

Centers for Medicare & Medicaid Services, HHS

§ 413.64

(2) *Carve out method.* The following illustrates how apportionment is determined in a hospital reimbursed under the carve out method (subject to the private room differential provisions of paragraph (a)(1)(ii) of this section):

HOSPITAL K

[Determination of cost of routine SNF-type and ICF-type services and general routine hospital services ¹]

Facts	Days of care		
	General routine hospital	SNF-type	ICF-type
Total days of care	2,000	400	100
Medicare days of care ...	600	300	
Average Medicaid rate ..	N/A	\$35	\$20
Total inpatient general routine service costs: \$250,000			

Calculation of cost of routine SNF-type services applicable to Medicare:

$$\$35 \times 300 = \$10,500$$

Calculation of cost of general routine hospital services:

Cost of SNF-type services: $\$35 \times 400$..	\$14,000
Cost of ICF-type services: $\$20 \times 100$...	2,000
Total	\$16,000

Average cost per diem of general routine hospital services:

$$\$250,000 - \$16,000 \div 2,000 \text{ days} = \$117$$

Medicare general routine hospital cost:

$$\$117 \times 600 = \$70,200$$

Total Medicare reasonable cost for general routine inpatient days:

$$\$10,500 + \$70,200 = \$80,700$$

[51 FR 34793, Sept. 30, 1986, as amended at 59 FR 45401, Sept. 1, 1994; 61 FR 51616, Oct. 3, 1996; 61 FR 58631, Nov. 18, 1996]

§ 413.56 [Reserved]

Subpart E—Payments to Providers

§ 413.60 Payments to providers: General.

(a) The fiscal contractors will establish a basis for interim payments to each provider. This may be done by one of several methods. If an contractor is already paying the provider on a cost basis, the contractor may adjust its rate of payment to an estimate of the result under the Medicare principles of reimbursement. If no organization is paying the provider on a cost basis, the contractor may obtain the previous year's financial statement from the provider and, by applying the principles of reimbursement, compute or approximate an appropriate rate of payment. The interim payment may be related to the last year's average per

diem, or to charges, or to any other ready basis of approximating costs.

(b) At the end of the period, the actual apportionment, based on the cost finding and apportionment methods selected by the provider, determines the Medicare reimbursement for the actual services provided to beneficiaries during the period.

(c) Basically, therefore, interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period. Interim payments will be made as often as possible and in no event less frequently than once a month. The retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than on an estimated basis.

§ 413.64 Payments to providers: Specific rules.

(a) *Reimbursement on a reasonable cost basis.* Providers of services paid on the basis of the reasonable cost of services furnished to beneficiaries will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of a reporting period.

(b) *Amount and frequency of payment.* Medicare states that providers of services will be paid the reasonable cost of services furnished to beneficiaries. Since actual costs of services cannot be determined until the end of the accounting period, the providers must be paid on an estimated cost basis during the year. While Medicare provides that interim payments will be made no less often than monthly, contractors are expected to make payments on the most expeditious basis administratively feasible. Whatever estimated cost basis is used for determining interim payments during the year, the intent is that the interim payments shall approximate actual costs as nearly as is practicable so that the retroactive adjustment based on actual costs will be as small as possible.

(c) *Interim payments during initial reporting period.* At the beginning of the

program or when a provider first participates in the program, it will be necessary to establish interim rates of payment to providers of services. Once a provider has filed a cost report under the Medicare program, the cost report may be used as a basis for determining the interim rate of reimbursement for the following period. However, since initially there is no previous history of cost under the program, the interim rate of payment must be determined by other methods, including the following:

(1) If the contractor is already paying the provider on a cost or cost-related basis, the contractor will adjust its rate of payment to the program's principles of reimbursement. This rate may be either an amount per inpatient day, or a percent of the provider's charges for services furnished to the program's beneficiaries.

(2) If an organization other than the contractor is paying the provider for services on a cost or cost-related basis, the contractor may obtain from that organization or from the provider itself the rate of payment being used and other cost information as may be needed to adjust that rate of payment to give recognition to the program's principles of reimbursement.

(3) If no organization is paying the provider on a cost or cost-related basis, the contractor will obtain the previous year's financial statement from the provider. By analysis of such statement in light of the principles of reimbursement, the contractor will compute an appropriate rate of payment.

(4) After the initial interim rate has been set, the provider may at any time request, and be allowed, an appropriate increase in the computed rate, upon presentation of satisfactory evidence to the contractor that costs have increased. Likewise, the contractor may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(d) *Interim payments for new providers.*

(1) Newly-established providers will not have cost experience on which to base a determination of an interim rate of payment. In such cases, the contractor will use the following methods to determine an appropriate rate:

(i) If there is a provider or providers comparable in substantially all rel-

evant factors to the provider for which the rate is needed, the contractor will base an interim rate of payment on the costs of the comparable provider.

(ii) If there are no substantially comparable providers from whom data are available, the contractor will determine an interim rate of payment based on the budgeted or projected costs of the provider.

(2) Under either method, the contractor will review the provider's cost experience after a period of three months. If need for an adjustment is indicated, the interim rate of payment will be adjusted in line with the provider's cost experience.

(e) *Interim payments after initial reporting period.* Interim rates of payment for services provided after the initial reporting period will be established on the basis of the cost report filed for the previous year covering Medicare services. The current rate will be determined—whether on a per diem or percentage of charges basis—using the previous year's costs of covered services and making any appropriate adjustments required to bring, as closely as possible, the current year's rate of interim payment into agreement with current year's costs. This interim rate of payment may be adjusted by the contractor during an accounting period if the provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate. Likewise, the contractor may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(f) *Retroactive adjustment.* (1) Medicare provides that providers of services will be paid amounts determined to be due, but not less often than monthly, with necessary adjustments due to previously made overpayments or underpayments. Interim payments are made on the basis of estimated costs. Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during the

period into agreement with the reimbursable amount payable to the provider for the services furnished to program beneficiaries during that period.

(2) In order to reimburse the provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received. For this purpose, the costs will be accepted as reported, unless there are obvious errors or inconsistencies, subject to later audit. When an audit is made and the final liability of the program is determined, a final adjustment will be made.

(3) To determine the retroactive adjustment, the amount of the provider's total allowable cost apportioned to the program for the reporting year is computed. This is the total amount of reimbursement the provider is due to receive from the program and the beneficiaries for covered services furnished during the reporting period. The total of the interim payments made by the program in the reporting year and the deductibles and coinsurance amounts receivable from beneficiaries is computed. The difference between the reimbursement due and the payments made is the amount of the retroactive adjustment.

(g) *Accelerated payments to providers.* Upon request, an accelerated payment may be made to a provider of services that is not receiving periodic interim payments under paragraph (h) of this section if the provider has experienced financial difficulties due to a delay by the contractor in making payments or in exceptional situations, in which the provider has experienced a temporary delay in preparing and submitting bills to the contractor beyond its normal billing cycle. Any such payment must be approved first by the contractor and then by CMS. The amount of the payment is computed as a percentage of the net reimbursement for unbilled or unpaid covered services. Recovery of the accelerated payment may be made by recoupment as provider bills are processed or by direct payment.

(h) *Periodic interim payment method of reimbursement—(1) Covered services furnished before July 1, 1987.* In addition to the regular methods of interim payment on individual provider billings for covered services, the periodic interim

payment (PIP) method is available for Part A hospital and SNF inpatient services.

(2) *Covered services furnished on or after July 1, 1987.* Effective with claims received on or after July 1, 1987, or as otherwise specified, the periodic interim payment (PIP) method is available for the following:

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, as specified in §412.1(a)(1) of this chapter under subpart B of part 412 of this subchapter, or are paid under the prospective payment systems described in subpart N, O, and P of part 412 of this chapter.

(ii) Part A services furnished in hospitals receiving payment in accordance with a demonstration project authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)), or a State reimbursement control system approved under section 1886(c) of the Act and subpart C of part 403 of this chapter, if that type of payment is specifically approved by CMS as an integral part of the demonstration or control system. If that type of payment is not an integral part of the demonstration or control system, PIP is available for the hospital under paragraph (h)(1)(i) of this section for hospitals excluded from the prospective payment systems or under §412.116(b) of this chapter for prospective payment hospitals.

(iii) Part A SNF services furnished in cost reporting periods beginning before July 1, 1998. (For services furnished in subsequent cost reporting periods, see §413.350 regarding periodic interim payments for skilled nursing facilities).

(iv) Part A services furnished in hospitals paid under the prospective payment system, including distinct part psychiatric or rehabilitation units, as described in §412.116(b) of this chapter.

(v) Services furnished in a hospice as specified in part 418 of this chapter. Payment on a PIP basis is described in §418.307 of this chapter.

(vi) Effective for payments made on or after July 1, 2004, inpatient CAH services furnished by a CAH as specified in §413.70. Payment on a PIP basis is described in §413.70(d).

(3) Any participating provider furnishing the services described in paragraphs (h)(1) and (h)(2) of this section that establishes to the satisfaction of the contractor that it meets the following requirements may elect to be reimbursed under the PIP method, beginning with the first month after its request that the contractor finds administratively feasible:

(i) The provider's estimated total Medicare reimbursement for inpatient services is at least \$25,000 a year computed under the PIP formula or, in the case of an HHA, either its estimated—

(A) Total Medicare reimbursement for Part A and Part B services is at least \$25,000 a year computed under the PIP formula; or

(B) Medicare reimbursement computed under the PIP formula is at least 50 percent of estimated total allowable cost.

(ii) The provider has filed at least one completed Medicare cost report accepted by the contractor as providing an accurate basis for computation of program payment (except in the case of a provider requesting reimbursement under the PIP method upon first entering the Medicare program).

(iii) The provider has the continuing capability of maintaining in its records the cost, charge, and statistical data needed to accurately complete a Medicare cost report on a timely basis.

(4) [Reserved]

(5) The contractor's approval of a provider's request for reimbursement under the PIP method will be conditioned upon the contractor's best judgment as to whether payment can be made to the provider under the PIP method without undue risk of its resulting in an overpayment because of greatly varying or substantially declining Medicare utilization, inadequate billing practices, or other circumstances. The contractor may terminate PIP reimbursement to a provider at any time it determines that the provider no longer meets the qualifying requirements or that the provider's experience under the PIP method shows that proper payment cannot be made under this method.

(6) Payment will be made biweekly under the PIP method unless the provider requests a longer fixed interval

(not to exceed one month) between payments. The payment amount will be computed by the contractor to approximate, on the average, the cost of covered inpatient or home health services furnished by the provider during the period for which the payment is to be made, and each payment will be made two weeks after the end of such period of services. Upon request, the contractor will, if feasible, compute the provider's payments to recognize significant seasonal variation in Medicare utilization of services on a quarterly basis starting with the beginning of the provider's reporting year.

(7) A provider's PIP amount may be appropriately adjusted at any time if the provider presents or the contractor otherwise obtains evidence relating to the provider's costs or Medicare utilization that warrants such adjustment. In addition, the contractor will recompute the payment immediately upon completion of the desk review of a provider's cost report and also at regular intervals not less often than quarterly. The contractor may make a retroactive lump sum interim payment to a provider, based upon an increase in its PIP amount, in order to bring past interim payments for the provider's current cost reporting period into line with the adjusted payment amount. The objective of contractor monitoring of provider costs and utilization is to assure payments approximating, as closely as possible, the reimbursement to be determined at settlement for the cost reporting period. A significant factor in evaluating the amount of the payment in terms of the realization of the projected Medicare utilization of services is the timely submittal to the contractor of completed admission and billing forms. All providers must complete billings in detail under this method as under regular interim payment procedures.

(i) *Bankruptcy or insolvency of provider.* If on the basis of reliable evidence, the contractor has a valid basis for believing that, with respect to a provider, proceedings have been or will shortly be instituted in a State or Federal court for purposes of determining whether such provider is insolvent or bankrupt under an appropriate State or Federal law, any payments to the

provider will be adjusted by the contractor, notwithstanding any other regulation or program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made.

(j) *Interest payments resulting from judicial review*—(1) *Application*. If a provider of services seeks judicial review by a Federal court (see § 405.1877 of this chapter) of a decision furnished by the Provider Reimbursement Review Board or subsequent reversal, affirmation, or modification by the Secretary, the amount of any award of such Federal court will be increased by interest payable by the party against whom the judgment is made (see § 413.153 for treatment of interest). The interest begins to accrue on the first day of the first month following the 180-day period described in § 405.1835(a)(3)(i) or (a)(3)(ii) of this chapter, as applicable.

(2) *Amount due*. Section 1878(f) of the Act, 42 U.S.C. 1395oof), authorizes a court to award interest in favor of the prevailing party on any amount due as a result of the court's decision. If the contractor withheld any portion of the amount in controversy prior to the date the provider seeks judicial review by a Federal court, and the Medicare program is the prevailing party, interest is payable by the provider only on the amount not withheld. Similarly, if the Medicare program seeks to recover amounts previously paid to a provider, and the provider is the prevailing party, interest on the amounts previously paid to a provider is not payable by the Medicare program since that amount had been paid and is not due the provider.

(3) *Rate*. The amount of interest to be paid is equal to the rate of return on equity capital (see § 413.157) in effect for the month in which the civil action is commenced.

Example: An contractor made a final determination on the amount of Medicare program reimbursement on June 15, 1974, and the provider appealed that determination to the Provider Reimbursement Review Board. The Board heard the appeal and rendered a decision adverse to the provider. On October 28, 1974, the provider commenced civil action to have such decision reviewed. The rate of return on equity capital for the month of October 1974 was 11.625 percent. The period for

which interest is computed begins on January 1, 1975, and the interest beginning January 1, 1975, would be at the rate of 11.625 percent per annum.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 42238, Nov. 24, 1986; 53 FR 1628, Jan. 21, 1988; 57 FR 39830, Sept. 1, 1992; 59 FR 36713, July 19, 1994; 64 FR 41682, July 30, 1999; 65 FR 41211, July 3, 2000; 66 FR 41394, Aug. 7, 2001; 67 FR 56056, Aug. 30, 2002; 69 FR 49252, Aug. 11, 2004; 69 FR 66981, Nov. 15, 2004; 73 FR 30267, May 23, 2008]

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions*. (1) *Scope*. (i) This section applies to all facilities for which provider-based status is sought, including remote locations of hospitals, as defined in paragraph (a)(2) of this section and satellite facilities as defined in §§ 412.22(h)(1) and 412.25(e)(1) of this chapter, other than facilities described in paragraph (a)(1)(ii) of this section.

(ii) The determinations of provider-based status for payment purposes described in this section are not made as to whether the following facilities are provider-based:

(A) Ambulatory surgical centers (ASCs).

(B) Comprehensive outpatient rehabilitation facilities (CORFs).

(C) Home health agencies (HHAs).

(D) Skilled nursing facilities (SNFs) (determinations for SNFs are made in accordance with the criteria set forth in § 483.5 of this chapter).

(E) Hospices.

(F) Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services.

(G) Independent diagnostic testing facilities furnishing only services paid under a fee schedule, such as facilities that furnish only screening mammography services (as defined in section 1861(jj) of the Act), facilities that furnish only clinical diagnostic laboratory tests, other than those clinical diagnostic laboratories operating as parts of CAHs on or after October 1, 2010, or facilities that furnish only some combination of these services.

(H) Facilities, other than those operating as parts of CAHs, furnishing only

physical, occupational, or speech therapy to ambulatory patients, throughout any period during which the annual financial cap amount on payment for coverage of physical, occupational, or speech therapy, as described in section 1833(g)(2) of the Act, is suspended by legislation.

(I) ESRD facilities (determinations for ESRD facilities are made under § 413.174 of this chapter).

(J) Departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid (for example, laundry or medical records departments).

(K) Ambulances.

(L) Rural health clinics (RHCs) affiliated with hospitals having 50 or more beds.

(2) *Definitions.* In this subpart E, unless the context indicates otherwise—

Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

Department of a provider means a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A department of a provider may not by itself be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and the Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term

“department of a provider” does not include an RHC or, except as specified in paragraph (n) of this section, an FQHC.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity.

Main provider means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider of health care services, or an RHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the ownership and administrative and financial control of the main provider, in accordance with the provisions of this section. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A provider-based entity may, by itself, be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and the Medicare conditions of participation do apply to a provider-based entity as an independent entity.

Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.

Remote location of a hospital means a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital

comprises both the specific physical facility that serves as the site of services for which separate payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. The Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term “remote location of a hospital” does not include a satellite facility as defined in §§412.22(h)(1) and 412.25(e)(1) of this chapter.

(b) *Provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

(2) If a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until the start of the hospital’s first cost reporting period beginning on or after July 1, 2003. The requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), (h), and (i) of this section will not apply to that hospital or CAH until the start of the hospital’s first cost reporting period beginning on or after July 1, 2003. For purposes of this paragraph (b)(2), a facility is considered as provider-based on October 1, 2000 if, on that date, it either had a written determination from CMS that it was provider-based, or was billing and being paid as a provider-based department or entity of the hospital.

(3)(i) Except as specified in paragraphs (b)(2) and (b)(5) of this section, if a potential main provider seeks a determination of provider-based status for a facility that is located on the campus of the potential main provider, the provider would be required to submit an attestation stating that the facility meets the criteria in paragraph (d) of this section and, if it is a hospital, also attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider seeking such a determination would also be required to maintain documentation of the basis for its attestations and to make that documentation available to CMS and

to CMS contractors upon request. If the facility is operated as a joint venture, the provider would also have to attest that it will comply with the requirements of paragraph (f) of this section.

(ii) If the facility is not located on the campus of the potential main provider, the provider seeking a determination would be required to submit an attestation stating that the facility meets the criteria in paragraphs (d) and (e) of this section, and if the facility is operated under a management contract, the requirements of paragraph (h) of this section. If the potential main provider is a hospital, the hospital also would be required to attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider would be required to supply documentation of the basis for its attestations to CMS at the time it submits its attestations.

(iii) Whenever a provider submits an attestation of provider-based status for an on-campus facility or organization, as described in paragraph (b)(3)(i) of this section, CMS will send the provider written acknowledgment of receipt of the attestation, review the attestation for completeness, consistency with the criteria in this section, and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility or organization is provider-based.

(iv) Whenever a provider submits an attestation of provider-based status for an off-campus facility or organization, as described in paragraph (b)(3)(ii) of this section, CMS will send the provider written acknowledgment of receipt of the attestation, review the attestation for completeness, consistency with the criteria in this section, consistency with the documentation submitted with the attestation and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility or organization is provider-based.

(4) A facility that is not located on the campus of a hospital and that is used as a site where physician services

of the kind ordinarily furnished in physician offices are furnished is presumed as a free-standing facility, unless CMS determines the facility has provider-based status.

(5) A facility that has requested provider-based status in relation to a hospital or CAH on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed (to the extent required by the State), staffed and equipped to treat patients until the date on which CMS determines that the facility does not qualify for provider-based status.

(c) *Reporting of material changes in relationships.* A main provider that has had one or more facilities or organizations considered provider-based also may report to CMS any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that would affect the provider-based status of the facility or organization.

(d) *Requirements applicable to all facilities or organizations.* Any facility or organization for which provider-based status is sought, whether located on or off the campus of a potential main provider, must meet all of the following requirements to be determined by CMS to have provider-based status:

(1) *Licensure.* The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, CMS

will determine that the facility or organization does not have provider-based status.

(2) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(3) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as

evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.

(4) *Public awareness.* The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(5) *Obligations of hospital outpatient departments and hospital-based entities.* In the case of a hospital outpatient department or a hospital-based entity, the facility or organization must fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section.

(e) *Additional requirements applicable to off-campus facilities or organizations.* Except as described in paragraphs (b)(2) and (b)(5) of this section, any facility or organization for which provider-based status is sought that is not located on the campus of a potential main provider must meet both the requirements in paragraph (d) of this section and all of the following additional requirements, in order to be determined by CMS to have provider-based status.

(1) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The business enterprise that constitutes the facility or organization is 100 percent owned by the main provider.

(ii) The main provider and the facility or organization seeking status as a department of the main provider, a re-

mote location of a hospital, or a satellite facility have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the main provider where it is based.

(iv) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the facility or organization.

(2) *Administration and supervision.* The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:

(i) The facility or organization is under the direct supervision of the main provider.

(ii) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(A) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility or organization are integrated with those of the

provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(A) Contracted out under the same contract agreement; or

(B) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

(3) *Location.* The facility or organization meets the requirements in paragraph (e)(3)(i), (e)(3)(ii), (e)(3)(iii), (e)(3)(iv), (e)(3)(v), or, in the case of an RHC, paragraph (e)(3)(vi) of this section, and the requirements in paragraph (e)(3)(vii) of this section.

(i) The facility or organization is located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider.

(ii) The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent or is described in § 412.106(c)(2) of this chapter implementing section 1886(d)(5)(F)(i)(II) of the Act and is—

(A) Owned or operated by a unit of State or local government;

(B) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

(iii) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as

the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider; or

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider).

(iv) If the facility or organization is unable to meet the criteria in paragraph (e)(3)(iii)(A) or paragraph (e)(3)(iii)(B) of this section because it was not in operation during all of the 12-month period described in paragraph (e)(3)(iii) of this section, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph (e)(3)(iii) of this section, accounted for at least 75 percent of the patients served by the main provider.

(v) The facility or organization meets all of the following criteria:

(A) The facility or organization is seeking provider-based status with respect to a hospital that meets the criteria in § 412.23(d) for reimbursement under Medicare as a children's hospital;

(B) The facility or organization meets the criteria for identifying intensive care type units set forth in the Medicare reasonable cost reimbursement regulations under § 413.53(d).

(C) The facility or organization accepts only patients who are newborn infants who require intensive care on an inpatient basis.

(D) The hospital in which the facility or organization is physically located is in a rural area as defined in § 412.64(b)(1)(ii)(C) of this chapter.

(E) The facility or organization is located within a 100-mile radius of the children's hospital that is the potential main provider.

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(F) The facility or organization is located at least 35 miles from the nearest other neonatal intensive care unit.

(G) The facility or organization meets all other requirements for provider-based status under this section.

(vi) Both of the following criteria are met:

(A) The facility or organization is an RHC that is otherwise qualified as a provider-based entity of a hospital that has fewer than 50 beds, as determined under §412.105(b) of this chapter; and

(B) The hospital with which the facility or organization has a provider-based relationship is located in a rural area, as defined in §412.64(b)(1)(ii)(C) of this subchapter.

(vii) A facility or organization may qualify for provider-based status under this section only if the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

(f) *Provider-based status for joint ventures.* In order for a facility or organization operated as a joint venture to be considered provider-based, the facility or organization must—

(1) Be partially owned by at least one provider'

(2) Be located on the main campus of a provider who is a partial owner;

(3) Be provider-based to that one provider whose campus on which the facility or organization is located; and

(4) Also meet all the requirements applicable to all provider-based facilities and organizations in paragraph (d) of this section. For example, where a provider has jointly purchased or jointly created a facility under joint venture arrangements with one or more other providers, and the facility is not located on the campus of the provider or the campus of any other provider engaged in the joint venture arrangement, no party to the joint venture arrangement can claim the facility as provider-based.

(g) *Obligations of hospital outpatient departments and hospital-based entities.* To qualify for provider-based status in relation to a hospital, a facility or organization must comply with the following requirements:

(1) The following departments must comply with the antidumping rules of

§§489.20(l), (m), (q), and (r) and 489.24 of this chapter:

(i) Any facility or organization that is located on the main hospital campus and is treated by Medicare under this section as a department of the hospital; and

(ii) Any facility or organization that is located off the main hospital campus that is treated by Medicare under this section as a department of the hospital and is a dedicated emergency department, as defined in §489.24(b) of this chapter.

(2) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined under the rules of Part 414 of this chapter.

(3) Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

(4) Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with the non-discrimination provisions in §489.10(b) of this chapter.

(5) Hospital outpatient departments (other than RHCs) must treat all Medicare patients, for billing purposes, as hospital outpatients. The department must not treat some Medicare patients as hospital outpatients and others as physician office patients.

(6) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at §412.2(c)(5) of this chapter and at §413.40(c)(2), respectively.

(7) When a Medicare beneficiary is treated in a hospital outpatient department that is not located on the main provider's campus, the treatment is not required to be provided by the anti-dumping rules in §489.24 of this chapter, and the beneficiary will incur a co-insurance liability for an outpatient visit to the hospital as well as for the

physician service, the following requirements must be met:

(i) The hospital must provide written notice to the beneficiary, before the delivery of services, of—

(A) The amount of the beneficiary's potential financial liability; or

(B) If the exact type and extent of care needed are not known, an explanation that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based, an estimate based on typical or average charges for visits to the facility, and a statement that the patient's actual liability will depend upon the actual services furnished by the hospital.

(ii) The notice must be one that the beneficiary can read and understand.

(iii) If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

(iv) In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules of § 489.24 of this chapter, notice, as described in this paragraph (g)(7), must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.

(8) Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

(h) *Management contracts.* A facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of paragraphs (d) and (e) of this section, but is operated under management contracts, must also meet all of the following criteria:

(1) The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care

services of a type that would be paid for by Medicare under a fee schedule established by regulations at part 414 of this chapter. Other than staff that may be paid under such a Medicare fee schedule, the main provider may not utilize the services of "leased" employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

(2) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph (e)(2)(iii) of this section.

(3) The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph (e)(2)(ii) of this section.

(4) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

(i) *Furnishing all services under arrangement.* A facility or organization may not qualify for provider-based status if all patient care services furnished at the facility or organization are furnished under arrangements.

(j) *Inappropriate treatment of a facility or organization as provider-based—*(1) *Determination and review.* If CMS learns that a provider has treated a facility or organization as provider-based and the provider did not request a determination of provider-based status from CMS under paragraph (b)(3) of this section and CMS determines that the facility or organization did not meet the requirements for provider-based status under paragraphs (d) through (i) of this section, as applicable (or, in any period before the effective date of these regulations, the provider-based requirements in effect under Medicare program regulations or instructions), CMS will—

(i) Issue notice to the provider in accordance with paragraph (j)(3) of this section, adjust the amount of future payments to the provider for services of the facility or organization in accordance with paragraph (j)(4) of this section, and continue payments to the

provider for services of the facility or organization only in accordance with paragraph (j)(5) of this section; and

(ii) Except as otherwise provided in paragraphs (b)(2), (b)(5), or (j)(2) of this section, recover the difference between the amount of payments that actually was made and the amount of payments that CMS estimates should have been made, in the absence of compliance with the provider-based requirements, to that provider for services at the facility or organization for all cost reporting periods subject to reopening in accordance with §§ 405.1885 and 405.1889 of this chapter.

(2) *Exception for good faith effort.* CMS will not recover any payments for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001, if, during all of that period—

(i) The requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(4) of this section were met;

(ii) All facility services were billed as if they had been furnished by a department of a provider, a remote location of a hospital, a satellite facility, or a provider-based entity of the main provider; and

(iii) All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(2) of this section.

(3) *Notice to provider.* If CMS determines that a facility or organization was inappropriately treated as provider-based, CMS will issue written notice to the provider that payments for past cost reporting periods may be reviewed and recovered as described in paragraph (j)(1)(ii) of this section, and that future payments for services in or of the facility or organization will be adjusted as described in paragraph (j)(4) of this section.

(4) *Adjustment of payments.* If CMS determines that a facility or organization was inappropriately treated as provider-based, CMS will adjust future payments to the provider or the facility or organization, or both, to estimate the amounts that would be paid for the same services furnished by a freestanding facility.

(5) *Continuation of payment.* (i) The notice of denial of provider-based status sent to the provider will ask the provider to notify CMS in writing, within 30 days of the date the notice is issued, of whether the provider intends to seek a determination of provider-based status for the facility or organization under this section or whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a freestanding facility.

(ii) If the provider indicates that it will not be seeking a determination for the facility or organization under this section or that the facility or organization or its practitioners will not be seeking to enroll, or if CMS does not receive a response within 30 days of the date the notice was issued, all payment under this paragraph (j)(5) will end as of the 30th day after the date of notice.

(iii) If the provider indicates that it will be seeking a determination for the facility or organization under this section or that the facility or organization or its practitioners will be seeking to meet enrollment and other requirements for billing for services in a freestanding facility, payment for services of the facility or organization will continue, at the adjusted amounts described in paragraph (j)(4) of this section, for as long as is required for all billing requirements to be met (but not longer than 6 months) if the provider or the facility or organization or its practitioners—

(A) Submits, as applicable, a complete request for a determination of provider-based status or a complete enrollment application and provide all other required information within 90 days after the date of notice; and

(B) Furnishes all other information needed by CMS to make a determination regarding provider-based status or process the enrollment application, as applicable, and verifies that other billing requirements are met.

(v) If the necessary applications or information are not provided, CMS will terminate all payment to the provider, facility, or organization as of the date

CMS issues notice that necessary applications or information have not been submitted.

(k) *Temporary treatment as provider-based.* If a provider submits a complete attestation of compliance with the requirements for provider-based status for a facility or organization that has not previously been found by CMS to have been inappropriately treated as provider-based under paragraph (j) of this section, the provider may bill and be paid for services of the facility or organization as provider-based from the date it submits the attestation and any required supporting documentation until the date that CMS determines that the facility or organization does not meet the provider-based rules. If CMS subsequently determines that the requirements for provider-based status are not met, CMS will recover the difference between the amount of payments that actually was made since the date the complete attestation of compliance with provider-based requirements was submitted and the amount of payments that CMS estimates should have been made in the absence of compliance with the provider-based requirements. For purposes of this paragraph (k), a complete attestation of compliance with provider-based requirements is one that includes all information needed to permit CMS to make a determination under paragraph (b)(3) of this section.

(1) *Correction of errors.* (1) If CMS determines that a facility or organization that had previously been determined to be provider-based under this section no longer qualifies for provider-based status, and the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did report to CMS under paragraph (c) of this section, treatment of the facility or organization as provider-based ceases with the date that CMS determines that the facility or organization no longer qualifies for provider-based status.

(2) If CMS determines that a facility or organization that had previously been determined to be provider-based under this section no longer qualifies for provider-based status, and if the

failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did not report to CMS under paragraph (c) of this section, CMS will take the actions with respect to notice to the provider, adjustment of payments, and continuation of payment described in paragraphs (j)(3), (j)(4), and (j)(5) of this section, and will recover past payments to the provider to the extent described in paragraph (j)(1)(ii) of this section.

(m) *Status of Indian Health Service and Tribal facilities and organizations.* Facilities and organizations operated by the Indian Health Services and Tribes will be considered to be departments of hospitals operated by the Indian Health Service or Tribes if they furnish only services that are billed, using the CCN of the main provider and with the consent of the main provider, as if they had been furnished by a department of a hospital operated by the Indian Health Service or a Tribe and they are:

(1) Owned and operated by the Indian Health Service;

(2) Owned by the Tribe but leased from the Tribe by the IHS under the Indian Self-Determination Act (Pub. L. 93–638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes; or

(3) Owned by the Indian Health Service but leased and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93–638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes.

(n) *FQHCs and “look alikes.”* A facility that has, since April 7, 1995, furnished only services that were billed as if they had been furnished by a department of a provider will continue to be treated, for purposes of this section, as a department of the provider without regard to whether it complies with the criteria for provider-based status in this section, if the facility—

(1) Received a grant on or before April 7, 2000 under section 330 of the Public Health Service Act and continues to receive funding under such a grant, or is receiving funding from a grant made on or before April 7, 2000

under section 330 of the Public Health Service Act under a contract with the beneficiary of such a grant, and continues to meet the requirements to receive a grant under section 330 of the Public Health Service Act; or

(2) Based on the recommendation of the Public Health Service, was determined by CMS on or before April 7, 2000 to meet the requirements for receiving a grant under section 330 of the Public Health Service Act, and continues to meet such requirements.

(o) *Effective date of provider-based status*—(1) *General rule.* Provider-based status for a facility or organization is effective on the earliest date all of the requirements of this part have been met.

(2) *Inappropriate treatment as provider-based or not reporting material change.* Effective for any period on or after October 1, 2002 (or, in the case of facilities or organizations described in paragraph (b)(2) of this section, for cost reporting periods starting on or after July 1, 2003), if a facility or organization is found by CMS to have been inappropriately treated as provider-based under paragraph (j) of this section for those periods, or previously was determined by CMS to be provider-based but no longer qualifies as provider-based because of a material change occurring during those periods that was not reported to CMS under paragraph (c) of this section, CMS will not treat the facility or organization as provider-based for payment purposes until CMS has determined, based on documentation submitted by the provider, that the facility or organization meets all requirements for provider-based status under this part

[65 FR 18538, Apr. 7, 2000, as amended at 65 FR 58920, Oct. 3, 2000; 66 FR 1599, Jan. 9, 2001; 66 FR 59920, Nov. 30, 2001; 67 FR 50114, Aug. 1, 2002; 68 FR 46070, Aug. 4, 2003; 68 FR 53261, Sept. 9, 2003; 70 FR 47487, Aug. 12, 2005; 74 FR 44000, Aug. 27, 2009; 82 FR 38515, Aug. 14, 2017]

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH (other than services of distinct part units).* (1) Effective for cost reporting periods beginning on or after January 1, 2004, payment for inpatient services of a CAH, other than services

of a distinct part unit of the CAH and other than the items included in the incentive payment described in paragraph (a)(5) of this section and subject to the adjustments described in paragraph (a)(6) of this section, is 101 percent of the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

- (i) Lesser of cost or charges;
- (ii) Ceilings on hospital operating costs;
- (iii) Reasonable compensation equivalent (RCE) limits for physician services to providers; and
- (iv) The payment window provisions for preadmission services, specified in § 412.2(c)(5) of this subchapter and § 413.40(c)(2) of this part.

(2) Except as specified in paragraph (a)(3) of this section, payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients, and is subject to the Part A hospital deductible and coinsurance, as determined under subpart G of part 409 of this chapter.

(3) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services furnished by qualified nonphysician anesthetists employed by the CAH or obtained under arrangements, payment to the CAH for the costs of those services is made in accordance with § 412.113(c).

(4) Payment for inpatient services of distinct part psychiatric or rehabilitation units is described in paragraph (e) of this section.

(5) A qualifying CAH receives an incentive payment for the reasonable costs of purchasing certified EHR technology in a cost reporting period during a payment year as determined under § 495.106 of this chapter in lieu of payment for such reasonable costs under paragraph (a)(1) of this section.

(6)(i) For cost reporting periods beginning in or after FY 2015, if a CAH is not a qualifying CAH for the applicable

EHR reporting period, as defined in §§ 495.4 and 495.106(a) of this chapter, then notwithstanding the percentage applicable in paragraph (a)(1) of this section, the reasonable costs of the CAH in providing CAH services to its inpatients are adjusted by the following applicable percentage:

(A) For cost reporting periods beginning in FY 2015, 100.66 percent.

(B) For cost reporting periods beginning in FY 2016, 100.33 percent.

(C) For cost reporting periods beginning in FY 2017 and each subsequent fiscal year, 100 percent.

(ii) The Secretary may on a case-by-case basis, exempt a CAH that is not a qualifying CAH from the application of the payment adjustment under paragraph (a)(6)(i) of this section if the Secretary determines that compliance with the requirement for being a meaningful user would result in a significant hardship for the CAH. In order to be considered for an exception, a CAH must submit an application demonstrating that it meets one or more of the criteria specified in this paragraph (a)(6) for the applicable payment adjustment year no later than November 30 after the close of the applicable EHR reporting period, or a later date specified by CMS. The Secretary may grant an exception for one or more of the following:

(A) During any 90-day period from the beginning of the cost reporting period that begins in the fiscal year before the payment adjustment year to November 30 after the end of the payment adjustment year, or a later date specified by CMS, the hospital was located in an area without sufficient Internet access to comply with the meaningful use objectives requiring Internet connectivity, and faced insurmountable barriers to obtaining such Internet connectivity.

(B) A CAH that faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user during the payment adjustment year.

(C) The CAH is new in the payment adjustment year and has not previously operated (under previous or present ownership). This exception expires beginning with the first Federal fiscal year that begins on or after the

hospital has had at least one 12-month (or longer) cost reporting period after they accept their first Medicare-covered patient. For the purposes of this exception, the following CAHs are not considered new CAHs:

(1) A CAH that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.

(2) A CAH that closes and subsequently reopens.

(3) A CAH that has been converted from an eligible hospital as defined at § 495.4 of this chapter.

(iii) *Exception for decertified EHR technology.* Beginning with the fiscal year 2018 payment adjustment year, the Secretary shall exempt a CAH that is not a qualifying CAH from the application of the payment adjustment under paragraph (a)(6)(i) of this section if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by the CAH has been decertified under ONC's Health IT Certification Program. In order to be considered for an exception, a CAH must submit an application, in the manner specified by CMS, demonstrating that the certified EHR technology was decertified during the 12-month period preceding the applicable EHR reporting period for the payment adjustment year, or during the applicable EHR reporting period for the payment adjustment year, and that the CAH made a good faith effort to obtain another certified EHR technology for that EHR reporting period. Applications requesting this exception must be submitted by November 30 after the end of the applicable payment adjustment year, or a later date specified by CMS.

(iv) Exceptions granted under paragraphs (a)(6)(ii) and (iii) of this section are subject to annual renewal, but in no case may a CAH be granted such an exception for more than 5 years.

(7) There is no administrative or judicial review under section 1869 and 1878 of the Act otherwise of the following:

(i) The methodology and standards for determining the amount of payment under paragraph (a)(5) of this section, including the calculation of reasonable costs under §495.106(c) of this chapter.

(ii) The methodology and standards for determining the amount of payment adjustments made under paragraph (a)(6).

(iii) The methodology and standards for determining a CAH to be a qualifying CAH under §495.106 of this chapter.

(iv) The methodology and standards for determining if the hardship exemption applies to a CAH under paragraph (a)(6)(ii) of this section.

(v) The specification of the cost reporting periods, payment years, or fiscal years as applied under this paragraph.

(b) *Payment for outpatient services furnished by CAH*—(1) *General*. (i) Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is determined under paragraph (b)(2) of this section.

(ii) Except as specified in paragraph (b)(6) of this section, payment to a CAH for outpatient services does not include any costs of physician services or other professional services to CAH outpatients.

(2) *Reasonable costs for facility services*. (i) Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient services of a CAH is 101 percent of the reasonable costs of the CAH in providing CAH services to its outpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH outpatient services:

(A) Lesser of cost or charges; and

(B) RCE limits.

(ii) Payment to a CAH under paragraph (b)(2) of this section does not include any costs of physician services or other professional services to CAH outpatients and, other than for clinical diagnostic laboratory tests, is subject to

the Part B deductible and coinsurance amounts as determined under §§410.152(k), 410.160, and 410.161 of this chapter.

(iii) [Reserved]

(3) *Election to be paid reasonable costs for facility services plus fee schedule for professional services*. (i) A CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004 under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section.

(A)(1) *For cost reporting periods beginning before October 1, 2010*. The election must be made in writing, made on an annual basis, and delivered to the contractor or MAC servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made. An election, once made for a cost reporting period, remains in effect for all of that period.

(2) *For cost reporting periods beginning on or after October 1, 2010*. If a CAH had elected the method specified in paragraph (b)(3)(i) of this section in its most recent cost reporting period beginning prior to October 1, 2010, that election remains in effect for all of that period and for all subsequent cost reporting periods, unless the CAH submits a termination request to the contractor or MAC servicing the CAH at least 30 days before the start of the next cost reporting period. However, for cost reporting periods beginning in October 2010 and November 2010, if a CAH wishes to terminate its previous election, the CAH must submit a termination request to the contractor or MAC servicing the CAH prior to December 1, 2010. If a CAH had no election in effect in its most recent preceding cost reporting period and chooses to elect the method specified in paragraph (b)(3)(i) of this section on or after October 1, 2010, the election must be made in writing and delivered to the contractor or MAC servicing the CAH at least 30 days before the start of the first cost reporting period for which the election is made. Once the election is made, it remains in effect for all of that period and for all subsequent cost reporting periods unless the CAH submits a termination request to the contractor or MAC servicing the CAH at

least 30 days before the start of the next cost reporting period.

(B) An election of the payment method specified under paragraph (b)(3)(i) of this section applies to all services furnished to outpatients by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with subpart F of part 424 of this chapter. If a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with subpart F of part 424 of this chapter, payment for the physician's or practitioner's services furnished to CAH outpatients will be made on a fee schedule or other applicable basis as specified in subpart B of part 414 of this subchapter.

(C) In the case of a CAH that made an election under this section before November 1, 2003, for a cost reporting period beginning before December 1, 2003, the rules in paragraph (b)(3)(i)(B) of this section are applicable to cost reporting periods beginning on or after July 1, 2001.

(D) An election made under paragraph (b)(3)(i) of this section is effective as provided for under paragraph (b)(3)(i)(A) or paragraph (b)(3)(i)(C) of this section and does not apply to an election that was terminated prior to the start of the cost reporting period for which it would otherwise apply.

(ii) If the CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following:

(A) Effective for cost reporting periods beginning on or after January 1, 2004, for facility services not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, 101 percent of the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and

(B) For professional services that are furnished by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with part 424, subpart F of this chapter, and that would otherwise be payable to the physician or other practitioner if the rights to bill for them had not been reassigned, 115 percent of the amounts that otherwise would be paid for the service if the

CAH had not elected payment under this method. Effective for primary care services furnished by primary care practitioners (as defined in § 414.80(a)) and major surgical procedures furnished by general surgeons in health professional shortage areas (as defined in § 414.2) furnished on or after January 1, 2011 and before January 1, 2016, incentive payments specified under § 414.80 and § 414.67(b), respectively, of this title must not be included in determining payment made under this paragraph.

(iii) Payment to a CAH, other than for clinical diagnostic laboratory tests, is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152(k), 410.160, and 410.161 of this chapter.

(4) *Costs of certain emergency room on-call providers.* (i) Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at any other provider or facility. Effective for costs incurred for services furnished on or after January 1, 2005, the payment amount of 101 percent of the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following emergency room providers who are on call but who are not present on the premises of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility: physician assistants, nurse practitioners, and clinical nurse specialists.

(ii) For purposes of this paragraph (b)(4)—

(A) “Amounts for reasonable compensation and related costs” means all allowable costs of compensating emergency room physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on call to the extent that the costs are found to be reasonable under the rules specified in paragraph (b)(2) of this section and

the applicable sections of part 413. Costs of compensating these specified medical emergency room staff are allowable only if the costs are incurred under written contracts that require the physician, physician assistant, nurse practitioner, or clinical nurse specialist to come to the CAH when the physician's or other practitioner's presence is medically required.

(B) Effective for costs incurred on or after January 1, 2005, an "emergency room physician, physician assistant, nurse practitioner, or clinical nurse specialist who is on call" means a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care who is immediately available by telephone or radio contact, and is available onsite within the timeframes specified in § 485.618(d) of this chapter.

(5) *Costs of ambulance services.* (i)(A) Effective for services furnished on or after December 21, 2000 and on or before December 31, 2003, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.

(B) Effective for cost reporting periods beginning on or after January 1, 2004 and on or before September 30, 2011, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.

(C) Effective for cost reporting periods beginning on or after October 1, 2011 and on or before September 30, 2019, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH. If there is no

provider or supplier of ambulance services located within a 35-mile drive of the CAH and there is an entity that is owned and operated by a CAH that is more than a 35-mile drive from the CAH, payment for ambulance services furnished by that entity is 101 percent of the reasonable costs of the entity in furnishing those services, but only if the entity is the closest provider or supplier of ambulance services to the CAH.

(D) Effective for cost reporting periods beginning on or after October 1, 2019, payment for ambulance services furnished by a CAH or by a CAH-owned and operated entity is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH, excluding ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals to or from the CAH. If there is no provider or supplier of ambulance services located within a 35-mile drive of the CAH and there is an entity that is owned and operated by a CAH that is more than a 35-mile drive from the CAH, payment for ambulance services furnished by that entity is 101 percent of the reasonable costs of the entity in furnishing those services, but only if the entity is the closest provider or supplier of ambulance services to the CAH.

(ii) For purposes of paragraph (b)(5) of this section, the distance between the CAH or the entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the closest provider or supplier of ambulance services are garaged. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road will be considered to include the paved surface up to the front entrance of the hospital and the front entrance of the garage.

(6) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services

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furnished by nonphysician anesthetists employed by the CAH or obtained under arrangement, payment to the CAH for the costs of those services is made in accordance with § 412.113(c) of this chapter.

(7) *Payment for clinical diagnostic laboratory tests included as outpatient CAH services.* (i) Payment for clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts.

(ii) Subject to the provisions of paragraphs (b)(7)(iii) through (b)(7)(vi) of this section, payment to a CAH for clinical diagnostic laboratory tests will be made at 101 percent of reasonable costs of the services as determined in accordance paragraph (b)(2)(i) of this section.

(iii) For services furnished before July 1, 2009, payment to a CAH for clinical diagnostic laboratory tests will be made under paragraph (b)(7)(ii) of this section only if the individual is an outpatient of the CAH, as defined in § 410.2 of this chapter, and is physically present in the CAH at the time the specimen is collected.

(iv) Except as provided in paragraphs (b)(7)(iii) and (b)(7)(v) of this section, payment to a CAH for clinical diagnostic laboratory tests will be made under paragraph (b)(7)(ii) of this section only if the individual is an outpatient of the CAH, as defined in § 410.2 of this chapter, without regard to whether the individual is physically present in the CAH at the time the specimen is collected and at least one of the following conditions is met:

(A) The individual is receiving outpatient services in the CAH on the same day the specimen is collected; or

(B) The specimen is collected by an employee of the CAH.

(v) Notwithstanding paragraph (b)(7)(iv) of this section, payment for outpatient clinical diagnostic laboratory tests will not be made under paragraph (b)(7)(ii) of this section if the billing rules under § 411.15(p) of this chapter apply.

(vi) Payment for clinical diagnostic laboratory tests for which payment may not be made under paragraph (b)(7)(iii) or paragraph (b)(7)(iv) of this section will be made in accordance with the provisions of sections

1833(a)(1)(D) and 1833(a)(2)(D) of the Act.

(c) *Final payment based on cost report.* Final payment to the CAH for CAH facility services to inpatients and outpatients furnished during a cost reporting is based on a cost report for that period, as required under § 413.20(b).

(d) *Periodic interim payments.* Subject to the provisions of § 413.64(h), a CAH receiving payments under this section may elect to receive periodic interim payments (PIP) for Part A inpatient CAH services, effective for payments made on or after July 1, 2004. Payment is made biweekly under the PIP method unless the CAH requests a longer fixed interval (not to exceed one month) between payments. The biweekly interim payment amount is based on the total estimated Medicare payment (after estimated beneficiary deductibles and coinsurance) for the cost reporting period. Each payment is made 2 weeks after the end of a biweekly period of service, as described in § 413.64(h)(6). These PIP provisions are further described in § 413.64(h)(6). Under certain circumstances that are described in § 413.64(g), a CAH that is not receiving PIP may request an accelerated payment.

(e) *Payment for service of distinct part psychiatric and rehabilitation units of CAHS.* Payment for inpatient services of distinct part psychiatric units of CAHS—

(1) For cost reporting periods beginning before January 1, 2005, payment is made on a reasonable cost basis, subject to the provisions of § 413.40.

(2) For cost reporting periods beginning on or after January 1, 2005, payment is made in accordance with regulations governing inpatient psychiatric facilities at subpart N (§ 412.400 through § 412.432) of Part 412 of this subchapter.

(3) Payment for inpatient services of distinct part rehabilitation units of CAHS is made in accordance with regulations governing the inpatient rehabilitation facilities prospective payment system at subpart P (§ 412.600 through § 412.632) of part 412 of this subchapter.

[65 FR 47109, Aug. 1, 2000]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 413.70, see the List of CFR Sections Affected, which appears in the

Finding Aids section of the printed volume and at www.govinfo.gov.

§ 413.74 Payment to a foreign hospital.

(a) *Principle.* Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospital services furnished by foreign hospitals to Medicare beneficiaries. Subpart H of part 424 of this chapter, together with this section, specifies the conditions for payment.

(b) *Amount of payment.* Effective with admissions on or after January 1, 1980, the reasonable cost for services covered under the Medicare program furnished to beneficiaries by a foreign hospital will be equal to 100 percent of the hospital's customary charges (as defined in § 413.13(b)) for the services.

(c) *Submittal of claims.* The hospital must establish its customary charges for the services by submitting an itemized bill with each claim it files in accordance with its election under § 424.104 of this chapter.

(d) *Exchange rate.* Payment to the hospital will be subject to the official exchange rate on the date the patient is discharged and to the applicable deductible and coinsurance amounts described in §§ 409.80 through 409.83.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 41351, Nov. 14, 1986; 53 FR 6648, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 71 FR 48141, Aug. 18, 2006]

Subpart F—Specific Categories of Costs

§ 413.75 Direct GME payments: General requirements.

(a) *Statutory basis and scope—(1) Basis.* This section and §§ 413.76 through 413.83 implement section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section and §§ 413.76 through 413.83 apply to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section and §§ 413.76 through 413.83, the following definitions apply:

All or substantially all of the costs for the training program in the nonhospital setting means—

(1) Effective on or after January 1, 1999 and for cost reporting periods beginning before July 1, 2007, the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education (GME); and

(2) Effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct GME activities.

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

Approved medical residency program means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, Suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting