

§ 413.24

42 CFR Ch. IV (10–1–24 Edition)

its fiscal and other records for the purpose of determining such provider's ongoing recordkeeping capability and inform the contractor of the date its initial Medicare cost reporting period ends. This examination is intended to assure that—

(1) The provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes under section 1815 of the Act; and

(2) No financial arrangements exist that will thwart the commitment of the Medicare program to reimburse providers the reasonable cost of services furnished beneficiaries. The data and information to be examined include cost, revenue, statistical, and other information pertinent to reimbursement including, but not limited to, that described in paragraph (d) of this section and in § 413.24.

(d) *Continuing provider recordkeeping requirements.* (1) The provider must furnish such information to the contractor as may be necessary to—

(i) Assure proper payment by the program, including the extent to which there is any common ownership or control (as described in § 413.17(b)(2) and (3)) between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports;

(ii) Receive program payments; and

(iii) Satisfy program overpayment determinations.

(2) The provider must permit the contractor to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records include, but are not limited to, matters pertaining to—

(i) Provider ownership, organization, and operation;

(ii) Fiscal, medical, and other recordkeeping systems;

(iii) Federal income tax status;

(iv) Asset acquisition, lease, sale, or other action;

(v) Franchise or management arrangements;

(vi) Patient service charge schedules;

(vii) Costs of operation;

(viii) Amounts of income received by source and purpose; and

(ix) Flow of funds and working capital.

(3)(i) The provider must furnish the contractor, upon request, copies of patient service charge schedules and changes thereto as they are put into effect; and

(ii) The contractor evaluates the charge schedules as specified in paragraph (d)(3)(i) of this section to determine the extent to which they may be used for determining program payment.

(e) *Suspension of program payments to a provider.* If an contractor determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the Medicare program, payments to such provider will be suspended until the contractor is assured that adequate records are maintained. Before suspending payments to a provider, the contractor will, in accordance with the provisions in § 405.372(a) of this chapter, send written notice to such provider of its intent to suspend payments. The notice will explain the basis for the contractor's determination with respect to the provider's records and will identify the provider's recordkeeping deficiencies. The provider must be given the opportunity, in accordance with § 405.372(b) of this chapter, to submit a statement (including any pertinent evidence) as to why the suspension must not be put into effect.

[51 FR 34793, Sept. 30, 1986, as amended at 61 FR 63749, Dec. 2, 1996; 85 FR 59023, Sept. 18, 2020; 86 FR 45521, Aug. 13, 2021]

§ 413.24 Adequate cost data and cost finding.

(a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting, except for—

(1) Governmental institutions which operate on a cash basis method of accounting. Cost data based on such basis

of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

(2) Costs of qualified defined benefit pension plans shall be reported on a cash basis method of accounting, as described at § 413.100(c)(2)(vii)(D) for cost reporting periods beginning on or after October 1, 2011.

(b) *Definitions*—(1) *Cost finding*. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services furnished. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) *Accrual basis of accounting*. As used in this part, the term *accrual basis of accounting* means that revenue is reported in the period in which it is earned, regardless of when it is collected; and an expense is reported in the period in which it is incurred, regardless of when it is paid. (See § 413.100 regarding limitations on allowable accrued costs in situations in which the related liabilities are not liquidated timely.)

(c) *Adequacy of cost information*. Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.

(d) *Cost finding methods*. After the close of the accounting period, providers must use one of the following methods of cost finding to determine

the actual costs of services furnished during that period. (These provisions do not apply to SNFs that elect and qualify for prospectively determined payment rates under subpart I of this part for cost reporting periods beginning on or after October 1, 1986. For the special rules that are applicable to those SNFs, see § 413.321.) For cost reporting periods beginning after December 31, 1971, providers using the departmental method of cost apportionment must use the step-down method described in paragraph (d)(1) of this section or an "other method" described in paragraph (d)(2) of this section. For cost reporting periods beginning after December 31, 1971, providers using the combination method of cost apportionment must use the modified cost finding method described in paragraph (d)(3) of this section. Effective for cost reporting periods beginning on or after October 1, 1980, HHAs not based in hospitals or SNFs must use the step-down method described in paragraph (d)(1) of this section. (HHAs based in hospitals or SNFs must use the method applicable to the parent institution.) However, an HHA not based in a hospital or SNF that received less than \$35,000 in Medicare payment for the immediately preceding cost reporting period, and for whom this payment represented less than 50 percent of the total operating cost of the agency, may use a simplified version of the step-down method, as specified in instructions for the cost report issued by CMS.

(1) *Step-down method*. This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have

received some service from a center whose cost is apportioned later. Generally, if two centers furnish services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(2) *Other methods*—(i) *The double-apportionment method.* The double-apportionment method may be used by a provider upon approval of the contractor. This method also recognizes that the nonrevenue-producing departments or centers furnish services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of non-revenue-producing centers is made. These centers or departments are not “closed” after this preliminary allocation. Instead, they remain “open,” accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers.

(ii) *More sophisticated methods.* A more sophisticated method designed to allocate costs more accurately may be used by the provider upon approval of the contractor. However, having elected to use the double-apportionment method, the provider may not thereafter use the step-down method without approval of the contractor. Written request for the approval must be made on a prospective basis and must be submitted before the end of the fourth month of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use either the double-apportionment or step-down methods without similar request and approval.

(3) *Modified cost finding for providers using the Combination Method for reporting periods beginning after December 31, 1971.* This method differs from the step-down method in that services furnished by nonrevenue-producing departments

or centers are allocated directly to revenue-producing departments or centers even though these services may be utilized by other nonrevenue-producing departments or centers. In the application of this method the cost of nonrevenue-producing centers having a common basis of allocation are combined and the total distributed to revenue-producing centers. All nonrevenue-producing centers having significant percentages of cost in relation to total costs will be allocated this way. The combined total costs of remaining nonrevenue-producing costs centers will be allocated to revenue-producing cost centers in the proportion that each bears to total costs, direct and indirect, already allocated. The bases which are to be used and the centers which are to be combined for allocation are not optional but are identified and incorporated in the cost report forms developed for this method. Providers using this method must use the program cost report forms devised for it. Alternative forms may not be used without prior approval by CMS based upon a written request by the provider submitted through the contractor.

(4) *Temporary method for initial period.* If the provider is unable to use either cost-finding method when it first participates in the program, it may apply to the contractor for permission to use some other acceptable method that would accurately identify costs by department or center, and appropriately segregate inpatient and outpatient costs. Such other method may be used for cost reports covering periods ending before January 1, 1968.

(5) *Simplified optional reimbursement method for small, rural hospitals with distinct parts for cost reporting periods beginning on or after July 20, 1982.* (i) A rural hospital with a Medicare-certified distinct part SNF may elect to be reimbursed for services furnished in its hospital general routine service area and distinct part SNF using the reimbursement method specified in § 413.53 for swing-bed hospitals, if it meets the following conditions:

(A) The institution is located in a rural area as defined in § 482.58 of this chapter.

(B) On the first day of the cost reporting period, the hospital and distinct part SNF have fewer than 50 beds in total (with the exception of beds for newborns and beds in intensive care type inpatient units).

(ii) In applying the optional reimbursement method, only those beds located in the hospital general routine service area and in the distinct part SNF certified by Medicare are combined into a single cost center for purposes of cost finding.

(iii) The reasonable cost of the routine extended care services is determined in accordance with §413.114(c). The reasonable cost of the hospital general routine services is determined in accordance with §413.53(a)(2).

(iv) The hospital must make its election to use the optional swing-bed reimbursement method in writing to the contractor before the beginning of the hospital's cost reporting year. The hospital must make any request to revoke the election in writing before the beginning of the affected cost reporting period.

(v) The contractor must approve requests to terminate use of the optional swing-bed reimbursement method. If a hospital terminates use of this optional method, no further elections may be made by the facility to use the optional method.

(6) *Provider-based entities and departments: Preventing duplication of cost.* In some situations, the main provider in a provider-based complex may purchase services for a provider-based entity or for a department of the provider through a contract for services (for example, a management contract), directly assigning the costs to the provider-based entity or department and reporting the costs directly in the cost center for that entity or department. In any situation in which costs are directly assigned to a cost center, there is a risk of excess cost in that cost center resulting from the directly assigned costs plus a share of overhead improperly allocated to the cost center which duplicates the directly assigned costs. This duplication could result in improper Medicare payment to the provider. Where a provider has purchased services for a provider-based entity or for a provider department, like general

service costs of the provider (for example, like costs in the administrative and general cost center) must be separately identified to ensure that they are not improperly allocated to the entity or the department. If the like costs of the main provider cannot be separately identified, the costs of the services purchased through a contract must be reclassified to the main provider and allocated among the main provider's benefiting cost centers.

Example: A provider-based complex is composed of a hospital and a hospital-based rural health clinic (RHC). The hospital furnishes the entirety of its own administrative and general costs internally. The RHC, however, is managed by an independent contractor through a management contract. The management contract provides a full array of administrative and general services, with the exception of patient billing. The hospital directly assigns the costs of the RHC's management contract to the RHC cost center (for example, Form CMS 2552-96, Worksheet A, Line 71). A full allocation of the hospital's administrative and general costs to the RHC cost center would duplicate most of the RHC's administrative and general costs. However, an allocation of the hospital's cost (included in hospital administrative and general costs) of its patient billing function to the RHC would be appropriate. Therefore, the hospital must include the costs of the patient billing function in a separate cost center to be allocated to the benefiting cost centers, including the RHC cost center. The remaining hospital administrative and general costs would be allocated to all cost centers, excluding the RHC cost center. If the hospital is unable to isolate the costs of the patient billing function, the costs of the RHC's management contract must be reclassified to the hospital administrative and general cost center to be allocated among all cost centers, as appropriate.

(7) *Costs of services furnished to free-standing entities.* The costs that a provider incurs to furnish services to free-standing entities with which it is associated are not allowable costs of that provider. Any costs of services furnished to a free-standing entity must be identified and eliminated from the allowable costs of the servicing provider, to prevent Medicare payment to that provider for those costs. This may be done by including the free-standing entity on the cost report as a nonreimbursable cost center for the purpose of allocating overhead costs to that entity. If this method would not result in

an accurate allocation of costs to the entity, the provider must develop detailed work papers showing how the cost of services furnished by the provider to the entity were determined. These costs are removed from the applicable cost centers of the servicing provider.

(e) *Accounting basis.* The cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. However, governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

(f) *Cost reports.* For cost reporting purposes, the Medicare program requires each provider of services to submit periodic reports of its operations that generally cover a consecutive 12-month period of the provider's operations. Amended cost reports to revise cost report information that has been previously submitted by a provider may be permitted or required as determined by CMS.

(1) *Cost reports—Terminated providers and changes of ownership.* A provider that voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change of ownership must file a cost report for that period under the program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement or change of ownership.

(2) *Due dates for cost reports.* (i) Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

(ii) Extensions of the due date for filing a cost report may be granted by the contractor only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire.

(3) *Changes in cost reporting periods.* A provider may change its cost reporting

period if a change in ownership is experienced or if the—

(i) Provider requests the change in writing from its contractor;

(ii) Contractor receives the request at least 120 days before the close of the new reporting period requested by the provider; and

(iii) Contractor determines that good cause for the change exists. Good cause would not be found to exist if the effect is to change the initial date that a hospital would be affected by the rate of increase ceiling (see § 413.40), or be paid under the prospective payment systems (see part 412 of this chapter).

(4) *Electronic submission of cost reports.*

(i) As used in this paragraph (f)(4), “provider” means a hospital, rural emergency hospital, skilled nursing facility, home health agency, hospice, organ procurement organization, histocompatibility laboratory, rural health clinic, federally qualified health center, community mental health center, or end-stage renal disease facility.

(ii) Effective for cost reporting periods beginning on or after October 1, 1989, for hospitals; cost reporting periods ending on or after February 1, 1997, for skilled nursing facilities and home health agencies; cost reporting periods ending on or after December 31, 2004, for hospices, and end-stage renal disease facilities; cost reporting periods ending on or after March 31, 2005, for organ procurement organizations, histocompatibility laboratories, rural health clinics, federally qualified health centers, and community mental health centers; and cost reporting periods beginning on or after January 1, 2023, for rural emergency hospitals, a provider is required to submit cost reports in a standardized electronic format. The provider's electronic program must be capable of producing the CMS standardized output file in a form that can be read by the contractor's automated system. This electronic file, which must contain the input data required to complete the cost report and to pass specified edits, must be forwarded to the contractor for processing through its system.

(iii) The contractor stores the provider's as-filed electronic cost report and may not alter that file for any reason. The contractor makes a “working

copy” of the as-filed electronic cost report to be used, as necessary, throughout the settlement process (that is, desk review, processing audit adjustments, and final settlement). The provider’s electronic program must be able to disclose if any changes have been made to the as-filed electronic cost report after acceptance by the contractor. If the as-filed electronic cost report does not pass all specified edits, the contractor must return it to the provider for correction. For purposes of the requirements in paragraph (f)(2) of this section concerning due dates, an electronic cost report is not considered to be filed until it is accepted by the contractor.

(iv)(A) Effective as specified in paragraphs (f)(4)(iv)(A)(1) through (5) of this section and except as provided in paragraph (f)(4)(iv)(C) of this section, a provider must submit a hard copy of a settlement summary, if applicable, which is a statement of certain worksheet totals found within the electronic file, and the certification statement described in paragraph (f)(4)(iv)(B) of this section signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report.

(1) For hospitals, effective for cost reporting periods ending on or after September 30, 1994;

(2) For skilled nursing facilities and home health agencies, effective for cost reporting periods ending on or after February 1, 1997;

(3) For hospices and end-stage renal disease facilities, effective for cost reporting periods ending on or after December 31, 2004;

(4) For organ procurement organizations, histocompatibility laboratories, rural health clinics, federally qualified health centers, and community mental health centers, effective for cost reporting periods ending on or after March 31, 2005; and

(5) For rural emergency hospitals, effective for cost reporting periods beginning on or after January 1, 2023.

(B) The following certification statement must immediately precede the dated original signature, or electronic signature as set forth in paragraph (f)(4)(iv)(C)(I) of this section, of the

provider’s administrator or chief financial officer:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

I hereby certify that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ____ (Provider Name(s) and Number(s)) for the cost reporting period beginning ____ and ending ____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(C) Effective for cost reporting periods ending on or after December 31, 2017—(I) A provider that is required to file an electronic cost report may elect to electronically submit the settlement summary, if applicable, and the certification statement with an electronic signature of the provider’s administrator or chief financial officer. The following checkbox for electronic signature and submission will immediately follow the certification statement as set forth in paragraph (f)(4)(iv)(B) of this section and must be checked if electronic signature and submission is elected.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be

the legally binding equivalent of my original signature.

(2) A provider that is required to file an electronic cost report but does not elect to electronically submit the certification statement with an electronic signature, must submit a hard copy of the settlement summary, if applicable, and a certification statement with an original signature of the provider's administrator or chief financial officer as set forth in paragraphs (f)(4)(iv)(A) and (B) of this section.

(v) A provider may request a delay or waiver of the electronic submission requirement in paragraph (f)(4)(ii) of this section if this requirement would cause a financial hardship or if the provider qualifies as a low or no Medicare utilization provider. The provider must submit a written request for delay or waiver with necessary supporting documentation to its contractor no later than 30 days after the end of its cost reporting period. The contractor reviews the request and forwards it, with a recommendation for approval or denial, to CMS central office within 30 days of receipt of the request. CMS central office either approves or denies the request and notifies the contractor within 60 days of receipt of the request.

(5) An acceptable cost report submission is defined as follows:

(i) The provider must accurately complete and submit the required cost reporting forms, including all necessary signatures and supporting documents. For providers claiming costs on their cost reports that are allocated from a home office or chain organization, the Home Office Cost statement must be submitted by the home office or chain organization as set forth in paragraph (f)(5)(i)(E) of this section. A cost report is rejected for lack of supporting documentation if it does not include the following, except as provided in paragraphs (f)(5)(i)(A)(2)(ii) and (f)(5)(i)(E) of this section:

(A) *Teaching hospitals.* For teaching hospitals, the Intern and Resident Information System (IRIS) data.

(1) *Data format.* For cost reporting periods beginning on or after October 1, 2021, the IRIS data must be in the new XML IRIS format.

(2) *Resident counts.* (i) Effective for cost reporting periods beginning on or

after October 1, 2021, the IRIS data must contain the same total counts of direct GME FTE residents (unweighted and weighted) and IME FTE residents as the total counts of direct GME FTE and IME FTE residents reported in the provider's cost report.

(ii) For cost reporting periods beginning on or after October 1, 2021, and before October 1, 2022, the cost report is not rejected if the requirement in paragraph (f)(5)(i)(A)(2)(i) of this section is not met.

(B) *Bad debt*—Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming Medicare bad debt reimbursement, a detailed bad debt listing that corresponds to the amount of bad debt claimed in the provider's cost report.

(C) *DSH eligible hospitals*—Effective for cost reporting periods beginning on or after October 1, 2018, for hospitals claiming a disproportionate share hospital payment adjustment, a detailed listing of the hospital's Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the hospital's cost report. If the hospital submits an amended cost report that changes its Medicaid eligible days, the hospital must submit an amended listing or an addendum to the original listing of the hospital's Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the hospital's amended cost report.

(D) *Charity care and uninsured discounts*—Effective for cost reporting periods beginning on or after October 1, 2018, for DSH eligible hospitals reporting charity care and/or uninsured discounts, a detailed listing of charity care and/or uninsured discounts that corresponds to the amounts claimed in the DSH eligible hospital's cost report.

(E) *Home office cost allocation.* (1) *Same fiscal year end.* Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming costs on their cost report that are allocated from a home office or chain organization with the same fiscal year end, a Home Office Cost Statement completed and submitted by the home office or chain organization to its chain provider's servicing contractor that corresponds to the amounts allocated

from the home office or chain organization to the provider's cost report.

(2) *Differing fiscal year end.* Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming costs on their cost report that are allocated from a home office or chain organization with a different fiscal year end, a Home Office Cost Statement completed and submitted by the home office or chain organization to its chain provider's servicing contractor that corresponds to some portion of the amounts allocated from the home office or chain organization to the provider's cost report.

(ii) For providers that are required to file electronic cost reports—In addition to the requirements of paragraphs (f)(4) and (f)(5)(i) of this section, the provider must submit its cost reports in an electronic cost report format in conformance with the requirements contained in the Electronic Cost Report (ECR) Specifications Manual (unless the provider has received an exemption from CMS).

(iii) The contractor makes a determination of acceptability within 30 days of receipt of the provider's cost report. If the cost report is considered unacceptable, the contractor returns the cost report with a letter explaining the reasons for the rejection. When the cost report is rejected, it is deemed an unacceptable submission and treated as if a report had never been filed.

(g) *Exception from full cost reporting for lack of program utilization.* If a provider does not furnish any covered services to Medicare beneficiaries during a cost reporting period, it is not required to submit a full cost report. It must, however, submit an abbreviated cost report, as prescribed by CMS.

(h) *Waiver of full or simplified cost reporting for low program utilization.* (1) If the provider has had low utilization of covered services by Medicare beneficiaries (as determined by the contractor) and has received correspondingly low interim payments for the cost reporting period, the contractor may waive a full cost report or the simplified cost report described in § 413.321 if it decides that it can determine, without a full or simplified report, the reasonable cost of covered services provided during that period.

(2) If a full or simplified cost report is waived, the provider must submit within the same time period required for full or simplified cost reports:

- (i) The cost reporting forms prescribed by CMS for this situation; and
- (ii) Any other financial and statistical data the contractor requires.

(i) [Reserved]

(j) *Substantive reimbursement requirement of an appropriate cost report claim—*

(1) *General requirement.* In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—

(i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or

(ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.

(2) *Self-disallowance procedures.* In order to properly self-disallow a specific item, the provider must—

(i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and

(ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

(3) *Procedures for determining whether there is an appropriate cost report claim.* Whether the provider's cost report for its cost reporting period includes an appropriate claim for a specific item (as prescribed in paragraph (j)(1) of this section) must be determined by reference to the cost report that the provider submits originally to, and was accepted by, the contractor for such period, provided that none of the following exceptions applies:

(i) If the provider submits an amended cost report for its cost reporting period and such amended cost report is accepted by the contractor, then whether there is an appropriate cost report claim for the specific item must be determined by reference to such amended cost report, provided that neither of the exceptions set forth in paragraphs (j)(3)(ii) and (iii) of this section applies;

(ii) If the contractor adjusts the provider's cost report, as submitted originally by the provider and accepted by the contractor or as amended by the provider and accepted by the contractor, whichever is applicable, with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the final contractor determination (as defined in § 405.1801(a) of this chapter) for the provider's cost reporting period, provided that the exception set forth in paragraph (j)(3)(iii) of this section does not apply;

(iii) If the contractor reopens either the final contractor determination for the provider's cost reporting period (pursuant to § 405.1885 of this chapter) or a revised final contractor determination for such period (issued pursuant to § 405.1889 of this chapter) and the contractor adjusts the provider's cost report with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the most recent revised final contractor determination for such period.

(4) *Reimbursement effects of contractor's determination of whether there is an appropriate cost report claim.* If the contractor determines that the provider's cost report included an appropriate claim for a specific item (as specified in paragraphs (j)(1), (2), and (3) of this section) and that all the other substantive reimbursement requirements for the specific item are also satisfied, the final contractor determination (as defined in § 405.1801(a) of this chapter) must include reimbursement for the specific item to the extent permitted by Medicare policy. If the contractor determines that the provider made an appropriate cost report claim for a specific item but the contractor disagrees with material aspects of the provider's claim for the specific item, the contractor must make appropriate adjustments to the provider's cost report and include reimbursement for the specific item in the final contractor determination in accordance with such cost report adjustments and to the extent permitted by program policy. If the contractor determines that the provider did not make an appropriate cost report claim for a specific item, the final contractor determination must not include any reimbursement for the specific item, regardless of whether the other substantive reimbursement requirements for the specific item are or are not satisfied.

(5) *Administrative review of whether there is an appropriate cost report claim.* If the provider files an administrative appeal (pursuant to Part 405, Subpart R of this chapter) seeking reimbursement for a specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item under appeal (as specified in paragraphs (j)(1), (2), (3), and (4) of this section), the reviewing entity (as defined in § 405.1801(a) of this chapter) must follow the procedures prescribed in § 405.1873 of this chapter (if the appeal was filed originally with the Board), or the procedures set forth in § 405.1832 of this chapter (if the appeal was filed initially with the contractor), for review of whether the substantive reimbursement requirement of an appropriate cost report claim for the specific item under appeal is satisfied. The reviewing

entity must follow the procedures set forth in paragraph (j)(3) of this section in determining whether the provider's cost report included an appropriate claim for the specific item under appeal. The reviewing entity may permit reimbursement for the specific item under appeal solely to the extent authorized by § 405.1873(f) of this chapter (if the appeal was filed originally with the Board) or by § 405.1832(f) of this chapter (if the appeal was filed initially with the contractor).

[51 FR 34793, Sept. 30, 1986]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 413.24, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

Subpart C—Limits on Cost Reimbursement

§ 413.30 Limitations on payable costs.

(a) *Introduction*—(1) *Scope*. This section implements section 1861(v)(1)(A) of the Act by setting forth the general rules under which CMS may establish limits on SNF and HHA costs recognized as reasonable in determining Medicare program payments. It also sets forth rules governing exemptions and exceptions to limits established under this section that CMS may make as appropriate in considering special needs or situations of particular providers.

(2) *General principle*. Reimbursable provider costs may not exceed the costs CMS estimates to be necessary for the efficient delivery of needed health care services. CMS may establish estimated cost limits for direct or indirect overall costs or for costs of specific services or groups of services. CMS imposes these limits prospectively and may calculate them on a per admission, per discharge, per diem, per visit, or other basis.

(b) *Procedure for establishing limits*. (1) In establishing limits under this section, CMS may classify SNFs and HHAs by factors that CMS finds appropriate and practical, including the following:

- (i) Type of services furnished.
- (ii) Geographical area where services are furnished, allowing for grouping of

noncontiguous areas having similar demographic and economic characteristics.

(iii) Size of institution.

(iv) Nature and mix of services furnished.

(v) Type and mix of patients treated.

(2) CMS bases its estimates of the costs necessary for efficient delivery of health services on cost reports or other data providing indicators of current costs. CMS adjusts current and past period data to arrive at estimated costs for the prospective periods to which limits are applied.

(3) Before the beginning of a cost period to which revised limits will be applied, CMS publishes a notice in the FEDERAL REGISTER, establishing cost limits and explaining the basis on which they are calculated.

(4) In establishing limits under paragraph (b)(1) of this section, CMS may find it inappropriate to apply particular limits to a class of SNFs or HHAs due to the characteristics of the SNF or HHA class, the data on which CMS bases those limits, or the method by which CMS determines the limits. In these cases, CMS may exclude that class of SNFs or HHAs from the limits, explaining the basis of the exclusion in the notice setting forth the limits for the appropriate cost reporting periods.

(c) *Requests regarding applicability of cost limits*. For cost reporting periods beginning before July 1, 1998, a SNF may request an exception or exemption to the cost limits imposed under this section. An HHA may request only an exception to the cost limits. The SNF or HHA must make its request to its contractor within 180 days of the date on the contractor's notice of program reimbursement.

(1) *Home health agencies*. The contractor makes a recommendation on the HHA's request to CMS, which makes the decision. CMS responds to the request within 180 days from the date CMS receives the request from the contractor. The contractor notifies the HHA of CMS's decision. The time required by CMS to review the request is considered good cause for the granting of an extension of the time limit for requesting a contractor hearing or a Provider Reimbursement Review Board (Board) hearing as specified in