WORKSHEET S-10 AUDITS

FEBRUARY 2025

NORIDIAN HEALTHCARE SOLUTIONS

Elevating Operations, Enabling Care.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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- Noridian Medicare website
- CMS website

WEBINAR PROTOCOL

- Lines muted upon entry
- Must be logged into GoToWebinar to receive Continuing Education Unit (CEU)
  - Attend entire webinar
- Webinar questions
  - Keep questions to previous or current slide and scenarios not addressed
  - Unrelated questions or not a Noridian provider? Call Customer Service in your jurisdiction
- Audio or video issues
  - Check your internet connection and system requirements
- Webinar may be recorded
  - High-demand webinars available on website for future viewing

AGENDA

- Overview
- Listing Workbook and Questionnaire
- Transmittal 18
- Charity Care
- Top Findings 2024
- What’s New
- Resources and Reminders
- Questions

OVERVIEW

WHO COMPLETES WORKSHEET S-10

- Hospitals under Section 1886(d) of the Social Security Act
- Critical Access Hospitals (CAHs)
- Sole Community Hospitals (SCHs)
- Charity care, financial assistance policies (FAP), and bad debt
  - Completeness and accuracy
- May result in adjustments
- Exempt hospitals

TIMELINES – BROAD OVERVIEW

- Notification of audit and initial request
  - Subcontractor
    - Notification
  - Questions or Concerns?
    - S10@noridian.com
- Entrance conference
  - Shortly after initial documentation received
- Work completed
- Adjustments sent
  - Two-week adjustment review period
- Exit conference
  - Waived
  - Held
- Finalized

REGULATIONS

- Section 1886(r) of the Social Security Act
  - Adjustments to Medicare DSH Payments
- 42 CFR 412.106(f)-(h)
  - Empirically justified Medicare DSH payments, additional payment for uncompensated care, supplemental payment for Indian Health Service and Tribal hospitals and Puerto Rico hospitals
- Provider Reimbursement Manual (PRM) 15-2, Chapter 40, Section 4012
  - Worksheet S-10 – Hospital Uncompensated and Indigent Care Data

LISTING WORKBOOK AND QUESTIONNAIRE

PURPOSE

- Help providers pull proper data for S-10 audit listing
- Tells auditors how you generated data
- Sections
  - Total Charity Care
  - Patient Payments
  - Total Hospital Bad Debt
  - Attestations
- Optional, highly encouraged
  - Requested one week prior to scheduled entrance conference
  - Allows time for auditors to review and bring initial concerns or questions to entrance conference

TOTAL CHARITY CARE

- Submitted by all hospitals
- Charges written off for patients who meet hospital's charity care policy or FAP
- Only amounts patient is not financially responsible

PATIENT PAYMENTS

- Amounts previously claimed as charity
  - Worksheet S-10, line 20
  - Do not report in Worksheet S-10, line 22
- Column N
  - Payments this cost reporting period related to previous period charity care
  - Worksheet S-10, line 22
- Multiple write-off dates
  - Report as separate encounters

TOTAL HOSPITAL BAD DEBT

- Column Q – Total Hospital Bad Debt
  - Reflect all charity care for claim
    - Regardless of fiscal year
  - May not match amounts in line 20
    - Help explain adjustments for total charges

ATTESTATIONS

Health Resources and Services Administration (HRSA)

	A	B	C	D	E	F	G	H	I
1	Patients That Received Health Resources and Services Administration (HRSA)								
2	Administered COVID-19 Uninsured Program Payments Attestation								
3									
4									
5	Provider Name:		0						
6	Provider #:		0						
7	FYE:		1/0/1900						
8									
9									
10	On behalf of this provider and FYE noted above, I attest that we have excluded all patient encounters from our charity care and bad debt listings for uninsured patients that received HRSA administered COVID-19 Uninsured Program payments, as authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136).								
11									
12	Furthermore, I understand that under the terms and conditions of the HRSA-administered COVID-19 Uninsured Program, these payments are considered payment in full for such care or treatment and should not be claimed as uncompensated care on Worksheet S-10 of the Medicare Cost Report.								
13									
14									
15									
16									
17		Signature							
18									
19									
20									
21		Date							

Professional Fee and Physician Charges

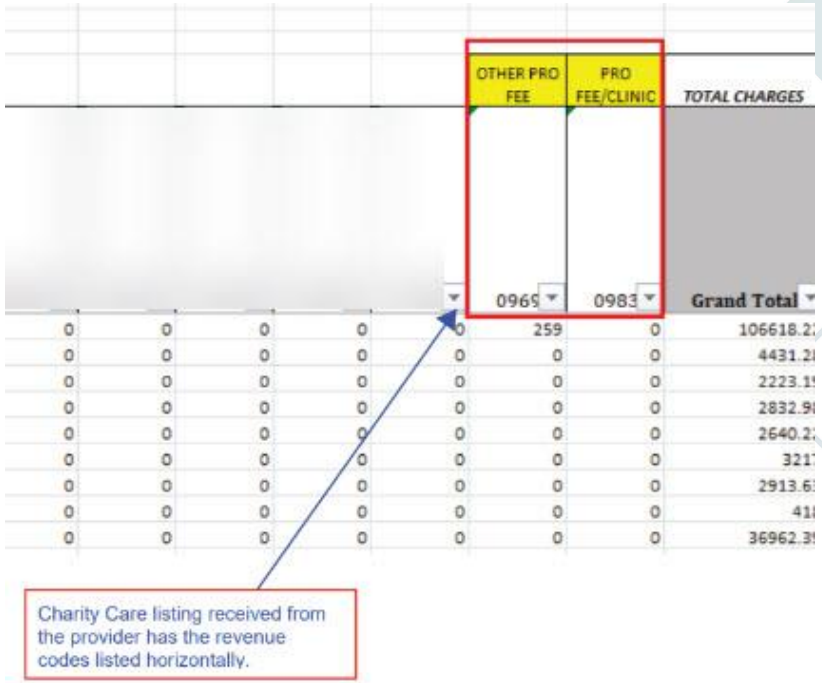
	A	B	C	D	E	F	G	H	I
1	Professional Fees/Physician Charges Attestation								
2									
3									
4	Provider Name:		0						
5	Provider #:		0						
6	FYE:		1/0/1900						
7									
8	On behalf of this provider and FYE noted above, I attest that professional fees/physician charges were tracked in a separate system from hospital charges.								
9									
10									
11									
12									
13		Signature							
14									
15									
16									
17		Date							
18									
19									

HRSA

- Claims with dates of service of 02/04/2020 through 03/22/2022
- Scrub listing to remove from the primary and secondary payor columns
  - Charity care and bad debt listings
- If HRSA pays
  - Considered payment in full

PROFESSIONAL FEES AND PHYSICIAN CHARGES IDENTIFICATION

- If not separately tracked
  - Calculated within the listing
    - Query logic encouraged for analyzing
    - Revenue code breakout



TRANSMITTAL 18

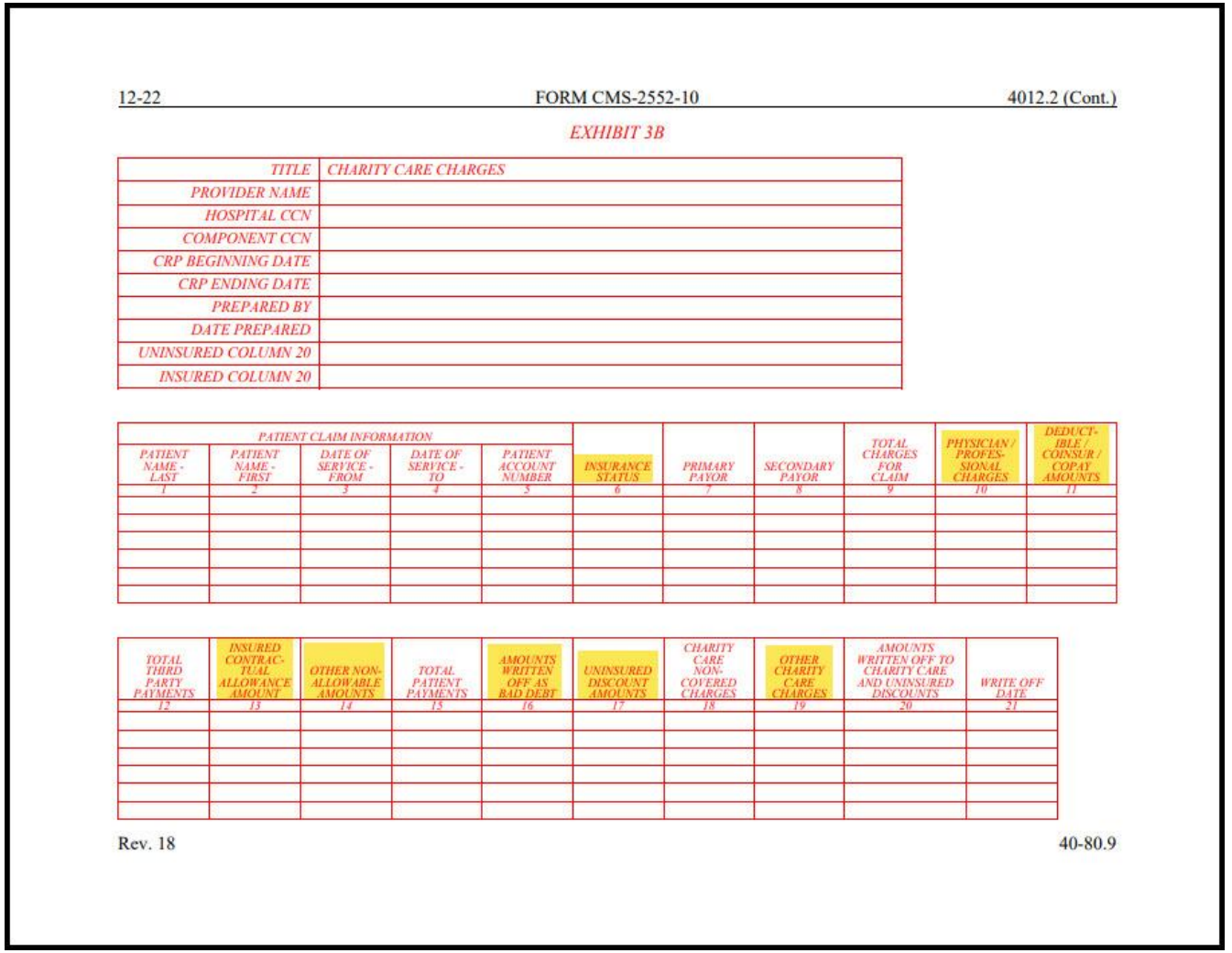
BACKGROUND

- Issued December 29, 2022
- Cost reporting periods beginning on or after October 1, 2022
  - CMS 2552-10
- Data requirement changes for
  - Medicare Disproportionate Share Hospital (DSH) reporting
  - Worksheet S-10 Uncompensated Care Cost reporting
  - Medicare bad debt reporting
- New Exhibits introduced
  - 3B and 3C relate to S-10

PRE-SUBMITTED QUESTION

- Q: What form will be used for audit submission, T18 or prior?
- A: Providers are expected to use the Transmittal 18 templates as they are the required CMS standard templates. We have updated our workpaper templates to match the CMS guidelines, providers who do not utilize the new templates may see a prolonged audit timeframe.

BLANK EXHIBIT 3B



12-22 FORM CMS-2552-10 4012.2 (Cont.)

EXHIBIT 3B

TITLE	*CHARITY CARE CHARGES*
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
UNINSURED COLUMN 20	
INSURED COLUMN 20	

PATIENT CLAIM INFORMATION										
PATIENT NAME - LAST	*PATIENT NAME - FIRST*	*DATE OF SERVICE - FROM*	*DATE OF SERVICE - TO*	*PATIENT ACCOUNT NUMBER*	*INSURANCE STATUS*	*PRIMARY PAYOR*	*SECONDARY PAYOR*	*TOTAL CHARGES FOR CLAIM*	*PHYSICIAN / PROFES-SIONAL CHARGES*	*DEDUCT-IBLE / COINSUR / COPAY AMOUNTS*
1	2	3	4	5	6	7	8	9	10	11

TOTAL THIRD PARTY PAYMENTS	*INSURED CONTRAC-TUAL ALLOWANCE AMOUNT*	*OTHER NON-ALLOWABLE AMOUNTS*	*TOTAL PATIENT PAYMENTS*	*AMOUNTS WRITTEN OFF AS BAD DEBT*	*UNINSURED DISCOUNT AMOUNTS*	*CHARITY CARE NON-COVERED CHARGES*	*OTHER CHARITY CARE CHARGES*	*AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS*	*WRITE OFF DATE*
12	13	14	15	16	17	18	19	20	21

Rev. 18 40-80.9

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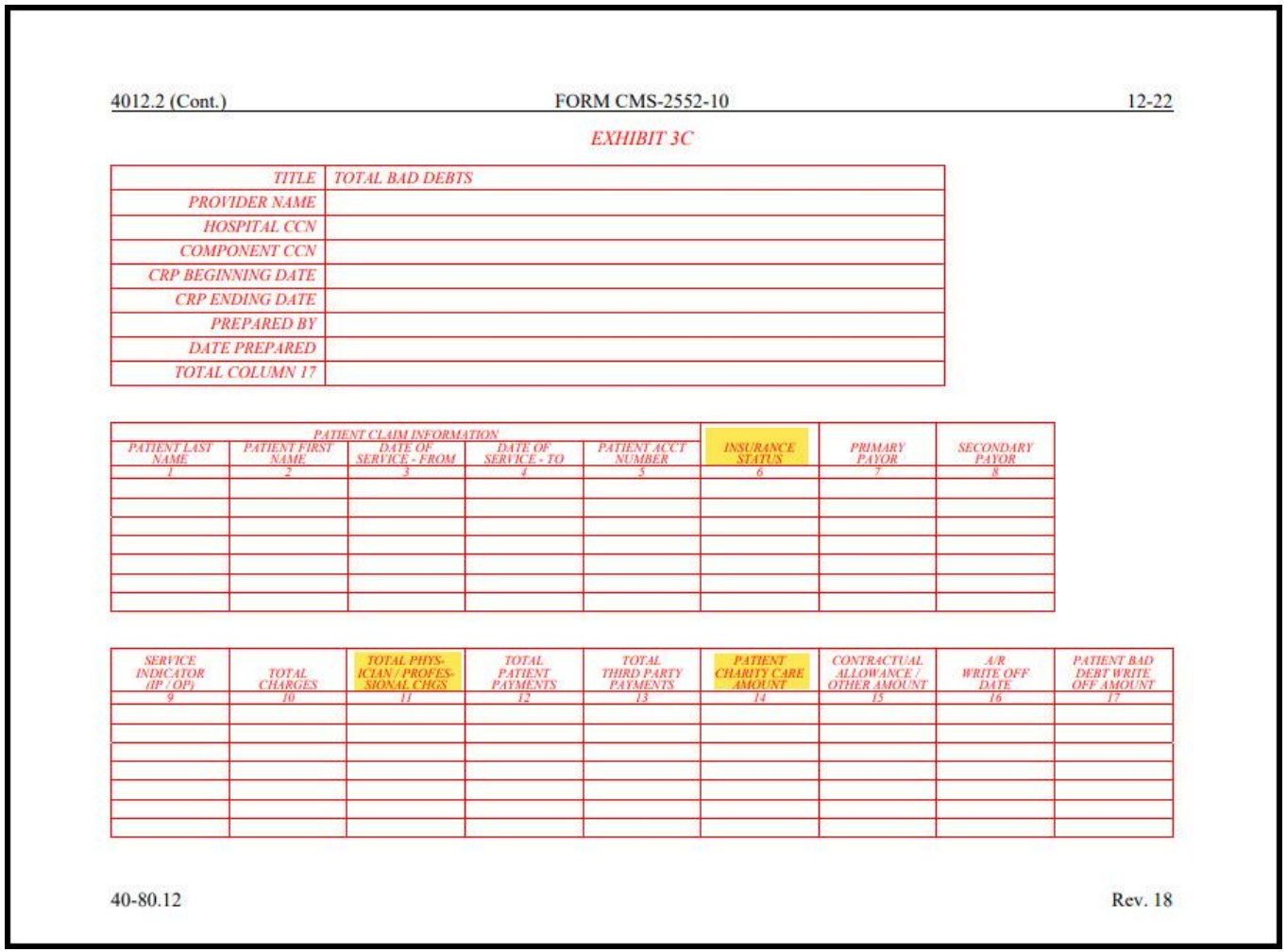
EXHIBIT 3B IMPORTANT COLUMNS

- 6 – Insured Status
  - 1 – Uninsured, no coverage
  - 2 – insured but not covered
    - No contractual relationship with company
    - Services medically necessary but not covered
    - Benefits exhausted
  - 3 – patient insured
- 10 – Physician and Professional Charges
  - Ensure no charity care charges included
- 11 – Deductible, Co-insurance, and Copay Amounts
  - Helps support insured vs. uninsured status
- 13 – Insured Contractual Allowance Amounts
  - Difference of what was billed and what insurance contractually pays post-deductible and co-insurance
- 14 – Other Nonallowable Amounts
- 16 – Amounts Written Off As Bad Debt
  - If duplicates
- 17 – Uninsured Discount Amounts
- 19 – Other Charity Care Charges

BLANK EXHIBIT 3C



4012.2 (Cont.) FORM CMS-2552-10 12-22

EXHIBIT 3C

TITLE	*TOTAL BAD DEBTS*
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 17	

PATIENT CLAIM INFORMATION							
PATIENT LAST NAME 1	*PATIENT FIRST NAME* 2	*DATE OF SERVICE - FROM* 3	*DATE OF SERVICE - TO* 4	*PATIENT ACCT NUMBER* 5	*INSURANCE STATUS* 6	*PRIMARY PAYOR* 7	*SECONDARY PAYOR* 8

SERVICE INDICATOR (IP / OP) 9	*TOTAL CHARGES* 10	*TOTAL PHYSICIAN / PROFESSIONAL CHGS* 11	*TOTAL PATIENT PAYMENTS* 12	*TOTAL THIRD PARTY PAYMENTS* 13	*PATIENT CHARITY CARE AMOUNT* 14	*CONTRACTUAL ALLOWANCE / OTHER AMOUNT* 15	*A/R WRITE OFF DATE* 16	*PATIENT BAD DEBT WRITE OFF AMOUNT* 17

40-80.12 Rev. 18

NORIDIAN HEALTHCARE SOLUTIONS

EXHIBIT 3C IMPORTANT COLUMNS

- 6 – Insurance Status
  - 1 – Uninsured, no coverage
  - 2 – insured but not covered
    - No contractual relationship with company
    - Services medically necessary but not covered
    - Benefits exhausted
  - 3 – patient insured
- 11 – Total Physician/Professional Charges
  - Ensure no charity care charges included
- 14 – Patient Charity Care Amount
  - If duplicates, able to trace that claim and patient with bad debt

PRE-SUBMITTED QUESTION 2

- Q: Should the Exhibit 3C S-10 total bad debt include Medicare bad debts that are already reported and submitted on Exhibit 2A?
- A: Yes. In the instructions it states to enter the amount of Medicare and non-Medicare bad debts/implicit price concessions written off during this cost reporting period for the entire facility. You would omit bad debts from physician and other professional services, amounts from line 20, and amounts for privately insured patients that were the obligation of an insurer rather than the patient.

KNOWLEDGE CHECK

- If you mark a patient as insurance status 3 on the exhibit templates, what does that mean?
  - Insured, but not covered
  - Insured
  - Uninsured

CHARITY CARE

DEFINITION

- Result of providing all or a portion of services free of charge
  - Can be full or partial discount
  - Meet charity care policy or financial assistance policy (FAP)
- Do not include discounts for ineligible patients
- Charity care
  - Not reimbursable
  - Not allowable Medicare Bad Debt
- See guidance in line 20 instructions

PRE-SUBMITTED QUESTION 3

- Q: We have a new home office; will that change anything with our charity care submission?
- A: There will be no change to how the charity care is submitted. It will still be submitted to the auditor as it has been in the past.

LINE 20

- Actual charge amounts for entire facility
  - Exclude physician and other professional services
  - For uninsured given discounts within charity care or FAP
  - Written off
- Do not include courtesy discounts
  - Or uninsured who do not meet criteria
- Can include non-covered services for Medicaid or other indigent care program
  - Must meet policy criteria

LINE 20, COLUMN 1

- Total charges or portion of total charges written off to charity care
  - Uninsured patients
  - No contractual relationship
- Charges for non-covered services for Medicaid or other indigent care program
  - Must meet policy criteria
- Charges patient is not financially responsible for

LINE 20, COLUMNS 2 AND 3

- Deductible and coinsurance payments required by payer
  - For insured patients with contractual relationship
  - Written off to charity care
- Non-covered charges for days exceeding length-of-stay limit
  - Medicaid or other indigent care program
    - If inclusion in is charity care policy or FAP, patient meets criteria
- No amounts included as Medicare Bad Debt
- Complete Lines 20 and 22 independently
- Column 3 = Column 1 + Column 2

PRE-SUBMITTED QUESTION

- Q: For claims where the patient is insured, but there is no insurance payment received, how do we go about completing line 20, column 2?
- A: Insured patients must have a demonstrated deductible, coinsurance, or copay amounts as supported by requested documentation, such as a Remittance Advice.

LINE 22

- All payments received during cost reporting period
  - Regardless of when for previous line 20 write offs
  - Do not include physician or other professional services
  - Column 1
    - Uninsured or no contractual relationship
  - Column 2
    - Contractual relationship
- Do not include grants or other mechanism of funding charity care, payments as patient liability, amounts not previously line 20 write offs

LINE 25 AND LINE 25.01

- Line 25 – Patient Days Beyond Length of Stay
  - Enter charges delivered covered by Medicaid or other indigent care program
  - Must match such charges in line 20, column 2
- Line 25.01 – Charges for Insured Patient's Liability
  - Corresponds to column 18 of Exhibit 3B
  - Also reported on line 20, column 2

TOP FINDINGS 2024

COMMON FINDINGS

- Missing columns on listings or improper listings
- Write Off Dates and Fiscal Years
  - Bad debt and charity care
    - Must be written off in current fiscal year being worked
    - Write off dates need to be addressed per account
      - No missing or blank columns with an asterisk (*) to indicate multiple write off dates

UNINSURED VS. INSURED RECLASSIFICATION

"Uninsured" is as follows:

- Uninsured charity care (full or partial charity write-offs);
- Non-covered services provided to Medicaid eligible and indigent care program patients written off to charity care (and meet charity care policy and FAP);
- Charity care for patients with coverage from an entity without a hospital contractual relationship (and meet charity care policy and FAP).

"Insured" is as follows:

- Deductibles and coinsurance under third party coverage (public or private insurer) written off to charity care.
  - Do not include deductibles and coinsurance claimed as Medicare bad debts.
- Non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs if included in hospital's charity care policy or FAP.

Note: *For an insured patient (including a Medicare beneficiary) that has exhausted their benefits or otherwise has a non-covered portion of the claim, any charges that were approved for charity care related to the non-covered service must be reported in line 20, column 1 (subject to the CCR). Any charity care approved deductibles and coinsurance related to the covered portion of the claim will be reported on line 20, column 2 (not subject to the CCR).*

PRE-SUBMITTED QUESTION 4

- Q: Why are auditors reclassing Insured accounts to Uninsured bucket if there are no third-party payments?
- A: CMS requires us to further review accounts claimed as Insured if there are no third-party payments (deductible, coinsurance, co-pay) to ensure that the accounts were properly reported as insured.
  - **Filling out the CMS Transmittal 18 exhibit templates accurately and correctly will assist in the process (Column 6 and 11 for Exhibit 3B, Column 6 for Exhibit 3C).**

DOCUMENTATION

- Commonly requested
  - Remittance Advices (RAs), account history, Explanation of Benefits (EOBs) or Explanation of Payment (EAP), documentation to support amounts claimed
    - Coinsurance amounts, deductible amounts, copay amounts to match listing and total amount claimed
- Documentation due dates
  - Initial request letter
    - Three weeks given to support documents
  - Additional documentation
    - Auditor will include deadline
- Missing documentation due dates
  - May lead to a delay to audit completion
  - Can lead to adjustments due to lack of documentation

POLLING QUESTION

- Having seen top findings and common adjustments, will this result in your facility making any changes in the future?
  - Yes
  - No
  - Unsure

WHAT'S NEW

CHARITY CARE AND TOTAL HOSPITAL BAD DEBT

- Allow provider to let them use the as-filed listing instead of having to submit a separate or revised listing
  - Can't say they want to make revisions a month later
- Common issues with as-filed listings
  - Missing or blank columns
    - Required information
  - Column titles not relevant to the S-10 review

POLLING QUESTION 2

- Does your facility anticipate on utilizing the as-filed listings for this year's S-10 audit?
  - Yes
  - No
  - Unsure at this time

SAMPLING AND INSURED ACCOUNTS

- Statistical sampling for audits
- Insured accounts with high dollar amounts
  - Verify proper claiming of insured accounts for deductible, coinsurance, and copay amounts only in listing preparation

PRE-SUBMITTED QUESTION 4

- Q: What does sample size and timing look like for this year's audits?
- A: We will be utilizing statistical sampling, and we will be asking more questions upfront to avoid delays further into the audit when a provider may be undergoing other audits or desk reviews, preparing for cost report submissions, or staffing shortages due to holidays and vacations.

RESOURCES AND REMINDERS

CONTACT INFORMATION

- S10@noridian.com
  - Questions specific to S-10
- Provider Contact Center
  - Jurisdiction E
    - 855-609-9960
    - Monday-Friday
      - 6AM – 5PM PT
  - Jurisdiction F
    - 877-908-8431
    - Monday-Friday
      - 8AM – 6PM CT

FORMS

- Noridian Medicare website > Audit and Reimbursement > Audit & Reimbursement Forms
  - Cost Report Extension Form
  - Cost Report Forms
  - Inpatient Rehabilitation Facility (IRF) Self-Attestation
  - Provider Audit Media Submission Form
    - Passwords to nhspass@noridian.com
  - Provider-Based Designation Checklist

AMENDED COST REPORT REMINDERS

- Include wage index and S-10 adjustments if completed
  - Work has already been completed
  - Shows most updated information
- Not accepted if
  - After desk review start date
  - Protest amounts differ from amounts on original submission
    - PRM 15-2, Chapter 1, Section 115
- One submission per cost reporting year

EDUCATION OPPORTUNITIES

- Critical Access Hospital Coverage
  - 2/20
- Part A Hospital Forms
  - 2/25
- Ask the Contractor Meeting (ACM)
  - 2/27
- Top Denials and Solutions – Q1
  - 3/18
- Registration
  - JE – Schedule of Events
  - JF – Schedule of Events

TAKE THE MAC CUSTOMER EXPERIENCE (MCE) SURVEY!

- **Did you know you can provide feedback for more than just the Education team?**
  - Noridian has surveys for: Appeals, Audit & Reimbursement, Contact Center, EDI, Education, Medical Review, Portal, Provider Enrollment and the Website

- View our You Spoke, We Listened webpage(s) to see a list of improvements we have made to our services based on your feedback!

SURVEY EMAIL EXAMPLE

Hello Claire,

We hope this email finds you well. Noridian recently completed a review of the cost report for [redacted]. Your opinion matters to us, and we would greatly appreciate your feedback on how we can improve our Audit and Reimbursement services. Please take 3-5 minutes to share your thoughts with us using the survey link below.

Share Your Thoughts

Please answer based on this specific review:
Provider Name: [redacted]
PTAN: [redacted]
Fiscal Year End: [redacted]

Noridian is committed to delivering the best possible experience to our customers, and your insights are crucial to achieving this goal. Every response is carefully reviewed and directly contributes to positive changes.

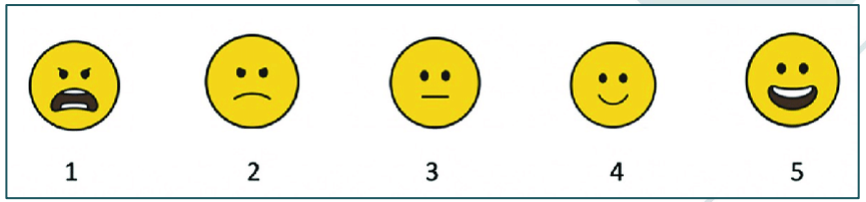
Thank you for your valuable feedback!

Best regards,
Noridian Customer Experience Team

Click to take your survey.

ALL MAC CUSTOMER EXPERIENCE (MCE) SURVEY

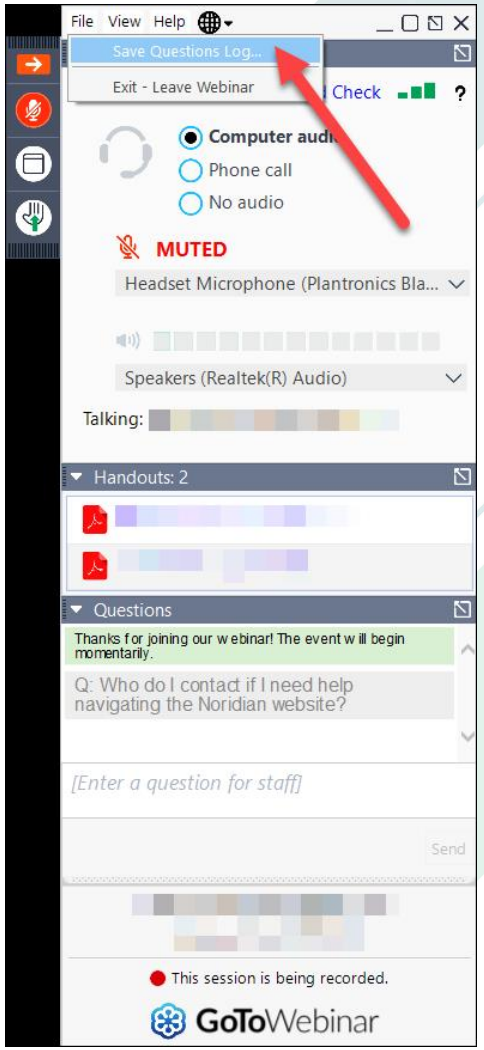
- POE Survey
  - Webinars (three chances!)
    - Via **QR code** below and last slide after Resources
    - Via automated email one hour after event
    - Via email with CEU within one business day of event
  - POE Webpages (Schedule of Events, ACM)
  - YouTube Tutorials
- Feedback Appreciated
  - Drive Change
  - Identify Best Practices
  - Every Result Reviewed



QUESTIONS?

ASKING QUESTIONS

- Verbal questions
  - Raise your hand using the green arrow
  - Lower your hand using the red arrow
- Written questions
  - Type into Questions field and click “Send”
- Ask same question only once
  - Either verbally or written
- Download the Q&A log
  - File > Save Questions Log
  - Must be using GoToWebinar on desktop



THANK YOU!

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

CLOSING REMINDERS

QUESTIONS

- Keep to slides provided
- Ask written or verbal
- No scenarios
- Lower hand when answered
- Unrelated questions? Call Customer Service in your jurisdiction
- Not a Noridian provider? Send questions to your respective MAC

CEUS

- Emailed within one day after the event
- Must attend entire webinar
- Telephone-only ineligible
- No index number for AAPC members
  - CMS/MAC Sponsored
- Not reissued for past events

SATISFACTION SURVEY

- Feedback is Appreciated
  - Emoji rating
  - Drive Change and Best Practices
  - Every Result Reviewed
- Scan the QR code below: