad Debt – Charity Care

• Type of indigent bad debt:
  - Written off under the hospital’s charity care policy
  - This is often overlooked by hospitals
  - Not subject to the 120-day rule

Tip: Can claim partial and full write-offs
Worksheets M

- **Purpose:** Calculate cost-per-visit and settlement for RHC
- **Goal:** Expand worksheet A information, apply physician visits and hours
- **Process:** Utilize internal statistics and PS&R
M Series - Summary

• Separate M series for each RHC

• Key Calculation – Cost per visit
  ▪ (Total Costs / Total Visits)

  ▪ Costs
    • Direct costs and indirect allocated costs

  ▪ Visits
    • Greater of productivity standard visits or actual visits
Worksheet M-2

• Visits
  - Medically necessary, face-to-face encounter with a physician or mid-level
    • Does not include nursing visits
  - Fewer visits creates a higher adjusted cost per visit (denominator)
  - A higher adjusted cost per visit increases reimbursement though the cost report
    • Also means clinic is likely inefficient
• Things to include and bill as an RHC visit:
  - Office visits
  - Home visits
  - Assisted living visits
  - Nursing home visits
  - Swing-bed visits
Worksheet M-2  (Continued)

• Things NOT to include in RHC visit count:
  ▪ Nurse visits
  ▪ Physician visits not medically necessary
  ▪ Hospital visits such as:
    • Emergency room visits
    • Observation
    • Inpatient days
# Effect of Including Nurse Visits

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare visits per the PS&amp;R</td>
<td>4,210</td>
</tr>
<tr>
<td>Total encounters</td>
<td>9,500</td>
</tr>
<tr>
<td>Nurse visits</td>
<td>750</td>
</tr>
<tr>
<td>Total if nurse included</td>
<td>10,250</td>
</tr>
<tr>
<td>Total costs</td>
<td>$1,662,500</td>
</tr>
<tr>
<td>Medicare cost per visit</td>
<td>$175.00</td>
</tr>
<tr>
<td>Medicare cost per visit with nurse</td>
<td>$162.20</td>
</tr>
<tr>
<td>Decrease in cost-per-visit</td>
<td>$12.80</td>
</tr>
<tr>
<td>Times Medicare visits</td>
<td>4,210</td>
</tr>
<tr>
<td>Cost of nurse visits</td>
<td>$53,888</td>
</tr>
</tbody>
</table>
• **Minimum visits**
  
  
  \[\text{Productivity standard} \times \text{FTE}\]

• **Productivity standard:**
  
  ▪ Consistent between facilities and years
  ▪ 4200 visits per physician FTE
  ▪ 2100 visits per mid-level FTE
Worksheet M-2 (Continued)

• Determination of FTEs
  ▪ Actual hours worked vs. paid hours
    • Include PTO hours
  
  ▪ Time excluded:
    • Supervisory
    • Hospital time
    • ER time

  ▪ Lower FTEs lowers the minimum visits

  ▪ Lower minimum visits reduces the risk of having productivity issues
### Overstated FTEs: the Calculation

<table>
<thead>
<tr>
<th>Situation</th>
<th>Hours</th>
<th>FTEs</th>
<th>Productivity Visits</th>
<th>Actual Visits</th>
<th>Cost/Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician works &quot;full time&quot;</td>
<td>2,080</td>
<td>1.00</td>
<td>4,200</td>
<td>3,800</td>
<td>160.71</td>
</tr>
<tr>
<td>Physician 5 days, 7 hours, 1 hour lunch</td>
<td>1,560</td>
<td>0.75</td>
<td>3,150</td>
<td>3,800</td>
<td>177.63</td>
</tr>
<tr>
<td>Decrease in cost-per-visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(16.92)</td>
</tr>
<tr>
<td>Times Medicare visits</td>
<td></td>
<td></td>
<td></td>
<td>1,300</td>
<td></td>
</tr>
</tbody>
</table>

Cost of misstated FTEs: $(21,996)
# What did we learn today?

<table>
<thead>
<tr>
<th>Worksheet</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost reports are fun</td>
</tr>
<tr>
<td>S</td>
<td>Information, settlement</td>
</tr>
<tr>
<td>A</td>
<td>Expenses</td>
</tr>
<tr>
<td>B</td>
<td>Allocation of overhead costs</td>
</tr>
<tr>
<td>C</td>
<td>Revenues and cost to charge ratios</td>
</tr>
<tr>
<td>D</td>
<td>Determination of Medicare’s costs</td>
</tr>
<tr>
<td>E</td>
<td>Medicare settlement (Medicare bad debts)</td>
</tr>
<tr>
<td>G</td>
<td>Summary financial statements</td>
</tr>
<tr>
<td>M</td>
<td>Rural health clinics</td>
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</tbody>
</table>
Questions?

IT WAS MY UNDERSTANDING THAT THERE WOULD BE NO MATH
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