

## **Cost Reporting Issues for Provider-based RHCs**

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Jeffrey M. Johnson, CPA, Partner  
Wipfli LLP - Health Care Practice



**Michigan Critical Access Hospital Conference**

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### **Presentation Objectives**

- Overview of Medicare reimbursement principles.
- Review of common cost report inaccuracies.
- Implications of operational strategies on Medicare reimbursement.

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## Overview of Medicare Reimbursement Principles

- Costs must be related to patient care
- Costs must be related to allowable services
- Costs must be reasonable - Prudent buyer concept



## Cost Report Accuracy



## Cost Report Accuracy

1. Direct health care cost vs. overhead cost
2. Allowable vs. non-allowable costs
3. Total visits
4. Provider FTEs



## Cost Report Accuracy

### Scenario:

- RHC with four physicians and one physician assistant on staff.
- Medicare visits are 40% of total visits.
- RHC is not subject to maximum rates.



## Cost Report Accuracy – Direct vs. Overhead

Direct health care cost staff costs include all clinic staff providing direct patient care.

Facility overhead staff costs include all clinic staff providing general or administrative services.



## Cost Report Accuracy – Direct vs. Overhead

Assume one FTE nurse was inaccurately reported as office staff. Total cost of \$50,000 per FTE reported as facility overhead (office staff) but should have been reported as direct health care (other nurse).



## Cost Report Accuracy – Direct vs. Overhead

To correct this error a reclassification of \$50,000 is made to increase direct health care costs and . . .

	COMPEN- SATION	OTHER COSTS	TOTAL	RECLASS- IFICATIONS	NET EXPENSES FOR ALLOCATION
	1	2	3	4	7
FACILITY HEALTH CARE STAFF COSTS					
1 Physician	850,000	150,000	1,000,000		1,000,000
2 Physician Assistant	120,000	40,000	160,000		160,000
3 Nurse Practitioner					
4 Visiting Nurse					
5 Other Nurse	175,000		175,000	50,000	225,000
6 Clinical Psychologist					
7 Clinical Social Worker					
8					
9 Other Facility Health Care Staff Costs					
10 Subtotal (sum of lines 1-9)	1,145,000	190,000	1,335,000	50,000	1,385,000



## Cost Report Accuracy – Direct vs. Overhead

A reclassification of \$50,000 is made to decrease facility overhead administrative costs.

	COMPEN- SATION	OTHER COSTS	TOTAL	RECLASS- IFICATIONS	NET EXPENSES FOR ALLOCATION
	1	2	3	4	7
FACILITY OVERHEAD ADMIN. COSTS					
38 Office Salaries	130,000	26,000	156,000	(50,000)	106,000
39 Depreciation - office equip		30,000	30,000		30,000
40 Office Supplies		10,000	10,000		10,000
41 Legal		5,000	5,000		5,000
42 Accounting		15,000	15,000		15,000
43 Insurance		2,000	2,000		2,000
44 Telephone		7,000	7,000		7,000
45 Fringe Benefits and Payroll Taxes			-		-
46 Other		30,000	30,000		30,000
49 Subtotal (sum of lines 38-48)	130,000	125,000	255,000	(50,000)	205,000



## Cost Report Accuracy – Direct vs. Overhead

How is reimbursement impacted?

	Before Reclass.	After Reclass.	Difference
Cost of RHC Services - excluding overhead	1,300,000	1,350,000	50,000
Cost of Other Than RHC Services - excl. OH	100,000	100,000	-
Cost of All Services - excluding overhead	1,400,000	1,450,000	50,000
Ratio of RHC Services	0.9286	0.9310	0.0025
Total Overhead (Admin. + Facility)	1,075,000	1,025,000	(50,000)
Overhead Applicable to RHC Services	998,214	954,310	(43,904)
Total Allowable Cost of RHC Services	2,298,214	2,304,310	6,096
Medicare %	40%	40%	
Medicare Allowable Cost	919,286	921,724	2,438



## Cost Report Accuracy – Allowable vs. Non-Allowable

Costs related to non-RHC services such as lab, radiology (technical component), dental, professional hospital care, etc. are excluded from RHC allowable costs.

For independent RHCs, these costs are classified as “Cost Other Than RHC Services”, lines 51 – 57 of the CMS-222-92.

For provider-based RHCs, these costs are classified within the respective hospital department (lab, radiology, etc.) on the hospital cost report.



## Cost Report Accuracy – Allowable vs. Non-Allowable

Assume one FTE nurse was inaccurately reported as lab staff. Total cost of \$50,000 per FTE reported in laboratory but should have been reported as clinic nurse.



## Cost Report Accuracy – Allowable vs. Non-Allowable

To correct this error a reclassification of \$50,000 is made to increase direct health care costs and . . .

	COMPEN- SATION	OTHER COSTS	TOTAL	RECLASS- IFICATIONS	NET EXPENSES FOR ALLOCATION
	1	2	3	4	7
FACILITY HEALTH CARE STAFF COSTS					
1 Physician	850,000	150,000	1,000,000		1,000,000
2 Physician Assistant	120,000	40,000	160,000		160,000
3 Nurse Practitioner					
4 Visiting Nurse					
5 Other Nurse	175,000		175,000	50,000	225,000
6 Clinical Psychologist					
7 Clinical Social Worker					
8					
9 Other Facility Health Care Staff Costs					
10 Subtotal (sum of lines 1-9)	1,145,000	190,000	1,335,000	50,000	1,385,000



## Cost Report Accuracy – Direct vs. Overhead

### For Independent RHC:

a reclassification of \$50,000 is made to decrease costs “Other Than RHC Services”.

	COMPEN- SATION	OTHER COSTS	TOTAL	RECLASS- IFICATIONS	NET EXPENSES FOR ALLOCATION
	1	2	3	4	7
<b>COST OTHER THAN RHC SERVICES</b>					
51 Pharmacy			-		-
52 Dental			-		-
53 Optometry			-		-
54 Other (Specify)			-		-
55 <i>Laboratory</i>		75,000	75,000	(50,000)	25,000
56 <i>Hospital Inpatient/Outpatient</i>		25,000	25,000		25,000
57 Subtotal (sum of lines 51-56)	-	100,000	100,000	(50,000)	50,000



## Cost Report Accuracy – Direct vs. Overhead

How is reimbursement impacted for the Independent RHC?

	Before Reclass.	After Reclass.	Difference
Cost of RHC Services - excluding overhead	1,300,000	1,350,000	50,000
Cost of Other Than RHC Services - excl. OH	100,000	50,000	(50,000)
Cost of All Services - excluding overhead	1,400,000	1,400,000	-
Ratio of RHC Services	0.9286	0.9643	0.0357
Total Overhead (Admin. + Facility)	1,075,000	1,075,000	-
Overhead Applicable to RHC Services	998,214	1,036,607	38,393
Total Allowable Cost of RHC Services	2,298,214	2,386,607	88,393
Medicare %	40%	40%	
Medicare Allowable Cost	919,286	954,643	35,357



## Cost Report Accuracy – Direct vs. Overhead

*For provider-based RHC:*

a reclassification of \$50,000 is made to decrease laboratory costs on the hospital cost report.

COST CENTER		SALARIES	OTHER	TOTAL	RECLASS- IFICATIONS	NET EXPENSES FOR ALLOCATION
		1	2	3	4	7
ANCILLARY SRVC COST CNTRS						
37	3700	OPERATING ROOM	900,000	725,000	1,625,000	1,625,000
40	4000	ANESTHESIOLOGY	400,000	110,000	510,000	510,000
41	4100	RADIOLOGY-DIAGNOSTIC	860,000	1,070,000	1,930,000	1,930,000
44	4400	LABORATORY	650,000	900,000	1,550,000	1,500,000
49	4900	RESPIRATORY THERAPY	170,000	25,000	195,000	195,000
50	5500	PHYSICAL THERAPY	560,000	140,000	700,000	700,000
51	5100	OCCUPATIONAL THERAPY	130,000	50,000	180,000	180,000



## Cost Report Accuracy – Direct vs. Overhead

*For provider-based RHC:*

a reclassification decreasing lab costs by \$50,000 will decrease the laboratory ratio of cost-to-charges.

Excerpts from Worksheet C of Medicare Hospital Cost Report

COST CENTER		Total Costs Worksheet B Part 1 (col. 27)	Total Charges	New Ratio of Cost to Charges	Old Ratio of Cost to Charges	
		1	7			
ANCILLARY SRVC COST CNTRS						
37	3700	OPERATING ROOM	1,625,000	2,955,000	0.5500	0.5500
40	4000	ANESTHESIOLOGY	510,000	3,400,000	0.1500	0.1500
41	4100	RADIOLOGY-DIAGNOSTIC	1,930,000	4,825,000	0.4000	0.4000
44	4400	LABORATORY	1,500,000	4,286,000	0.3500	0.3616
49	4900	RESPIRATORY THERAPY	195,000	331,000	0.5900	0.5900
50	5500	PHYSICAL THERAPY	700,000	875,000	0.8000	0.8000
51	5100	OCCUPATIONAL THERAPY	180,000	200,000	0.9000	0.9000



## Cost Report Accuracy – Direct vs. Overhead

How is reimbursement impacted for the Provider-based RHC?

	Before Reclass.	After Reclass.	Difference
Cost of RHC Services - excluding overhead	1,300,000	1,350,000	50,000
Cost of Other Than RHC Services - excl. OH	50,000	50,000	-
Cost of All Services - excluding overhead	1,350,000	1,400,000	50,000
Ratio of RHC Services	0.9630	0.9643	0.0013
Total Overhead (Admin. + Facility)	1,075,000	1,075,000	-
Overhead Applicable to RHC Services	1,035,185	1,036,607	1,422
Total Allowable Cost of RHC Services	2,335,185	2,386,607	51,422
Medicare %	40%	40%	
Medicare Allowable Cost	934,074	954,643	20,569



## Cost Report Accuracy – Direct vs. Overhead

How is reimbursement impacted for the Provider-based RHC?

In a Critical Access Hospital, reimbursement impact will vary based on Medicare utilization and ratio of cost-to-charges as follows:

Laboratory Medicare utilization		20%
Medicare charges	\$	857,200
Multiply by "new" RCC	0.3500	\$ 300,020
Multiply by "old" RCC	0.3616	\$ 310,000
Hospital Medicare lab impact	\$	(9,980)
Plus: RHC cost center impact		20,569 (previous slide)
Overall hospital financial impact	\$	<u>10,589</u>

In a PPS hospital, there will be no lab reimbursement impact for the reduction of hospital lab costs since these lab services are currently reimbursed on a fee schedule. Therefore, the hospital would receive the entire \$20,569 benefit



## Cost Report Accuracy – Total Visits

RHC visits are defined as medically necessary, face-to-face encounters with RHC practitioner.

VISITS AND PRODUCTIVITY					
	Number			Minimum	Greater of
	of FTE	Total	Productivity	Visits (col. 1	col. 2 or
	Personnel	Visits	Standard (1	x col. 3)	col. 4
Positions	1	2	3	4	5
1 Physicians	3.80	13,000	4,200	15,960	
2 Physician Assistants	0.90	5,200	2,100	1,890	
3 Nurse Practitioners			2,100	-	
4 Subtotal (sum of lines 1-3)	4.70	18,200		17,850	18,200
5 Visiting Nurse					
6 Clinical Psychologist					
7 Clinical Social Worker					
8 Total FTEs and Visits (sum of lines 4-7)	4.70	18,200			18,200
9 Physician Services Under Agreements					



## Cost Report Accuracy – Total Visits

Assume 1,000 nurse only visits (99211) were erroneously reported as physician RHC visits. Physician visits of 13,000 were reported on line 1, but physician visits of 12,000 should have been reported.

To correct this error, a reduction of 1,000 visits was made. Total visits of 18,200 were reduced to 17,200.



## Cost Report Accuracy – Total Visits

Corrected total visits of 17,200 are now reported on worksheet B, column 2.

VISITS AND PRODUCTIVITY					
	Number of FTE Personnel	Total Visits	Productivity Standard (1 x col. 3)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
Positions	1	2	3	4	5
1 Physicians	3.80	12,000	4,200	15,960	
2 Physician Assistants	0.90	5,200	2,100	1,890	
3 Nurse Practitioners			2,100	-	
4 Subtotal (sum of lines 1-3)	4.70	17,200		17,850	17,850
5 Visiting Nurse					
6 Clinical Psychologist					
7 Clinical Social Worker					
8 Total FTEs and Visits (sum of lines 4-7)	4.70	17,200			17,850
9 Physician Services Under Agreements					



## Cost Report Accuracy – Total Visits

Productivity screens limit the actual reduction in visits to 17,850 “adjusted” visits.

Medicare reimbursement increases by approximately \$15,000. Why?

Medicare reimbursement could have increased by over \$43,000. Why did it not?



## Cost Report Accuracy – Provider FTEs

FTE personnel are based on clinical time in the RHC site-of-service.

VISITS AND PRODUCTIVITY					
	Number			Minimum	Greater of
	of FTE	Total	Productivity	Visits (col. 1	col. 2 or
	Personnel	Visits	Standard (1	x col. 3)	col. 4
Positions	1	2	3	4	5
1 Physicians	3.80	12,000	4,200	15,960	
2 Physician Assistants	0.90	5,200	2,100	1,890	
3 Nurse Practitioners			2,100	-	
4 Subtotal (sum of lines 1-3)	4.70	17,200		17,850	17,850
5 Visiting Nurse					
6 Clinical Psychologist					
7 Clinical Social Worker					
8 Total FTEs and Visits (sum of lines 4-7)	4.70	17,200			17,850
9 Physician Services Under Agreements					



## Cost Report Accuracy – Provider FTEs

Assume 20 hours per week (0.5 FTE) of physician time is spent supervising midlevel practitioners and providing clinic administrative services.

This time had erroneously been reported as part of the 3.8 physician FTEs on worksheet B, column 1.

To correct this error, a reduction of 0.5 physician FTEs was made. Total physician FTEs were reduced to 3.3.



## Cost Report Accuracy – Provider FTEs

Corrected FTE personnel are now reported as 4.20; physician FTEs are 3.30.

VISITS AND PRODUCTIVITY					
	Number			Minimum	Greater of
	of FTE	Total	Productivity	Visits (col. 1	col. 2 or
	Personnel	Visits	Standard (1	x col. 3)	col. 4
Positions	1	2	3	4	5
1 Physicians	3.30	12,000	4,200	13,860	
2 Physician Assistants	0.90	5,200	2,100	1,890	
3 Nurse Practitioners			2,100	-	
4 Subtotal (sum of lines 1-3)	4.20	17,200		15,750	17,200
5 Visiting Nurse					
6 Clinical Psychologist					
7 Clinical Social Worker					
8 Total FTEs and Visits (sum of lines 4-7)	4.20	17,200			17,200
9 Physician Services Under Agreements					



## Cost Report Accuracy – Provider FTEs

Productivity screens no longer limit the actual visits since the corrected visits are equal to the minimum visits of 17,200.

Medicare reimbursement increases by about \$28,000.  
 Why?



# Operational Strategies and Medicare Reimbursement Impact



## Strategies and Reimbursement Impact

1. Shared office space
2. Non-RHC carve-outs
3. Claiming Bad Debts



## Strategies and Reimbursement Impact – Shared Office Space

### Scenario:

- Cardiologist from nearby community approaches RHC to rent space 2 days per month.
- Cardiologist's staff will schedule appointments, room patients, and provide billing.
- Cardiologist is not considered part of RHC staff.



## Strategies and Reimbursement Impact – Shared Office Space

### Under the proposed rule:

- CMS prohibits an RHC and a Medicare fee-for-service practice from operating simultaneously to prevent shared practices from selecting patient encounters for enhanced Medicare Part B billing.
- Operation of a multipurpose facility is acceptable, but any shared staff, space, or other resources must be allocated appropriately between the RHC and non-RHC usage to avoid duplicate reimbursement.



## Strategies and Reimbursement Impact – Shared Office Space

### Issue #1:

- Cardiologist must be charged fair market value (FMV) rent.
  - What is FMV rent for furnished exam rooms, use of waiting area, and parking?
  - What factor is used to compute the rental amount (i.e., hourly rate, daily rate, monthly rate)?



## Strategies and Reimbursement Impact – Shared Office Space

### Issue #2:

- RHC cost report must be adjusted to reflect use of resources by non-RHC provider.
  - How is the rental arrangement shown on the RHC cost report?



## Strategies and Reimbursement Impact – Shared Office Space

If FMV rent paid by the cardiologist is \$6,000, the RHC cost report may be adjusted as shown below.

	Reclassi- fications	Reclassified Trial Balance	Adjust- ments	Net Expenses
	4	5	6	6
<b>FACILITY OVERHEAD-FACILITY COST</b>				
26 Rent		24,000	(4,300)	19,700
27 Insurance				
28 Interest on Mortgage or Loans				
29 Utilities		6,000	(1,100)	4,900
30 Depreciation - Buildings				
31 Depreciation - Equipment				
32 Housekeeping and Maintenance		3,600	(600)	3,000



## Strategies and Reimbursement Impact – Non-RHC Carve Out

### Scenario:

- RHC determines that physical therapy services are in high demand in the community.
- RHC hires physical therapist, buys equipment, and then learns that PT visits are not RHC face-to-face billable encounters.
- RHC wants to provide PT services outside of RHC hours of operations and bill Medicare Part B.



## Strategies and Reimbursement Impact – Non-RHC Carve Out

### Avoid Commingling:

- Maintain cost records for each facility or department—if operating specialty clinic next to RHC, need to maintain time studies for staff sharing between departments.
- Do not use same staff simultaneously.
- Separate certification may be necessary.
- Establish separate hours of operation (post it!).



## Strategies and Reimbursement Impact – Non-RHC Carve Out

- Independent RHC cost report must reflect use of resources for non-RHC services.
- Total of all direct costs should be reported as “Cost Other than RHC Services.”
- Indirect cost allocation will be done on worksheet B.



## Strategies and Reimbursement Impact – Non-RHC Carve Out

“Cost Other Than RHC Services” would include costs for PT services including staff, supplies, equipment, etc.

	COMPEN- SATION	OTHER COSTS	TOTAL
	1	2	3
<b>COST OTHER THAN RHC SERVICES</b>			
51 Pharmacy			
52 Dental			
53 Optometry			
54 Other - Laboratory			
55 Other - Physical Therapy	60,000	30,000	90,000
56			
57 Subtotal - Cost Other Than RHC			



## Strategies and Reimbursement Impact – Non-RHC Carve Out

Overhead costs are allocated to non-RHC services on Worksheet B. How much overhead is allocated to PT in this example?

<b>WORKSHEET B, PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC SERVICES</b>		
10	Cost of RHC services - excluding overhead	1,300,000
11	Cost of Other Than RHC Services - excluding Overhead	90,000
12	Cost of all services (excluding overhead)	1,390,000
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	0.935252
14	Total overhead	250,000
15	Overhead applicable to RHC/FQHC services (line 13 x line 14)	233,813
16	Total allowable cost of RHC/FQHC services (sum of lines 10 and 15)	1,533,813



## Strategies and Reimbursement Impact – Non- RHC Carve Out

- PT services in provider-based setting would typically be considered part of hospital physical therapy department.
- CAH may be restricted from forming new off-site provider-based locations.



## Strategies and Reimbursement Impact – Medicare Bad Debt

Medicare bad debts are being disallowed if they are still being worked by a collection agency. Intermediaries are requesting a copy of the correspondence from the collection agency as to which claims have been returned to the provider as being noncollectible before they are allowing the bad debt to be claimed on the cost report.



## Strategies and Reimbursement Impact – Medicare Bad Debt

Medicare will reimburse the rural health clinic for all uncollectible Medicare deductibles and coinsurance, if considered to be “allowable” bad debts.

The amount of allowable Medicare bad debts is added to the RHC cost report settlement.



## Strategies and Reimbursement Impact – Medicare Bad Debt

CMS Pub. 15-1 Section 308 states the criteria for allowable Medicare bad debts:

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



## Strategies and Reimbursement Impact – Medicare Bad Debt

CMS Pub. 15-I Section 310 defines reasonable collection effort:

- Similar to effort for non-Medicare patients.
- Issuance of bill to responsible party.
- May include subsequent statements, collection letters, and telephone calls.
- Referral to collection agency if used for non-Medicare patients of “like amounts.”



## Strategies and Reimbursement Impact – Medicare Bad Debt

Presumption of Non-collectibility,  
CMS Pub. 15-I Section 310.2:

If after reasonable and customary attempts to collect a bill, the dept remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.



## Strategies and Reimbursement Impact – Medicare Bad Debt

### Indigent Patients, CMS Pub. 15-I Section 312:

- Clinics can claim bad debt without waiting the 120-day collection period.
- Determination of indigence must be documented in the patient's file.
- Beneficiary considered indigent if eligible for Medicaid.
- Provider must determine that no other source is legally responsible for payment.



## Strategies and Reimbursement Impact – Medicare Bad Debt

### Documentation Required With Cost Report:

- Beneficiary name and HIC number.
- Date(s) of service.
- Date of first bill sent to patient.
- Medicare paid date (R/A).
- Write-off date.
- Separation of deductible and coinsurance amounts.
- Medicaid payment and paid date (if any).



# Questions



# Thank you!



## Speaker Information

Jeff Johnson, CPA  
Partner – Wipfli Health Care Practice  
Wipfli LLP  
7601 France Avenue South, Suite 400  
Minneapolis, MN 55435  
952.548.3367  
[jjohnson@wipfli.com](mailto:jjohnson@wipfli.com)



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