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J6 Audit & Reimbursement Update to the MN HFMA Regulatory Conference

November 2023

Introduction

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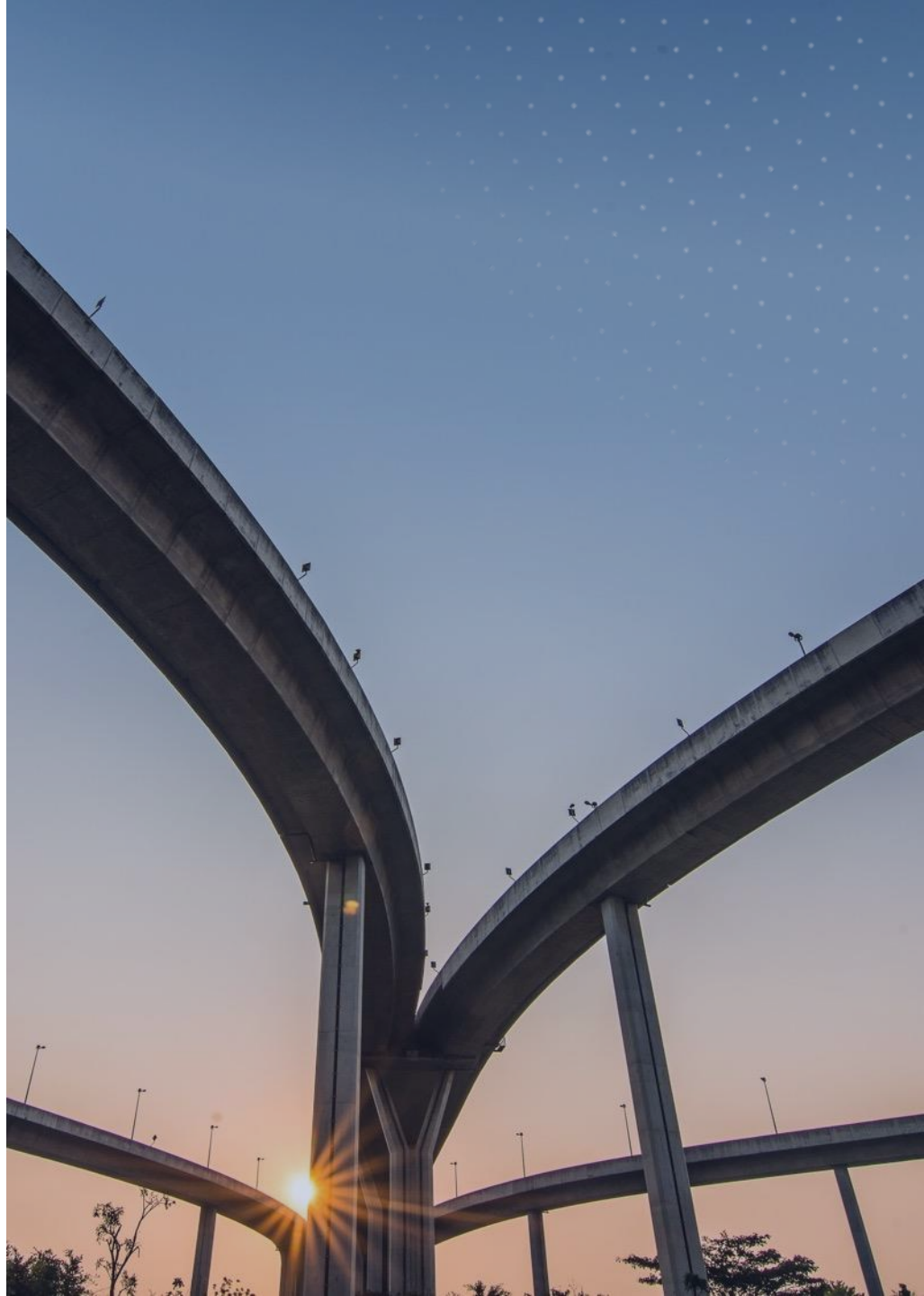


Cost Report Acceptance

Supporting Documentation Requirements

Supporting documentation requirements:

- FY 2019 IPPS Final Rule (8/17/2018) and MLN Matters SE19015 8/21/2019
- Implemented 12/31/2020 for cost reports with FYB 10/1/2018 and after
- When provider files cost report we will ensure required supporting documentation is also submitted. Will reject within 30 days if not received
  - IRIS Files – new XML format
  - Bad Debt Listings – amounts correspond to submitted cost report
  - DSH Listings supporting number of days – days correspond to submitted cost report
  - Charity Care Listings – amounts correspond to submitted cost report
- **Home Office Cost Reports** – we will ensure Home Office cost report was submitted (with NGS or other MAC)

Electronic Templates for Cost Report Exhibits

- CMS has published and uploaded ready-to-use documentation for the optional electronic specifications and templates to a new info page on CMS.gov: Electronic Cost Report Exhibit Templates
- The published specifications and templates support the Medicare Bad Debt Listing (across the various applicable cost report forms), and the Medicaid Eligible Days (Exhibit 3A , Charity Care Charges (Exhibit 3B), and Total Bad Debt (Exhibit 3C) exhibits for the 2552-10.
- If used in conjunction with e-filings in MCReF, providers can receive immediate feedback about potential issues with their listings, along with faster acceptance and tentative settlement.

New IRIS Requirements

Teaching hospitals – changes to IRIS

- FY 2022 IPPS Final Rule – 8/13/21 FR, Vol. 86, No. 154, pages 45311-45313
- New .XML format for cost reports beginning on/after 10/1/2021. CMS has finalized cost report instructions and specifications for the new format
- Approved XML IRIS Vendors:
    - Besler – iRotations
    - HFS – HFSSoft IRIS
    - MyEvaluations.com – MyGME
    - New Innovations
- Effective for cost reports beginning on/after 10/1/2022, IRIS IME and GME FTEs must correspond to what is reported on the cost report

Amended Cost Reports

Submitting an Amended Cost Report

- Include a cover letter that indicates what items were originally submitted on the as-filed cost report, what changed, and the reason for the change
- Amended cost reports must be received prior to the start of the desk review-see exceptions at www.ngsmedicare.com under Resources > Cost Reports
- Once received we will review the amended cost report for acceptability, subject to the same requirements for the as-filed cost report
- It may not be necessary to resubmit all of the original supporting documentation if no changes were made from the original filing

Submitting an Amended Cost Report

- Amended cost reports must be received prior to starting the desk review (Recommended no less than 30 days prior to projected start to allow for acceptance process to complete). Contact J6leads@anthem.com for status of desk reviews and projected start. Please note the following exceptions/details for PPS Hospitals:
    - One amended cost report for DSH can be submitted within 12 months of the original cost report due date.
    - Changes to w/s S-3 Pts II-V for wage index must be made by the CMS published wage index revision request deadline. Note: wage index changes, by the deadline, are not required to be furnished via formally amending the cost report.
    - Changes to w/s S10 should be made prior to the start of the w/s S10 audit. The updated listing can be submitted prior to amending the cost report.
        - Any changes to the S-10 data after our review has started requires NGS approval. Contact the assigned auditor(s) and the lead/manager.

MAC-Provider Communication

Cost Report Filing Resources

Questions:

J6_Cost_Report_Filing@anthem.com

Manager:

Bobbi.Jo.Luciano@elevancehealth.com

PS&R:

PSR@anthem.com

MCReF System Login:

https://mcref.cms.gov

Cost Report Mailing Addresses

NEW

Cost Report Address	Check Address
Street Address (FedEx/Courier) National Government Services, Inc Attn: Cost Reporting Unit 220 Virginia Ave Indianapolis IN 46204	**Street Address (FedEx/Courier)** US Bank Lockbox Services – J6 A Attn: Lockbox 809199 5635 South Archer Ave Chicago IL 60638
USPS Mailing Address National Government Services, Inc Attn: Cost Reporting Unit PO Box 7040 Indianapolis IN 46207-7040	**USPS Mailing Address** National Government Services US Bank Lockbox Services – J6 A PO Box 809199 Chicago IL 60680-9199

As-Filed Cost Report Overpayment and Extended Repayment Plans (ERS)

Providers wishing to request an ERS for an as-filed cost report overpayment:

- Indicate intent to apply for ERS in cover letter submitted with cost report
- Submit check copy and ERS Request to ERS mailbox, noting that the request relates to an As-Filed Cost Report
  - j6A.ers.requests@anthem.com
- When the cost report is accepted, A&R will include cover letter with the overpayment submission to Finance
- Demand letter will still generate, but payments will not be withheld while ERS request is being reviewed

NGSConnex A&R Inquiries

NGSConnex A&R Inquiries

- NGS A&R utilizes both 1-Way and 2-Way correspondence through NGSConnex. The A&R Inquiries function is used to communicate correspondence such as desk review documentation requests, final settlements, tentative settlements, interim rate review documents, and detailed PS&R reports. Multiple contacts can be designated to receive A&R correspondence per provider.
- It is very important to maintain your access to NGS Connex to receive this correspondence. It is also very important to review the documents upon receipt. If you miss a requested due date, we may move forward with our review without your documentation. When it relates to amounts due to Medicare, recoupment will automatically begin after the 15th day if no check is received.
- We have a dedicated shared email mailbox for inquiries related to using NGSConnex A&R Inquiries: ARConnex@Anthem.com. Please use this email address to update your contacts for A&R NGSConnex, such as when associates leave or when you have new associates.

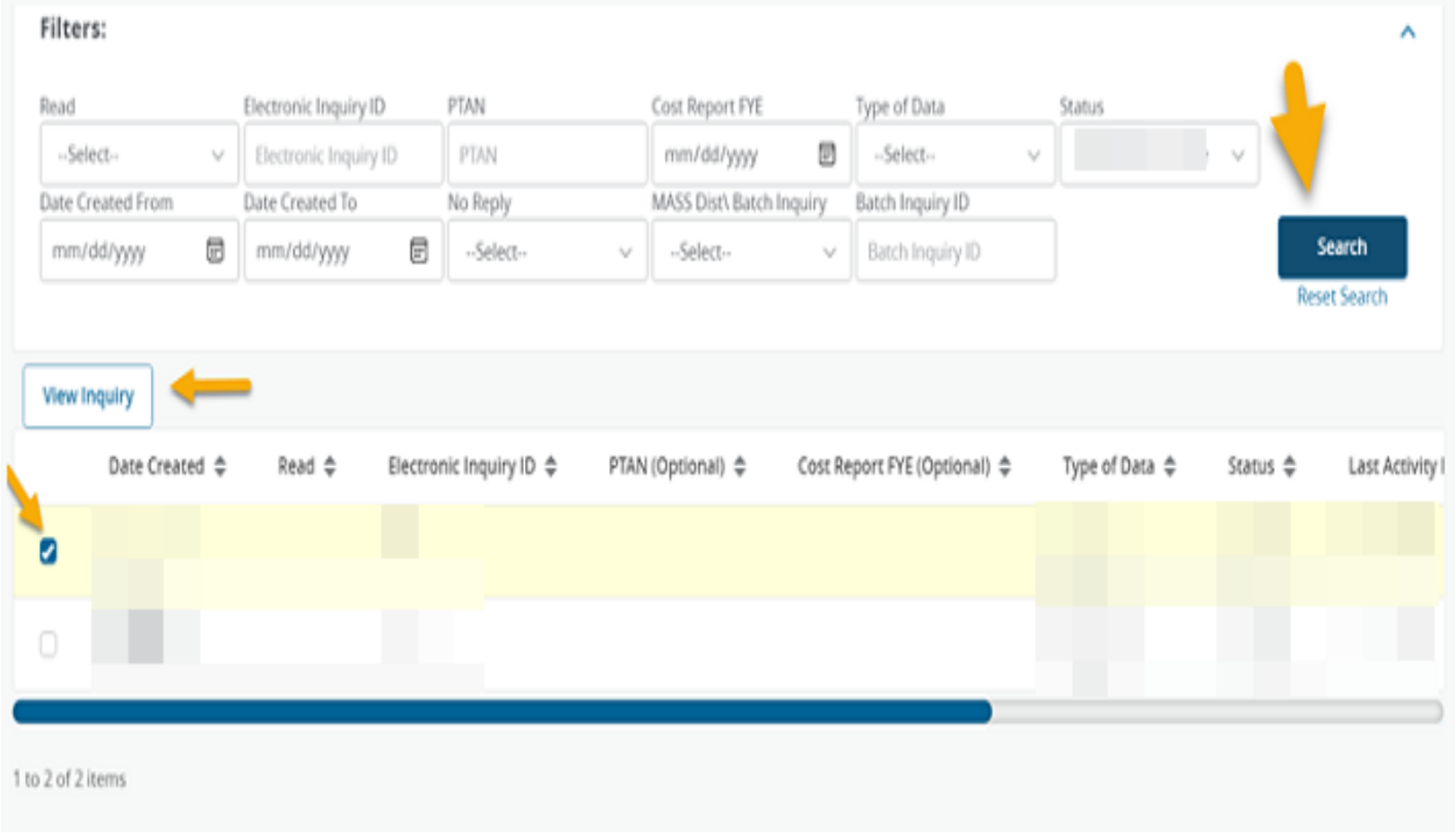
NGSConnex A&R Inquiries

- If the person you want to add already has an NGSConnex ID set up, your email should indicate their name, NGSConnex ID and the list of provider numbers to associate their ID with.
- If you want to add a consultant to the distribution, the provider should send an email to ARConnex@Anthem.com requesting the consultant's NGSConnex ID be added for their provider number. This request must come from the provider, not the consultant. We must have at least one provider contact if you are including a consultant in the distribution.
- To have a new NGSConnex contact set up for A&R Inquiries, send an email to ARConnex@anthem.com including the information below. A&R will establish an ID for them.
  - Designated Contact Name
  - Title
  - Phone Number
  - Mailing Address
  - Email Address
  - Provider Numbers Impacted
- The primary contact (to whom the letter is addressed) must be either the Authorized or Delegated Official from the current PECOS enrollment record, or a person designated by the Authorized/Delegated Official. To designate an alternate primary contact, an email request must be sent by the Authorized or Delegated Official of your facility.

2-Way vs 1-Way Connex

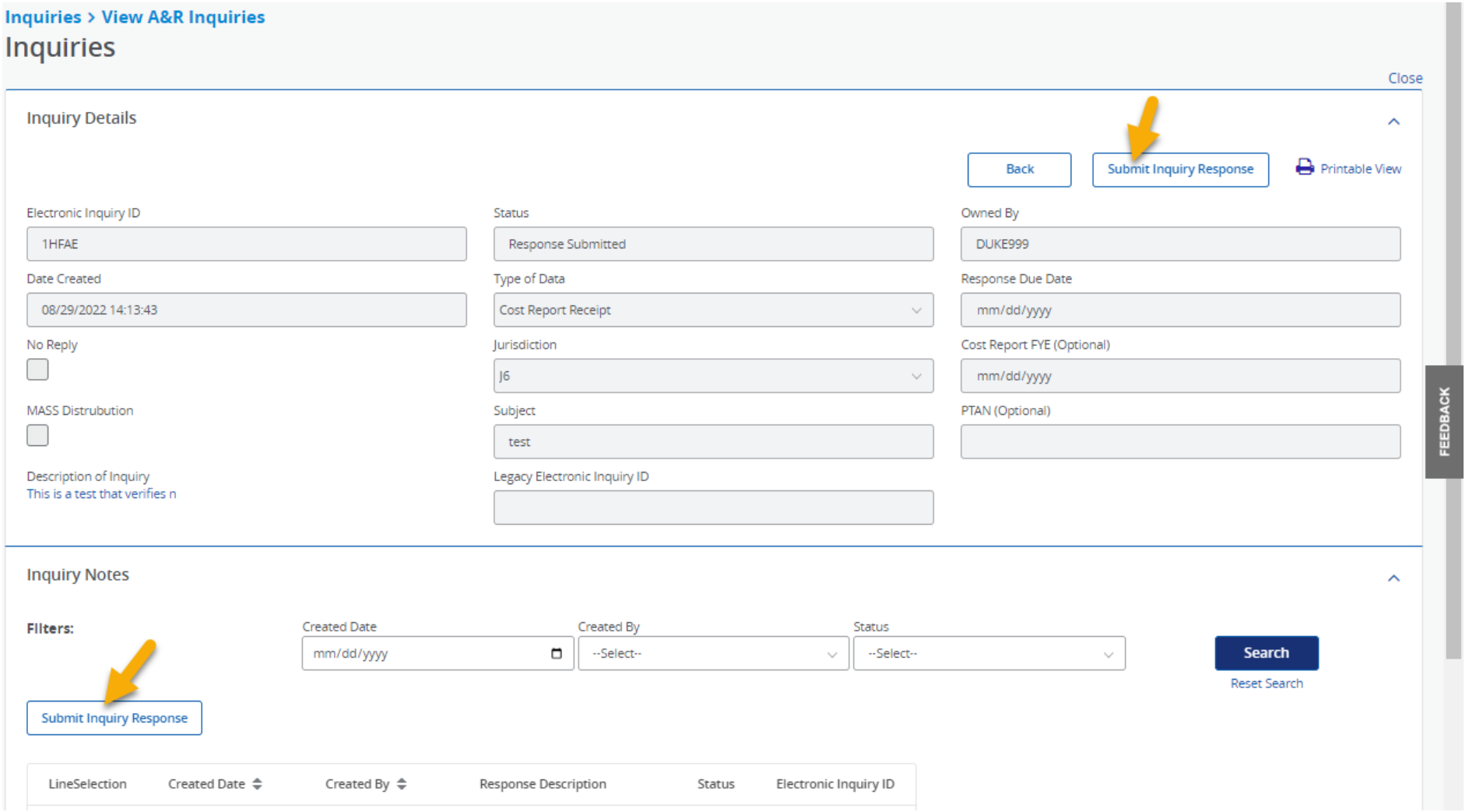
Use 2-Way Connex to find and respond to an inquiry from NGS

- Log into Connex and perform a search
- Click the checkbox and then “View Inquiry” to open it and respond, add attachments
- https://www.ngsmedicare.com/web/ngs/ngsconnex-user-guide



Using 2-Way Connex to Respond to NGS

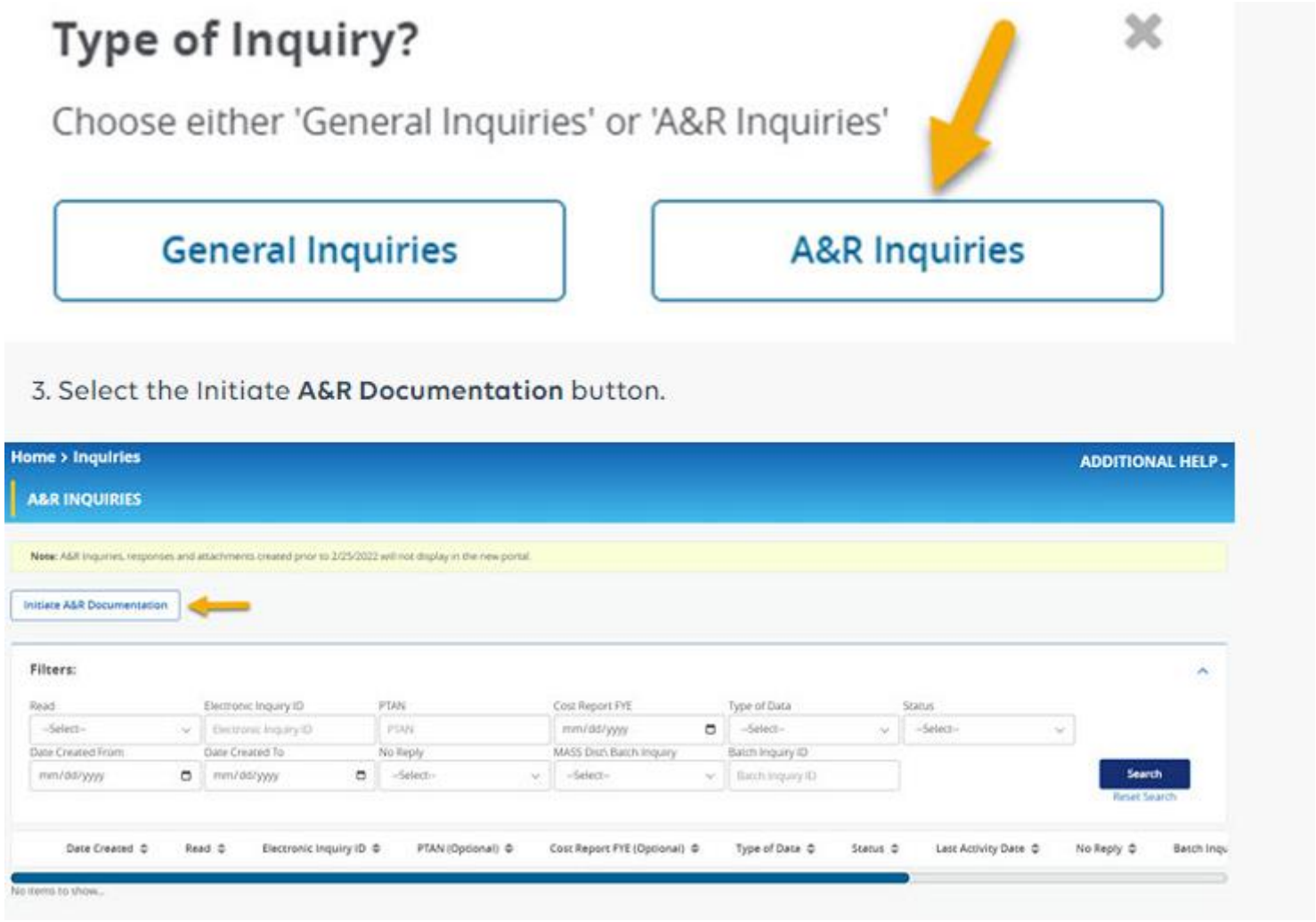
From the Inquiry Details screen find the Submit Inquiry Response button to add a response and add attachments if requested



1-Way Connex

Use one way Connex to start a <u>new</u> inquiry to submit files to NGS

- Inquiries may be sent to A&R by selecting the ‘Inquiries’ button on the NGSConnex homepage
- For ‘Type of Inquiry’ select ‘A&R Inquiries’
- https://www.ngsmedicare.com/web/ngs/ngsconnex-user-guide



Provider Statistical & Reimbursement Reports (PS&Rs)

PS&R Detail Policy

Each provider is allowed one PS&R detail request aligning with your current cost report year at no charge. We provide this to assist with cost report preparation. Any non-aligning or additional requests require the PS&R Detail Request Form and payment of $200.00 per request/year.

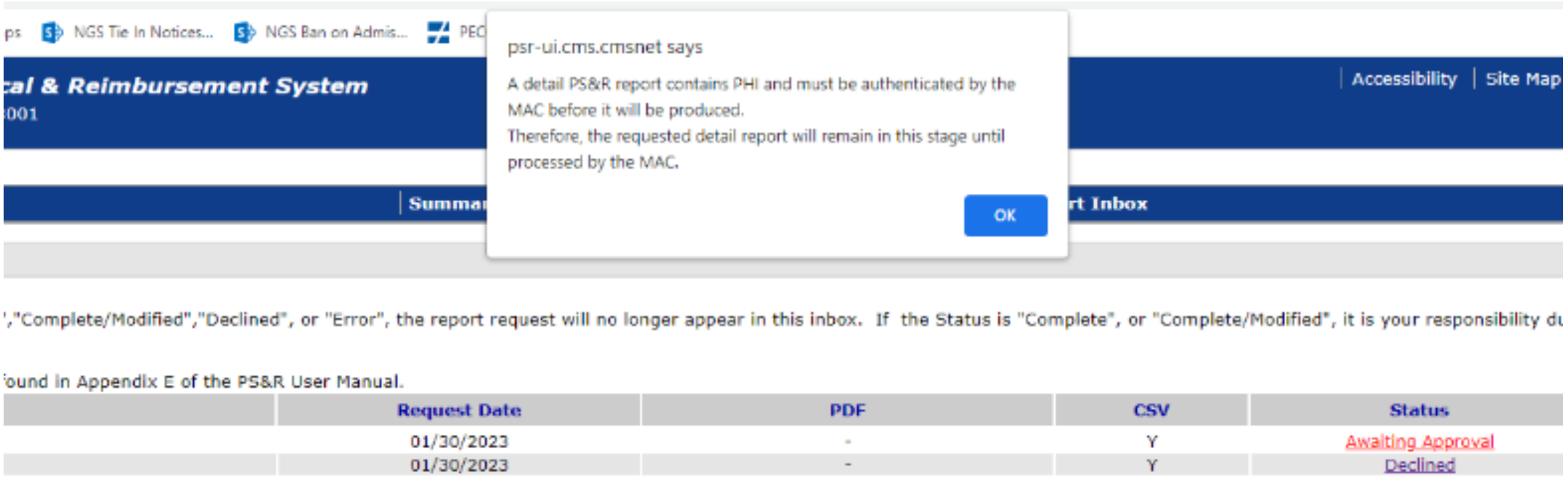
Download the request form from our website:

- NGSMedicare.com
- Resources menu, select Forms
- Cost Reports category
- Provider Request for PS&R Form

Mail the form and check in per the instructions on the request form. **To expedite the processing of your request, email a copy of the form and check to the PS&R mailbox below.** Ensure you enter your request into the PS&R redesign system for the same period as indicated on your request form.

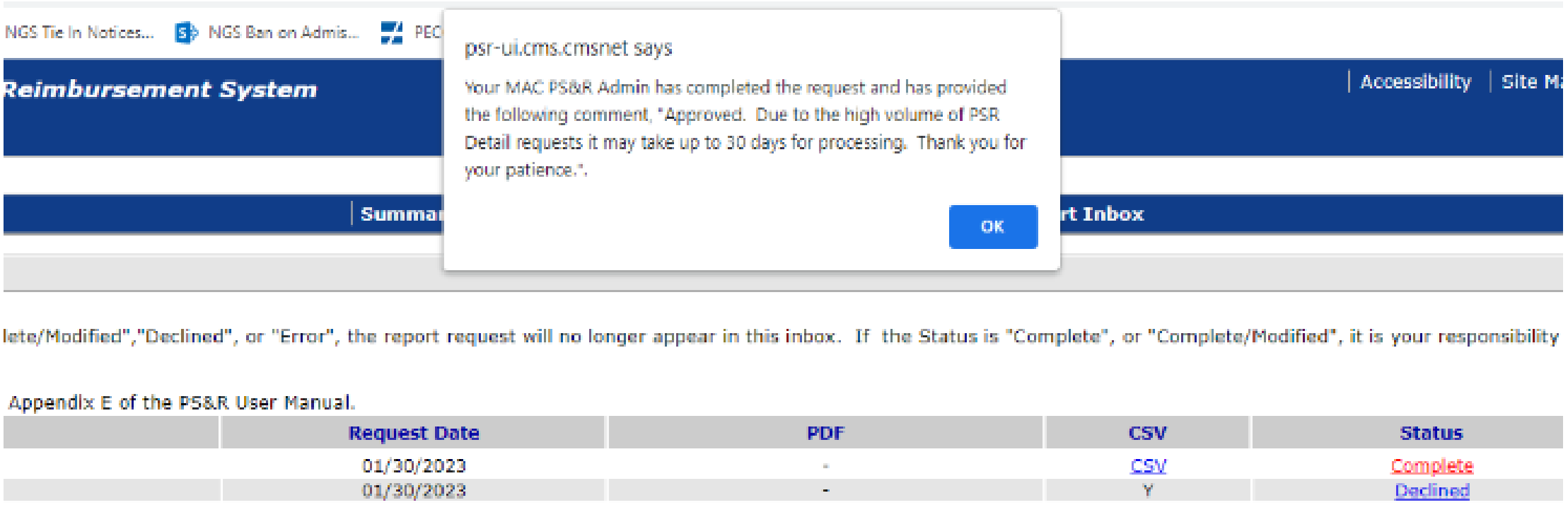
Please feel free to contact us at our email address: PSR@anthem.com

Check the status of your request

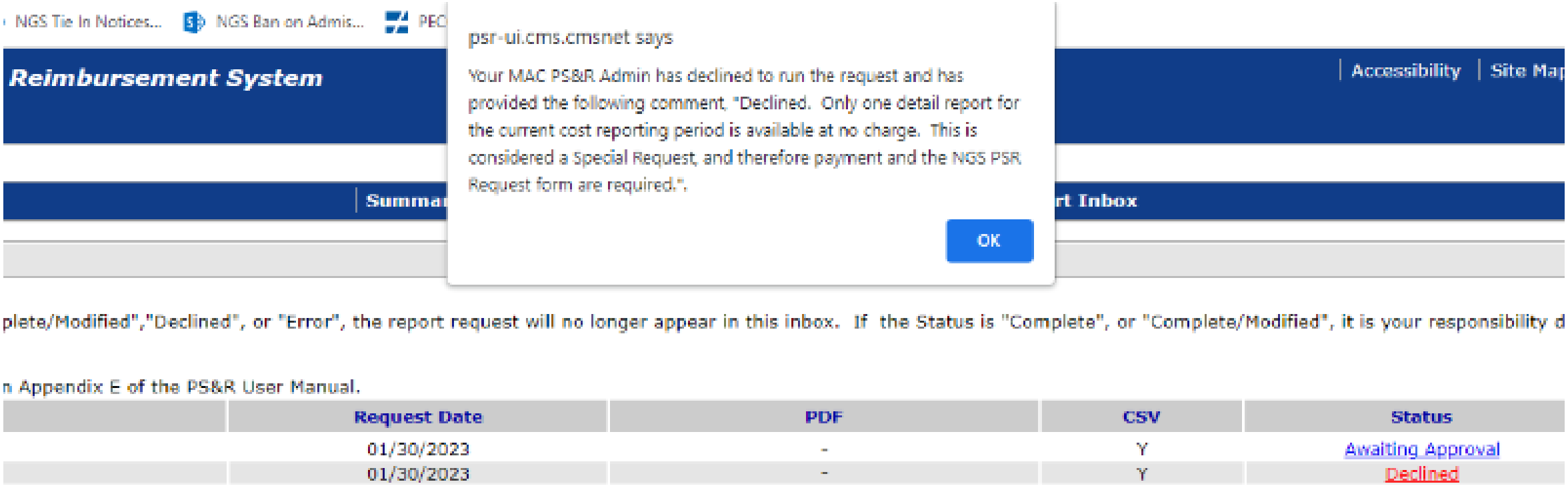


	Request Date	PDF	CSV	Status
	01/30/2023	-	Y	Awaiting Approval
	01/30/2023	-	Y	Declined

Approved Status



Declined Status



PIP/Pass Through Reports

- System generated based on Fiscal Year End and don't generate until the end of the month in which they receive their last payment applicable to that year.
  - Example, 12/31 FYE reports generate at the end of January and are not available until February.
  - Please wait until these reports are available to request via email to PSR@anthem.com.

Desk Reviews, Audits, and Final Settlements

J6 Hospital Cost Report Inventory – Minnesota

- 128 Minnesota hospitals
  - 47 Prospective Payment System Hospitals
  - 76 Critical Access Hospitals
  - 2 Long Term Care Hospitals
  - 0 Rehabilitation Hospitals
  - 1 Psychiatric Hospitals
  - 1 Childrens Hospitals

J6 Desk Review/Audit/Final Settlement Workload

OPTION YEAR 3: 8/1/2023 – 7/31/2024

Medicare Cost Report Workload

- Desk reviews (~1,700 targeted)
- Audits (~77 targeted)
  - Complete (~59 targeted)
  - Additional starts (~18 targeted)
- PPS Hospitals final settlement timeframes
  - FY 19 SSI: 100% NPR'd by 12/31/2023*
  - FY 20 SSI: 75% NPR'd by 3/31/2024*
    100% NPR'd by 9/30/2024*
- All other final settlement timeframes
  - Generally to be final settled within 16-18 months from initial cost report acceptance*

**Unless going to audit, on a currency plan, or on hold*

S-10 Audits

S-10 Update: Background

- Audits of DSH S-10 data were performed on FY 2015, FY 2017, FY 2018, FY 2019 and most recently FY 2020 data.
  - FY 2018 – All providers qualifying for DSH on E Part A were audited
  - FY 2019 - All providers qualifying for DSH on E Part A were audited
  - FY 2020 – All providers qualifying for DSH on E Part A were audited
  - FY 2021 – All providers qualifying for DSH on E Part A are being audited

S-10 Audits: 2023

- All providers qualifying for DSH again selected for S-10 Audit in 2023
  - FYE 2021 data will be reviewed (09/30/21s, 12/31/21s, 06/30/22s)

- NGS has 194 audits to complete in J6 using CMS developed Audit Program
  - 44 MN providers being audited this year (45 providers in 2022).
  - Figliozzi & Co. is being utilized again as a subcontractor to complete about 16% of the audits with NGS staff completing the other 84% in total for MN providers.
  - NGS letters were emailed to all providers during the last week of February or the first week of March, 2023.
  - Audit exit conferences will be more evenly spread out throughout the year, with some much earlier in the year, which should alleviate pressure on providers.

S-10 Audits: Initial Requests

Request letter looking for the following items:

A. Copy of the provider's charity care policy and Financial Assistance Policy (FAP)

B. Copy of Audited Financial Statements and/or Working Trial Balance for period under review

C. Reconciliation of total hospital bad debts claimed on S-10 Line 26 to the FS and or WTB

D. Detailed listing of hospital's transaction codes along with descriptions and explanations

E. Detailed query logic – how did the provider determine account to be included?

F. WTB/AFS reconciliation to Worksheet C Charges.

G. Detailed patient listings of charity care, patient payments, and total hospital bad debts

- Name, DOB, Social Security #, Admit/Discharge Dates, Primary/Secondary Payors, Revenue Codes, Patient Payments, Third party payments, Contractual amounts, Date of Write off, Non Covered Charges

S-10 Audits

Audits will focus mainly on Lines 20, 22 and 26 of W/S S-10

- Line 20 – Charity Care Charges will be reconciled between cost report and submitted listings
  - Review providers Query Logic for Line 20
  - Review Charity policies and/or Financial Assistance Policies (FAPs) – Providers must be following their policy and policy must be for cost reporting period
  - Recommending providers to submit one excel spreadsheet with one tab that reconciles to line 20 or that we will adjust to at audit
  - Review for transaction codes/adjustment codes to ensure charity codes
  - Bad debts claimed on E Series cannot be included on S-10 Line 20
  - Ensure all charity claims were written off in the current year

S-10 Audits

Line 20 – Charity Care Charges will be reconciled between cost report and submitted listings (continued):

- Ensure no physician/professional fees have been included (listings should contain columns for Rev codes unless physician/professional fees are captured in a separate system). Attestation alone that they are not included is not enough. We will need transaction codes as well associated with physician/professional fees
- Review for duplicates within the listing
- Included in the correct column for insured vs. uninsured
- HRSA/COVID payments cannot be included on Line 20

S-10 Audits

Line 22 – Payments Received from patients will be reconciled between cost report and submitted listings

- **Payments should be for amounts previously written off as charity care**
- **If recovery occurs in current year it should be offset and only remaining balance claimed on Line 20 in the current year**

Line 26 – Total Bad Debt Expense will be reconciled between cost report and submitted listings

- **Review providers query logic**
- **Recommending providers to submit one excel spreadsheet with one tab that reconciles to line 26 or that we will adjust to**
- **Medicare bad debts are to be included in the line 26 listing**
- **Recoveries should be netted**

S-10 Audits

Line 26 – Total Bad Debt Expense (continued)

- **No Physician or professional fees should be included**
- **Only amounts owed by patients should be included-no 3rd party liabilities should be included**
- **All claims are to be written off in the current year**
- **No duplicates**

S-10 Audits: Samples

- Initial review will consist of a thorough review of the listing and bring potential issues to the surface to address with providers.
    - Providers may need to submit revised listings as part of this process
- Samples will then be selected and reviewed
- Entire patient account detail with the total charge, contractual amount and write off amount identified
- Patient account should include and identify dates of when transactions occurred and the type of charges being written off (i.e. deductible, coinsurance, uninsured charges, non-covered charges, courtesy discounts and professional fees)
- Complete Charity Care application and approval
- UBs
- All EOBs
- A copy of the signed financial/charity application
- Proof charity care policy was met
- Timely submission of sampled documentation is very important to allow proper time to review

Wage Index/Occupational Mix

FY 2025 Wage Index

- **September 1, 2023**
  - **Deadline for hospitals to request revisions to their Worksheet S-3 wage data and CY 2022 occupational mix data as included in the wage and occupational mix preliminary PUFs, and to provide documentation to support the request. MACs must receive the revision requests and supporting documentation by this date. MACs will have approximately 10 weeks to complete their reviews, make determinations, and transmit revised data to CMS's Division of Acute Care (DAC).**
- **November 3, 2023**
  - **Deadline for MACs to notify State hospital associations regarding hospitals that fail to respond to issues raised during the desk reviews. The purpose of the letter is to inform the State association and its member hospitals that a hospital's failure to respond to matters raised by the MAC can result in lowering an area's wage index value and, therefore, lower Medicare payments for all hospitals in the area.**
- **November 15, 2023**
  - **Deadline for MACs to complete all desk reviews for hospital wage data and transmit revised Worksheet S-3 wage data and occupational mix data to DAC. Worksheet S-3 wage data must be sent to DAC in electronic format (HCRIS hdt format). Occupational mix data must be sent to DAC on the Excel spreadsheet provided by DAC for specific use by MACs.**

FY 2025 Wage Index

- **January 31, 2024**
  - **Release of revised FY 2025 wage index and occupational mix files as PUFs on the CMS Web site. These data will have been desk reviewed and verified by the MACs before being published. Also, a file including each urban and rural area's average hourly wages for the FYs 2024 (final) and 2025 (preliminary) wage indexes will be provided on the CMS Web site.**
- **February 16, 2024**
  - **Deadline for hospitals to submit requests (including supporting documentation) for:**
  1. **Corrections to errors in the January PUFs (wage index S-3 wage data and occupational mix) due to CMS or MAC mishandling of the wage index data, or**
  2. **Revisions of desk review adjustments to their wage index and occupational mix data) as included in the January PUFs (and to provide documentation to support the request).**
  - **MACs must receive the requests and supporting documentation by this date. No new requests for wage index and occupational mix data revisions will be accepted by the MACs at this point, as it is too late in the process for MACs to handle data that is new in a timely manner.**

FY 2025 Wage Index

- **March 20, 2024**
  - **Deadline for the following:**
  1. **MACs to transmit final revised wage index data (in HCRIS hdt format) to DAC for inclusion in the final wage index. Worksheet S-3 wage data must be transmitted in HCRIS hdt format. Occupational mix data must be sent to DAC on the electronic Excel spreadsheet provided by DAC for specific use by MACs. All wage index data revisions must be transmitted to DAC by this date.**
  2. **MACs must also send written notification to hospitals regarding the status of the hospitals' February 16, 2024 correction/revision request(s) by this date.**

FY 2025 Wage Index

- **April 3, 2024**
  - **Deadline for hospitals to appeal MAC determinations and request CMS' intervention in cases where the hospital disagrees with the MAC's determination. It should be noted that during this review, CMS does not consider issues such as the adequacy of a hospital's supporting documentation, as CMS believes that the MACs are generally in the best position to make evaluations regarding the appropriateness of these types of issues (which should have been resolved earlier in the process). The request must include all correspondence between the hospital and MAC that documents the hospital's attempt to resolve the dispute earlier in the process. Data that was incorrect in the preliminary or January wage index data PUFs, but for which no correction request was received by the February 16, 2024 deadline, will not be considered for correction at this stage.**
  - **Hospitals must submit appeals with all supporting documentation for the FY 2025 wage index cycle via the Wage Index Appeals (WIA) module in the Medicare Electronic Application Request Information System (MEARIS) at https://mearis.cms.gov. To ensure compatibility with MEARIS, supporting documentation shall preferably be PDF or Word files and spreadsheets shall be in Excel. If a hospital is unable to submit an appeal via MEARIS, for FY 2025 the hospital may submit via email to wageindexreview@cms.hhs.gov.**

FY 2025 Wage Index

- **April 3, 2024**
  - **Deadline for hospitals to dispute data corrections made by CMS of which the hospital is notified after the January 31, 2024 PUF and at least 14 calendar days prior to April 3, 2024 (i.e., March 20, 2024), that do not arise from a hospital's request for revisions. CMS and the MACs must receive requests with complete documentation by this date.**
  - **Hospitals must submit appeals with all supporting documentation for the FY 2025 wage index cycle via the Wage Index Appeals (WIA) module in the Medicare Electronic Application Request Information System (MEARIS) at https://mearis.cms.gov. To ensure compatibility with MEARIS, supporting documentation shall preferably be PDF or Word files and spreadsheets shall be in Excel. If a hospital is unable to submit an appeal via MEARIS, for FY 2025 the hospital may submit via email to wageindexreview@cms.hhs.gov.**

FY 2025 Wage Index

- **April/May 2024**
  - **Approximate date proposed rule will be published; includes proposed wage index, which is calculated based on the revised wage index data through the end of February; 60-day public comment period and 45-day withdrawal deadline for hospitals applying for geographic reclassification.**
- **Early April 2024**
  - **Notice sent from CMS to each MAC regarding the April 29, 2024, release of the final FY 2025 wage index data PUFs and the May 27, 2024, deadline for hospitals to request corrections to the wage and occupational mix data as reflected in the final files.**

FY 2025 Wage Index

- **Early April 2024**
  - **Notice must be forwarded by MACs to hospitals they service to alert hospitals to the availability of the final wage index and occupational mix data files for their review in the April 29, 2024 PUF, and to inform hospitals that this will be their last opportunity to request corrections to errors in the final data. Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review of the final April PUFs. Data that was incorrect in the preliminary or January wage index data PUFs, but for which no correction request was received by the February 16, 2024 deadline, will not be considered for correction at this stage.**

FY 2025 Wage Index

- **April 29, 2024**
  - **Release of final FY 2025 wage index and occupational mix data PUFs on CMS Web page. Hospitals will have approximately 1 month to verify their data and submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data.**
- **May 29, 2024**
  - **Deadline for hospitals to submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data as posted in the April 29, 2024 PUF. Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review of the final April PUFs. CMS and the MACs must receive all requests by this date.**

FY 2025 Wage Index

- **August 1, 2024**
  - **Approximate date for publication of the FY 2025 final rule; wage index includes final wage index data corrections.**
- **October 1, 2024**
  - **Effective date of FY 2025 wage index.**

Medicare Cost Report Reopenings & Appeals

Reopenings

- NGSMedicare.com – Cost Reports – Submitting a Cost Report Reopening
  - Includes guidance on what to include in the request
  - Includes guidance on how NGS evaluates reopening request
- Preferred Method of sending Reopening requests or Reopening inquiries: cost.report.reopenings@anthem.com
- Reopenings for DSH (SSI realignments, paid/eligible days) for any cost reporting period that includes 9/30/2013 and prior is on hold – No NPR or RNPR will be issued
  - Work is being completed, when able, but RNPR will not be issued
- Closing out aged inventory
  - If any hospitals have pending reopenings with NGS and you need a status or have not heard from us in some time; please reach out with an email to the Reopening mailbox - cost.report.reopenings@anthem.com

Reopenings

Reopening guidance:

- **The cover letter or the body of the email should contain:**
  - Medicare provider name, six-digit provider number and cost report fiscal year end.
  - Clearly specify the issue requested to be reopened, the reason, and why it is believed to meet the conditions to qualify for a reopening.
  - Include the estimated reimbursement dollar impact.
  - Include the specific requested adjustments to the cost report (i.e. worksheet, line, column and amount for each adjustment.
- **Be prepared to supply any supporting documentation within 30-60 days from initial request**
  - **Failure to do so could result in a denial of the reopening**

Reopenings

- **CR 13337 – Revision to Implementation of Consolidated Appropriations Act (CAA) of 2023, Section 4143**

  - **Waiver of Cap on Annual Payments for Nursing and Allied Health Education Payments**
  - **This CR supersedes the calculations previously specified under CR 13122, in order to adjust certain payments made under CRs 11642, 12586 and 12407.**
  - **This CR conforms to revised policy issued on August 1, 2023 in FY 2024 IPPS/LTCH PPS final rule**
  - **Eligible hospital must be receiving MA NAH and Part A NAH pass-through payments on an interim basis on the date of enactment (December 29, 2022)**

  - **All reopenings will be contractor initiated and the work completed by March 19, 2024**

Appeals

- Similar to Reopenings, Appeals for DSH (most are paid/eligible days) for any cost reporting period that includes 9/30/2013 and prior is still on hold – No NPR or RNPR will be issued
  - Work is being completed, when able, but we cannot enter into Administrative Resolutions and an RNPR will not be issued.

- On June 9, 2023, CMS issued Final Rule regarding the treatment of Medicare Part C days in the calculation of a hospital‘s Disproportionate Patient Percentage (DPP)
  - The final rule establishes a policy concerning the treatment of patient days associated with persons enrolled in a Medicare Part C plan for purposes of calculating a hospital's DPPP for cost reporting periods starting before fiscal year 2014 in response to the Supreme Court’s ruling in *Azar v. Allina Heath Services*, 139 S. Ct. 1804 (June 3, 2019).
  - A patient enrolled in a Part C (Medicare Advantage) plan remains entitled to benefits under Medicare Part A, and patient days associated with that patient should be counted in the Medicare fraction of the DPP and not in the numerator of the Medicaid fraction.
  - The Secretary has determined that in order to comply with the statutory requirement to make DSH payments it is necessary for CMS to engage in retroactive rulemaking to establish a policy specifically governing the treatment of Part C- Medicare Advantage patient days. The Secretary has determined that it is in the publics best interest for CMS to adapt retroactive policy in order to calculate DSH payments for hospitals that have not received payments due to the cost report hold.
  - The policy is effective August 8, 2023.
  - MACs are awaiting final instructions from CMS with regard to this Final Rule.

Appeals

- Current hot topic in Appeals: Substantive claim - 42 C.F.R. § 405.1873 dated 11/13/2015
  - Effective for cost reports beginning on or after 1/1/2016, in order to document dissatisfaction with a final determination, the Provider must document its dissatisfaction through a substantive claim on the cost report associated with the appeal.
  - A substantive claim is similar to a protested item, in that the Provider must claim an estimated reimbursement amount related to an issue that the MAC has no authority to grant relief (i.e. SSI%, Part C, IPPS Standard Discharges, Outliers, ATRA, etc.), in order to show its dissatisfaction related to that particular issue.
  - For Providers, it is important to note the requirements of 42 C.F.R. § 413.24(j) in order to properly self-disallow a specific item.
    - The provider must include an estimated reimbursement amount for each specific self-disallowed item in the protested amount(s) on the provider's cost report.
    - The Provider must provide a separate explanation explaining why the provider self-disallowed each item.
    - The Provider must include an explanation of how the estimated reimbursement amount for each of the item(s) self-disallowed was calculated.
  - It is also important to note that the appropriate claim for a specific item must be determined by reference to the Provider's most recently submitted and accepted cost report.

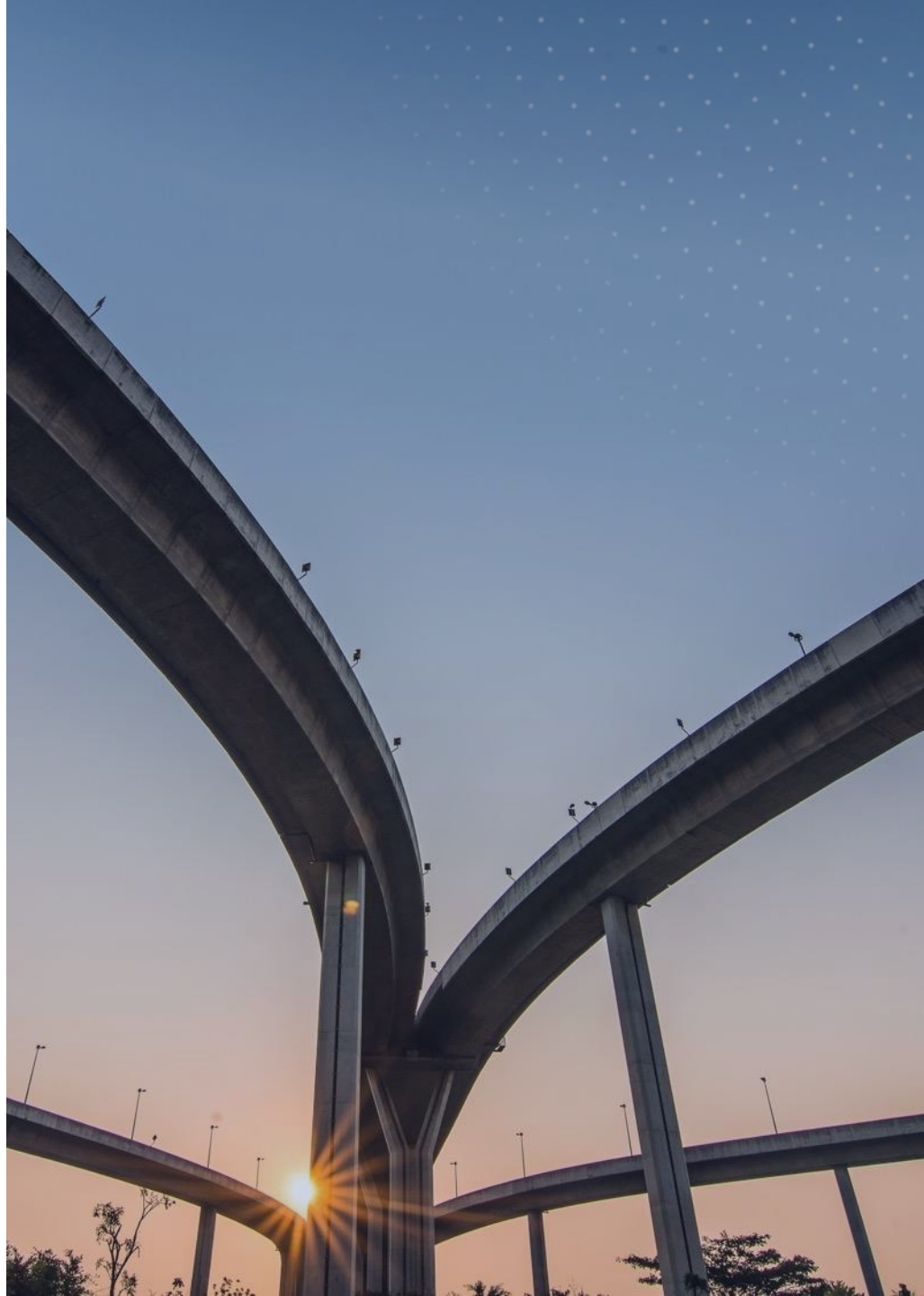
Miscellaneous Contact Information

Subcontractors

Systematic Medical Billing & Credentialing Services, Inc. – NGS subcontracts to complete MSP Audits. Uses secure portal called ShareFile for documentation. Hospitals will need to set up a login.

Figliozzi & Company – Cost Report Audits and S-10 Audits

CMS Contractor – Myers & Stauffer LLC – Intern and Resident Duplicate Review. IRISDuplicates@mslc.com



national government SERVICES

Standard Mailboxes and Contact Info

J6 Provider Contact Center: 1-877-702-0990

Other Contact Information on our website:

www.ngsmedicare.com

Standard Email Boxes for J6 Medicare Part A Audit & Reimbursement:

Cost Report Filing: J6_Cost_Report_Filing@anthem.com

Cost Report Reopenings: cost.report.reopenings@anthem.com

Cost Report Appeals: NGSCostReportAppeal2@anthem.com

Wage Index: **j6wageindex@anthem.com**

J6 Lead Auditors: **j6leads@anthem.com**

PS&R: PSR@Anthem.com

Hospice Caps: selfreportedhospicecap@anthem.com

Audit Inquiries: **j6leads@anthem.com**

Provider Based Determinations:
ngsprovbaseddeterminations@anthem.com

Contact Information

Director
Gene Nickerson
gene.nickerson@elevancehealth.com
207-317-1001

Director I
Kyle Browning
kyle.browning@elevancehealth.com
618-731-1655

Audit Manager-Key Personnel
John Stoll
John.stoll@elevancehealth.com
262-202-6053

Audit Manager
Kevin Glorioso
kevin.glorioso@elevancehealth.com
315-256-3355

Audit Manager
Anna Swingle
anna.swingle@elevancehealth.com
317-679-5181

Reimbursement Manager
John Stoll
John.stoll@elevancehealth.com -262-
202-6053

Acceptance Manager
Bobbi Jo Luciano
bobbi.jo.luciano@elevancehealth.com
207-253-3382

Appeals Managers
Celeste Stabler
celeste.stabler@elevancehealth.com
803-315-2504

Laurie Lyles
laurie.lyles@elevancehealth.com
803-360-2684

Reopening Manager
Mark Hudak
mark.hudak@elevancehealth.com
412-400-5303

S-10 Audit Manager
Steve Kapsa
steven.kapsa@elevancehealth.com
317-408-1027

Other Miscellaneous Contact Information

Credit Balance Fax

1-315-442-4287

National Government Services, Inc.

Part A ORU/Credit Balance Reports

P.O. Box 6474

Indianapolis, IN 46207-6474

ERS Mailbox

j6A.ers.requests@anthem.com

National Government Services, Inc.

ATTN: ORU Part A – ERS Requests

P.O. Box 809199

Chicago, IL 60680-9199

MAC Customer Experience (MCE) Audit & Reimbursement Surveys

We're looking for ways to improve your Audit and Reimbursement experience.
Please take a few minutes to share your thoughts with us!

Beginning in April 2022, NGS has been including links to a survey at the completion of certain workloads:

- Notice of Program Reimbursement (NPR) review
- Revised NPR review
- S-10 Audit
- Interim Rate Review

We encourage you to navigate to the link in the letter you receive for the above workload completion and provide us feedback on your experience. Thank you in advance!

Questions?