



New Documentation Requirements for Filing Medicare Cost Reports

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This MLN Matters Special Edition (SE) article is for all providers who file Medicare cost reports.

WHAT YOU NEED TO KNOW

SE19015 reminds providers of the new documentation requirements for filing Medicare Cost Reports that were published in the Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) Final Rule.

BACKGROUND

Participating Medicare providers are required under [42 Code of Federal Regulations \(CFR\) Section 413.20\(a\)](#) to maintain sufficient financial records and statistical data for proper determination of costs payable under the Medicare program. In accordance with Section 413.20(d), providers must furnish such information to Medicare contractors as necessary to assure proper payment.

The FY 2019 Medicare IPPS final rule ([83 Federal Register \(FR\) 41144](#)), published on August 17, 2018, changed the required supporting documentation that you must submit with the Medicare cost report. Meeting these requirements allows for an acceptable cost report submission for cost-reporting periods beginning on or after October 1, 2018.

Note: Cost-report submissions that do not include the required documentation will be rejected for lack of supporting documentation (per Section 413.24(f)(5)(i)).

Causes for cost report rejection can vary by organization or situation, such as:

1. **Teaching Hospitals (Section 413.24(f)(5)(i)(A))** – A cost report will be rejected for lack of supporting documentation if it does not include the Intern and Resident Information System data.
2. **Bad Debt (Section 413.24(f)(5)(i)(B))** – For providers claiming Medicare bad debt reimbursement, a cost report will be rejected for lack of supporting documentation if it does not include a detailed bad debt listing that corresponds to the amount of bad debt claimed in the provider's cost report.
3. **Disproportionate Share Hospital (DSH) Eligible Hospitals (Section 413.24(f)(5)(i)(C))** – For hospitals claiming a DSH payment adjustment, a cost report will be rejected for lack of supporting documentation if it does not include a detailed listing of the hospital's Medicaid-eligible days that corresponds to the Medicaid-eligible days claimed in the hospital's cost report. Also, if the hospital submits an amended cost report that changes its Medicaid-eligible days, the hospital must submit an amended listing or an addendum to the original listing of the hospital's Medicare-eligible days that corresponds to the Medicaid-eligible days claimed in the hospital's amended cost report.
4. **Charity Care and Uninsured Discounts (Section 413.24(f)(5)(i)(D))** – For DSH-eligible hospitals reporting charity care and/or uninsured discounts, a cost report will be rejected for lack of supporting documentation if it does not include a detailed listing of charity care and/or uninsured discounts that corresponds to the amounts claimed in the DSH-eligible hospital's cost report. Also, until a standard format is adopted, a hospital must submit a charity care and/or uninsured discount list with its cost report that supports the amounts reported in its cost report including information such as patient name, dates of service, insurer (if applicable), and the amount of the charity care and/or uninsured discount given to the patient.
5. **Home Office Cost Allocations (Section 413.24(f)(5)(i)(E))** – For providers claiming costs on their cost reports that are allocated from a home office or chain organization with the same FY end, a cost report will be rejected for lack of supporting documentation if the home office or chain organization has not submitted a Home Office Cost Statement to the chain provider's servicing contractor that corresponds to some portion of the amounts allocated from the home office or chain organization to the provider's cost report. Conversely, for providers claiming costs on their cost report that are allocated from a home office or chain organization that has a different fiscal year end, a cost report will be rejected for lack of supporting documentation if the home office or chain organization has not submitted to the chain provider's servicing contractor, a Home Office Cost Statement that corresponds to some portion of the amounts allocated from the home office or chain organization to the provider's cost report.

As noted in the Final Rule, the Centers for Medicare & Medicaid Services (CMS) agrees that requiring this information to be submitted in standardized formats would ensure consistency of the documentation and facilitate the contractor's review. CMS plans to include standard formats (templates) in a Paperwork Reduction Act notice to request public comment. Therefore, standardized formats will not be required for cost-report periods beginning on or after October 1, 2018, until further notice.

ADDITIONAL INFORMATION

For more information, [find your MAC's website](#).

DOCUMENT HISTORY

Date of Change	Description
August 21, 2019	Initial article released.

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