

# RHC Limited Professional Desk Review Program

Federally Qualified Health Center/Rural Health Center Cost Report Form CMS 222-92

**Provider Name:** \_\_\_\_\_ **Provider No.:** \_\_\_\_\_

**Period Covered From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**Purpose:** To document the completion of the FQHC/RHC Limited Professional Desk Review Program for the above provider for the period indicated.

Review in conjunction with FQHC/RHC MARP and the Standardized Workpapers as applicable

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Module B - General Audit Areas

Module C - Bad Debts

Module D - Settlement Data

Module E - Fraud and Abuse

Module F – Permanent File

## RHC Limited Professional Desk Review Program

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials and Date	Remarks
<p><u>Module A - Information from Prior Year Cost Report Review</u></p> <ol style="list-style-type: none"> <li>1. Review the points for future audit for items that may require further review.</li> <li>2. Determine if significant prior year adjustments have been considered on the current year's cost report. For adjustments affecting GME/IME, Nursing School/Allied Health, DSH, Organ Acquisition, and Bad Debts see the respective modules in this desk review program.</li> <li>3. Review the prior year management letter for items that should be considered on the current year cost report.</li> </ol>					
<p><u>B. General Audit Areas</u></p> <ol style="list-style-type: none"> <li>1. Does the correspondence file contain any significant items that may impact Program reimbursement in the current year limit.</li> </ol>					
<ol style="list-style-type: none"> <li>2. Review the following and consider the findings of items a &amp; b in the review.               <ol style="list-style-type: none"> <li>a. Is the provider restricted by the maximum payment limits on the as-filed cost report? By how much? _____</li> <li>b. Is the provider limited to the productivity standards on W/S B, Part1? By how many visits? _____</li> </ol> </li> </ol>					

## RHC Limited Professional Desk Review Program

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials and Date	Remarks
<p>3. Ensure the proper maximum payment rate or consolidated maximum payment rate has been reported on Worksheet C, Part I, Columns 1 &amp; 2.</p> <p>4. Review the pneumococcal and influenza vaccine on W/S B-1 for reasonableness.</p> <p style="padding-left: 40px;">NOTE: If the average cost/shot for the pneumococcal &amp; influenza vaccine is less than the thresholds, pass on further review.</p> <p>If the average influenza cost per vaccine is greater than \$21, pneumococcal cost per vaccine greater than \$38 and (W/S B-1, line 12) and the Medicare cost is greater than \$5000 (W/S B-1, line 14), then review the provider's staff time ratio (W/S B-1, line 2) and supply cost (W/S B-1, line 4). Adjust if necessary.</p> <p style="padding-left: 40px;">If costs exceed parameters, request and review documentation to support the cost. Do not automatically adjust without requesting documentation.</p>					
<p><u>C. - Bad Debts</u></p> <p>1. Verify whether the amounts on the detailed bad debt listings submitted with the cost report agree with the inpatient and outpatient bad debts reported on the cost report.</p> <p>Also, perform this verification for bad debts reported by the hospital-based ESRD unit if the unit was not selected for review based on the requirements of Section 4558 of the BBA of 1997.</p> <p>2. If total bad debt reimbursement (inpatient, outpatient, ESRD) claimed is less than \$50,000 you can allow without further review.</p> <p>Otherwise, complete steps 3 through 5 for only the specific type of bad debt (i.e., inpatient, outpatient or, if applicable, ESRD) that meets any of these thresholds: (1) the amount claimed for the specific type of bad debt is more than 5 percent of the total related deductibles and coinsurance, (2) the specific type of bad debt increased more than 15 percent over the prior year, (3) the specific</p>					

## RHC Limited Professional Desk Review Program

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials and Date	Remarks
<p>type of bad debt was not reviewed in the past three years.</p> <p>NOTE: Based on your knowledge of the provider, you can perform Steps 3 through 5 even if these thresholds are not exceeded.</p> <p>3. Determine if the bad debt listing contains the following information:</p> <ul style="list-style-type: none"> <li>• Name of beneficiary</li> <li>• HIC number</li> <li>• Date of discharge</li> <li>• Date of first bill to beneficiary after discharge</li> <li>• Medicare payment date</li> <li>• Amount of write-off</li> <li>• Date of write-off</li> <li>• Amount of deductible and/or coinsurance</li> <li>• Indigent designation</li> <li>• Medicaid number</li> </ul> <p>If needed to complete the desk review, request this information from the provider if it has not been included on the bad debt listing.</p> <p>4. Scan the bad debt listing to identify accounts which do not show a Medicaid number (see Form CMS-339, Exhibit 5, column 4) that were written off sooner than 120 days from the date of the first bill or the first bill was not issued within the timeframes specified in PRM-I, 310. Before making adjustments for any exceptions noted pertaining to the 120-day rule, consider further review to determine whether the patient was otherwise indigent.</p> <p>5. Examples of other items to consider in determining whether further review is necessary:</p> <ol style="list-style-type: none"> <li>a. Material adjustments to bad debts during prior year reviews.</li> <li>b. Need to request additional documentation for patients deemed indigent by the provider.</li> <li>c. Evidence of recoveries of prior year bad debts but insufficient information</li> </ol>					

## RHC Limited Professional Desk Review Program

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials and Date	Remarks
<p>available to verify that the offset was properly made.</p> <p>d. A need to verify whether the hospital billed Medicaid or other secondary payers and received either a payment or a remittance advice denying payment.</p> <p>e. Need to verify if the deductible/coinsurance amounts claimed as bad debts relate only to covered services and trace to the PS&amp;R or the Medicare remittance advice?</p> <p>6. Document the reason for your decision to further review or not review bad debts.</p>					
<p><u>D. Settlement Data</u></p> <p>1. For cost reporting periods ending on or after 11/30/95, ascertain what method (identified in Form CMS-339) the provider used to file the cost report. Review the settlement data documentation accordingly.</p> <p>NOTE: If the hospital used the PS&amp;R settlement data to file the cost report or you decided to use the PS&amp;R data because the hospital's reported settlement data is not documented properly, update the PS&amp;R settlement data in accordance with Pub. 100-06, Chapter 8, Section 90.</p> <p>2. Scan the settlement worksheets for unusual items. Adjust as necessary.</p> <p>NOTE: Update settlement data in accordance with Section 90 of Pub. 100-06. When settling the cost report, use a PS&amp;R with a paid through date no earlier than 120 days prior to the issuance of the final audit adjustment report. If an adjustment report is not issued, use a PS&amp;R with a paid through date no earlier than 120 days prior to the NPR. However if the cost report is settled later than 18 months after the end of the provider's fiscal year, a PS&amp;R must have a paid through date that is no earlier than 15 months after the end of the provider's fiscal year.</p>					

## RHC Limited Professional Desk Review Program

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials and Date	Remarks
3. Remove protested items reported on the cost report.					
<u>Module E – Fraud and Abuse</u>  1. Watch for recurring incidents of the provider including cost disallowed in prior years and not declared as protested item(s) on the settlement summary and accompanying schedules.					
<u>Module F - Permanent File</u>  1. Update the permanent file using information submitted with the cost report or obtained during the desk review.					

Auditor: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

## FQHC Limited Professional Desk Review Program

Federally Qualified Health Center –Excel Worksheets in lieu of Cost Report Form CMS 222-92

**Provider Name:** \_\_\_\_\_ **Provider No.:** \_\_\_\_\_

**Period Covered From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**Desk Review Start Date:** \_\_\_\_\_

**Purpose:** To document the completion of the FQHC Limited Professional Desk Review Program for the above provider for the period indicated.

Review in conjunction with FQHC MARP and the Standardized Workpapers as applicable.

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Module D - Settlement Data

Module E - Fraud and Abuse

Module F - Permanent File

Exhibit 2

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials	Remarks
<p><u>Module A - Information from Prior Year Cost Report Review</u></p> <ol style="list-style-type: none"> <li>1. Review the points for future audit for items that may require further review.</li> <li>2. Determine if significant prior year adjustments have been considered on the current year cost report. For adjustments affecting Bad Debts see the respective modules in this desk review program.</li> <li>3. Review the prior year management letter for items that should be considered on the current year cost report.</li> </ol>					
<p><u>B. General Audit Areas</u></p> <ol style="list-style-type: none"> <li>1. Does the correspondence file contain any significant items that may impact Program reimbursement in the current year.</li> </ol>					
<ol style="list-style-type: none"> <li>2. Review the following and consider the findings of items a &amp; b in the review.               <ol style="list-style-type: none"> <li>a. Is the provider restricted by the maximum payment limits on the as-filed cost report? By how much \$</li> <li>b. Is the provider limited to the productivity standards on W/S B, Part1? By how many visits? _____</li> </ol> </li> </ol>					

Exhibit 2

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials	Remarks
<p>3. Ensure the proper maximum payment rate or consolidated maximum payment rate has been reported on Worksheet C, Part I, Columns 1 &amp; 2.</p> <p>4. Review the pneumococcal and influenza vaccine on W/S B-1 for reasonableness.</p> <p>NOTE: If the average cost/shot for the pneumococcal &amp; influenza vaccine is less than the thresholds, pass on further review.</p> <p>If the average influenza cost per vaccine is greater than \$21, pneumococcal cost per vaccine greater than \$38 and (W/S B-1, line 12) and the Medicare cost is greater than \$5000 (W/S B-1, line 14), review the provider's staff time ratio (W/S B-1, line 2) and supply cost (W/S B-1, line 4). Adjust if necessary.</p> <p>If costs exceed parameters, request and review documentation to support the cost. Do not automatically adjust without requesting documentation.</p>					
<p><u>C. - Bad Debts</u></p> <p>1. Verify whether the amounts on the detailed bad debt listings submitted with the cost report agree with the bad debts reported on the cost report.</p> <p>2. If total bad debt reimbursement (inpatient, outpatient, ESRD) claimed is less than \$50,000 you can allow without further review.</p> <p>Otherwise, complete steps 3 through 5 for only the specific type of bad debt (i.e., outpatient) that meets any of these thresholds: (1) the amount claimed for the specific type of bad debt is more than 5 percent of the total related deductibles and coinsurance, (2) the specific type of bad debt increased more than 15 percent over the prior year, (3) the specific type of bad debt was not reviewed in the past three years.</p> <p>NOTE: Based on your knowledge of the provider, you can perform Steps 3 through 5 even if these thresholds are not exceeded.</p>					

Exhibit 2

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials	Remarks
<p>3. Determine if the bad debt listing contains the following information:</p> <ul style="list-style-type: none"> <li>• Name of beneficiary</li> <li>• HIC number</li> <li>• Date of discharge</li> <li>• Date of first bill to beneficiary after discharge</li> <li>• Medicare payment date</li> <li>• Amount of write-off</li> <li>• Date of write-off</li> <li>• Amount of deductible and/or coinsurance</li> <li>• Indigent designation</li> <li>• Medicaid number</li> </ul> <p>If needed to complete the desk review, request this information from the provider if it has not been included on the bad debt listing.</p> <p>4. Scan the bad debt listing to identify accounts which do not show a Medicaid number (see Form CMS-339, Exhibit 5, column 4) that were written off sooner than 120 days from the date of the first bill or the first bill was not issued within the timeframes specified in PRM-I, 310. Before making adjustments for any exceptions noted pertaining to the 120-day rule, consider further review to determine whether the patient was otherwise indigent.</p> <p>5. Examples of other items to consider in determining whether further review is necessary:</p> <ol style="list-style-type: none"> <li>a. Material adjustments to bad debts during prior year reviews.</li> <li>b. Need to request additional documentation for patients deemed indigent by the provider.</li> <li>c. Evidence of recoveries of prior year bad debts but insufficient information available to verify that the offset was properly made.</li> <li>d. A need to verify whether the hospital billed Medicaid or other secondary payers and received either a payment or a remittance advice denying payment.</li> </ol>					

Exhibit 2

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials	Remarks
<p>e. Need to verify if the deductible/coinsurance amounts claimed as bad debts relate only to covered services and trace to the PS&amp;R or the Medicare remittance advice?</p> <p>6. Document the reason for your decision to further review or not review bad debts.</p>					
<p><u>D. Settlement Data</u></p> <p>1. For cost reporting periods ending on or after 11/30/95, ascertain what method (identified in Form CMS-339) the provider used to file the cost report. Review the settlement data documentation accordingly.</p> <p>NOTE: If the hospital used the PS&amp;R settlement data to file the cost report or you decided to use the PS&amp;R data because the hospital's reported settlement data is not documented properly, update the PS&amp;R settlement data in accordance with Pub. 100-06, Chapter 8, Section 90.</p> <p>2. Scan the settlement worksheets for unusual items. Adjust as necessary.</p> <p>NOTE: Update settlement data in accordance with Section 90 of Pub. 100-06. When settling the cost report, use a PS&amp;R with a paid through date no earlier than 120 days prior to the issuance of the final audit adjustment report. If an adjustment report is not issued, use a PS&amp;R with a paid through date no earlier than 120 days prior to the NPR. However if the cost report is settled later than 18 months after the end of the provider's fiscal year, a PS&amp;R must have a paid through date that is no earlier than 15 months after the end of the provider's fiscal year.</p> <p>3. Remove protested items reported on the cost report.</p>					
<p><u>Module E – Fraud and Abuse</u></p>					

Exhibit 2

Review Step	Yes No N/A	Desk Review WP Ref	Scope For Field Review	Preparer's Initials	Remarks
1. Watch for recurring incidents of the provider including cost disallowed in prior years and not declared as protested item(s) on the settlement summary and accompanying schedules.					
<u>Module F - Permanent File</u>  1. Update the permanent file using information submitted with the cost report or obtained during the desk review.					

Auditor: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

## T 19 VT RHC Settlement Data.

*Be sure to code to the time you spend doing this to VT Medicaid (J70 E) & in Deltek.*

Vermont Medicaid costs settles RHCs similar to how Medicare does it. The only difference is that there are some RHCs that also receive a settlement for Dental Services, more on that later. The state uses the same cost per visit limit for free standing RHC that Medicare uses. See the Hospital instruction for provider based RHCs.

This is a listing of the RHCs that we perform a VT Medicaid Settlement for:

0473808	The Health Center (terminated 9/1/06; effective 10/1/06 Northeast Washington County Community Health d/b/a The Health Center)
0473813	Dartmouth-Hitchcock, Lyndonville (terminated 2/28/07)
0473988	NVRH Corner Medical Center – Hospital Based
0473814	Newport Pediatrics and Adolescent Medicine
0473815	Orleans Medical Clinic
0473989	NVRH St. Johnsbury Pediatrics – Hospital Based
0473821	Keeler Bay Family Practice
0473823	Central Vermont Physicians Practice Corp. d/b/a/ Valley Health Center (term. 12/31/03) – (Little Rivers FQHC effective 08/31/06)
0473824	Cold Hollow Family Practice
0473825	Wells River Clinic, Inc. – (Little River FQHC effective 8/31/06)
0473826	Francis W. Cook, M.D
0473827	Ryder Brook Pediatrics
0473829	Mtn Valley Health Council d/b/a Mtn Valley Med
0473830	Arlington Family Practice
0303809	David Fagan, M.D.
0303806	Summit Medical

The data reports are located on the R drive at R:\Medicaid\VT\Data. There are usually three files for each provider number. The primary one we will use is named **Audit\_provnumb\_fyemoye**. The other two files have correct data for Charges, Other Insurance Copays, and Payments, but the visit counts are incorrect. The state report counts treatments rather than visits. The files are saved in a text format, so they will need to be opened in excel to be useable.

In excel open the **Audit\_provnumb\_fyemoye** file as described previously. You will see a report like this:

ICN Number	Rec Rec Rec	ICN Detail	Procedure	Diagnosis	Claim Beg	Claim End	Paid Date	Billed Am	Allowed A	Copay Am	Other Insu	Paid Amount
1.02E+14 SL CA 009-	1	T1015		7245	6/26/2006	6/26/2006	10/27/2006	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63
1.02E+14 AT JAF 023-	2	T1015		3004	3/29/2006	3/29/2006	11/17/2006	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63
1.12E+14 BIL BEF 024-	1	92551	V202		4/18/2006	4/18/2006	8/25/2006	\$22.41	\$0.00	\$0.00	\$0.00	\$0.00
1.12E+14 BIL BEF 024-	1	T1015	V202		4/18/2006	4/18/2006	8/4/2006	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63
1.12E+14 BIL BEF 024-	2	99393	V202		4/18/2006	4/18/2006	8/4/2006	\$127.00	\$0.00	\$0.00	\$0.00	\$0.00
1.12E+14 BIL BEF 024-	3	90471	V202		4/18/2006	4/18/2006	8/25/2006	\$16.25	\$0.00	\$0.00	\$0.00	\$0.00
1.12E+14 BIL BEF 024-	3	90471	V202		4/18/2006	4/18/2006	10/13/2006	(\$16.25)	\$0.00	\$0.00	\$0.00	\$0.00
4.02E+14 AD MA 008-	1	T1015		29630	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63
4.02E+14 AD MA 008-	2	90805		29620	10/3/2005	10/3/2005	10/14/2005	\$115.00	\$0.00	\$0.00	\$0.00	\$0.00
4.02E+14 BR JES:014-	1	T1015		2967	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63
4.02E+14 BR JES:014-	2	90805		2967	10/3/2005	10/3/2005	10/14/2005	\$115.00	\$0.00	\$0.00	\$0.00	\$0.00
4.02E+14 JOIPA 029-	1	T1015		29620	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63
4.02E+14 JOIPA 029-	2	90805		29620	10/3/2005	10/3/2005	10/14/2005	\$115.00	\$0.00	\$0.00	\$0.00	\$0.00
4.02E+14 KCCA 572-	1	T1015		29620	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63
4.02E+14 KCCA 572-	2	90805		29620	10/3/2005	10/3/2005	10/14/2005	\$115.00	\$0.00	\$0.00	\$0.00	\$0.00
4.02E+14 GHKA 009-	1	T1015		29689	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63
4.02E+14 GHKA 009-	2	90807		29689	10/3/2005	10/3/2005	10/14/2005	\$163.00	\$0.00	\$0.00	\$0.00	\$0.00

Note that I shrank the PHI info in columns B,C,&D. The line of information we are interested in is the ones with the payment (in this case \$109.63 per visit). We want to sort the data by Procedure code, and delete all the lines that do not have a payment in them (generally the paid claims will be a T-code number, but sometimes there are other paid claims). Next we sort by Claim Begin date. Then we want to split the data between pre & post 12/31 dates for proper cost reporting. Finally we want to count the visits. Since it is possible to have negative claims on the report (corrected bills & such) you can't just count the lines. If you add a column to the right of the spreadsheet labeled Visits and enter the formula =IF(O2>0,1,-1) (where O is the column with the paid amount in it) then copy that formula down; it will enter a 1 or a -1 as appropriate. Go to the end of the paid claims thru 12/31 & total the columns Allowed Amount, Copay, Other Ins, Paid Amount, and Visits. Then go to the bottom of the spread sheet & total the same for columns for claims after 12/31.

These Totals will be reported on the Cost Report W/S C lines:

Line 8 column 1 & 2 Maximum Rate per Visit – **Use the same rate in effect as Medicare**

Line 11 column 1 Total Visits – **Visits thru 12/31**

Line 11 column 2 Total Visits – **Visits after 12/31**

Line 17 Primary Payer Amount –Sum of the pre & post 12/31 **Copay & OI Amount.**

Line 25 Interim Payments – Sum of the pre & post 12/31**Paid Amount**

**Line 24 Bad Debts – The State of VT uses this line to recognize the cost of Dental Services.** The Health Center of VT is the only RHC that is approved to bill the State for Dental Services. Note that effective for cost reporting periods starting on or after 1/1/06, VT Medicaid will pay the lower of cost or charge for Dental Services.

## T 19 VT FQHC Settlement Data.

*Be sure to code to the time you spend doing this to the Direct Activity Code VT Medicaid (J70 ) in Deltek.*

Vermont Medicaid cost settles FQHCs similar to how Medicare does it. The only difference is that there are some FQHCs that also receive a settlement for Dental and Pharmacy Services, more on that later. Also, they are paid at the lower of cost or the Medicare FQHC Limits x 125%.

This is a listing of the FQHCs that we perform a VT Medicaid Settlement for:

0000F02	Community Health Center
0001692	Community Health Center
0473811, 07, 05, 03	Northern Counties Health Care (7 sites)
0471808, 09	Northern Counties Health Care
1006335	Northern Counties Health Care
0007175	Northern Counties Health Care
0104229	Northern Counties Health Care
0000F04, 1006168,	Richford Health Center (formerly 473822) (4 sites)
0471811	Richford Health Center (d/b/a Swanton Health Center)
0471812	Richford Health Center (d/b/a Enosburg Health Center)
0471813	Richford Health Center (d/b/a Alburg Health Center)
0471818	Northeast Washington County Community Health (d/b/a The Health Center)
1006333	Northeast Washington County Community Health (d/b/a The Health Center)
0471819, 20, 21, 23	Copley Professional Services Group (Family Practice, Behavioral Medicine, Women's Health)
0471814, 15, 16	Community Health Centers of the Rutland Region (3 sites)
1013682	CHCRR Dental
1012615	Little Rivers Health Care
0301804	Ammonoosuc Community Health Services
0301819	Indian Stream Health Center

The data reports are located on the R drive at R:\Medicaid\VT\Data. There are usually three files for each provider number. The primary one we will use is named **Audit\_provnumb\_fyemoye**. The other two files have correct data for Charges, Other Insurance

Copays, and Payments, but the visit counts are incorrect. The state report counts treatments rather than visits. The files are saved in a text format, so they will need to be opened in excel to be useable.

In excel open the **Audit\_provnumb\_fyemoye** file as described previously. You will see a report like this:

ICN Number	Rec Rec Recl	ICN Detail	Procedure	Diagnosis	Claim Beg	Claim End	Paid Date	Billed Am	Allowed A	Copay Am	Other Insu	Paid Amount
1.02E+14 SL,CA 009-	1	T1015	7245	6/26/2006	6/26/2006	10/27/2006	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63	
1.02E+14 AT,JA 023-	2	T1015	3004	3/29/2006	3/29/2006	11/17/2006	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63	
1.12E+14 BIL,BEF 024-	1	92551	V202	4/18/2006	4/18/2006	8/25/2006	\$22.41	\$0.00	\$0.00	\$0.00	\$0.00	
1.12E+14 BIL,BEF 024-	1	T1015	V202	4/18/2006	4/18/2006	8/4/2006	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63	
1.12E+14 BIL,BEF 024-	2	99393	V202	4/18/2006	4/18/2006	8/4/2006	\$127.00	\$0.00	\$0.00	\$0.00	\$0.00	
1.12E+14 BIL,BEF 024-	3	90471	V202	4/18/2006	4/18/2006	8/25/2006	\$16.25	\$0.00	\$0.00	\$0.00	\$0.00	
1.12E+14 BIL,BEF 024-	3	90471	V202	4/18/2006	4/18/2006	10/13/2006	(\$16.25)	\$0.00	\$0.00	\$0.00	\$0.00	
4.02E+14 AD,MA 008-	1	T1015	29630	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63	
4.02E+14 AD,MA 008-	2	90805	29630	10/3/2005	10/3/2005	10/14/2005	\$115.00	\$0.00	\$0.00	\$0.00	\$0.00	
4.02E+14 BR,JES:014-	1	T1015	2967	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63	
4.02E+14 BR,JES:014-	2	90805	2967	10/3/2005	10/3/2005	10/14/2005	\$115.00	\$0.00	\$0.00	\$0.00	\$0.00	
4.02E+14 JO,PA 029-	1	T1015	29620	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63	
4.02E+14 JO,PA 029-	2	90805	29620	10/3/2005	10/3/2005	10/14/2005	\$115.00	\$0.00	\$0.00	\$0.00	\$0.00	
4.02E+14 KC,CA 572-	1	T1015	29620	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63	
4.02E+14 KC,CA 572-	2	90805	29620	10/3/2005	10/3/2005	10/14/2005	\$115.00	\$0.00	\$0.00	\$0.00	\$0.00	
4.02E+14 GH,KA 009-	1	T1015	29689	10/3/2005	10/3/2005	10/14/2005	\$0.00	\$109.63	\$0.00	\$0.00	\$109.63	
4.02E+14 GH,KA 009-	2	90807	29689	10/3/2005	10/3/2005	10/14/2005	\$163.00	\$0.00	\$0.00	\$0.00	\$0.00	

Note that I shrank the PHI info in columns B,C,&D. The line of information we are interested in is the ones with the payment (in this case \$109.63 per visit). We want to sort the data by Procedure code, and delete all the lines that do not have a payment in them (generally the paid claims will be a T-code number, but sometimes there are other paid claims). Next we sort by Claim Begin date. Then we want to split the data between pre & post 12/31 dates for proper cost reporting. Finally we want to count the visits. Since it is possible to have negative claims on the report (corrected bills & such) you can't just count the lines. If you add a column to the right of the spreadsheet labeled Visits and enter the formula =IF(O2>0,1,-1) (where O is the column with the paid amount in it) then copy that formula down; it will enter a 1 or a -1 as appropriate. Go to the end of the paid claims thru 12/31 & total the columns Allowed Amount, Copay, Other Ins, Paid Amount, and Visits. Then go to the bottom of the spread sheet & total the same for columns for claims after 12/31.

These Totals will be reported on the Cost Report W/S C lines:

Line 11 column 1 Total Visits – Visits thru 12/31

Line 11 column 2 Total Visits – Visits after 12/31

Line 17 Primary Payer Amount –Sum of the pre & post 12/31 **Copay & OI Amount.**

Line 25 Interim Payments – Sum of the pre & post 12/31**Paid Amount**

Line 24 Bad Debts – The State of VT uses this line to recognize the cost of Dental Services.

#### **VT Dental Settlements**

<u>Medicare #</u>	<u>Provider Name</u>	<u>Medicaid Dental #</u>
47-1814	Community Health Centers of the Rutland Region	1013682
47-1803	Northern Counties Health Center – Hardwick	1006335
47-1804	Northern Counties Health Center – Island Pond	1006335
47-1807	Richford Dental Center	1006168
47-1800	The Dental Center at CHCB – Burlington	0001692
47-1818	The Dental Unit at Plainfield Health Center	1006333

Note that effective for cost reporting periods starting on or after 01/01/06, the State of VT will pay the lower of cost or charges for Dental Services.

#### **VT Pharmacy Settlements**

<u>Medicare #</u>	<u>Provider Name</u>	<u>Medicaid Dental #</u>
47-1803	Northern Counties	0007175
47-1818	Cabot Health/ NE Washington	?