Cost Reporting – It's Never Too Early to Start Preparing

Besides being the greatest basketball player to ever live, Michal Jordan once said, "It's not the will to win that matters, it's the will to prepare to win that is important." That sentiment is true when it comes to preparing your Medicare cost report as well. We have several clients that wait until they get a letter from Medicare cutting off their Medicare payments to think about the cost report & then everything is a panic to complete the report as quickly as possible & get the Medicare money turned back on. Not only is this stressful & slows cash flow, as it normally results in missed opportunities to increase reimbursement for the clinic. Medicare Bad Debt, Influenza and Pneumococcal logs take time to complete accurately and are often lost in this process. Plus, the ability to accrue bonus payments to owners is lost as well. (They must be accrued & paid within 75 days of year-end).

With this in mind, start early. Start now. There are several things you can do now that will increase your reimbursement and settlement on the cost report when it is filed and will allow you to file the cost report timely and without the last second stress.

The cost report pays basically four different reimbursable items:

1) Settles the difference between the interim rate and the final cost per visit up to the cap if applicable minus the 2% sequestration adjustment
2) Pays the cost of Influenza and Pneumococcal injections only.
3) Currently pays 65% of Medicare Bad Debts (this may be going down so claim them now)
4) Settles amounts owed for preventive co-payments and deductibles owed

The Cost per visit is very important if you are a new rural health clinic and in a base year for Medicaid. You should discuss with your Cost Report preparer the need to complete a projected cost report about 2 months before the year-end. This report will help you determine if your cost per visit is too low and you can plan a course of action to accrue expenses or distribute salaries in the correct amounts at year-end.

Influenza and Pneumococcal Reimbursement: First, Cahaba has started limiting tentative settlements to $66 per injection for pneumonia shots and $28 for influenza shots respectively. This is only for the tentative settlement, not the final settlement and you should be able to receive your full cost of your pneumonia and influenza injections on the final settlement from Medicare if you have all your documentation and it is reasonable. Based upon the 2013 NARHC benchmarking study for independent RHCs the mean cost for pneumococcal injections was $144.67 per shot and $45.88 for influenza. For provider-based RHCs the mean cost is somewhat higher.

Start now by gathering your documentation including a log of the patient's name, HIC (Medicare) number, and date of the injection, for all Medicare patients (do not include Advantage or Replacement plans) and copies of the invoices of pneumococcal and influenza purchases during the fiscal year. If you conduct a time study of how much time it takes to provide influenza and pneumococcal shots that will be helpful as well. If you do not complete a time study, most MACs allow 10 minutes per shot.

Prevnar 13 and 23 are covered under the Medicare benefit and should be logged just like any other pneumococcal shot. If the patient does receive a second pneumococcal injection which is allowed it must be at least one year after the first injection. The Influenza and pneumococcal injections are the only injections that Medicare pays separately on the RHC cost report. All others are paid on the UB-04 as a part of the reimbursement rate except for a very limited number of immunizations that are covered by Medicare Part D.

Medicare Bad Debt

Medicare bad debts must be written off by the end of the fiscal year you are claiming them is the first most important thing to remember. Especially if you are a September 30, 2015 year-end or a December 31, 2015 year end. You must go into your

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Medicare Bad Debt continued…

accounting system and physically write off the accounts in this fiscal year or you will not get to claim the bad debt in this year. The CFR at 42 CFR 413.89(f) requires that the uncollectible Medicare deductible and coinsurance be charged off as bad debts in the accounting period when the bad debt is determined to be worthless.That is the first critical deadline.

First, it helps to understand what a Medicare Bad Debt is: – Deductibles and Coinsurance amounts uncollectible from Medicare beneficiaries after reasonable collection efforts for services billed to Medicare Part A on the UB-04.

Medicare Bad Debt IS NOT: – Uncollected deductibles and coinsurance from: private pay patients, or any other non-Medicare beneficiary Medicare Advantage or Medicare Part B – Charity, Courtesy, and Third-Party Payer Allowances – Uncollected amounts due from other payers – Disputed Medicare claims. – Contractual adjustments from Medicare or Medicaid (remember, Medicare bad debts only refer to uncollectible charges for deductibles or co-payments)

The criteria for allowable bad debts are as follows"

1. Debt must be related to covered services and derived from deductible and coinsurance amounts.
2. Provider must establish that reasonable collection efforts were made.
3. Debt was actually uncollectible when claimed as worthless.
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

The information necessary to claim a Medicare bad debt should be included in the Medicare Bad Debt log should include the following for each claim:

- Beneficiary Name
- Health Insurance Claim (HIC) Number
- Medicaid number (or indigence indication)
- Write off date
- Any payments from other insurance or beneficiary
- Date of Service
- Date of first bill
- Medicare Remittance Advice date
- Coinsurance and Deductible amounts
- Total write off amount

The Log should calculate: Coinsurance + Deductible – Payments = Write Off Amount and calculate at least 120 days from the date of first bill or the bad debt will be disallowed. Do not include Medicare Advantage/HMO patients and the collection efforts for Medicare and non-Medicare beneficiaries should be the same including the use of collection agencies should be the same for each payer type. Bad debts must be returned from the collection agency before they are eligible to be claimed.

Most MACs have a Medicare Bad Debt Excel spreadsheet they use to compile Medicare bad debts. If you need one just email us and we will be glad to email one to you.

Medicaid Crossovers or Dual Eligible Bad Debts- If Medicare is primary and Medicaid secondary, Medicaid should pay the entire deductible or co-payment due by the Medicare beneficiary. If for some reason, Medicaid does not pay the entire balance, the unpaid balance is not a contractual adjustment, but a Medicare bad debt that can be claimed on the Medicare cost report. Keep a separate log of the Crossovers from the regular Medicare Bad Debts. Here is an example of how the math works.

Patient Charge	$100	(per charge to patient -99213)
Medicare Cost per visit	$80	(per cost report)
Medicare pays	$64	($80 X .80 Medicare %)
Medicaid pays	$16	(64 + 16 = $80)
They should have paid	$20	($100 X 20%)
Medicare bad debt	$4	($20 - $16)

Medicare Bad Debts are a time consuming process so make sure to start early. Like a Boy Scout, you need to be prepared. One of the best ways to prepare is to join us at the NARHC Fall Institute in Saint Louis on October 27th to the 29th. See you there.

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