Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 11, Form CMS-339

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2796

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
1102.3 (Cont.) –1102.3 (Cont.)	11-11 – 11-14 (4 pp.)	11-11 – 11-14 (4 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: October 1, 2003

IMPLEMENTATION DATE: October 1, 2003

Section 1102.3 L. Reimbursement Information, is being revised to properly state the instructions to complete Exhibit 5, Column 4 of the CMS 339 and change HCFA to CMS throughout the instructions.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

Exhibits 4 and 4A- Hospital Emergency Department Provider-Based Physician Allowable Unmet Guarantee Amounts Under Minimum Guarantee Arrangements: Data Elements - Computation

Complete Exhibit 4 in accordance with §2109. Completion of Exhibit 4 (Data Elements) and a copy of the approved allocation agreement, together with the instruction and illustration in §2109.4C, enables you to complete Exhibit 4A (Computation Worksheet).

K. Home Office Costs.--Ensure that each intermediary servicing a provider in a chain is furnished with a detailed summary of the entire chain's direct, functional and pooled home office costs. (Where an intermediary serves more than one provider in a chain it is only necessary to submit one summary to that intermediary.) Failure to submit this summary schedule will result in the removal of all home office costs in accordance with §2153 and 42 CFR 413.9 and 42 CFR 413.20.

If the answer to question 7 is yes, then the provider must submit details for the total wages and wage-related cost, and hours associated with all home office or related organization personnel who perform services for the provider. The costs shown must be the costs to the home office or related organization.

L. Bad Debts.--A provider's bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries are considered in the program's calculation of reimbursement to the provider. Allowable Medicare bad debts must meet the following criteria:

- The debt must be related to Medicare covered services and derived from Medicare deductible and coinsurance amounts.

- The provider must be able to establish that reasonable collection efforts were made. Providers must issue bills, collection letters and telephone calls or personal contacts which constitute a genuine, rather than a token, collection effort. (See §310 and 42 CFR 413.80.)

  NOTE: If the provider's policy is to refer non-Medicare accounts, but not its Medicare accounts, to a collection agency, the Medicare accounts cannot be claimed as a Medicare bad debt even after 120 days. Moreover, if a provider refers all uncollected accounts to a collection agency, but only records in its books the Medicare accounts as bad debts at the point of referral, the Medicare bad debts cannot be allowed.

- The debt was actually uncollectible when claimed as worthless. If after the provider applied reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

  NOTE: When a provider claims Medicare bad debts in 120 days or less from the first bill, the provider must be prepared to demonstrate that the debts were "actually worthless." The provider, in all cases, must be able to support that it pursued reasonable collection efforts. (See §§308(2) and 310). A provider may claim Medicare bad debts under §310, presumption of

uncollectibility, if after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary unless there is reason to believe that the debt is collectable for example, the beneficiary is currently making payments on account, or has currently promised to pay the debt.

- o Sound business judgement established that there was no likelihood of recovery at any time in the future.

A provider whose Medicare bad debts meet the above criteria should complete Exhibit 5 or submit internal schedules duplicating documentation requested on Exhibit 5 to support bad debts claimed. If the provider claims bad debts for inpatient and outpatient services, complete a separate Exhibit 5 or internal schedules for each category.

We have added Exhibit 5 to the CMS-339, which can be used to list the bad debts claimed. It contains much of the information the intermediary will need in order for it to determine the allowability of the bad debts.

In accordance with OBRA 1987, intermediaries may not require hospitals to submit such a list that was not the intermediary's practice to require such data from the hospital as of August 1, 1987. However, voluntary submission of this exhibit would greatly assist the intermediary in verifying the allowability of the bad debts claimed. The submission of this listing may possibly provide the intermediary with sufficient information upon which to base its acceptance of the bad debts claimed on the hospital's cost report, without the necessity of an on-site visit.

Exhibit 5 requires the following documentation:

Columns 1,2,3 - Patient Names, HIC NO., Dates of Service (From - To).--The documentation requested for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number (social security number) and dates of service that correlate to the filed bad debt. (See §314 and 42 CFR 413.80.)

Column 4 - Indigency/Welfare Recipient.--If the patient included in column 1 has been deemed indigent, place a check in this column. If the patient in column one has a valid Medicaid number, also include this number in this column. See the criteria in Provider Reimbursement Manual - I §§312 and 322 and 42 CFR 413.80 for guidance on the billing requirements for indigent and welfare recipients.

Columns 5 & 6 - Date First Bill Sent to Beneficiary - Write-Off Date.--This information should be obtained from the provider's files that documented reasonable collection effort was pursued. The write-off date is not before the application of all policies contained in §310.

Column 7 - Remittance Advice Dates.--Enter in this column the remittance advice dates that correlate with the beneficiary name and date of service shown in columns 1, 2, and 3 of this exhibit. This will enable the intermediary to verify the authenticity of the Medicare patient and the related bad debt.

Columns 8 & 9 - Deductible - Coinsurance.--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services. These must not be claimed unless the provider bills for these services with the intention of payment. (See instructions for column 4 - Indigency/Welfare Recipient.)

Column 10 - Total Medicare Bad Debts.--Provider's Medicare bad debts are the sum of columns 8 and 9 and will be recorded on the filed cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

M. Bed Complement.-- Available beds are beds that are permanently maintained for lodging inpatients. They must be available for use and housed in patient rooms or wards (i.e., do not include beds in corridors or temporary beds). Beds in a completely or partially closed wing of the facility are considered available only if they are put into use when needed. Regarding instances where beds are taken out of service in order to renovate patient rooms, the beds are to be counted if the area can be included in the depreciable plant assets in accordance with Medicare regulations at 42 CFR 413.134, and the beds can be adequately staffed by either employed nurses or nurses from a nurse registry. Conversely, if the renovation is substantial enough that the area is unavailable for patient use and, thus, cannot be included in depreciable assets, the beds in that area would be considered unavailable for the renovation period. While the duration of the renovation is not a direct determinant of availability, it is a factor in determining whether the magnitude of the renovation is substantial enough that the area is unavailable for patient use. In that regard, renovations lasting only a month or two would most likely not be substantial enough to render an area unavailable.

A provider bed is an adult bed, pediatric bed, or neonatal intensive care unit bed, maintained in a patient care area for lodging patients. Beds in newborn nurseries, labor rooms, birthing rooms, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences and other such areas which are regularly maintained and utilized for only a portion of the stay of patients, primarily for special procedures or not for inpatient lodging, are not termed beds for these purposes.

N. Medicare Settlement Data (PS&R DATA).--The PS&R system generates several reports which provide apportionment, statistical, settlement and reimbursement data that can be used in filing the cost report. Although the primary input into the PS&R system is the Form CMS -1450 claims data, a significant amount of information is calculated and assembled through the PS&R. This includes outpatient prevailing charges, PPS capital elements, MSP data, and SCH data. This data is produced exclusively for the settlement of the Medicare cost report and as such is not reflected on the Medicare remittance advice

In some cases, the provider may have independent record keeping capabilities which provides them with the capacity to generate the appropriate cost report data consistent with that contained in the PS&R. This could include outpatient pricing and claims splitting modules such as ASC, radiology, and other diagnostic, as well as various other programs used to calculate the required data. The provider's record keeping capability, relative to cost report preparation, will vary by provider type and the scope of the services rendered. A provider's system, in order to be effective, requires all necessary updating of PRICER information, fees, prevailing charges, and other regulatory changes impacting the resultant PS&R, as well as adjustment claims. This is an ongoing process that does not end with the filing of the cost report, but continues through final settlement.

The PS&R system and all related reports were designed with the intent of completing and effecting a final settlement of the Medicare cost report as consistent with all related Program directives, instructions, and regulatory provisions. Since the PS&R system is not limited to only capturing and providers rely on the PS&R to complete specific cost report worksheets. It is anticipated that the

PS&R will be used in filing and settling many Medicare cost reports. However, in certain instances, the provider may use internal records in filing the cost report, either in part or in total. This decision may result from summarizing Form CMS -1450 claims data but actually calculating other cost report related data, many supplementing the PS&R with claims paid subsequent to its cut off date, or providers may indicate that they have full ongoing internal capabilities to produce all required data for completion of the cost report and elect to file using internal records only.

The revenue codes on the Form CMS -1450 have been standardized for Medicare billing purposes without regard to providers' actual revenue and expense accounting process. In many cases, therefore, there will be differences between the classifications of revenues in the PS&R and the general ledger classifications that can affect Medicare reimbursement. Providers must evaluate the impact of these classification differences and maintain accurate Medicare logs which collect charge data consistent with the general ledger classifications of revenues and expenses, if they are not using the PS&R in its entirety.

Several actions are required for providers in filing the cost report, whether they use the PS&R for the source document or internal log records. In each of the following examples, providers must include the summary of their "unpaid" log as support for any claims not included on the PS&R. The summary should include totals consistent with the breakdowns on the PS&R. This report should be generated to reflect claims paid that are unprocessed or unpaid as of the cut off date of the PS&R. The cut off date equates to the paid date reflected on the PS&R. These required actions vary slightly for Part A and Part B data and are summarized below:

Part A, using PS&R only - Providers are required to develop a table for inclusion with the filed cost report which provides a crosswalk between the revenue codes and charges found on the PS&R to the cost center groupings found on the cost report. This crosswalk reflects a one-on-one match, cost center to revenue code. No overlap is permitted in this example. Unpaid claims will be added to the PS&R totals, following the same revenue crosswalk. For crosswalk, see example 1.

Part A, using PS&R for totals, provider records for allocation - Providers are required to develop a table for inclusion with the cost report which provides a detailed crosswalk between the revenue codes, departments, and charges found on the PS&R to the cost center groupings found on the cost report. In this instance, there is not a requirement for a one on one match, but providers must show total dollars by cost center and the range of revenue codes within each cost center. The total revenue must match that found on the PS&R, plus any claims reflected on the unpaid log. Supporting workpapers must be maintained by the provider to identify the source of their data in order to attest to its accuracy.