TO: All Providers

FROM: CareFirst of Maryland, Inc.

DATE: April 22, 2003

SUBJECT: Revised Cost Reporting Forms and Instructions

EFFECTIVE DATE: CMHC changes effective for cost reporting periods ending on or after January 1, 2002.

This transmittal revises Chapter 18, Outpatient Rehabilitation Provider Cost Reporting Form CMS-2088-92 and instructions to accommodate community mental health centers (CMHCs) where the cost reporting period overlaps a transitional corridor date.

REVISED COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: CORF changes effective for cost reporting periods ending on or after June 30, 2001; OPT changes effective for cost reporting periods ending on or after January 1, 1999.

This transmittal also revises the effective dates that comprehensive outpatient rehabilitation facilities (CORF) and outpatient physical therapy (OPTs) providers (includes outpatient occupational therapy (OOT) providers and outpatient speech pathology (OSP) providers) transition to 100 percent reimbursement under the Medicare physician fee schedule (MPFS).

CORFs providing drugs, biologicals, and supplies were expected to be paid through the Medicare Physician Fee Schedule (MPFS), but were not until services rendered on or after April 1, 2001. Consequently, these services may require cost reimbursement through the cost report for cost reporting periods that precede or overlap April 1, 2001. CORFs not furnishing drugs, biologicals and/or supplies or any other services that are not cost reimbursed, would still not need to file a cost report for cost reporting periods ending on or after June 30, 2001. CORFs do not file cost reports for cost reporting periods beginning on or after April 1, 2001.

OPT, OSP, and OOT services provided by OPTs were expected to be paid through the MPFS, but were not until services rendered on or after July 1, 2003, (to be addressed in a forthcoming PM). Consequently, these services may require reimbursement through the cost report for cost reporting periods that have ended. OPTs whose cost reporting periods have not ended, must file a low utilization or full cost report for periods which precede or overlap the July 1, 2003 date. Effective for services rendered on or after July 1, 2003, payment for drugs and biologicals including vaccines in an OPT setting will no longer be reimbursed on a cost basis. Additionally, OPTs should not bill for supplies they furnish since supplies are part of the practice expense under the MPFS and are already taken into account in the practice expense for services rendered on or after July 1, 2003. OPTs do not file cost reports for cost reporting periods beginning on or after July 1, 2003.

CORFs and OPTs that have not filed cost reports, but wish to do so, must be able to justify to their intermediary that cost reimbursed services were sufficient to warrant the filing of cost reports (full, low utilization or amended).

DISCLAIMER: **The revision date and transmittal number only apply to the bolded material. All other material was previously published in the manual and is only being reprinted.**

This cost report provides for the determination of allowable costs which are reimbursable by the health insurance program under title XVIII, Part B, of the Act. These worksheets are used only by rehabilitation agencies, clinics and public health agencies certified as outpatient physical therapy (OPT), outpatient occupational therapy (OOT) and outpatient speech pathology (OSP) providers, comprehensive outpatient rehabilitation facilities (CORF), and community mental health centers (CMHC) providing partial hospitalization services. Form CMS-2088-92 is used only by freestanding

providers.

NOTE: **CORFs not furnishing drugs, biologicals, and/or supplies or any other services that are not cost reimbursed, would still not need to file a cost report for cost reporting periods ending on or after June 30, 2001** where the remainder of the services rendered are reimbursed on a fee schedule basis. However, such providers with cost reimbursed services may file a low utilization cost report in accordance with PRM, Part II, Section 110. **For CORFs providing drugs, biologicals, and supplies these services are cost reimbursed through March 31, 2001. Consequently, these services may require cost reimbursement through the cost report for cost reporting periods that precede or overlap April 1, 2001. CORFs do not file cost reports for cost reporting periods beginning on or after April 1, 2001. OPTs may require cost reimbursement through the cost report for cost reporting periods that have ended. OPTs whose cost reporting periods have not ended must file a low utilization or full cost report for periods which end prior to or overlap July 1, 2003. Payment for drugs and biologicals including vaccines will no longer be reimbursed on a cost basis and should not bill for the supplies since supplies are part of the practice expense under the MPFS for services rendered on or after July 1, 2003. OPTs do not file cost reports for cost reporting periods beginning on or after July 1, 2003**. CMHCs must continue to file cost reports in accordance with PRM, Part II, Section 100.

A. Effective Date.--

1. Rehabilitation agencies, clinics and public health agencies certified as OPT, OOT, or OSP providers must use these worksheets for cost reporting periods ending on or after April 30, 1993.

2. CORFs must use these worksheets for the facility's first cost reporting period which ends on or after April 30, 1993, and for which a facility is certified as a comprehensive outpatient rehabilitation provider.

3. CMHCs must use this cost report for the facility's first cost reporting period on or after October 1, 1991, provided that the CMHC has filed a request for Medicare participation and has met all Federal requirements for partial hospitalization services to be reimbursable by the Medicare program

Reasonable cost as used in this discussion of reimbursement is the remaining reasonable cost after subtracting any applicable deductible.

Effective for services rendered prior to January 1, 1999, OPT, OOT, and OSP providers are reimbursed on the basis of the lower of reasonable cost or customary charges or reasonable cost minus amounts that may be billed to Medicare beneficiaries for providing services to Medicare beneficiaries In no case may the reimbursement exceed 80 percent of the reasonable cost.

CMHCs are reimbursed (for partial hospitalization services) the lesser of reasonable cost or customary charges, less the amount of coinsurance that may be charged to the beneficiaries. In no case may the reimbursement exceed 80 percent of the reasonable cost.

Effective for services rendered prior to January 1, 1999 (and some services rendered on or after January 1, 1999 that continue to be reimbursed on a cost basis) CORF reimbursement is based on the reasonable cost that remains after subtracting any applicable deductibles and is the lesser of:

- o Eighty percent of the remaining reasonable cost, or
- o The remaining reasonable cost minus 20 percent of reasonable charges.

Part I of the Provider Reimbursement Manual (CMS Pub. §15-I) and the applicable regulations issued by CMS set forth the criteria to use to determine reimbursable costs under the health insurance program.

Form CMS-2088-92 is used to effect provider reimbursement, using cost finding with cost apportionment based on gross charges.

The gross charges method is the ratio of Medicare program charges to total charges applied to total allowable costs. This ratio is developed for each individual reimbursable cost center. Each of the different types of providers using this cost report has specific services for which they may be

reimbursed under the Act. Therefore, a provider develops the ratio only for those cost centers for which it may be reimbursed.

In order for a provider to properly complete its Medicare cost report, a record of its Medicare billing must be maintained. Providers generally maintain their own records of billings, but in addition, the intermediary keeps a record, known as the Provider Statistical & Reimbursement (PS&R) report. The PS&R report compiles the provider's Medicare claims data and summarizes it for use by the provider in the cost report. Throughout these instructions and the related forms, there have been references to the provider's records as a source for entries in a cost center. In order for any such entries to be accurate, reconcile the provider's records and the intermediary's PS&R.

The cost finding calculations provide for the allocation of the cost of services rendered by each general service cost center to other cost centers which utilize such services. Once the costs of a general service cost center have been allocated, that cost center is considered closed. Once closed, it does not receive any of the costs subsequently allocated from the remaining general service cost centers. This method of cost finding is the stepdown method.

You may use a more sophisticated method of cost finding designed to allocate costs more accurately upon approval of the intermediary. However, having elected to use the more sophisticated method, you may not thereafter use the stepdown method without approval of the intermediary.

The cost report form contains the methodology in which covered charges, deductibles, and coinsurance amounts for services rendered are considered in the calculation of Medicare reimbursement.

Form CMS-2088-92 consists of 26 pages. Generally, complete these pages in sequence. However, some pages must be started but cannot be completed until some of the succeeding pages are first completed. The instructions point out these differences.

In completing the worksheets, show reductions to expenses in parentheses ( ).

Where you did not furnish any covered services to Medicare beneficiaries, or where there is low Medicare utilization of such services during the entire cost reporting period, a full cost report need not be filed. Your intermediary may authorize less than a full cost report if you have had low utilization of covered services by Medicare beneficiaries in a reporting period and you received correspondingly low interim reimbursement payments. This authorization is only effective if, prior to the end of the cost reporting period or filing period, the intermediary advises you that you may file less than a full cost report and you give assurance that you will timely file such data as may be required by the intermediary. See CMS Pub. 15-I, Chapter 24, §2414.4 and 42 CFR §413.24(h) for a further explanation of this procedure.

1800.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in the use of fractions. The following rounding standards must be employed for such computation.

1. Round to 2 decimal places
    a. Percentages
    b. Averages

    c. Full time equivalent employees
    d. Per diems, hourly rates

2. Round to 5 decimal places
    a. Payment reduction (e.g., outpatient cost reduction)

3. Round to 6 decimal places
    a. Ratios (e.g., unit cost multipliers, cost/charge ratios)

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost being allocated. Adjust this residual to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount being allocated.

1801. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-2088-92

Step	Worksheet	
1	S	Complete Parts I and IV.
2	S-1	Complete lines 1 through 4.
3	A	Complete columns 1 through 3, all lines.
4	A-1	Complete entire worksheet if applicable.
5	A	Complete columns 4 and 5, all lines.
6	A-3	Complete lines 1 through 12.
7	A-3-1	Complete Part A. If the answer to Part A is "Yes," complete Parts B and C.
8	A-3	Complete lines 13 through 19.
9	Supp. A-8-2	Complete entire worksheet, if applicable.
10	Supp. A-8-3	Complete entire worksheet, if applicable.
11	Supp. A-8-4	Complete entire worksheet, if applicable.
12	Supp. A-8-5	Complete entire worksheet, if applicable.
13	A-3	Complete remainder of Worksheet A-3.
14	A	Complete columns 6 and 7, all lines.
15	B & B-1	Complete entire worksheets.
16	C	Complete entire worksheet.
17	D	Complete lines 1 through 5, 9, 11, 18, and 20 through 29.
18	D	Complete lines 6 through 8, 10, 12 through 17, and 19.
19	G	Complete entire worksheet.

1802. WORKSHEET S - OUTPATIENT REHABILITATION PROVIDER COST REPORT

The intermediary indicates in the appropriate box whether this is the initial cost report (first cost report filed for the period), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened.

1802.1 Part I - Identification Data.--

The information required in this section is needed to properly identify the provider.

Line 1.--Enter the Outpatient Rehabilitation Facility name.

Line 1.01.--Enter the street address. and P.O. Box (if applicable) of the facility.

Line 1.02.--Enter the city, state, and zip code of the facility.

Line 2.--

Column 1.--Enter the provider identification number.

Column 2.--Type of Control.--Indicate the ownership or auspices of the provider by entering the number below that corresponds to the type of control of the facility.

Voluntary Nonprofit:
- 1 = Church
- 2 = Other (specify)

Proprietary:
- 3 = Individual
- 4 = Corporation
- 5 = Partnership
- 6 = Other (specify)

Government (Non-Federal):
- 7 = State
- 8 = Hospital District
- 9 = County
- 10 = City
- 11 = City-County
- 12 = Other (specify)

If item 12 is selected, "Other (specify)" category, specify the type of provider in column 3 of the worksheet.

Column 4.--Type of Provider.--Enter the number which corresponds to the type of provider as defined in the conditions of participation.

OPT/OSP/OOT Provider:
- 1 = Rehabilitation Agency
- 2 = Public Health Agency
- 3 = Clinic
- 4 = Comprehensive Outpatient Rehabilitation Facility (CORF)
- 5 = Community Mental Health Center (CMHC)

OPT, OOT, OSP Provider.--This is a provider furnishing either outpatient physical therapy, outpatient occupational therapy and/or outpatient speech pathology services. These services are furnished through one of the following:

Rehabilitation Agency.--This is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy, occupational therapy or speech pathology services, and a rehabilitation program which, in addition to OPT, OOT, or OSP services, includes social or vocational adjustment services.

1809. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

Worksheet C consists of two pages. Page one is used by providers certified as CORFs, while page two is used by CMHCs and other providers required to file Form CMS-2088-92. On page two, the CMHC completes lines 29 through 39 and the other providers complete lines 40 through 44. The

other providers are agencies and clinics certified as OPT, OOT, and OSP.

To determine the allowable costs applicable to the Medicare program, apportion the costs between the Medicare beneficiaries and the other patients. The basis of the apportionment is the gross amount of charges for each reimbursable cost center.

On this worksheet, the lines in columns 1, 3, and 4 are divided into two parts: The first part resides on subline .01 and the second part resides on subline .02. In each instance, cost data is entered on subline .01. The following column instructions apply to both pages.

Column 1.--Enter on subline .01 of each line the total cost of each cost center as computed on Worksheet B, column 17, corresponding lines. Do not bring forward any cost center with a credit balance from Worksheet B, column 17. However, the charges applicable to such cost centers with a credit balance must be reported on subline .02 of the appropriate line on Worksheet C.

Enter on subline .02 of each line (from your records) the gross total patient charges for each cost center including in the appropriate cost center items reimbursed on a fee schedule (i.e., DME, oxygen, prosthetics and orthotics). However, do not include Medicare charges applicable to those items in the Medicare charges reported in column 3, lines 22, 25 or 26 of the worksheet. If you charge some patients less than the customary charges for services rendered because of the patients' inability to pay or for any other reason, those charges are increased (for apportionment purposes) to reflect the gross amounts.

Thus, for computing reimbursable costs on this worksheet, the individual amounts applicable to Medicare program patients must not differ from the amounts applicable to all other patients for the same services.

When certain services by a provider are furnished under arrangements and an adjustment is made on Worksheet A-3 to gross up costs, the related charges entered on Worksheet C are also grossed up in accordance with CMS Pub. 15-I, 2314.

Column 2.--Divide the cost on subline .01 of each line in column 1 by the gross charges on subline .02 of each line in column 1 to determine the ratio of total cost to total charges for each cost center. Enter the resultant cost center ratios in column 2. Carry the ratio out to six decimal places.

Column 3.--Enter on subline .02 of each line the Medicare program charges (from your records) for each cost center. Multiply the charges for each cost center by the ratio in column 2 (same line) to determine the cost. Enter the result on subline .01 of the line.

Section 4541 of BBA 1997 mandates a fee schedule payment basis for all CORF services (lines 15-27) rendered on or after January 1, 1999. However, drugs, biologicals, and supplies rendered **through March 31, 2001, continue to be reimbursed on a cost basis. Such services rendered on or after April 1, 2001, are reimbursed under the Medicare Physician Fee Schedule (MPFS) and do not require the input of the corresponding Title XVIII cost and charge data. CORFs enter in column 5 the costs of services reimbursed on cost basis (drugs, biologicals, and supplies) rendered prior to April 1, 2001.**

Section 4541 also mandates a fee schedule payment basis for other outpatient physical therapy (which includes outpatient speech pathology) and outpatient occupational therapy services (lines 40-42) rendered on or after **July 1, 2003**. These outpatient services are reimbursed the lesser of the applicable fee schedule amount or the actual charge for the service on a claim-by-claim basis. **Such services rendered on or after July 1, 2003, are reimbursed the lesser of the applicable fee schedule amount or the actual charge for the service on a claim-by-claim basis, and do not require the input of the corresponding Title XVIII cost and charge data. Additionally, OPTs enter in column 5 the costs of services reimbursed on a cost basis (includes drugs, biologicals, and supplies) prior to July 1, 2003. Effective for services rendered on or after July 1, 2003, payment for drugs and biologicals including vaccines in an OPT setting will no longer be reimbursed by OPTs and, as such, should not bill for the supplies they furnish since supplies are part of the practice expense, under the MPFS and already taken into account in the practice expense.**

Additionally, the three outpatient therapy services are subject to a statutory financial limitation which is applied on a beneficiary specific basis through the Medicare claims system. As such, the Medicare (Title XVIII) charges for these services **(MPFS reimbursed services)** must not be included in column 3, subline .02. However, the Medicare (title XVIII) charges applicable to those remaining services reimbursed on a reasonable cost basis are still required in column 3, subline .02. Contact your intermediary for specific services reimbursed on a fee schedule.

Line 22.--Do not enter the charges for prosthetic or orthotic devices as these devices are reimbursed on a fee schedule.

Lines 25 and 26.--Do not enter the charges for DME as these devices are reimbursed on a fee schedule.

Column 4.--Enter on subline .02 of each line the non-Medicare program charges (from your records) for each cost center. Multiply the charges for each cost center by the ratio in column 2 (same line) to determine the cost. Enter the result on subline .01 of the line.

For CMHCs only (excluding CORFs and OPTs), sublines .01 and .02 in columns 3 and 4 of each line must total to sublines .01 and .02 in column l of each line.

Enter on line 28.01, columns l, 3, and 4, respectively, the sum of lines 15.01 through 27.01. Enter on line 28.02, columns l, 3, and 4, respectively, the sum of lines 15.02 through 27.02.

Enter on line 39.01, columns l, 3, and 4, respectively, the sum of lines 29.01 through 38.01. Enter on line 39.02, columns l, 3, and 4, respectively, the sum of lines 29.02 through 38.02.

Enter on line 44.01, columns l, 3, and 4, respectively, the sum of lines 40.01 through 43.01. Enter on line 44.02, columns l, 3, and 4, respectively, the sum of lines 40.02 through 43.02.

Outpatient Therapy Cost Reduction Computation.--For CORF services (lines 15-27) and other outpatient therapy providers (lines 40-42), columns 5 through 7 compute the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology and outpatient occupational therapy) as required by 1834(k) of the Act and enacted by §4541 of the Balanced Budget Act (BBA) of 1997. **For CORFs**, the amount of the reduction is 10 percent for **cost reimbursed services** rendered **on or after** January 1, 1998, through **March 31, 2001. Additionally,** the 10 percent reduction still applies to **reasonable cost reimbursed services as** well as vaccines (drugs cost center) administered from January 1, 1999 **through March 31, 2001**, which are reimbursed on a reasonable cost basis. For OPTs, the amount of the reduction is 10 percent for **cost reimbursed services** rendered **on or after** January 1, 1998, through **June 30, 2003**. The reduction does not apply to CMHC services.

Column 5, lines 15-27 and 40-42.--CORFs, for each cost center (lines 15-27) and OPTs for each cost center (lines 40-42), enter the Title XVIII charges (from your records) for services rendered January 1, 1998, through March 31, 2001, for CORFs and January 1, 1998 through June 30, 2003, for OPTs. CORFs and OPTs complete all lines as applicable for cost reimbursed services as these they are subject to the 10 percent reduction. CORFs enter the applicable title XVIII charges for vaccines (line 23) rendered from January 1, 1999, through March 31, 2001. Do not enter the charges for services which are fee reimbursed.

Column 6, lines 15-27 and 40-42.--Determine the Title XVIII cost for services rendered on or after January 1, 1998 by multiplying the charges in column 5 by the ratio in column 2, and enter the result.

Column 7, lines 15-27 and 40-42.--Determine the reduction amount by multiplying the cost in column 6 by 10 percent (.10), and enter the result.

Column 8, lines 15-27 and 40-42.--Determine the title XVIII cost net of the applicable cost reduction by subtracting the amount in column 7 from the amount in column 3, subline .01. Enter zero in this column if column 5 (charges) also equals zero.

Line 28.--Enter the total of lines 15 through 27, columns 5 through 8. See the instructions for Worksheet D, Part I, lines 1 and 1.1 to determine the amounts to transfer to Worksheet D.

Partial hospitalization services provided by CMHCs reimbursed based on a Prospective Payment System (PPS).--For CMHC services (lines 29-38) rendered on or after August 1, 2000, reimbursement is based on PPS subject to a transitional corridor payment. Vaccines furnished by CMHCs are reimbursed based on outpatient PPS. **To facilitate completion of this worksheet, the heading for columns 5, 6, and 8 will change (identified as the pre transition date, and the on or after date) based on the cost reporting period.**

Column 5, lines 29-38.--For each cost center, enter the Title XVIII charges (from your records) for services rendered on or after August 1, 2000**, January 1, 2002, January 1, 2003, or January 1, 2004. For cost reporting periods beginning on or after January 1, 2004, enter zero (0).**

Column 6, lines 29-38.--Determine the title XVIII cost for services rendered on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004 by multiplying the charges in column 5 by the ratio in column 2, and enter the result. **For cost reporting periods beginning on or after January 1, 2004, enter zero (0).**

Column 8, lines 29-38.--Determine the title XVIII pre transition date (August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004) cost by subtracting the amount in column 6 from the amount in column 3, subline .01, and enter the result. For lines 29 through 38 and line 43, transfer the cost from column 3, subline .01 to the corresponding line in column 8. **For cost reporting periods beginning on or after January 1, 2004, this column must equal zero (0).**

Line 39.--Enter the total of lines 29 through 38, and transfer the amount on line 39 in accordance with the instructions for Worksheet D, Part I, line 1.

Line 43.--Enter in column 8 the cost from column 3, subline .01 to the corresponding line in column 8.

Line 44.--Enter the total of lines 40 through 43, columns 5 through 8 and transfer the amount on line 44, column 8 to Worksheet D in accordance with the instructions for Worksheet D, Part I, line 1.

1810. WORKSHEET D - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR OUTPATIENT REHABILITATION SERVICES - TITLE XVIII

Worksheet D applies to title XVIII only and provides for the reimbursement calculation of outpatient rehabilitation services rendered to Medicare beneficiaries.

NOTE: CORFs with cost reporting periods overlapping January 1, 1998, complete Part I and lines 22 through 27 of Part II for services rendered prior to January 1, 1998. For CORF services rendered on or after January 1, 1998, complete lines 21 through 29 as applicable as the Lesser of Reasonable Cost or Customary Charges (LCC) applies to these services.

Worksheet D consists of two parts:

Part I - Computation of Reimbursement Settlement
Part II - Computation of the Lesser of Reasonable Cost or Customary Charges

1810.1 Part I - Computation of Reimbursement Settlement.--

Line Descriptions

Line 1.--CORFs and OPTs with cost reporting periods ending prior to January 1, 1998, enter the applicable cost from Worksheet C, column 3, line 28.01 (CORF) and line 44.01 (OPT), respectively. CORFs with cost reporting periods overlapping January 1, 1998, enter cost of services provided on or after January 1, 1998 by subtracting the amount on Worksheet C, column 7, line 28 from the amount in column 6, line 28. OPTs with cost reporting periods overlapping January 1, 1998,enter the total expenses applicable to the health insurance program obtained from Worksheet C, column

8, line as appropriate (other providers from line 44). CORFs & OPTs use column 1 only.

CMHCs with cost reporting periods ending prior to August 1, 2000, enter the applicable cost from Worksheet C, column 3, line 39.01. CMHCs with cost reporting periods overlapping August 1, 2000,enter in the applicable column the cost of services provided prior to the applicable transition date from Worksheet C, column 8, line 39 and enter in the applicable column the cost of services provided on or after the applicable transition date from Worksheet C, column 6, line 39. CMHCs with cost reporting periods beginning on or after January 1, 2004, enter zero (0) as CMHC services are reimbursed under 100% PPS.

NOTE: For CMHCs only, column 1 is subscripted for lines 1 through 12 for cost reporting periods which overlap August 1, 2000, January 1, 2002, January 1, 2003, and December 31, 2003, to accommodate the transitional corridor payment calculation associated with the portion of the cost reporting period which overlaps any of the aforementioned dates. For cost reporting periods which overlap a transition date enter in column 1 any data applicable to CMHC services rendered prior to the transition and enter in column 1.01 data applicable to CMHC services rendered on or after the transition date. For cost reporting periods that do not overlap transition dates and for cost reporting periods beginning on or after January 1, 2004, only complete column 1.

Lines 1.01 through 1.05 are to be completed by CMHCs for title XVIII services rendered on or after August 1, 2000.

Line 1.01.--Enter the gross PPS payments (includes deductible and coinsurance) received including payments for drugs and outliers.

Line 1.02.--Enter the 1996 CMHC specific payment to cost ratio (to 3 decimal places) provided by your intermediary.

Line 1.03.--Line 1, column 1.01 times line 1.02.

Line 1.04.--Line 1.01 divided by line 1.03.

Line 1.05.-- Enter the transitional corridor payment amount calculated based on the following:

For services rendered on or after August 1, 2000 through December 31, 2001:
a. If line 1.04 is => 90% but < 100% enter 80% of the result of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .71 times line 1.03 minus .70 times line 1.01.
c. If line 1.04 is => 70% but < 80% enter the result of .63 times line 1.03 minus .60 times line 1.01.
d. If line 1.04 is < 70% enter 21% of line 1.03.

For services rendered on or after January 1, 2002 through December 31, 2002:
a. If line 1.04 is => 90% but < 100% enter 70% of the result of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .61 times line 1.03 minus .60 times line 1.01.
c. If line 1.04 is < 80% enter 13% of line 1.03.

For services rendered on or after January 1, 2003 through December 31, 2003:
a. If line 1.04 is => 90% but < 100% enter 60% of the result of line 1.03 minus line 1.01.
b. If line 1.04 is < 90% enter 6% of line 1.03.

Line 1.1.--CORFs with cost reporting periods overlapping January 1, 1998, enter the total expenses for services provided prior to January 1, 1998 by subtracting the amount in column 6, line 28 from the amount in column 3, line 28.01. CORFs with cost reporting periods beginning on or after January 1, 1998, enter zero (0). CMHCs and OPTs make no entry on this line.

Line 2.--Enter the amounts paid or payable by primary payers when Medicare liability is secondary to that of the primary payer. There are several situations, as explained fully in 42 CFR 411, in which Medicare liability is secondary to a primary payer.

Medicare is not the primary payer under the following situations:

1. If the items of services have been, or can reasonably be expected to be paid under a worker's compensation law of a State or of the United States, including the Federal Black Lung Program;

2. If the items of services have been, or can reasonably be expected to be paid by automobile medical or no-fault insurance, or any liability insurance;

3. If the beneficiary is entitled to Medicare solely on the basis of end stage renal disease (ESRD) and is covered by an employer group health plan (EGHP), Medicare is the secondary payer for the first 18 months (See §1862(b)(1)(C) of the Act);

4. If the beneficiary is age 65 or over and either employed, or the spouse of an employed individual of any age, and the beneficiary is thereby covered by an EGHP; and

5. If the beneficiary is under age 65 and disabled and is covered by a large group health plan (LGHP) as a current employee, self-employed individual, or family member of such an employee, or self-employed individual.

When payment by the primary payer satisfies the total liability of the beneficiary, the services are treated as if they were non-Medicare services. The patient charges are included in total patient charges but are not included in Medicare charges, and no primary payer payment is entered on line 2.

If the primary payment does not satisfy the beneficiary's liability, include the covered charges in Medicare charges, and include the total charges in total charges for cost apportionment purposes. Enter the primary payment on line 2 to the extent the primary payer payment is not applied to the beneficiary's deductible and coinsurance.

Any part of the payment by the primary payer that satisfies some or all of the beneficiary's Medicare deductible and coinsurance is applied against the deductible and coinsurance. Do not enter primary payer payments that are applied against the deductible or the coinsurance on line 2. The providers must familiarize themselves with primary payer situations because they have a legal responsibility to attempt to recover their costs from the primary payer before seeking payment from Medicare. The primary payer rules are more fully explained in 42 CFR 411.

Line 3--For cost based CMHC services rendered prior to August 1, 2000, enter in the applicable column the total expenses for CMHC services by subtracting line 2 from line 1. Enter in the applicable column the total PPS payment for CMHC services furnished on or after August 1, 2000, by adding lines 1.01 and 1.05 minus line 2. CORFs and OPTs enter the result of line 1 plus line 1.1 minus line 2.

Line 4.--Enter the total amount of deductibles billed to program patients.

Line 6.--CMHCs (only the portion of the reporting period reimbursed under cost during the beginning transition year) enter in the applicable column the amount from line 29 of Part II. For CMHCs with cost reporting periods beginning on or after August 1, 2000, do not complete this line as PPS reimbursed services are not subject to LCC. CORFs, and other providers enter in column 1 the amount from line 29 of Part II.

Line 8.--CORFs, OPTs, and CMHCs (only the portion of the reporting period reimbursed under cost during the beginning transition year), enter in the applicable column 80 percent of the amount shown on line 7. CMHCs enter 0 (zero) for services reimbursed under PPS.

Line 9.--CORFs and OPTs enter in the applicable column the coinsurance amount billed to Medicare beneficiaries, but this amount may not exceed 20 percent of the customary charges as shown on line 27, Part II. For CMHCs, enter in the applicable the column the gross coinsurance amount billed to Medicare beneficiaries.

Line 11.--Enter reimbursable bad debts, net of bad debt recoveries, applicable to any Medicare

deductibles and coinsurance. The amount entered applicable to CMHC PPS must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

Line 12.--CORFs, OPTs and CMHCs for cost reimbursed services only, enter in the appropriate column the result of line 11 plus the lesser of the amounts on line 8 or 10. For CMHC PPS reimbursed services, enter in the appropriate column the result of line 11 plus the lesser of the amounts on line 7 or 10.

Line 15.--Enter the sum of columns 1 and 1.01, line 12 plus line 14.

Line 16.--Enter the sequestration adjustment as required by the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177). (See §120 of CMS Pub. 15-II).

Line 16.5.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4)

Line 17.--Subtract lines 16 and 16.5 from line 15 and enter the result.

Line 18.--Enter the total interim payments applicable to this cost reporting period from Worksheet S-1, line 4. For intermediary final settlement, report on line 18.5 the amount from Worksheet S-1, line 5.99.

Line 19.--Subtract the total amount entered on line 18 from the amount entered on line 17 and enter the resulting amount. This represents the amount due to or from the provider before any tentative or final settlement. Transfer this amount to Worksheet S, Part III, line 6.

1810.2 Part II - Computation of Lesser of Reasonable Cost or Customary Charges.--Part II provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

NOTE: For CORF services rendered prior to January 1, 1998, complete lines 22 through 27 as these services are not subject to LCC but are reimbursed based on Reasonable Costs. For CORF services rendered on or after January 1, 1998, complete lines 21 through 29, as these services are subject to LCC.

Line Descriptions

Line 21.--CMHCs enter the reasonable cost of Title XVIII services as follows: Reporting periods overlapping August 1, 2000, from Part I, line 1, column 1; Reporting periods beginning on or after August 1, 2000 do not complete Part II of this worksheet. For CORFs this line represents the reasonable cost of Title XVIII services rendered on or after January 1, 1998 from line 1. OPTs enter the reasonable cost of Title XVIII services from Worksheet C, column 8, line 44.

Line 21.1.--This line is the CORF reasonable cost of Title XVIII services rendered prior to January 1, 1998 from Part I, line 1.1.

Line 22.--This line provides for the charges which relate to the reasonable cost on line 21. CMHCs with cost reporting periods which overlap August 1, 2000, enter the result of Worksheet C, column 3, line 39.02 minus column 5, line 39 and for reporting periods beginning on or after August 1, 2000 do not complete Part II of this worksheet. OPTs enter the amount from Worksheet C, column 3, line 44.02. Do not include the charges for any services that are reimbursed under any method other than cost reimbursement. CORFs enter the total charges for Medicare services provided on or after January 1, 1998 from Worksheet C, column 5, line 28.

Line 22.1.--This line provides for CORF charges prior to January 1, 1998, which relate to the reasonable cost on line 21.1. Enter the result of Worksheet C, column 3, line 28.02 minus Worksheet C, column 5, line 28. Do not include the charges for any services that are reimbursed under any method other than cost reimbursement.

Lines 23 through 27.--These lines provide for the reduction of Medicare charges when you do not

actually impose such charges in the case of most patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 24 through 26, but enter on line 27 the amount from line 22 and enter on line 27.1 the amount from line 22.1. See 42 CFR 413.13(b). In no instance may the customary charges on line 27 exceed the actual charges on line 22, or the customary charges on line 27.1 exceed the actual charges on line 22.1.

1812. WORKSHEET G - STATEMENT OF REVENUE AND EXPENSES

Worksheet G is prepared from your accounting books and records. Additional worksheets may be supplied if necessary.

Worksheet G is completed by all providers.

You may substitute your own forms for Worksheet G. However, you must provide the minimum detail contained in Worksheet G.

1813. SUPPLEMENTAL WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 405.480, 42 CFR 405.481, 42 CFR 405.482, and 42 CFR 405.550(e), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider. 42 CFR 405.482 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Supplemental Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost incurred. 42 CFR 405.481 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services, e.g, research. Only provider services are reimbursable to you through the cost report. If you are a CORF, see 42 CFR 410.100(a) for an explanation of which services constitute provider services. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 405.482. The methodology used in this worksheet is to apply the RCE limit to the total physician compensation attributable to provider services that are reimbursable on a reasonable cost basis.

NOTE: Where several physicians work in the same department, see CMS Pub. 15-I, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

Column Descriptions

Columns 1 and 10.--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians subject to RCE limits. Enter the line numbers in the same order as displayed on Worksheet A.

Columns 2 and 11.--Enter (on the same line as the cost center) the description of the cost center used on Worksheet A.

When RCE limits are applied on an individual basis to each physician in a department, each physician must be listed on successive lines below the cost center. Each physician must be listed using an individual identifier which is not necessarily either the name or social security number of the individual (e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to the fiscal intermediary upon audit.

When RCE limits are applied on a departmental basis, insert the word "aggregate" instead of the physician identifiers on the line below the cost center description.

Columns 3 through 9 and 12 through 18.--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used,

enter the data for each column on the individual physician identifier lines for each cost center.

Column 3.--Enter the total physician compensation paid by the provider for each cost center. Physician compensation is monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services. (See 42 CFR 405.481(a).) Include the compensation in column 3 of Worksheet A or, if necessary ,through appropriate reclassifications or as a cost paid by a related organization through Worksheet A-3-1.

Column 4.--Enter the amount of total remuneration included in column 3 which is applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 405.550(b). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 405.481(f).)

Column 5.--For each cost center, enter the amount of the total remuneration included in column 3 which is applicable to general services to the provider (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 405.481(f).)

NOTE: 42 CFR 405.481(b) requires that physician compensation be allocated between physician services to patients, the provider and nonallowable services such as research. A physician's nonallowable services must not be included in columns 4 or 5 above. The instructions for column 18 ensure that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-3.

Column 6.--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the Federal Register before any allowable adjustments.

The RCE limits are updated annually on the basis of updated economic index data. A notice is published in the **Federal Register**, which sets forth the new limits. The RCE applicable to the various specialties is obtained from that notice. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable (non metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million).

Column 7.--Enter, for each line of data, the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040.

The hours entered are the actual hours for which the physician is compensated by the provider for furnishing services of a general benefit to its patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered in this column. Time records, or other documentation that supports this allocation, must be available for verification by the intermediary upon request. (See CMS Pub. 15-I, §2182.3E.)

Column 8.--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 6 and the ratio of the physician's provider component hours entered in column 7 to 2080 hours.

Column 9.--Enter, for each line of data, five percent of the amounts entered in column 8.

Column 12.--The computed RCE limit in column 8 may be adjusted upward, up to five percent of the computed limit (column 9), to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by the provider.

Enter, for each line of data, the actual amounts of these expenses which you paid.

Column 13.--Enter, for each line of data, the result of multiplying the amount in column 5 by the amount in column 12 and divide the result by the amount in column 3.

Column 14.--The computed RCE limit in column 8 may also be adjusted upward to reflect the actual malpractice expense incurred by you for the physician's (or a group of physicians,) services to your patients. In making this adjustment, the intermediary determines the ratio of that portion of compensated physician time spent in furnishing services in the provider (both to you and to your patients) to the physician's total working time in the provider and adjusts the total malpractice expense proportionately.

Enter, for each line of data, the actual amounts of these malpractice expenses which you paid.

Column 15.--Enter, for each line of data, the result of multiplying the amount in column 5 by the amount in column 14 and divide the result by the amount in column 3.

Column 16.--Enter, for each line of data, the sum of the amounts in columns 8 and 15 plus the lesser of the amounts in columns 9 or 13.

Column 17.--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from the provider component remuneration in column 5. If the result is a negative amount, enter zero in this column.

Column 18.--The adjustment for each cost center to be entered represents the provider-based physician (PBP) elimination from provider costs entered on Worksheet A-3, column 2, line 14. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.

Line Descriptions

Total Line.--Total the amounts in columns 3 through 5, 7 through 9 and 12 through 18.

(Source: Medicare Provider Reimbursement Manual; Transmittal #6)

THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. ALL BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILABLE AT NO COST FROM OUR WEB SITE AT www.marylandmedicare.com.