4150. WORKSHEET I-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR SNF-BASED RHC/FQHC SERVICES

This worksheet provides for the reimbursement calculation for a SNF-based RHC/FQHC. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due to or from the program for the cost reporting period.

4150.1 Part I - Determination of Rate For SNF-based RHC/FQHC Services.--Part I calculates the cost per visit for SNF-based RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line Descriptions

Line 1.--Enter the total allowable cost from Worksheet I-2, Part II, line 20.

Line 2.--Enter the cost of vaccines and their administration from Worksheet I-4, line 15.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Enter the greater of the minimum or actual visits by the health care staff from Worksheet I-2, Part I, column 5, line 10.

Line 5.--Enter the visits made by physicians under agreement from Worksheet I-2, Part I, column 5, line 11.

Line 6.--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7.--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 and 9.--The limits are updated every January 1, Complete columns 1, 2 and if needed 3 of lines 8 and 9, if applicable (add a column 3 for lines 8-14 if the cost reporting period overlaps 3 limit update periods) to identify costs and visits affected by different payment limits during a cost reporting period. If only one payment limit is applicable during the cost reporting period, complete column 2 only.

Line 8.--Enter the maximum rate per visit that can be received by you. Obtain this amount from your contractor.

Line 9.--Enter the lesser of the amount on line 7 or line 8. For cost reporting periods beginning on January 1, complete column 2 only. For cost reporting periods beginning other than January 1, amounts will be entered in columns 1 and 2.

4150.2 Part II - Calculation of Settlement for SNF-based RHC/FQHC.--Part II calculates the total payment amount due to or from the Medicare program for covered SNF-based RHC/FQHC services furnished to program beneficiaries during the cost reporting period.

Complete columns 1 and/or 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period. If the provider's cost reporting period begins on January 1, then only column 2 is completed. For cost reporting periods beginning other than January 1, both columns 1 and 2 must be completed.

Line Descriptions

Line 10.--Enter the number of program covered visits, excluding visits subject to the outpatient mental health services limitation from your contractor's records (PS&R).

Line 11.--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered Medicare beneficiary visits for SNF-based RHC/FQHC services during the cost reporting period).

Line 12.--Enter the number of program covered visits subject to the outpatient mental health services limitation from your contractor's records (PS&R).

Line 13.--Enter the program covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14.--Enter the limit adjustment. This limit applies only to therapeutic services, not initial diagnostic services. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: for services rendered through December 31, 2009, the limitation is 62.50 percent; for services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; for services from January 1 2012, through December 31, 2012, the limitation is 75 percent; for services from January 1, 2013, through December 31, 2013, the limitation is 81.25 percent; and for services on and after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15.--Enter the total program cost. Enter the sum of the amounts on lines 11 and 14, in columns 1 and 2 respectively. For cost reporting periods beginning on or after January 1, 2011 do not complete column 1 and enter the sum of the amounts on lines 11 and 14, columns 1 and 2 in column 2.

NOTE: Section 4104 of the Affordable Care Act (ACA) eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. RHCs/FQHCs must provide detailed HCPCS coding for preventive services to ensure coinsurance and deductible are not applied. RHC/FQHC must maintain this documentation in order to apply the appropriate reductions on lines 15.03 and 15.04.

Line 15.01.--Enter the total program charges from the contractor's records (PS&R). For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter total program charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in column 2.

Line 15.02.--Enter the total program preventive charges from the RHC/FQHC's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter total program preventive charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in column 2.

Line 15.03.--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter the total program preventive costs ((line 15.02 divided by line 15.01) times line 15)) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 15.02 divided by line 15.01) times line 15, columns 1 and 2)) in column 2.

Line 15.04.--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter the total program non- preventive costs ((line 15 minus lines 15.03 and 17) times .80)) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-preventive costs ((line 15, columns 1 and 2 minus lines 15.03 and 17) times .80)) in column 2.

Line 15.05.--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter the total program costs (line 15 times .80) for services rendered prior to January 1, 2011, in column 1, and enter total program costs (line 15.03 plus line15.04) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program costs (line 15.03 plus line15.04), in column 2.

Line 16.--Enter the amounts paid or payable by workmen's compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program patient days and charges. In this situation, no primary payer payment is entered on line 16.

Line 17.--Enter the amount credited to the RHC program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the contactor from clinic bills processed during the cost reporting period. RHCs determine this amount from the interim payment lists provided by the contractor. FQHCs enter zero on this line as deductibles do not apply.

Line 18.--Enter the coinsurance amount applicable to the RHC/FQHC for program patients for visits on lines 10 and 12 as recorded by the contactor from clinic/center bills processed during the cost reporting period. Informational only.

Line 19.--Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amount on line 16 from the amounts on line 15.05, columns 1 and 2.

Line 20.--Enter the total reimbursable program cost of vaccines and their administration from Worksheet I-4, line 16.

Line 21.--Enter the total reimbursable program cost (line 19 plus line 20).

Line 22.--Enter the allowable bad debts, net of recoveries, from your records.

Line 22.01.--Enter the total reimbursable bad debt for cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: line 22 times 88 percent. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: line 22 times 76 percent. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 22 times 65 percent.

Line 23.--Enter the allowable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 22.

Line 24.--Enter any other adjustment. Specify the adjustment in the space provided.

Line 24.50.--Enter all demonstration payment adjustment amounts before sequestration. Obtain this amount from the PS&R.

Line 24.55.--Enter all demonstration payment adjustment amounts after sequestration. Obtain this amount from the PS&R.

Line 25.--Enter the sum of line 21 plus line 22, plus or minus line 24. For cost reporting periods that begin on or after October 1, 2012, enter the sum of line 21 plus line 22.01, plus or minus line 24, minus line 24.50.

Line 25.01.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 25]. If line 25 is less than zero, do not calculate the sequestration adjustment.

Line 26.--Enter the total interim payments made to you for covered services furnished to program beneficiaries during the reporting period (from contractor records). Transfer amount from Worksheet I-5, line 4.

Line 27.--Your contractor will enter the tentative adjustment from Worksheet I-5, line 5.99.

Line 28.--Enter the total amount due to/from the program, line 25 minus lines 24.55, 25.01, 26 and 27. Transfer this amount to Worksheet S, Part III, columns 1, 3, or 4 as applicable, line 5 or line 6 accordingly.

Line 29.--Enter the program reimbursement effect of protested items. The reimbursement effect of non-allowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2 §115.2)

4151. WORKSHEET I-4 - COMPUTATION OF SNF-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines. Use this worksheet only for vaccines rendered to patients who at the time of receiving the vaccine(s) were not inpatients or outpatients of the SNF. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the SNF and cannot be claimed by the RHC/FQHC.

Effective for services rendered on and after September 1, 2009, in accordance with CR 6633, dated August 27, 2009, the administration of influenza A (H1N1) vaccines furnished by RHC's and FQHC's is cost reimbursed.

Line 1.--Enter the health care staff cost from Worksheet I-1, column 7, line 10.