

SETTLEMENT DATA
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

1

SETTLEMENT DATA

GENERAL:

The Medicare apportionment data (for example, days and charges) must be related to the actual volume of services rendered during the cost reporting period; however, in those hospitals subject to PPS, payment for inpatient services is based on discharges. Therefore, the apportionment data (for example, days and charges) must agree with the billings applicable to discharges occurring during the cost reporting period. Cut-off bills are no longer required for PPS providers after the first year under PPS. Cut-off bills are still required for non-PPS providers. See PRM-I, §2805.

Use the PS&R data to make the settlement unless the provider furnishes proof that this data is inaccurate.

OBJECTIVES:

1. To settle Medicaid reimbursement data based on most accurate Medicaid data available.

OTHER REFERENCES:

PRM-I, §2805

Cost Reporting Forms: Hospital:
HCFA-2552, Worksheet E-3

SETTLEMENT DATA
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

2

SETTLEMENT DATA INDEX

MEDICAID SETTLEMENT DATA

PHYSICIAN SERVICE CHARGES GROSS UP OR GROSS DOWN

PAYMENTS TO THE PROVIDER

TEFRA TARGET

PROTESTED AMOUNTS

SETTLEMENT DATA (Continued)
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

3

<u>STEP</u>	<u>PROCEDURE DESCRIPTION</u>	<u>AUDITOR'S INITIALS AND DATE</u>	<u>WP REF</u>
-------------	------------------------------	--	---------------

SETTLEMENT DATA (Continued)
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

4

<u>STEP</u>	<u>PROCEDURE DESCRIPTION</u>	<u>AUDITOR'S INITIALS AND DATE</u>	<u>WP REF</u>
-------------	------------------------------	--	---------------

MEDICAID SETTLEMENT DATA

Use the Unisys Report to obtain the Medicaid settlement data for each provider component.

Examine the crosswalk, which provides detail between the charge codes, departments and charges found on the PS&R to the cost center groupings on the cost report. Providers must show total dollars by cost center and the range of charge codes within each cost center.

PHYSICIAN SERVICE CHARGES GROSS UP OR GROSS DOWN

Use the information obtained in Exhibit 2, Step 4, to determine whether an adjustment for physician's professional charges is required.

Note: If the total charges on Worksheet C for all patients in a department include a charge for the provider-based physician's professional component, then total and Medicare charges used on Worksheets D and D-4 and Worksheets D-2, D-3 and D-6 must also include the PBP's professional component charge in order to correctly apportion costs to the program. Similarly, when total charges on Worksheet C, Part I, for a department are for provider services only, charges on Worksheets D and D-4 and Worksheets D-2, D-3 and D-6 must also include provider services only. See PRM-II, §2813.1. See PRM-II, §2807, instructions for line 45 for handling of clinical laboratory services.

PAYMENTS TO THE PROVIDER

Verify the payments made to the provider and claimed on the cost report, including both interim payments and lump-sum payments. Propose an audit adjustment, where necessary.

TEFRA TARGET

For TEFRA hospitals and excluded units, ensure that the correct target rate is used.

Propose an audit adjustment, where necessary.

PROTESTED AMOUNTS

Review settlement Worksheet E-3 for appealed items and protested amounts. Ensure that protested amounts for the acute hospital and excluded units are eliminated including excluded units. Consider these items for audit adjustments.

SETTLEMENT DATA (Continued)
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

<u>STEP</u>	<u>PROCEDURE DESCRIPTION</u>	AUDITOR'S INITIALS	<u>AND DATE</u> <u>WP REF</u>
-------------	------------------------------	-----------------------	-------------------------------