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Opportunities In Your Cost Medicare Report

2017 ICAHN Annual Conference

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WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

Agenda

- General Cost Report Items Overlooked
- Rural Health Clinics
- Connecting Your Chargemaster with your Cost Report
- New Opportunities

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General Cost Report Items Often Overlooked

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Worksheet S-3 Data

- Labor and Delivery Days
  - Counted for DSH formula in eligibility and payment
  - Not counted as patient day for cost finding and per diems
    - ◊ Excluding L&D days from total helps outlier reimbursement
    - ◊ Excluding L&D days helps CAHs actual per diems

- Baby border days are not L&D days
  - Days an infant stays in the hospital after mother is discharged

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Medicare S-3 Data

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- Labor and Delivery Days
  - Day the mother is in active labor/delivery but the baby does not come until the next day
    - ◊ Generally a 1 or 2 day difference is a labor and delivery day
  - Admission for non-active labor but patient goes into labor and delivers a baby is not a labor and delivery day.
    - ◊ Normally anything above three days is not a labor and delivery day
    - ◊ Must be documented by admission diagnosis
    - ◊ Anti-partum admission normally
  - Best to match all babies with a mother

Worksheet S-3 Data

- Managed Medicare Days and Discharges
  - Not shadow billing can have reimbursement impacts
    - ◊ Impacts E.H.R. reimbursement
    - ◊ Impacts paramed reimbursement
  - By regulation this is a mandatory requirement

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Worksheet S-3 Data

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- Swing-Bed Days
  - Only Medicare and Medicare Managed belong on line 5.0
    - ◊ days are included in the cost per diem
  - All other payers belong on line 6.0
    - ◊ Days are excluded from the cost per diem
    - ◊ Carved out of costs at approximately $155 per day
  - Days on both line 5 and 6 need to be reported on a calendar year basis on Worksheet D-1
    - ◊ Impacts proper carve out of SWB-NF costs
  - Is a Hospice or Respite day a SWB day or Hospital day?

ICU or Medical/Surgical?

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- ICU's at most CAHs are not providing an intensive care level of service
  - Often more isolation patients?
  - More for physician preference than medical need?

- Consolidating with Medical/Surgical can have reimbursement benefits and is more compliant based on the level of care provided

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Self Insurance Reporting

- Days should be removed from total days and reported on lines 30-31
  - Excluded from cost finding and per diems
- Charges should be removed from Worksheet C
- Amount "reimbursed" to yourself for care should be removed via Worksheet A-8

Self Insurance Reporting

- Discharges – recommend leaving in total as does impact E.H.R. reimbursement formulas and no place to report separately
- RHC Visits – should be excluded but need to pay attention if excluding would subject you to the minimum productivity tests
- Having a stop loss policy doesn't mean you have met the regulations for having outside commercial insurance.

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New Overpayment Compliance Law

- Cost Report Audit Adjustments
  - If need to be applied retroactively new law puts burden on the provider not the MAC
  - Law states six years lookback
  - Closed NPRs?
    - ◊ Law extended claims statue of limitations on re-openings
    - ◊ Law did NOT extended the cost report statue of limitations on re-openings

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Hospitalist

- Which cost center do you report them in?
  - Adults & Pediatrics?
  - NRCC

- Physicians providing both ER coverage and Hospitalist coverage are problematic
  - Does time study account for both?
  - Estimates will not be allowed per WPS

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E.H.R. Depreciation Offset

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- Verify that total depreciation offset on A-8 over the years does not exceed the approved E.H.R. costs paid at costs upfront
- Disposals of E.H.R. assets before being fully depreciated means depreciation offset should go down

Related Party System Costs

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- Verify that system home office costs are lining up within the cost report
  - E.H.R. depreciation comes in with A&G costs but offsets are to depreciation line?
  - If you componentize A&G are system costs getting to the correct A&G line?
- Be careful of “over” allocation of Home Office costs for services not utilized

Related Party Costs

- How are you reporting other related party costs?
  - Foundations
  - Auxiliaries
  - Physician Clinics/Physician Organizations
- How are you reporting 340B retail pharmacy costs?

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Rural Health Clinics

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Consolidating Multiple RHCs

- Instructions Use to State it was an Election
- Revised Instructions now demand that it be requested and approved by MAC
- Impacts Cost Report filing only
- Very Rare that it doesn't have a positive impact

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Rural Health Clinics

- Total Costs on line 10 of Worksheet M drive Vaccine reimbursement
- Productivity Test on Worksheet M-2
  - Should include contract physicians
  - Only non-reoccurring physicians are excluded
  - Psychiatrist are physicians and should be on line 1.0
  - Psychologists are NOT physicians and should be on line 6.0

Rural Health Clinics

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- Productivity Tests FTEs
  - Exclude time not available in the clinic
    - ◊ PTO/Holiday/Vacation/Sick Time
    - ◊ Time spent in the hospital doing rounds/surgeries/procedures
    - ◊ Continuing Medical Education
    - ◊ Jury Duty, Bereavement, or Unpaid time away (e.g., FML, LOA)

Rural Health Clinics

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- Preventive Visits
  - No coinsurance to the beneficiary
  - Still not utilized frequently by most clinics
- Chronic Care Management
  - Non-reimbursable service per FQHC new form set
- Total Visits
  - Exclude no show visits
  - Exclude nurse only visits
  - Include SNF/NH or SWB visits
  - Include visits to patient home (must be home bound)

Rural Health Clinics

- Monitor Coinsurance per Claims verses Cost Report
  - Coinsurance when claim is adjudicated is 20% of charges
  - Coinsurance per cost report is calculated at 20% of costs
    - ❑ The cost report actually ignores the coinsurance reported on the PS&R
  - When Cost per Visit exceeds Average charge per visit there will be lost reimbursement
    - ❑ Cannot bill beneficiary for the difference

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Connecting Your Chargemaster with your Cost Report

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Chargemaster Connecting to your Cost Report

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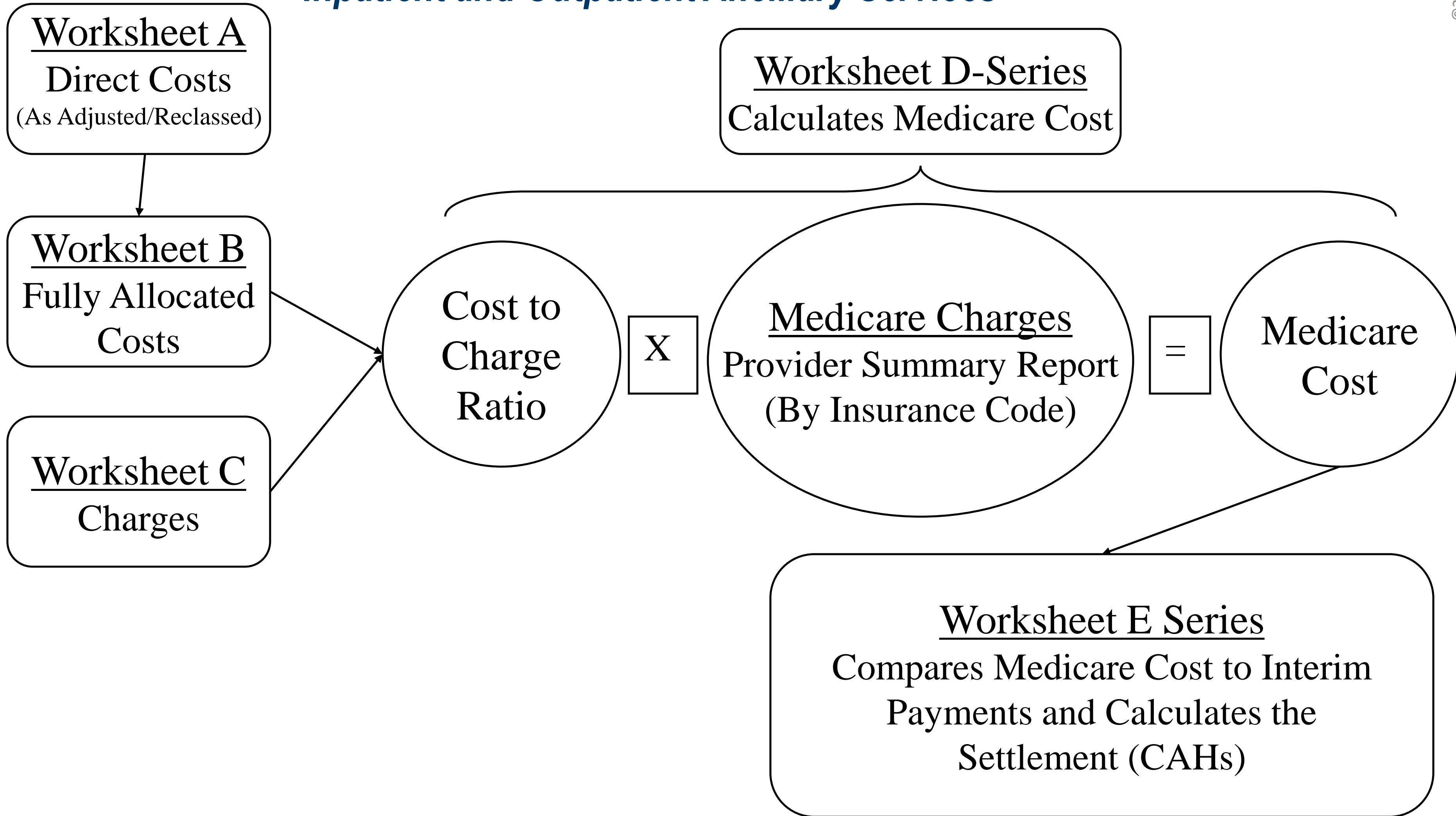
- Medicare Cost Report Crosswalk
  - In order to assure that all revenue codes are aligned with the appropriate cost center, a PS&R crosswalk should be developed, maintained, **and verified each year** as a step in preparing the Medicare cost report
  - Allocating Medicare PS&R totals based on your internal Medicare charges by department is no longer accepted by many MACs

Inpatient and Outpatient Ancillary Services



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Chargemaster Connecting to your Cost Report

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WS C Line	Line Description	Costs	Charges	Cost To Charge Ratio	Medicare Charges	Medicare Cost
55	MEDICAL SUPPLIES	$ 100,000	$ 200,000	0.50000	$ 50,000	$ 25,000
61	EMERGENCY	$ 150,000	$ 160,000	0.93750	$ 50,000	$ 46,875

ALIGNMENT WITH THE WRONG COST CENTER WILL IMPACT MEDICARE COST

Chargemaster Connecting to your Cost Report

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- Best Practice is to create a Pivot Table using the Revenue & Usage report and the Chargemaster
  - Provides solid audit trail
  - Can toggle to Medicare payer only to increase PS&R reclassification for accuracy
  - Can also use to reconcile patient days and visits

Chargemaster Alignment Best Practices

- Key Data Elements Required

Department Number	Department Name	Charge Number	Description	Units	Dollars	Revenue Code	Price
75.3022	UNIT 2 NURSING SVCS	30220004	OBSERVATION INITIAL HOUR	7,009	110,742.20	762	15.80
75.3022	UNIT 2 NURSING SVCS	30220105	SWING BED ROOM RATE	21	2,415.00	110	115.00
75.3022	UNIT 2 NURSING SVCS	30220135	BASIC ROOM RATE	1,472	559,360.00	110	380.00
75.3022	UNIT 2 NURSING SVCS	30220535	ORTHOTICS FITTING	1	2,322.43	761	0.00
75.3170	RESPIRATORY THERAPY	43600455	MDI/ TREATMENT	17	833.00	410	49.00
75.3170	RESPIRATORY THERAPY	43654152	OXYGEN PER HOUR	18,990	398,790.00	270	21.00
75.3170	RESPIRATORY THERAPY	43654153	OXYGEN INITIAL HOUR	760	59,280.00	270	78.00

From Revenue Usage Report

From CDM

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Chargemaster Alignment Best Practices

- Pivot Table Approach

WS C Lines			REV COD		
		Per PS&R crosswalk	**25**	**56**	**41**
		Sum of Dollars	REV COD		
		DEPT Number	110	250	255
25	UNIT 2 NURSING SVCS	75.3022	$561,775		
49	RESPIRATORY THERAPY	75.3170		$42,627	
37	OPERATING ROOM	75.3217			
61	EMERGENCY ROOM	75.3231			
55	CENTRAL SUPPLY	75.3251			
56	INTREVENOUS THERAPY	75.3254			
44	LABORATORY	75.4010			
49	EKG	75.4031			
41	RADIOLOGY	75.4040			$682
41	CT SCAN	75.4042			
41	NUCLEAR MEDICINE	75.4061			$612
56	PHARMACY SERVICES	75.4070		$1,568,718	
40	ANESTHESIA	75.4080			
50	PHYSICAL THERAPY	75.4091			
		Grand Total	561775	1611345.4	1294.45
			ok	PS&R Reclass #1	ok

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Chargemaster Alignment Best Practices

- Reconciliation to Worksheet C

WS C Line	Line Description	Total Per WS C	Variance	Total Per Revenue Usage
25	ADULTS & PEDIATRICS	935,030	1	935,031
37	OPERATING ROOM	688,376	-	688,376
40	ANESTHESIA	278,870	(2)	278,868
41	RADIOLOGY-DIAGNOSTIC	4,744,329	(3)	4,744,326
44	LABORATORY	4,055,058	1	4,055,059
49	RESPIRATORY THERAPY	1,482,404	-	1,482,404
50	PHYSICAL THERAPY	1,082,992	-	1,082,992
55	MEDICAL SUPPLIES CHARGED	986,480	(2)	986,478
56	DRUGS CHARGED	2,626,985	3	2,626,988
61	EMERGENCY	4,682,220	1	4,682,221
		21,562,744	(1)	21,562,743

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Common Case Study Misalignment Issues

- IV Administration/Infusions Service
  - Generally under 260 revenue code

These are Nursing Services Not IV Solutions.

Where is the Cost? Where are the Charges?

Realignment Can Take Several Forms

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Common Case Study Misalignment Issues

- IV Administration/Infusions Service Example

55.00	MEDICAL SUPPLIES CHARGED TO PATIENTS			
	850	Critical Access Hospital		
		260	IV THERAPY	173,501.75
		270	MED-SURG SUPPLIES	122,145.84
		271	NONSTER SUPPLY	2,475.00
		272	STERILE SUPPLY	95.00
		276	INTR OC LENS	75,860.00
Total	MEDICAL SUPPLIES CHARGED TO PATIENTS			374,078.00

  – Revenue Code 260 Incorrectly Assigned to Medical Supply Cost Center

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Common Case Study Misalignment Issues

- IV Administration/Infusions Service Example Impact

Rev Code	WS C Line	Line Description	Cost To Charge Ratio	Outatient Medicare Charges	Outatient Medicare Cost
As Filed Alignment					
260	55	MEDICAL SUPPLIES	0.61311	$ 173,502	$ 106,376
Corrected Alignment					
260	61	EMERGENCY	0.983891	$ 173,502	$ 170,707
				Resulted in Underpayment From Medicare Program of	**$ 64,331**

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Common Case Study Misalignment Issues

- Nursing Services
  - Are ancillary services being performed by your routine nursing staff for scheduled outpatient procedures?
    - IV Infusion
    - Blood Administration
    - Recovery Room Services
  - Where are the costs and charges for these?
  - Sometimes Requires a B-2 Post Step Down Adjustment
  - Be sure you are billing compliantly

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Common Case Study Misalignment Issues

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- Provider Based Clinics
  - Professional Carve out is critical
    - ❑ Need detailed proration of splits
      - ❖ R&U may assign 100% to a 9XX code but CBO redirects a portion to 510
    - ❑ Make sure resulting utilization makes sense
    - ❑ Watch for 100% professional line items (procedures)
    - ❑ Watch out for ancillaries (drugs, supplies, etc.)
    - ❑ Gross-Up on Worksheet C is generally required for most other payers
  - Don't assume just 510 revenue code needs to be aligned with line 90 Clinic
    - ❑ What other ancillaries are in these numbers?
      - ❖ Wound Care
      - ❖ Med/Surg
    - ❑ May need separate clinic system file to correctly align these.

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Common Case Study Misalignment Issues

- Professional Revenue Codes on PS&R
  - Should not be on cost based PS&R reports (110 or 850)
  - Be sure to look into how these are being billed Method I verses Method II
  - Might indicate incorrect billing
  - CRNA exemptions should have a 964 revenue code on their IP and OP PS&Rs

Common Case Study Misalignment Issues

- Radiology Contrast
  - Potential Revenue Codes = 255, 343, 344, 636
  - Revenue code 636 often gets combined with Pharmacy
  - Critical to understand where the costs and charges are being recorded
- IV Solutions
  - Revenue Code 258
  - Are the charges in the Pharmacy or Medical Supply area?
- EKGs/Telemetry
  - Revenue Codes 731 and 732
  - If in the routine nursing area this creates an issue with outpatient alignment

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Other Thoughts

- Before Filing, Review Utilization By Department on Your Cost Report to Assure it Makes Sense

TOTAL Comparison of MC		CY Total Charges	CY MC Total Charges	CY Total MC Utilization	PY Total MC Utilization	Change in Utilization
37	Operating Room	2,014,174	498,597	25%	26%	-1%
40	Anesthesiology	269,500	71,432	27%	27%	-1%
41	Radiology	3,156,473	859,097	27%	27%	0%
44	Laboratory	3,530,095	1,288,528	37%	37%	0%
49	Resp Therapy	123,085	105,247	86%	66%	20%
50	Physical Therapy	640,196	250,031	39%	37%	2%
51	Occup Therapy	350,141	81,127	23%	22%	1%
52	Speech Pathology	10,066	6,715	67%	67%	0%
53	EKG	549,390	255,744	47%	48%	-2%
55	Medical Supplies	846,860	233,259	28%	42%	-14%
56	Pharmacy	1,994,203	582,117	29%	28%	1%
60	Clinic	-	-	0%	19%	-19%
61	Emergency	979,662	299,036	31%	31%	0%
62	Observation Beds	53,696	6,242	12%	12%	0%

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Cost Report Opportunities

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- Ancillary services performed in inpatient units
  - Typically see IV Therapy and/or Blood Admin
  - Outpatient Recovery services in Med/Surg
  - Carve out as an ancillary service and move costs via B-2
    - ◊ May hurt inpatient but helps outpatient
    - ◊ Reassigning the revenue code elsewhere could be construed as fraud or abuse
- Grants
  - Should not be included as a non-reimbursable cost center
  - Do not net income against the expense within the WTB

Cost Report Opportunities

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- Outpatient Meals
  - NRCC or revenue offset?
- Marketing Departments
  - Advertising/Promotional Items should be reclassified to A&G and allowable amounts allocated; non-allowable should be offset.
- CAHs revenue codes 762, 450, and 510 should not be on an inpatient claim
  - NGS will deny the inclusion of these charges on the cost report at final settlement for inpatient and swing-bed

Cost Report Opportunities

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- Splitting PT/OT/ST into separate departments
  - WPS makes mandatory; other MACs have not followed
- Splitting Radiology, CT Scan, MRI, etc. into separate departments.
- Generally advantageous to CAHs
  - Utilization of CT Scans and MRI tends to be lower for Medicare and have lower CCRs

E.H.R. Audit Issues

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- AHA Useful Lives – no impact but truly annoying
- Double check dates assets went into service
- “Back-up” description gets asset disallowed
- Managed Care days not billed
- Charity care issues
  - Patient Responsibility = “deductible/coinsurance”
  - Documentation

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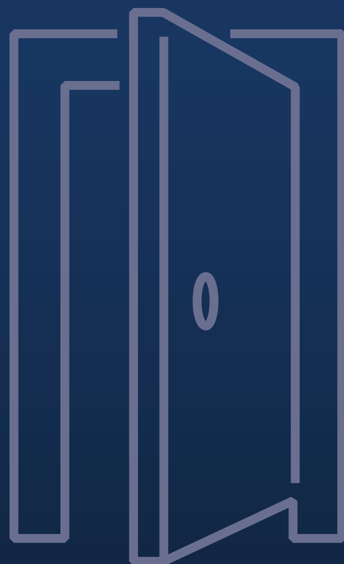

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