Cost Reporting for Rural Health Clinics - What is needed to file an accurate and timely cost report

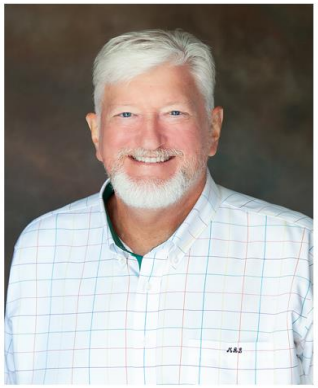
Healthcare Business Specialists, LLC

January 19, 2023

MEET OUR TEAM

Healthcare Business Specialists offers a variety of services designed to assist physician practices and RHCs in providing better primary medical services to underserved, rural residents by enhancing Medicare and Medicaid Reimbursement and staying compliant with Rural Health Clinic program requirements.

Through cost reporting preparation, program evaluations, RHC startups and conversions, Emergency Preparedness Compliance, CHOWs, RHC terminations, and feasibility studies, Healthcare Business Specialists is equipped to serve all your RHC needs.



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Services

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SERVICES

RHC COST REPORTING

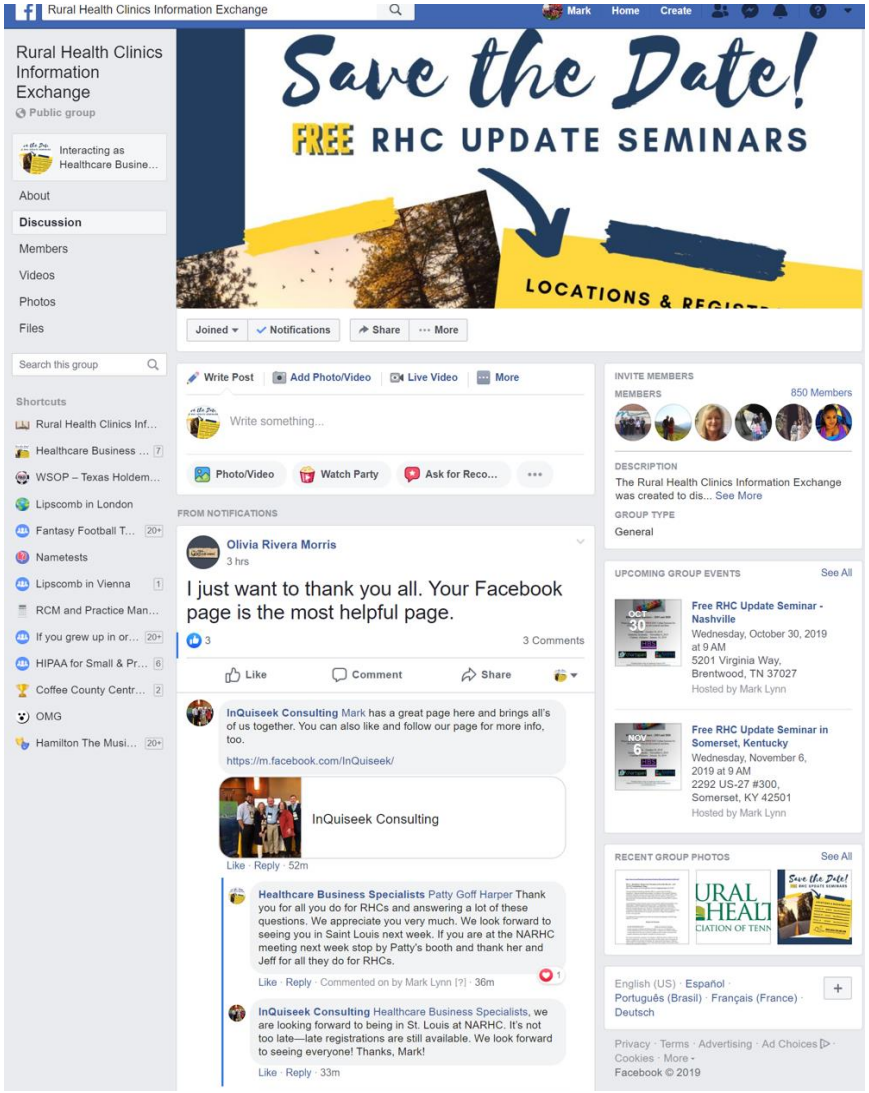
RHC PROGRAM EVALUATIONS

RHC STARTUPS & CONVERSIONS

EMERGENCY PREPAREDNESS COMPLIANCE

TENNCARE QUARTERLY REPORTING

FOR MORE INFORMATION: 833-787-2542 | www.ruralhealthclinic.com

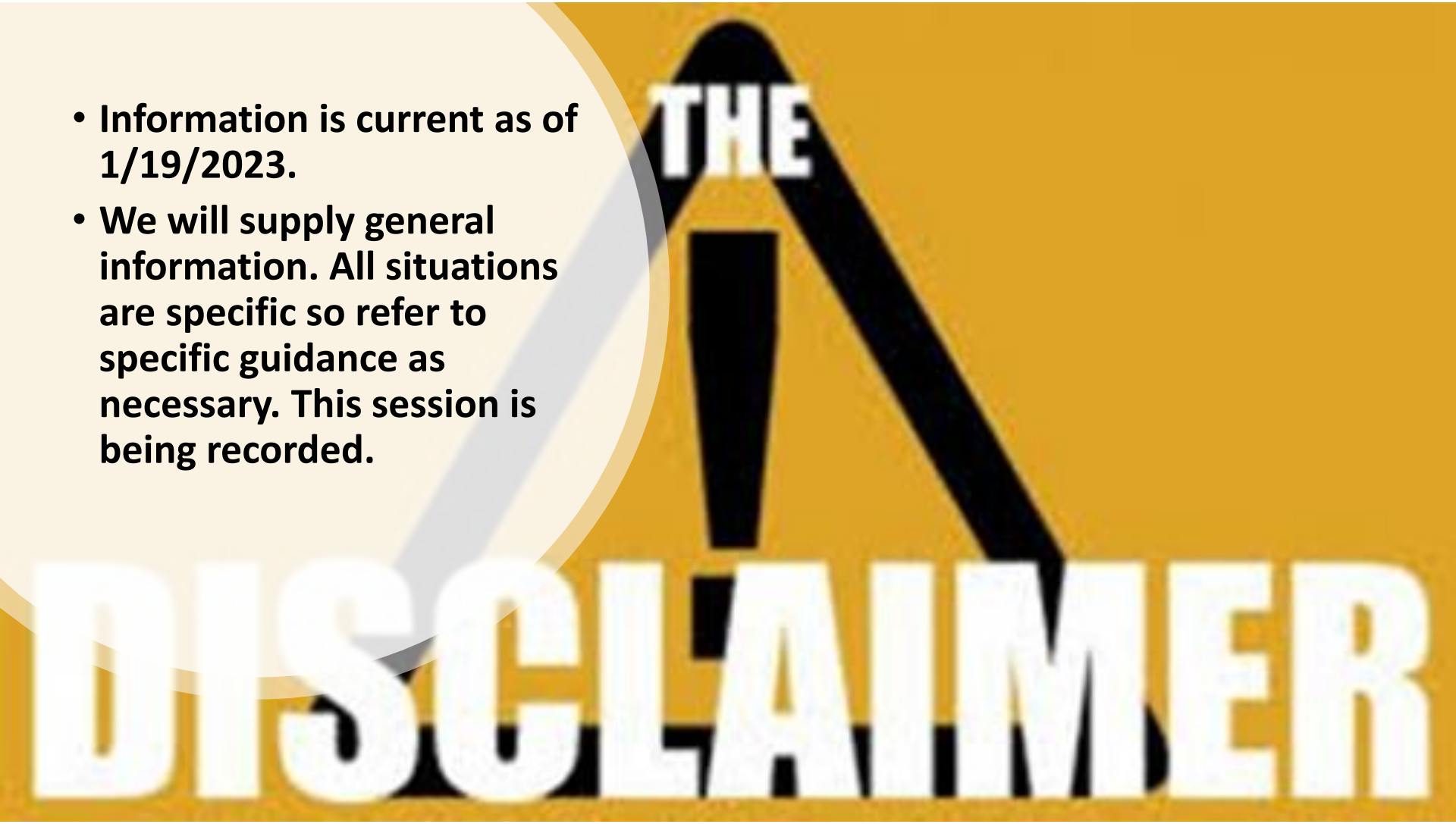


RHC Information Exchange Group on Facebook

Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs

https://www.facebook.com/groups/1503414633296362/

- Information is current as of 1/19/2023.
- We will supply general information. All situations are specific so refer to specific guidance as necessary. This session is being recorded.



Please type your questions in the Question box and submit them and if you raise your hand at the end of the session, we will open your line to ask a question.

Slides and Recording of this session will be posted to the Facebook Group and on the HBS Cost Reporting Website.

Join NARHC DC Staff for Virtual Office Hours!

NARHC DC Staff will host RHC Office Hours at 1 pm ET every other Wednesday via Zoom. We encourage anyone with RHC questions to join us! We hope that this form of technical assistance will increase the dialogue between NARHC staff and the RHC community. Questions regarding HRSA COVID-19 programs, RHC policy, Medicare, RHC certification, and more are all acceptable! Stop by the Zoom room anytime between 1 and 2 PM ET, and as always don't hesitate to contact us if you need assistance outside of this time.

The schedule for 2023 is as follows:

Wednesday, January 11
Wednesday, January 25
Wednesday, February 8
Wednesday, February 22
Wednesday, March 8
Wednesday, April 5
Wednesday, April 19
Wednesday, May 3
Wednesday, May 17
Wednesday, May 31
Wednesday, June 14

No registration is required, and RHCs can join using the below link or call-in information.

Zoom Webinar Information:
https://us06web.zoom.us/s/81747173194

Audio Conference Details:
Attendees without computer access or computer audio can use the dial-in information below:
Dial-in Toll-Free #: +1 301-715-8592 PIN: 817 4717 3194#
Meeting ID: 817 4717 319

http://www.ruralhealthclinic.com/rhc-cost-reporting

502 SHADOW PARKWAY, CHATTANOOGA, TN, 37421 (833) 787-2542

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HOME ABOUT SERVICES RESOURCES WEBINARS CALENDAR CONTACT

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RHC COST REPORTING | RHC PROGRAM EVALUATIONS | RHC STARTUPS & CONVERSIONS | EMERGENCY PREPAREDNESS COMPLIANCE | TENNCARE QUARTERLY REPORTING

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RHC COST REPORTING

Healthcare Business Specialists, LLC prepares approximately 230 RHC cost reports annually for Independent RHCs. Mark R. Lynn, CPA, CRHCP, CCRS has over 35 years' experience working with RHCs and Dani Gilbert, CPA, CRHCP is a Certified Rural Health Professional accredited by the NARHC. Our team also includes Page Chambers, CIA, CRHCP, and Trent Jackson, CCRS goal is to prepare your Medicare cost reports as accurately and timely as possible within the constraints of tight independent RHC budgets. The following is a link that will open our RHC Cost Reporting brochure if you are interested in more information related to cost reporting services for RHCs.

Medicare cost reports for independent RHCs have become much more important since the passage of the Consolidated Appropriations Act of 2021 which dramatically increased the Medicare upper payment limits for rural health clinics. These large increases in the upper payment limits allow RHCs that properly prepare the Medicare Cost Report to obtain much more Medicare reimbursement; however, it could result in large paybacks to Medicare if interim rates are higher than the actual cost per visit. Interim cost reports are an effective way to monitor the actual cost per visit and plan for ways to maximize your Medicare reimbursement within Medicare cost reporting rules.

If you would like Healthcare Business Specialists to help prepare your cost reports, please email Mark Lynn or Dani Gilbert at ruralhealthclinic@outlook.com and we will put together a proposal for this service.

Our Cost Report Checklist for 2022 cost reports and other cost report resources can be found as follows:

- RHC Medicare Cost Report Checklist with Forms for 2022 (23-page PDF)
- RHC Medicare Cost Report Checklist Only (3-page PDF)
- RHC Medicare Visit Count Sheet for 2022 (7-page PDF)

We have prepared a webinar to help you gather the information to prepare the cost report which will occur on January 19, 2023 at 1:00 PM Eastern time. Please register below to attend the webinar. The session will be recorded for later viewing if the time.

COST REPORTING FOR RURAL HEALTH CLINICS - WHAT IS NEEDED TO FILE AN ACCURATE AND TIMELY COST REPORT WEBINAR

JANUARY 19, 2023

In this webinar, Mark Lynn, CPA (Inactive), CRHCP, CCRS and Dani Gilbert, CPA, CRHCP, Page Chambers, CIA, CRHCP, and Trent Jackson, CCRS will go over cost reporting for Rural Health Clinics. Topics covered will include electronic filing of cost reports using MCREF, allowable expenses on the cost report, increased upper limits for RHCs, counting visits including how to treat telehealth, CCM, and other services not included in the calculation of the All-Inclusive Rate, Medicare Bad Debts, and flu, pneumococcal, COVID-19 vaccines, and MAB infusions/injections. The webinar will last one hour and there will be time for questions.

Please register for Cost Reporting for Rural Health Clinics - What is needed to file an accurate and timely cost report on Jan 19, 2023 2:00 PM EST at:

https://attendee.gotowebinar.com/register/5531040895397331798

July 31, 2022 Mark Lynn and Dani Gilbert are presenting today on Cost Reporting for the Rural Health Association of Tennessee. Here are some of the resources.

- RHC Cost Report Checklist for 2022 (3-page PDF)
- RHC Cost Report Presentation (PDF)

- Cost Report Overview – Mark Lynn
- IDM and Electronic Filing of cost reports – Dani Gilbert
- Canopy and Client files – Page Chambers
- Medicare Bad Debts – Trent Jackson
- Cost Report Checklist, Visits, Injections, FTEs – Mark Lynn

The Game has changed

Consolidated Appropriations Act of 2021 (CAA) enacted on April 1, 2021

1. Independent and newly established Provider-Based RHCs are subject to Medicare Upper Payment Limits as established in the CAA.
2. Provider-based RHCs enrolled on, or before, December 31, 2020, are grandfathered from being subject to the Medicare Upper Payment limit but have controls on the rate of growth of their Medicare reimbursement rate.

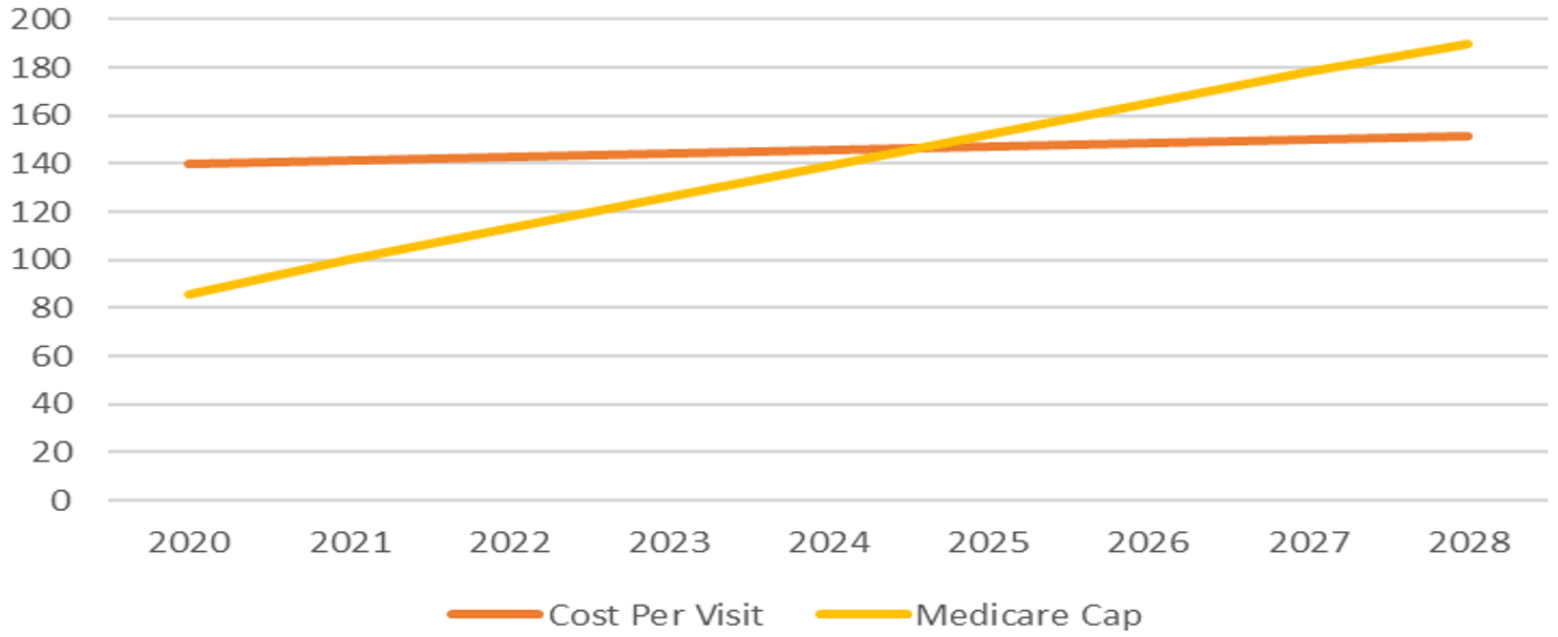
National Statutory Payment Limits for RHCs

Begin Date	End Date	Medicare Upper Limit
1/1/2020	12/31/2020	$ 86.31
1/1/2021	3/31/2021	$ 87.52
4/1/2021	12/31/2021	$ 100.00
1/1/2022	12/31/2022	$ 113.00
1/1/2023	12/31/2023	$ 126.00
1/1/2024	12/31/2024	$ 139.00
1/1/2025	12/31/2025	$ 152.00
1/1/2026	12/31/2026	$ 165.00
1/1/2027	12/31/2027	$ 178.00
1/1/2028	12/31/2028	$ 190.00
1/1/2029	12/31/2029	MEI

MEI = Medicare Economic Index

Laboratory, technical components, CCM, telehealth (except mental health starting in 2022) and hospital services are reimbursed outside the rate.

The National Statutory Payment Limits for RHCs will likely exceed the Cost Per visit in the future



Year	2020	2021	2022	2023	2024	2025	2026	2027	2028
Cost Per Visit	140	141	143	144	146	147	149	150	152
Medicare Cap	86	100	113	126	139	152	165	178	190

https://www.cms.gov/files/document/mm12185.pdf

2022 Projections with a $113 Cost Per Visit

Description	Medicare Part A	Medicare Advantage	Medicaid	Commercial	Totals
Payor Mix	20%	25%	30%	25%	100%
Visits	2,000	2,500	3,000	2,500	10,000
Payment per visit	$ 113	$ 105	$ 130	$ 110	$ 115
Total Payments	226,000	262,500	390,000	275,000	1,153,500
Cost per visit	$ 113	$ 113	$ 113	$ 113	$ 113
Total Cost	226,000	282,500	339,000	282,500	1,130,000
Net Income	-	(20,000)	51,000	(7,500)	23,500

2028 Projections with a $190 Cost Per Visit

Description	Medicare Part A	Medicare Advantage	Medicaid	Commercial	Totals
Payor Mix	20%	25%	30%	25%	100%
Visits	2,000	2,500	3,000	2,500	10,000
Payment per visit	$ 190	$ 125	$ 145	$ 120	$ 143
Total Payments	380,000	312,500	435,000	300,000	1,427,500
Cost per visit	$ 190	$ 190	$ 190	$ 190	$ 190
Total Cost	380,000	475,000	570,000	475,000	1,900,000
Net Income	-	(162,500)	(135,000)	(175,000)	(472,500)

Why is a Cost Report important?

1	Medicare will not pay you if you do not file a cost report and will ask for any Medicare money paid during the year to be refunded.
2	RHC Medicare and Medicaid rates are based upon the cost report.
3	RHCs receive a cost report settlement for flu, pnu, Covid vaccines, MAB, bad debts, preventive co-pays/deductibles and rate settlements.
4	Next year's rates are based upon this year cost report. The goal is to have a cost per visit higher than next year's cap. For example, if next year's cap is $139 that is the goal for the cost per visit in the 2022 cost report.
5	You are responsible for preparing the Cost Report accurately and in compliance with Medicare and Medicaid rules.

Medicare Cost Report Year End Rate Reviews

(How the Grinch stole Christmas)

This Christmas many rural health clinics (RHC) awoke to find the equivalent of a lump of coal in their stocking in the form of a letter from Medicare asking for relatively large amounts of Medicare monies to be paid back within 15 days or the clinics Medicare money would be withheld. Various Medicare Administrative Contractors (MACs) handled this process differently and individual clinics may have a different treatment than what I am describing; but, for a large portion of the RHCs we work with this is what happened.

1. The Consolidated Appropriations Act of 2021 implemented National Statutory Limits on RHCs that far exceeded the previous Medicare Upper Payment limits. The Medicare caps for independent RHCs essentially increased from $86 per visit to $113 in a relatively short 18-month period. This is certainly a welcome victory for independent RHCs who have been underpaid for the better part of a decade or more.
2. MACs are required to conduct two rate reviews for RHCs. One typically occurs on January 1 of each year when the limits/caps increase. The typical MAC process is to increase all the independent RHCs to the cap, since almost everyone's cost per visit is higher than the cap. That is what some of the MACs did in January 2022 when they raised the interim payment rate to the RHCs to $113 (remember Medicare only pays 80% of this minus sequestration). That is the normal process, and it normally works relatively well.
3. The next step is for the RHC to file a cost report which is normally filed by May 31st for RHCs with a 12/31 fiscal year. Once that cost report filed, the MAC should review it for acceptance, send a tentative settlement or final settle the report, and adjust the interim rate. Many of the MACs did this during the summer and lowered the interim rate for RHCs that had a cost per visit below the National Statutory limit of $113 per visit. They also asked the clinic for money back that was overpaid at this time.
4. Some MACs waited until December 2022 to review the interim rates and fulfil their responsibility to conduct two interim rate reviews which resulted in this Grinch-like Christmas present of large paybacks to Medicare in December 2022. This payback compounded the complexity of the year-end processes for RHCs that were already computing year-end bonuses for tax purposes, distributing any unused PRF or Covid-19 Testing and Mitigation funds, and cleaning up accounting records including accruing pension and payroll liabilities for cost reporting and tax purposes and was an unwelcome demand on much needed cash during this critical time.
5. An example of how this calculation worked for one small rural health clinic which was asked to pay back $10,697 in a letter dated 12/19/2022 is as follows:

National Statutory Limit (Interim payment rate for 2022)	$113.00
Cost Per visit on 12/31/2021 cost report	$92.70
Difference	$20.30
Original Medicare visits for the period	722
Subtotal	$14,657
Less amount related to patient co-pays, deductible, & sequestration	(3,690)
Net amount paid back to Medicare and included on C-1	$10,697

This overpayment is an unintended consequence of the increased payment caps for independent RHCs and while most RHCs have been upset about having to pay back the money to Medicare, there is actually a bright side to this situation. This overpayment was essentially an interest free loan (assuming you pay it back timely) that helped RHCs fund higher rates in 2022 allowing them to spend and compensate staff during the fiscal year. It is important to let your cost report preparer know about this repayment as this payment will be included in the cost report and will affect the reported settlement on your cost report. So, like the Dr. Seuss story, the Grinch did not really steal Christmas after all, it just sure seemed like it.

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Healthcare Business Specialists, LLC
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Report any Interim Payments to us so we can include on the cost report

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Worksheet C-1
Analysis of Payments to RHCs for Services Rendered

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

Interim Lump Sum Payments to RHCs

In recent years, the MACs are issuing interim lump sum payments (and occasionally a withhold of payment) to RHCs which are a part of the annual Medicare Cost Report Settlement. These payments or withholds must be recorded on Worksheet C-1 or it may result in a payback to Medicare on settlement of the cost report. If you received an interim payment or withhold please report this information to us below and provide the letter emailed to you documenting the payment or withhold.

Please provide the date and amount of Interim Payments or Withholds

Date of Interim Payments	Amount

Note: Failure to report these payments or withholds will affect the settlement of your cost report and may result in a payback to Medicare when the cost report is final settled. Please make an effort to identify any such payments to avoid the potential payback to Medicare.

What does Medicare Settle on the Cost Report?

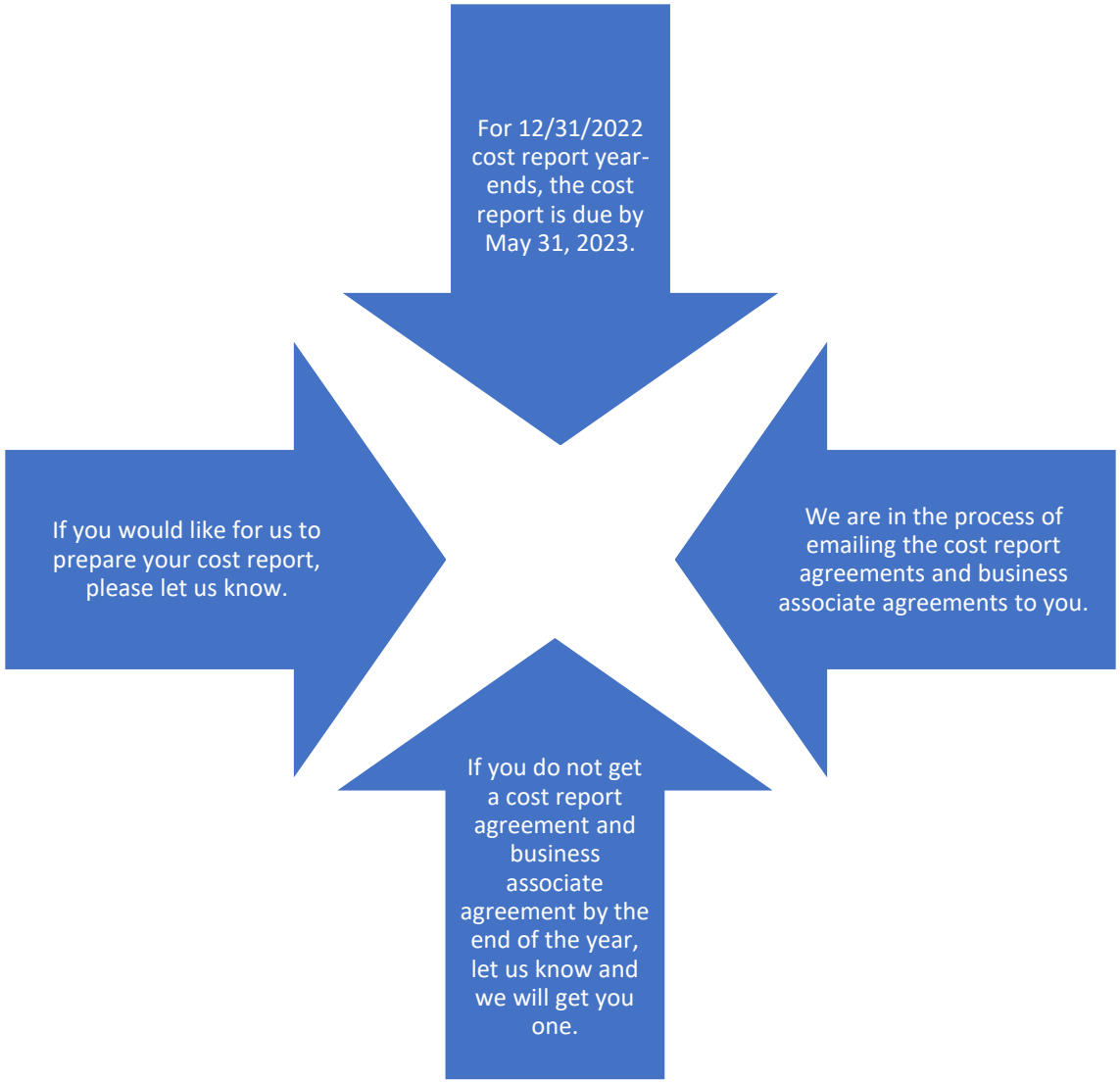
Difference between interim and final rate

Medicare Bad Debts

Flu & Pnu Shots – Covid Vaccines, MAB

Co-pays on Preventive services

Client Cost Report Update - 2023



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Steps for Filing the Medicare Cost Report

1. Sign BA and Cost Report agreements and send retainer

2. Receive Cost Report Checklist from HBS

3. Obtain information from Checklist (P S & R)

4. Upload to portal, Mail, Fax, Email information to HBS

5. HBS prepares the Report and mails to you or files electronically

6. Electronically file or Sign the cost reports and mail to Care/Caid

7. Receive Tentative settlement in 90 days.

8. Desk Review within 1 year of filing date.

Preparing the 2022 Medicare Cost Report

Identity Management (IDM) System

CMS created the IDM System to provide providers with a means to request and obtain a single User ID, which they can use to access one or more CMS applications.

The IDM System provides the means for users to be approved to access many other CMS systems and applications. IDM governs access to CMS systems by managing the creation of user IDs and passwords, setting up multi-factor authentication (MFA), and the assignment of roles within CMS applications.

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Identity Management (IDM) System
Learning Objectives

- How to Create a New User Account
- IDM Self Service Dashboard (Overview)
- How to Request a Role for a New Application
- How to Add Attributes to an Existing Role
- How to View and Cancel Role Requests

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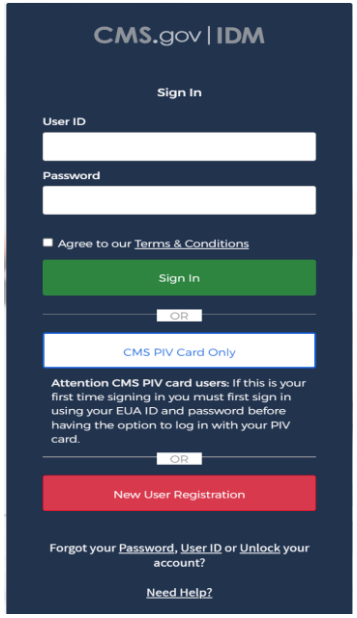
Identity Management (IDM) System

How to Create a New User Account

1. Navigate to https://home.idm.cms.gov/.
2. Click the ***New User Registration*** button.



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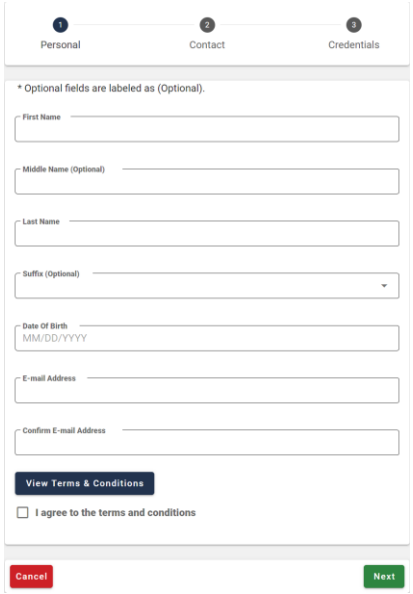
Identity Management (IDM) System

How to Create a New User Account

3. Enter the requested information (i.e., **Name**, **Date of Birth**, **E-mail Address**, etc.)
   - Make sure the you enter an exact match in the ‘E-mail Address’ and ‘Confirm E-mail Address’ fields.

4. Click the ***Terms & Conditions*** button. Read the IDM terms and conditions then click the ***Close Terms & Conditions*** button.

5. Click the checkbox to acknowledge agreement with the terms and conditions, then click the ***Next*** button.



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Identity Management (IDM) System

How to Create a New User Account

6. Enter the **Home Address**, **City**, **State**, **Zip Code** and **Phone Number**.

7. Click the ***Next*** button.

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Identity Management (IDM) System

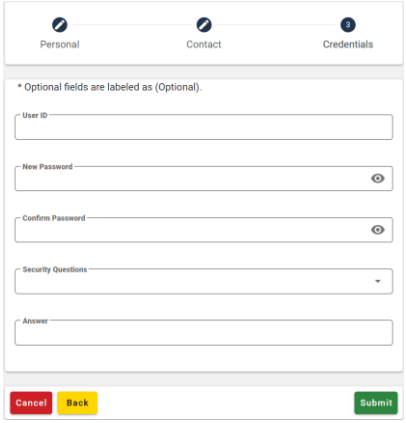
How to Create a New User Account

8. Enter the desired **User ID**, **Password** and **Confirm Password.**
   - The Password and Confirm Password must match.

9. Select a **Security Question** from the list.
   - Type the security question answer into the Answer dialog box.

10. Click the ***Submit*** button to submit the account registration request. The system will display a message that indicates the account was successfully created.

11. Click the ***Return*** button.



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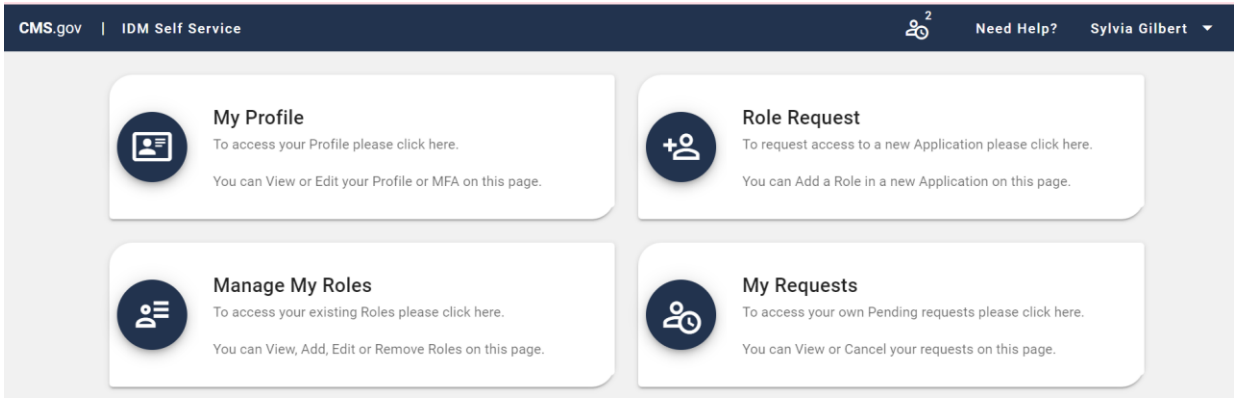
Identity Management (IDM) System

IDM Self Service Dashboard (Overview)

The IDM Self Service Dashboard provides access to functions that allow users to manage their user profile, request new applications, and manage roles for applications to which they have been granted access.



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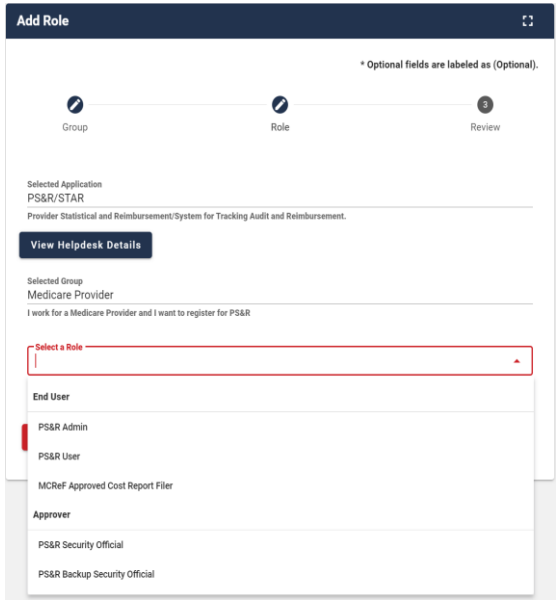
Identity Management (IDM) System

How to Request a Role for a New Application

1. Click the ***Role Request*** button.

2. Select an application (PS&R/STAR). The Select a Role menu appears after an application is selected.
   - You will want to select either 'PS&R Security Official' or 'PS&R User', depending on if someone from your clinic is already set up with access.

3. Select a role. The Remote Identity Proofing (RIDP) terms and conditions appear after role is selected.



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Identity Management (IDM) System
How to Request a Role for a New Application

4. Review the RIDP terms and conditions, check the “I agree to the terms and conditions” selection box, then clinic the ***Next*** button.

5. Complete the Identity Verification form and click the ***Next*** button.

6. Answer the proofing questions and click the ***Verify*** button.

7. Select the required attributes from the Attribute menu.

8. Review the role request information and click the ***Review Request*** button. The Reason for Request dialog box appears.

9. Enter a justification and click the ***Submit Role Request*** button. The Role Request window displays a Request ID and a message which states that the request was successfully submitted to an approver for action.

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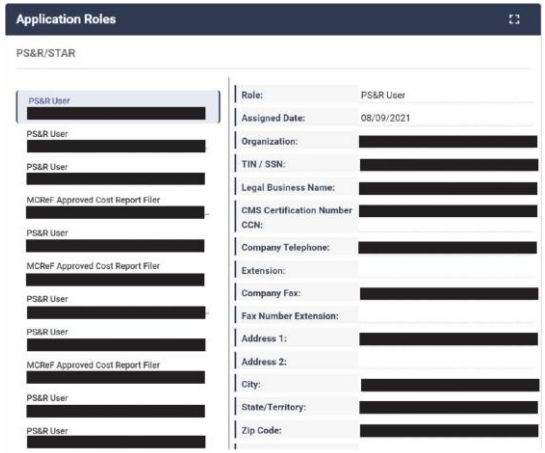
Identity Management (IDM) System
How to Add Attributes to an Existing Role

1. Click the ***Manage My Roles*** button.

2. Click the ***View Details*** button.



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Identity Management (IDM) System
How to Add Attributes to an Existing Role

3. Click the ***Modify Role*** button. The Edit Role Details window appears. This window contains fields that are similar to those used during the initial role request, but it only permits the user to modify role attributes.

4. Add one or more role attributes.

5. Enter a justification statement and click the ***Submit Changes*** button.

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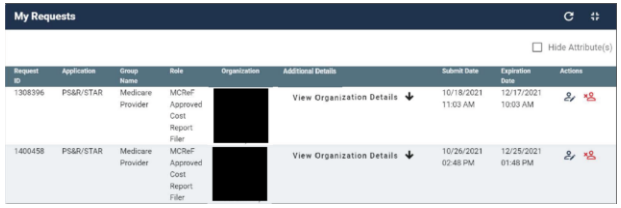
Identity Management (IDM) System
How to View and Cancel Role Requests

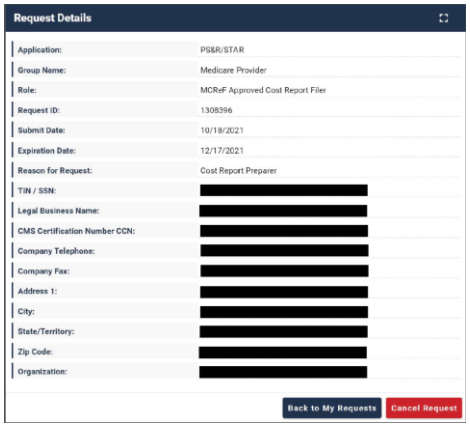
1. Click the ***My Requests*** button.



2. Click the ***View Details*** button.

3. Click the ***Cancel Request*** button for the role request that will be cancelled.

4. Click the ***Cancel Role Request*** button.



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Provider Statistical & Reimbursement (PS&R) System

Providers that file cost reports are required to register for the PS&R system through Individuals Authorized Access to the Centers for Medicare & Medicaid Services (CMS) Computer Services (IDM) to obtain the PS&R reports. The PS&R Redesign will be utilized for all cost reports with fiscal years ending January 31, 2009 and later. These cost reports will be both filed and settled using PS&R Redesign.

An approved PS&R User can order reports.

NOTE: For those clinics who plan on pulling their own PS&R reports, you will want to make sure that the Service Period is broken down into the following:

- **Period 1: 1/1/2021 – 3/31/2021 (RHC Capped Rate: $87.52)**
- **Period 2: 4/1/2021 – 12/31/2021 (RHC Capped Rate: $100.00)**

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CONTACT INFORMATION

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Canopy Client portal for cost reporting

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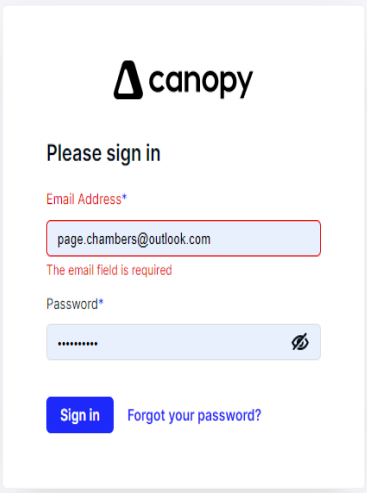
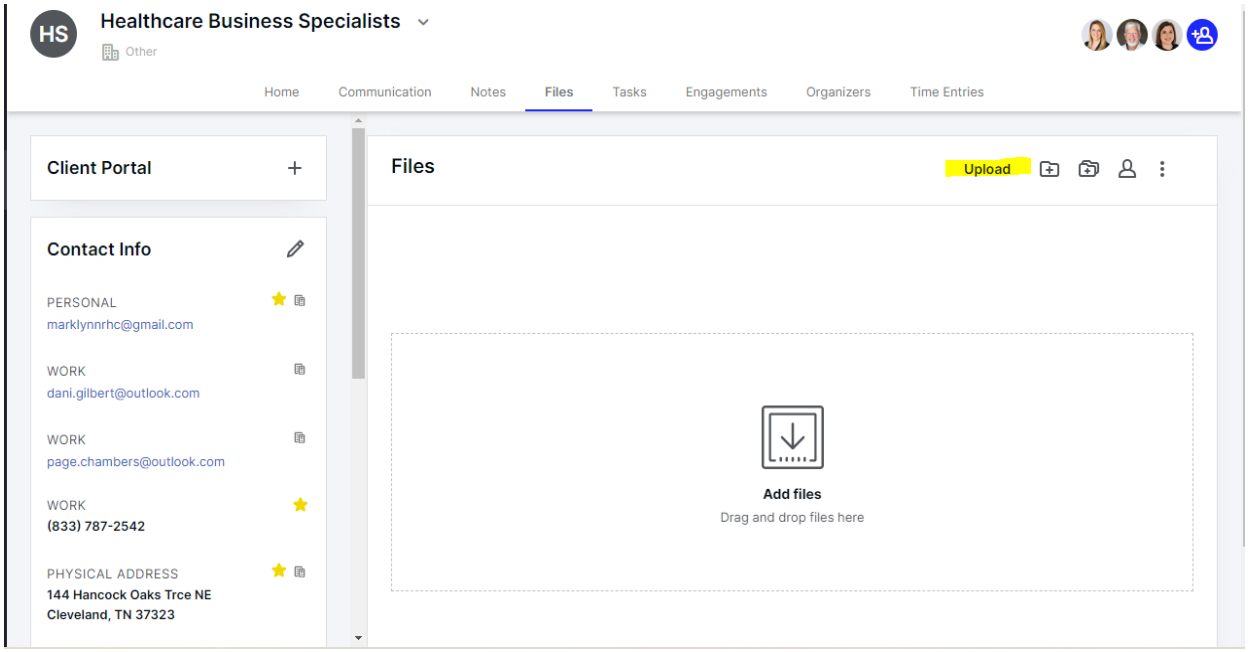
Secure Login



- Canopy is the platform we utilize to securely share documents, especially documentation with HIPAA and salary information.
- Each user will have an username and password. When we are onboarding clients, we setup the portal logins based on the email addresses we have on file; however, we can add and delete users as needed.

Uploading documents to Canopy



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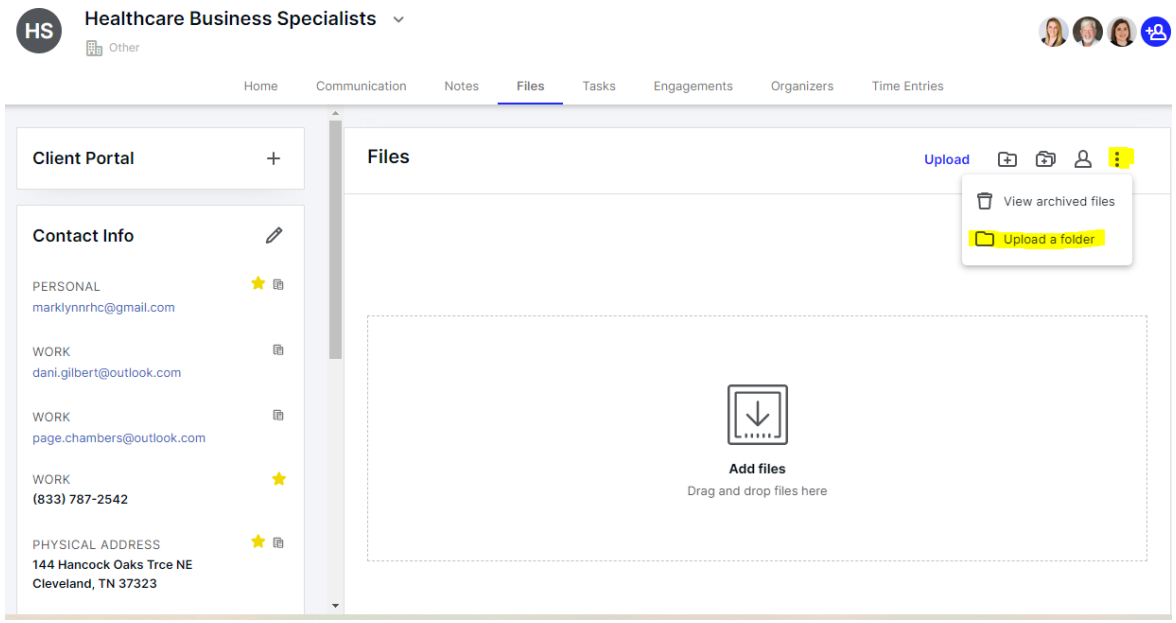
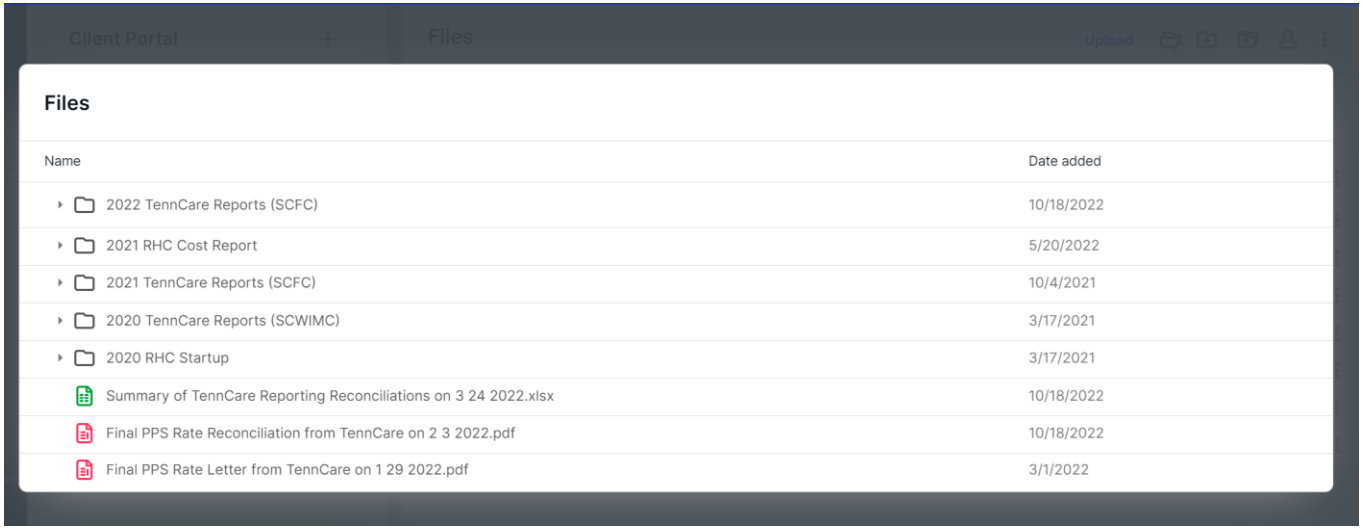


File view with folders



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Not sure if you have Canopy access?

- Visit https://app.canopytax.com/#/login to login.
- If you don't have access, I can send a Canopy invite where you will use your email to create a login to access your client portal.
- Please email me sooner rather than later so I can check into that for you!

Contact Information

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Medicare Bad Debt Reimbursement is 65% of uncollected Medicare Co-insurance and Deductibles

Medicare Bad Debt represents money on the table

Medicare Bad Debt Summary

A provider's bad debts resulting from Medicare *deductible and coinsurance* amounts that are uncollectible from Medicare beneficiaries are considered in the program's calculation of reimbursement to the provider if they meet the criteria specified in 42 CFR 413.89.

Per 42 CFR 413.89(e), a bad debt must meet the following criteria to be allowable:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts.
2. The provider must be able to establish that reasonable collection efforts were made.
3. The 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.

https://med.noridianmedicare.com/web/jea/audit-reimbursement/audit/bad-debt

A Medicare Bad Debt must meet the following Criteria:

1. The debt must be related to a covered service and derived from the Deductible and Coinsurance amounts.
    A. No Fee for Service. IE. Hospital, Technical Components.
    B. No Medicare Advantage plans.
2. The provider must be able to establish that reasonable collection efforts were made.
    A. At least 120 days of collection after first bill.
    B. First Bill as least within 120 days after the date of the Medicare RA or the RA from the beneficiary's secondary payer, if any; whichever is latest.
    C. Four documented collection efforts made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment indicated there was little likelihood of recovery in the future.

Source: 42 CFR 413.89(e)

Bad Debt Classification

Providers claiming Medicare bad debt must meet 42 CFR 413.89 and all requirements from Chapter 3 of the Provider Reimbursement Manual (https://go.usa.gov/xEuwD).

9-74 BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES 300

300. PRINCIPLE
Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable costs; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Program.

302. DEFINITIONS

302.1 Bad Debts.--Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

302.2 Allowable Bad Debts.--Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate to specific deductibles and coinsurance amounts.

Effective for cost reporting periods beginning on or after October 1, 2019, providers must comply with these longstanding Medicare bad debt requirements.

What Constitutes Reasonable Collection Efforts?

- Subsequent billings
- Telephone calls
- Collection letters
- Use of collection agency
  - A collection agency can be used in addition to or in lieu of other reasonable collection efforts
  - Any costs associated with the collection agency are allowable to be included as expenses on the cost report but are not allowed to be claimed as part of the bad debt.
    - The full amount recovered by the collection agency must be deducted from what is claimed on the log, even if a percentage of that was kept by the agency as payment.
- Must continue for at least 120 days and any payments received restart the clock

Sometimes Reasonable Collection Efforts are Unnecessary

There are two reasons for which RCE can be skipped

- Determined indigency via provider internal policy
  - Must be determined by provider not the patient
  - Must consider a patient's total resources including assets, liabilities, income, and expenses
  - Must determine no source other than the patient would be legally responsible
  - Must maintain documentation of how the patient's indigence was determined
- State Medicaid refusing payment (crossover bad debt)
  - If the patient is covered by Medicaid, then Medicaid must be billed first
  - Once payment is refused at the state level via a Medicaid Remittance Advice, the account can be included on the Medicare Bad Debt log

Crossover or Dual-Eligible Bad Debt

•If Medicaid does not pay the complete coinsurance or deductible; a RHC can include this difference as an allowable bad debt on the cost report and Medicare will reimburse you for this bad debt. Keep up with in a separate file.

Medicare Bad Debt Listing – Write off

Medicare Bad Debts must be written off by the end of the fiscal year to be claimed on the cost report.

Collection efforts must cease.

Medicare Bad Debt Summary

1. Medicare coinsurance 20% of charges.
2. Medicare deductible of $233.00 in 2022. ($226 in 2023)
3. Billed to the Part A MAC.
4. Nothing else is allowed.
5. Must meet Reasonable Collection Efforts
(or be determined indigent/Medicaid patient)
6. Must treat everyone the same.
7. Do not have to turn over to collection agency.
8. Must be written off in the fiscal year of the cost report.
9. Collection efforts must cease.

Capturing the information for Bad Debt

1.Use an Excel Spreadsheet
2. Keep Regular and Crossover Bad Debt in separate spreadsheets
3. Provide Medicare with the spreadsheet.
4. Start early. Start NOW.
5. Provide it to the Preparer ASAP.

Recoveries of Bad Debt

- Sometimes recoveries are made after the Bad debt has been claimed. When this happens, bad debt claims in the current period have to be reduced by the amount recovered.
- Identify the amount recovered and the amount previously reimbursed by Medicare (65% of the amount originally claimed). You do not have to reduce your current year claims by more than you were initially reimbursed.

Exhibit 2

Listing of Medicare Bad Debts and Appropriate Supporting Data

Provider ____________________

Prov. Number____________________

FYE ____________________

Prepared By ____________________

Date Prepared ____________________

Inpatient ____________________ Outpatient ____________________

SNF ____________________ RHC____________________

(1) Patient Name	(2) HIC NO.	(3) Dates of Service From	To	(4) Indigency & Wel. Recip (ck if apply) Yes	Medicaid #	(5) Date First Bill Sent To Beneficiary	(6) Date Collection Efforts Ceased	(7) Medicare Remittance Advice Date	(8) Deduct	(9) Co-Ins	(10) Total
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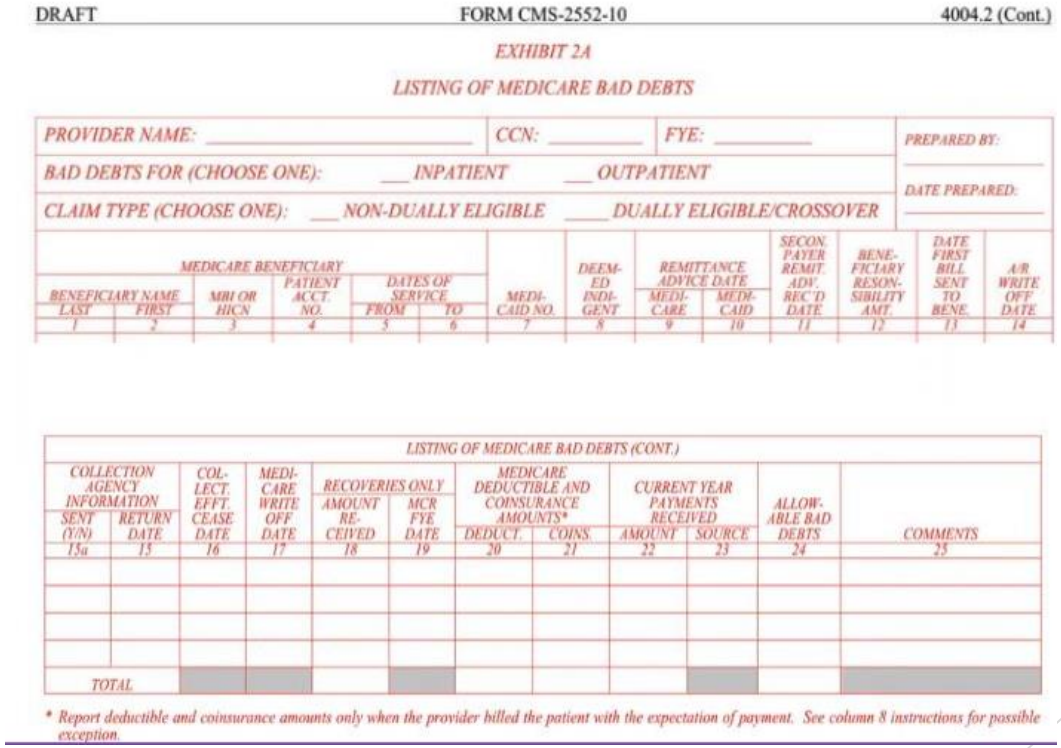
Exhibit 2A for Hospitals – For Provider based RHCs ask your cost report preparer



DRAFT FORM CMS-2552-10 4004.2 (Cont.)

EXHIBIT 2A

LISTING OF MEDICARE BAD DEBTS

PROVIDER NAME: _____ CCN: _____ FYE: _____ PREPARED BY: _____

BAD DEBTS FOR (CHOOSE ONE): ___ INPATIENT ___ OUTPATIENT DATE PREPARED: _____

CLAIM TYPE (CHOOSE ONE): ___ NON-DUALLY ELIGIBLE ___ DUALLY ELIGIBLE/CROSSOVER

MEDICARE BENEFICIARY													
BENEFICIARY NAME		MBI OR HICN	PATIENT ACCT. NO.	DATES OF SERVICE		MEDICAID NO.	DEEMED INDIGENT	REMITTANCE ADVICE DATE		SECON. PAYER REMIT. ADV. REC'D DATE	BENEFICIARY RESPONSIBILITY AMT.	DATE FIRST BILL SENT TO BENE.	A/R WRITE OFF DATE
LAST	FIRST			FROM	TO			MEDICARE	MEDICAID				
1	2	3	4	5	6	7	8	9	10	11	12	13	14

LISTING OF MEDICARE BAD DEBTS (CONT.)

COLLECTION AGENCY INFORMATION		COLLECT. EFFT. CEASE DATE	MEDICARE WRITE OFF DATE	RECOVERIES ONLY		MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS*		CURRENT YEAR PAYMENTS RECEIVED		ALLOWABLE BAD DEBTS	COMMENTS
SENT (Y/N)	RETURN DATE			AMOUNT RECEIVED	MCR FYE DATE	DEDUCT.	COINS.	AMOUNT	SOURCE		
15a	15	16	17	18	19	20	21	22	23	24	25
TOTAL											

* Report deductible and coinsurance amounts only when the provider billed the patient with the expectation of payment. See column 8 instructions for possible exception.

Bad Debt – Excel Spreadsheets

Description	Link
Bad Debt Policy for Medicare Cost Report and Policy and Procedure Manuals	https://www.dropbox.com/scl/fi/b1ob16e03ddjduahoksyi/2016-Sample-Bad-Debt-Policy-for-Rural-Health-Clinics.doc?dl=0&rlkey=4nba3t7x3i3mpcu58fxamoef9
Medicare Bad Debt Log in Excel	https://www.dropbox.com/scl/fi/rtfk6hs4janv6q7e8ae59/2020-Medicare-Bad-Debt-Listing-Template.xlsx?dl=0&rlkey=ybaleh28ybyza8k9o8al61xlw
Medicare/Medicaid Crossover Bad Debt Log in Excel	https://www.dropbox.com/scl/fi/ab4r349bo6fnjl164wedb/2020-Medicare-Crossovers-Bad-Debt-Listing-Template.xlsx?dl=0&rlkey=1cixd040el1qkxaawy0ulk4dx

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CONTACT INFORMATION

Trent Jackson, CCRS
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thomastrenton.jackson@outlook.com
www.ruralhealthclinic.com

There are Three Types of Cost Reports

RHCS may file three types of cost report

Type	Utilization	Settlement	Flu/Pnu	Bad Debts
No	None	No	No	No
Low	> $50,000	No	No	No
Full	<$50,000	Yes	Yes	Yes

There are three types of cost reports

Three Types of Medicare Cost report

Full	Low Utilization	No Utilization
Medicare Interim Payments • Required if $50,000 or more in interim payments	**Medicare Interim Payments** • Less than $50,000	**Medicare Interim Payments** • None
Why? • Settles difference in interim and final rate. • Reimburses Flu, Pnu, and Covid shots • Reimburses Bad Debts.	**Why?** • Simple. • Must submit a letter indicating you qualify and a Balance Sheet and Profit and Loss statement.	**Why?** • Extremely Simple. • Must submit a letter and attach Worksheet S of cost report.
Professional Fees? • High	**Professional Fees?** •Medium	**Professional Fees?** • Low

Some clinics may elect to file a low utilization cost report if they do not have Influenza, Pneumococcal, Covid vaccines, or bad debts and they qualify.

Low Utilization Cost Reports

"Low Medicare Utilization" Cost Report Criteria

The contractor may authorize less than a full cost report where a provider has had low utilization of covered services by Medicare beneficiaries in a reporting period and received correspondingly low interim reimbursement payments which, in the aggregate, appear to justify making a final settlement for that period based on less than a normally required full cost report. Effective for all cost reports filed on or after June 19, 2020, in order to file a low utilization cost report, the provider must meet one of the following thresholds:

Criteria	Hospital Threshold	SNF Threshold	RHC/FQHC Threshold
Total Reimbursement	$200,000	$200,000	$50,000

Less than $50,000 in Net Medicare Payments

Low Utilization Cost Reports

The following forms are required when filing a Low Utilization Medicare Cost Report:

- Signed Officer Certification Sheet with applicable "S" Worksheets,
- Balance Sheet
- Income and Expense Statement (the Worksheet G Series may be submitted to satisfy the Balance Sheet and Income and Expense Statement requirements), and
- Various worksheets based on provider type:

FQHC and RHC Facilities filing Form CMS-222-92 and 224-14

- Worksheet S Part I, II and III
- Worksheet C Part I and II

The Provider must submit the forms and data under this alternative procedure within the same time period required for full cost reports. If it is determined at a later date that a cost report does not meet the criteria for a low or no utilization cost report, or if the contractor determines that a full cost report is necessary to serve the best interest of the program, a full cost report will be required.

Low Utilization Cost Report Filers

1. Will not get paid for Flu and pnu shots + Covid and MABS
2. Co-pays on preventive services
3. Medicare Bad Debts
4. **Difference in interim rates and final reimbursement rates**

If you think you qualify for a low or no utilization cost report, pull the P S and R early and let’s get it filed in early 2023.

Gathering Information for the Cost Report

Your Cost Report Preparer will send you a checklist of information or Excel spreadsheet to submit to your cost report preparer.

Start Early and get the information to the preparer as soon as possible.

If you do not have the checklist by your cost report year-end or shortly thereafter contact your cost report preparer.

https://static1.squarespace.com/static/53c5f79de4b0f4932a3942a8/t/63c2e57eaa9f814cc594f06b/1673717118640/2023+RHC+Medicare+Cost+Report+Checklist+for+12+31+2022+%28Final1%29.pdf

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2023 RHC Medicare Cost Report Workpaper Checklist

Revised on January 11, 2023

ITEM NUMBER	DESCRIPTION OF WHAT IS NEEDED	√ IF INCLUDED
1	We need at least one of the following items to determine the total expenses paid by clinic during the cost reporting period. The reports should be for the entire accounting period (which is typically 12 months). a. Trial Balance b. Financial Statement from Accountant or QuickBooks c. Federal Tax Return for the Practice	
2	We need at least one of the following to determine the total patient visits or encounters. a. CPT Frequency Report (by Provider) b. Written, Manual Visit Count using the Updated Included Cheat Sheet	
3	• W-2's with the **employee's position listed** on the W-2 or what the employee did during their employment. **Please write the number of hours the employee worked during the year on the W-2, as well, and if the employee split time in laboratory or X-Ray.** • If the cost report period is something other than 1/1/XX to 12/31/XX, please provide a payroll journal report with gross pay for the cost report period. • Please provide a description of what each employee does (i.e., MD, PA, NP, nursing staff, janitorial, administrative staff, etc). • Please provide the total number of hours work by each employee during the cost report period.	
4	We need all of the following information to claim Influenza and Pneumococcal reimbursement on the cost report. a. Medicare Logs with Patient Name, MBI Number, and Date of Service b. A Count, Listing, or Log for Non-Medicare Patients c. Invoices Supporting the Vaccine Purchases During the Year	
5	**PS&R Report.** RHCs are required to obtain their own PS&R from the EIDM portal from the IACS system. Please start this process immediately if you do have a log-in as it may take six to eight weeks. We need the summary 710 and 71S reports for the period of the cost report. (We have included a seven-page PDF with instructions.) **Add Dani Gilbert, Page Chambers, or Trent Jackson as your Authorized Cost Report Preparer for EIDM if you want HBS to file the cost report electronically.**	

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ITEM NUMBER	DESCRIPTION OF WHAT IS NEEDED	√ IF INCLUDED
6	**Medicare Bad Debt Listing.** If you have any Medicare bad debts, please prepare a separate Bad Debt listing for Medicare bad debt and Medicare/Medicaid crossover bad debt, using the Excel template we provide. If you do not have a copy of the Excel template for this, please email us and request one. If you are not claiming bad debts, please indicate that as well.	
7	**Related Party Transactions.** List any related party transactions (RPT), including any rental payments by the clinic to the physician/owner or the owner's relatives. Please copy 1099s for our file if your think you may have a RPT.	
8	**S-3 Clinic Information** Please see the workpaper which includes identifying information about the clinic and includes the clinic's hours of operation. Please also indicate any non-RHC hours that the clinic may have.	
9	**Laboratory.** Please complete the Laboratory Time Log if you do not have dedicated employee to lab or expenses directly expensed to lab in the trial balance.	
10	**FTE Calculation.** Please complete the Provider FTE Calculation Workpaper attached to this document.	
11	**Depreciation.** Please include a depreciation schedule so we can convert depreciation to straight-line depreciation.	
12	**Please enclose any Medicare correspondence including letters requesting a cost report, Notices of Program Reimbursement for prior years, or any adjustment reports from the Medicare Administrative Contractor (MAC). This will ensure your cost report is filed to the correct MAC.**	
13	Please provide **visit counts** in the following formats: a. Total Medical visits, total mental health visits, and visits by interns and residents b. Visits by payor mix for inclusion on Worksheet S-3 i. Title V- CHIP ii. Title XVIII – Medicare iii. Title XIX – Medicaid iv. Other – Commercial, self-pay, etc. Please see the Workpaper S-3 Total Visits by Payor Mix and complete.	

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ITEM NUMBER	DESCRIPTION OF WHAT IS NEEDED	√ IF INCLUDED
14	Please complete Worksheet S-1 regarding your **Malpractice costs:** a. Malpractice premiums, _____ b. paid losses, and _____ **c.** self-insurance costs _____ **Is the malpractice insurance a claims-made or occurrence policy?**	_____
15.	**IMPORTANT: Please send any letter from the MAC with any type of settlement to for from the MAC. If we do not report these settlements on the cost report the clinic may have to pay back funds to Medicare when the report is final settled.**	
16	Please provide the information for the person who will sign the Cost Report First Name _____ Last Name _____ Title _____ Email _____	
17	Is the Clinic part of an entity that owns or leases multiple RHCs? If so, provide the following information: Name of Entity _____ Street _____ P.O. Box _____ City _____ State _____ Zip Code _____	

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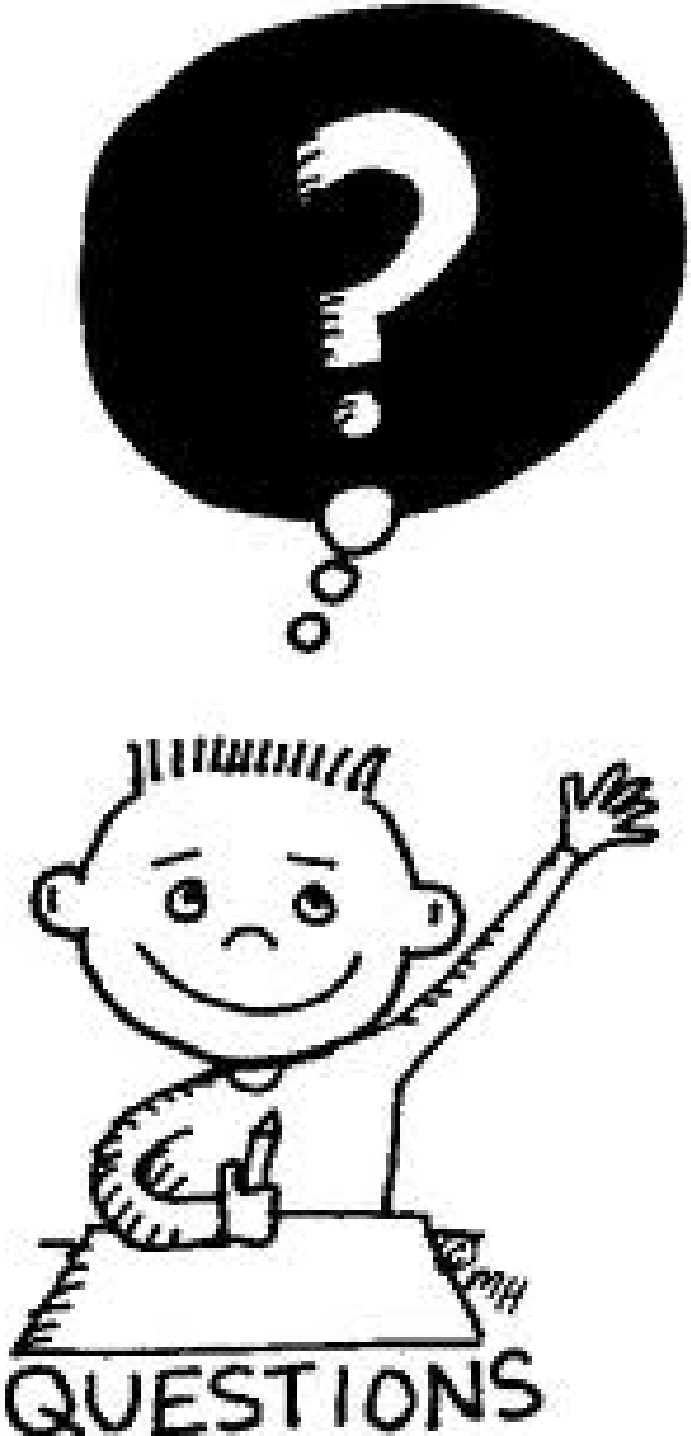

The Best way to count visits is ?

A. A manual hand count

B. A computer report broken down by payor

C. A CPT Frequency Report broken down by provider.

What is needed to count Visits

- We need a CPT Frequency report broken down by provider only (not payor). If you have a lot of physicians and only one NP, you can run a CPT frequency report for the practice and then one for the NP or vice versa (you have several NPs and only one physician) We do need physicians, NPs, PAs, LCSWs, and CPs broken out for cost reporting purposes.

Why are Visits so Important?

Visits are important because
They are the denominator in
The cost per visit calculation.

Do not count 99211 visits,
Injections, lab procedures,
hospital visits, non-rhc visits

Definition of an RHC Visit per Section 40 of Chapter 13 of the Medicare Benefits Policy Manual

- An RHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or practitioner are considered RHC visits.

RHC Cost Report Total Visit Count Cheat Sheet with CPT Codes[1]
For 12/31/2022 Cost Reports

Table 1: Use this table for all Visits that occurred person to person (not Telehealth)

Service	HCPCS/ CPT Codes	Cost Report Treatment	Physician Visits	PA Visits	NP Visits	Totals
Office Visits – E and M Codes (New and Established)	99201 to 99205 99212-99215	Include visit in RHC Visit count. Cost is an allowable expense. Do not count 99211 visits. Do not count visits with 25 modifiers **Do not count Telehealth Claims**				
Office Visit – E & M – Nurse only visit	99211	Do not count these visits as RHC. Service is allowable cost. Incident to.				
Procedures	10060-29130 54150-69200	Include visit in cost report unless billed incident to an E and M.				
Hospital visits	99217 to 99292	Count these visits. Do not include them with the RHC visit count. Exclude the cost via an adjustment or reclassifying the cost to the non-allowable section of the cost report. (Lines 51-60)				
Nursing Home Visits (Level 1 or Level 2) SNF or NF	99304-99316 99334-99335	Include visits in RHC visit counts. Cost is an allowable expense				
Home Visits	99347-99349	Include visits in RHC visit counts				
Physicals, EPSDT New Physicals, EPDST, Established	99381-99387 99391-99397	Count these visits. Do not include in the RHC visit count. Exclude the cost via a reclassification to the non-allowable section of the cost report				
Welcome to Medicare (IPPE)	G0402	Include visit in RHC Visit count. Cost is an allowable expense.				
Annual Wellness Exam (AWE)	G0438 & G0439	Include visit in RHC Visit count. Cost is an allowable expense. (unless billed incident to- then do not count)				

[1] This table is prepared using the most common scenarios in RHCs and using Medicare guidance as of January 11, 2023. Some clinics may elect to treat visits and billing differently depending on cost reporting and billing issues. These tables are designed to represent the most common scenarios and is not inclusive of all possible CPT codes.

Table 1: (Continued) Use this table for all Visits that occurred person to person (not Telehealth)

Service	HCPCS/ CPT Codes	Cost Report Treatment	Physician Visits	PA Visits	NP Visits	Totals
Tobacco Counseling	G0436 & G0437	Count as a visit if charged as a visit to Medicare. (unless billed incident to- then do not count)				
Weight Loss Counseling	G0447	Count as a visit if charged as a visit to Medicare. (unless billed incident to- then do not count)				
Alcohol Abuse Screening	G0442 & G0443	Count as a visit if charged as a visit to Medicare. (unless billed incident to- then do not count)				
Depression Screening	G0444	Count as a visit if charged as a visit to Medicare. (unless billed incident to- then do not count)				
STD Prevention	G0445	Count as a visit if charged as a visit to Medicare. (unless billed incident to- then do not count)				
IBT (Cardiovascular)	G0446	Count as a visit if charged as a visit to Medicare. (unless billed incident to- then do not count)				
Transition Care Mgmt.	99495-99496	Include visit in RHC Visit count.				
Advance Care Planning	99497-99498	Count as a visit if charged as a visit to Medicare. (unless billed incident to- then do not count)				
Chronic Care Management G0511 pays $77.94 in 2023	G0511 & G0512	Do not count these visits. Cost is non-allowable.				
Visits occurring during non-RHC hours		Count the total the number of visits. Do not include in RHC count. Reclassify this cost as non-allowable expense.				

On the two pages we have included Table 2 which is to be used for the Telehealth visits occurring in 2022. During the public health emergency RHCs can be a distant site for telehealth services and provide telephone only consults. Those services are billed to Medicare with a G2025 CPT code even though the RHC may use an E and M code such as a 99213 for example. **Please make sure not to double count these codes as this will double count the number of telehealth visits and increase the amount of expense disallowed on the cost report.**

Telehealth Total Visits (All payors – Medicare/Caid/Commercial/Self Pay)

Table 2: Use this table for all Visits that occurred via Telehealth by either video or telephone

Service	HCPCS/ CPT Codes	Cost Report Treatment	Physician Visits	PA Visits	NP Visits	Totals
Medicare RHC Telehealth Visit reimbursed at $98.27 for 2023	G2025 - RHC May have Modifier 95	**Do not include** in visit count for RHC All-Inclusive Rate and exclude cost from All-Inclusive Rate calculation. **Do not double count.** (IE. Count a 99213 below and include in this row as well.				
Medicare Mental Health visits via Telehealth (new treatment in 2022)	Use CPT Code (ie 90834) Modifier 95 or FQ, CG	Include in the RHC Visit Count and include the cost of this service in the allowable RHC cost.				
Virtual Communications – Pays $23.72 in 2023	G0071 -RHC. 99241-99243	Do **NOT** count these visits. Service is not an allowable cost.				
Digital assessment services Pays $23.72 in 2023	G0071 – RHC G2012 & G2010	Do **NOT** count these visits. Service is not an allowable cost.				
Telephone only E & M Services	99441-99443	Do **NOT** count these visits. Service is not an allowable cost.				
Office Visits – E and M Codes (New and Established)	99201 to 99205 99212-99215	Do **NOT** include visit in RHC Visit count. Cost is **NOT** an allowable expense. Do not count 99211 visits.				
Office Visit – E & M – Nurse only visit	99211	Do **NOT** count these visits. Service is not an allowable cost.				
Nursing Home Visits (Level 1 or Level 2) SNF or NF	99304-99316 99334-99335	Do **NOT** count these visits. Service is not an allowable cost.				
Welcome to Medicare (IPPE)	G0402	Do **NOT** count these visits. Service is not an allowable cost.				
Annual Wellness Exam (AWE)	G0438 & G0439	Do **NOT** count these visits. Service is not an allowable cost.				

Billing and Coding Crosswalk Cheat Sheet

Service	Example Coding CPT	Example Billing HCPCS	Payment	Cost Report Visit?	Allowable Medicare Cost?	Notes
Medicaid Visit (in some states)	99213 (QVL)	T1015	AIR	Yes	Yes	Only count 1 visit on your RHC Cost Report
Telehealth Visit	99213	G2025	$98.27	No	No	Medicaid may pay AIR
Mental Telehealth Visit (starting in 2022)	90834	90834 CG 95	AIR	Yes	Yes	Keep records on the costs of two different types of telehealth visits
Virtual Communication Services (G0071)	99421	G0071	$23.72	No	No	Exclude cost on cost report.
Chronic Care Management	99484	G0511	$77.94	No	No	Exclude cost on cost report.

Note: The CPT Code column is not an all-inclusive list of CPT codes.

5. Keeping good Provider Time records is important because?

A. It could lower the number of visits to meet minimum productivity.

B. It may be needed in case of an audit.

C. It could increase your payment from Medicare

D. All of the above.

Health Care Provider FTEs

- Cost report requires separation of provider visits, time, (and cost):
- Physician
- Physician Assistant
- Nurse Practitioner
- Visiting Nurse
- Clinical Psychologist
- Clinical Social Worker

The Provider FTE calculation is important For Productivity Calculations (based up a 2,080 Hour work year)

Provider Type	Minimum Annual Productivity based upon 40-hour work week	Daily Productivity based upon 250 work days	Monthly Productivity
Physician	4,200	16.8	350
Nurse Practitioner/ Physician Assistant	2,100	8.5	175

Productivity Standards Documentation – FTE Calculations

- Record provider FTE for clinic time only (this includes charting time):
  - –Time spent in the clinic
  - –Time with SNF patients
  - –Time with swing bed patients
- Do not include non-clinic time in provider productivity:
  - –Hospital time (inpatient or outpatient)
  - –Administrative time
  - –Committee time
  - **- Telehealth or Telemedicine time**
- Provider time for visits by physicians under agreement who do not furnish services to patients on a regular ongoing basis in the RHC are not subject to productivity standards.

Time Studies for Provider FTEs

Name of Clinic:								
Worksheet B: Provider Time Study								
FYE:								
Purpose: To determine what activities the provider engages in during the day so the time may be properly allocated on the RHC Cost Report. Please conduct this study at least one week per quarter and preferably one week per month per provider. This page may be copied and reproduced as necessary to fit your needs. Please label each use of this table with its associated provider and the week that it references.								
Provider Name:								
Week Ending								
Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total Weekly Hours**
Time In:								
Time Out:								
Total Hours Worked								
RHC Patient Care								
Clinic - RHC treating patients								
Nursing Home								
Other								
Total Clinical								
Administrative								
Medical Director								
Administrative								
CME								
Sick								
Vacation								
Total Admin								
Non- RHC Time								
Hospital								
Private Practice								
Telehealth								
Chronic Care Management								
Other:								
Total Non-RHC								
Sum of RHC, Admin, and Non-RHC								
The Sum of RHC, Administration and Non-RHC time should equal the Total Hours worked. Please sum each of the lightly shaded areas.								

Provider FTE Calculation

Name of Clinic	
Worksheet B: FTE Calculation	
Fiscal Year End	

On this page we need information about the amount of time spent by providers and nursing staff providing patient care. Please fill out the **name of each provider** in your clinic, as well as the number of **hours per week they spend providing patient care**, the number of **hours they spend per week on other tasks** such as administrative work, and the number of **months worked through the fiscal year**.

In the section labeled "FTEs for Nursing Staff" please give the **number of Nurses and Medical Assistants** which work in your clinic, as well as the total number of **hours that those employees worked** during the year.

FTEs for Providers

Provider Type	Name	Hours per week performing patient care	Hours per week performing admin tasks	Hours Per week in Non-RHC activities	Total hours worked per week	Number of months worked during fiscal year	Total Hours Worked Per Year	FTE
Physicians								0.00
								0.00
								0.00
								0.00
								0.00
Physician Assistants								0.00
								0.00
								0.00
								0.00
								0.00
Nurse Practioners								0.00
								0.00
								0.00
								0.00
								0.00
Mental Health								0.00
								0.00
								0.00
								0.00
								0.00

FTEs for Nursing Staff

Number of Nurses and Medical Assistants	Total Hours Worked by Nurses and Medical	Nursing Staff FTE

Covid-19 Vaccine Changes in 2022

Covid-19 Vaccines and MABs by Medicare Advantage Plan Patients are no longer reimbursed on the Cost Report

Year	Pnu	Flu	Covid Vaccine	MABs
2021	Originial	Originial	Originial & Advantage	Originial & Advantage
2022	Originial	Originial	Originial	Originial

- **COVID-19 Vaccines in RHCs**

  COVID-19 vaccines and their administration will be paid the same way influenza and pneumococcal vaccines and their administration are paid in RHCs. Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The beneficiary coinsurance and deductible are waived. For patients enrolled in Medicare Advantage, COVID-19 vaccines and their administration costs, as well as, monoclonal antibody products and their administration costs should be included on the RHC cost report. For additional information, please see https://www.cms.gov/covidvax.

https://www.cms.gov/covidvax

Covid Vaccine & Monoclonal Injections/shots

- Both are reported on the cost report like flu and pnu and reimbursed at cost. Keep a log.
- In 2021 include Medicare Advantage/Replacement Plan patients as well (**not so for flu and pnu, or 2022 Covid shots.**
- Keep up with Medicare Advantage/Replacement plans separately and do not include in the Medicare line on the cost report.
- Keep up with your cost of supplies and direct expenses in a separate general ledger account.
- Keep good time records for administration time.

- https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion?fbclid=IwAR0b56IOR4fYBDh53ex2Ifrg3OC9dd1hHCm7e6aibbQNWt-D1YaLAy-VWF8

Influenza, Covid and Pneumococcal Shot Logs

Patient Name	MBI Number	Date of Service
John Smith	411992345A	11/30/2022
Steve Jones	234123903A	12/15/2022
Ashley Taylor	903214934A	12/31/2022

Medicare Influenza and Medicare Pneumococcal shots should be maintained on separate logs. Pnumo pays around $250 per shot and influenza is $60 or so.

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Medicare Influenza Log

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

#	Patient Name	MBI Number	Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Page Number		Page Total		Total Medicare Flu Shots	

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Medicare Pnemococcal Log

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

#	Patient Name	MBI Number	Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Page Number		Page Total		Total Medicare Pnu Shots	

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Medicare COVID-19 Log

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

#	Patient Name	MBI Number	Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
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Page Number		Page Total		Total Medicare Covid Shots	

Questions, Comments, Thank You

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