

The attached material is cited in *Canonsburg General Hospital v. Burwell*, No. 13-5370, slip op. at 4, (D.C. Cir. December 1, 2015); (citing , Centers for Medicare and Medicaid Services, Provider Reimbursement Manual Part I, section 2534.5), available on 2/26/16 at <http://wayback.archive-it.org/2744/20111201152312/http://www.cms.gov/Manuals/PBM/list.asp>

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B. Bases for Qualification for New Provider Exemption.--Eligibility for a new provider exemption is determined based upon an examination in which the entire institution or institutional complex operated in the 3 years prior to its certification as, or with a Medicare SNF, under present and previous ownership. For example, did the nursing home or hospital render skilled nursing or rehabilitative services as a nursing home not certified for Medicare, Medicaid, or title V, a long term care facility certified for Medicare and/or Medicaid, a swing bed certified for Medicare and/or Medicaid, or any combination of the aforementioned? See subsection E for examples of what constitutes a change in ownership (CHOW). To be eligible for the new provider exemption, the institution or institutional complex must demonstrate a complete change in the operation of the institution. If an institution or institutional complex finds that:

1. It has operated as an SNF, or its equivalent for 3 or more years, under past or present ownership, prior to Medicare certification, it will not qualify for a new provider exemption. An exception to this rule exists where an institution or institutional complex undergoes a change in location, see three below.

2. It has operated as an SNF, or its equivalent for less than 3 full years, under past and present ownership, the institution or institutional complex may be eligible for a full or partial exemption as long as it meets all other applicable requirements in this section

3. An institution or institutional complex that has undergone a change in location may be granted new provider status when the normal inpatient population can no longer be expected to be served at the new location. In this case, the institution or institutional complex must demonstrate that in the new location a substantially different inpatient population is being served. This includes those institutions or institutional complexes that are established in whole or in part through the purchase, reallocation, or leasing of the right to operate (i.e., a certificate of need) long term care beds (operating or nonoperating) from an existing institution or institutional complex (operating or closed). The normal inpatient population is defined as the health service area (HSA) for long term care facilities, or its equivalent, as designated by the State planning agency or local planning authority in which the institution or institutional complex is located. If an institution or institutional complex relocates within the same HSA for long term facilities, or its equivalent, it will not qualify for a new provider exemption, as the population normally served would continue to be expected to be served at the new location, unless it can demonstrate that 50 percent or more of its admissions (all payers) are from a different HSA. Furthermore, the institution or institutional complex must show that the total number of inpatient days for all payers in the new location was substantially less than at the old location for a comparable period during the year prior to relocation. For HCFA to make this determination, the institution or institutional complex that has changed location must submit the following information with its request:

a. From the old location, a list of all patients admitted to and residing at the institution or institutional complex with their full home addresses, regardless of payer source, for one year prior to closure of the existing institution or institutional complex and/or the purchase, reallocation, or leasing of long term care beds. In some cases where there is insufficient information to make a proper determination, a list covering 2 years may be required.

b. From the new location, a list of all patients admitted to and residing at the institution or institutional complex with their full home addresses, regardless of payer source, for the first six months of operation.

c. The total number of inpatient days for all payers for the institution or institutional complex at the new location for the first 3 months of operation. For example the institution or institutional complex was relocated and opened on January 1, 1996. The first 3 months of operation would be January 1, 1996 through March 31, 1996.

d. The total number of inpatient days for all payers for the institution or institutional complex at the old location for the same 3-month period, in the year prior to relocation, as in the new location. Following the example as stated above, the same 3-month period at the old location would be January 1, 1995 through March 31, 1995.

This data will be reviewed to determine if a significant change (as defined above) in the normal inpatient population, has taken place and to determine if the inpatient days at the new location were substantially less than those at the old location for a comparable period of time. The institution or institutional complex must meet both conditions to be eligible for the new provider exemption.

C. Methodology for Calculating Exemption Period.--An exemption expires at the end of the provider's first cost reporting period beginning at least 2 years after it accepts its first patient requiring any of the skilled nursing or rehabilitative services identified in subsection G., as an SNF or its equivalent.

The phrase "accepts its first patient" does not denote Medicare-only patients. An institution or institutional complex must review all admissions since it began operating to determine if it rendered skilled nursing or rehabilitative services as an SNF or its equivalent. An SNF or its equivalent is defined in subsection G. The Medicare SNF coverage requirements (i.e., skilled level of care) are irrelevant in making a determination under the new provider exemption provision.

The cost reporting period used in determining the duration of the exemption period is the cost reporting period selected by the institution or institutional complex on its initial Long Term Care Facility Application for Medicare and Medicaid, Form HCFA-671 which is transcribed to the HCFA 1539 Medicare/Medicaid Certification and Transmittal by the State Agency. An institution or institutional complex must adhere to the cost reporting period initially selected unless a change has been authorized in writing by its fiscal intermediary. When an institution or institutional complex seeks to change its fiscal year, it must go through the proper regulatory procedures as set forth in 42 CFR 413.24(f)(3), and receive authorization described in '2414.3. The intermediary considers the request and determines whether the institution or institutional complex has demonstrated that good cause for the change exists. Good cause cannot be found to exist where the purpose of the change is to maximize reimbursement. The intermediary must notify HCFA of any approved requests or changes as a result of a change in ownership. HCFA will notify the institution or institutional complex in writing of the change as it affects the new provider exemption.

D. General Exemption Request Requirements.--SNFs must adhere to the following requirements when filing a request: failure to follow the requirements are grounds to deny a request.

1. A written request must be filed with the fiscal intermediary, in accordance with the instructions in '2531.1.

2. The request must contain the following supporting documentation:

- o A copy of the provider's Medicare Tie-In Notice,
- o A copy of the provider's initial Form HCFA-671,
- o If located in a State with a certificate of need (CON) program for long term care facilities the institution or institutional complex must submit a copy of the CON application and the original certificate of need approval letter for the institution or institutional complex,
- o Answers to all questions on Exhibit B, which is a suggested format to respond to these questions,

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- o A copy of the parent institution's Worksheet S-2 and Worksheet A for hospital-based facilities, for the three cost reporting periods prior to establishment of the SNF,
- o If located in a State without a CON program, the institution or institutional complex must submit a copy of the application for State licensure (not certification) submitted to the State for the institution or institutional complex requesting exemption,
- o A copy of the State licensure application for the hospital for hospital-based facilities, for the three years prior to establishment of the SNF,
- o Copies of any Notices of Program Reimbursement (NPRs), issued to the institution or the institutional complex since becoming a Medicare certified SNF,
- o A statement from the Director of Nursing (DON) for the institution or institutional complex attesting to the truthfulness of the dates each skilled nursing or rehabilitative service was first performed by the institution or institutional complex, included in response to the questions in Exhibit B. All information on the skilled nursing and rehabilitative services must be supported by medical records in the institution or institutional complex. HCFA reserves the right to review the medical records if deemed necessary, to validate the dates the services were provided for the first time,
- o A copy of each lease agreement, where an institution or institutional complex operates under a lease agreement, leases long term care beds (i.e., operating rights to long term care beds) and/or leases the space which houses the SNF or its equivalent, and
- o Any other additional documentation as deemed necessary by the Intermediary or HCFA in order to make a determination.

E. Change of Ownership.--42 CFR 413.30(e) requires HCFA to examine the operations of the institution or institutional complex both under past and present ownership to determine if an institution or institutional complex is eligible for a new provider exemption. The mere existence of a CHOW does not in itself make an institution or institutional complex eligible for a new provider exemption.

1. Transaction Types.--The Medicare program policies pertaining to the various types of CHOW transactions may be different from the treatment under generally accepted accounting principles. Sections 1500.1, 1500.2, 1500.3, 1500.4, 1500.5, 1500.6, 1500.7, and 1500.8 discuss, in general, the most frequent types of transactions which affect the ownership of provider organizational structures. The events described below represent specific examples of CHOW transactions that will be considered in determining eligibility for a new provider exemption, but are not intended to represent all possible situations. For purposes of determining new provider status, these transactions apply to entities currently participating in Medicare, as well as to those nonparticipating entities such as, a Medicaid certified nursing facility or a nursing home not certified for Medicare, Medicaid or title V.

a. Lease of an entire institution or institutional complex or a portion thereof to include the leasing of operating rights to long term care beds from an entity (see §1500.4).-- A lease of all or part of an institution or institutional complex is considered a CHOW of the leased portion for Medicare certification purposes. For reimbursement purposes, no CHOW for the depreciable assets is recognized, as it is the operations rather than ownership that is restructured in the lease transaction. In essence, the lessee has acquired "lease rights" to use and operate assets owned by another party.

b. Disposition of all or some of an institution or institutional complex or its assets used to render patient care (see §1500.7).--Disposition of all or some portion of an institution or institutional complex or its assets (used to render patient care) through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the institution or institutional complex is considered a CHOW. For example, an institution or institutional complex purchases the right to operate (i.e., a certificate of need) long term care beds from an existing institution or institutional complex (be it opened or closed), that has or is rendering skilled nursing or rehabilitative services to establish (in whole or part) a long term care facility or to enlarge an existing long term care facility. The foregoing sentence is not intended to imply that some or all of the costs incurred to purchase an existing certificate of need are allowable costs.

c. Reallocation or consolidation of long term care beds from an existing institution or institutional complex to another institution or institutional complex.

d. Merger (see §1500.3A).--A merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporation(s) by operation of State law.

e. Consolidation (see §1500.3B).--A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity.

2. Effect of a Change of Ownership on an Approved New Provider Exemption.--In accordance with 42 CFR 413.30(e), a new provider exemption expires at the end of the provider's first cost reporting period, beginning at least two years after the provider accepts its first patient requiring skilled nursing or rehabilitative services. However, when an institution or institutional complex that has been approved by HCFA for a new provider exemption from the routine service cost limits undergoes a CHOW transaction (see above), the exemption must be reevaluated by HCFA central office to determine if the provider continues to be eligible for its approved exemption. Those entities that undergo a CHOW transaction can no longer be considered the institution or institutional complex that was approved for a new provider exemption, even if the name, number, etc., remain identical. Therefore, this reevaluation will examine the length of the new provider exemption to ensure that if the CHOW involves another institution or institutional complex the operations of both are taken into consideration when determining the expiration date of the approved exemption. This procedure will ensure that the Medicare program does not continue to pay for costs over and above those incurred by the surviving entity that relate to the period of developing the ability to provide skilled nursing or rehabilitative services by a participating or nonparticipating entity and takes into consideration the experience that is gained as a result of the CHOW transaction.

A provider that voluntarily or involuntarily ceases to participate in the Medicare program or experiences a CHOW transaction, 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 the termination of its agreement or CHOW. This requirement to file a terminating cost report also includes those institutions or institutional complexes, that add long term care beds to the existing institution or institutional complex, through a purchase, lease, consolidation or reallocation of long term care beds from another institution or institutional complex.

When an institution or institutional complex, approved by HCFA for a new provider exemption enters into CHOW transaction with another entity, either participating or nonparticipating, it must submit the following documentation, in addition to filing a terminating cost report to its FI:

- o A written request must be filed with the fiscal intermediary, in accordance with the instructions in §2531.1,

- o Answers to all questions on Exhibit B, for all entities involved in the CHOW transaction,

o A statement from the DON for the institution or institutional complex attesting to the truthfulness of the dates each skilled nursing or rehabilitative service was first performed by the institution or institutional complex, included in response to the questions in Exhibit B. All information on the skilled nursing and rehabilitative services must be supported by medical records in the institution or institutional complex. HCFA reserves the right to review the medical records if deemed necessary, to validate the dates the services were provided for the first time,

o If located in a State with a CON program for long term care facilities the institution or institutional complex must submit a copy of the CON application and the original certificate of need approval letter for the additional beds requested by the institution or institutional complex,

o If located in a State without a CON program, the institution or institutional complex must submit a copy of the application for State licensure (not certification) for the additional beds submitted to the State for the institution or institutional complex, and

o Any other additional documentation as deemed necessary by the Intermediary or HCFA in order to make a determination.

This documentation will be evaluated by HCFA and the effect on the new provider exemption will be determined as follows:

a. If an entity is merely sold as an ongoing operation and there are no changes in the overall bed size of the institution or institutional complex originally approved for an exemption, the original exemption period that was approved is retained by the institution under its new ownership.

b. If two or more entities are participating in the Medicare program, and each are exempt from the routine service cost limits immediately preceding a CHOW transaction, the exemption period that ends first applies to the surviving entity, as long as there is no increase in bed size of the participating unit from that originally approved for each entity. If an increase in bed size from that originally approved occurs, the institution or institutional complex is subject to the requirements found in §2531.1 and in §2533.1.E.2.c.

EXAMPLE: SNF A has an exemption for 15 beds that is to expire with the cost reporting period ended December 31, 1996. SNF B has an exemption for 15 beds that is to expire with the cost reporting period ended June 30, 1997. The SNFs undergo a CHOW effective July 1, 1996 and SNF B is the surviving entity. The exemption approved for SNF A which ends with the cost reporting period ended December 31, 1996 applies to SNF B, the surviving entity for a total of 30 beds. The exemption originally approved for SNF B expires on the effective date of the CHOW transaction.

c. If an entity participating in the Medicare program undergoes a CHOW transaction with either a participating or nonparticipating entity, and it is exempt immediately preceding the CHOW transaction with the other entity, where it is the surviving entity:

1. The exemption ends on the effective date of the CHOW transaction if the entity with which it is undergoing a CHOW transaction has provided skilled nursing or rehabilitative services, as an SNF or its equivalent, for three or more years

EXAMPLE: SNF A was approved for an exemption for 15 beds and it undergoes a CHOW transaction with a participating institution or institutional complex that has provided skilled nursing services for three or more years, prior to the effective date of the merger as an SNF or its equivalent. On the effective date of the CHOW transaction, the exemption will end.

2. The exemption period for the surviving entity must be rebased by HCFA central office when it is found that either entity prior to the CHOW transaction has provided skilled nursing or rehabilitative services for less than three full years, as an SNF or its equivalent.

EXAMPLE: SNF A was approved for an exemption for 15 beds and undergoes a CHOW transaction with a nonparticipating institution or institutional complex that has provided rehabilitative services for two years. SNF A has been in existence for one year. The exemption will be rebased using the date of the first patient who received rehabilitative services from the nonparticipating institution or institutional complex. For instance, the exemption for SNF A was to expire at the end of the January 1, 2000 through December 31, 2000 cost reporting period. SNF A accepted its first patient requiring skilled nursing services on December 1, 1997. The other entity with which it has undergone a CHOW, accepted its first patient requiring rehabilitative services on February 1, 1995. The exemption for SNF A, the surviving entity, will now expire at the end of January 1, 1998 through December 31, 1998 cost reporting period.

F. Examples.--The following are examples of the effect of decertification, closure, replacement, remodeling, or additions to existing institutions for new provider exemption.

1. An institution or institutional complex that decertifies its Medicare certified SNF, but continues to provide skilled nursing or rehabilitative services as an SNF or its equivalent will have its continued provision of such services count toward the three-year period for qualification as a new provider (discussed in §2533.1).

2. If the physical plant utilized by the institution or institutional complex to house a long term care facility certified for Medicare was vacant prior to the establishment of the current operation, it must have been vacant for the three full years prior to the date the institution or institutional complex recommenced operations as an SNF or its equivalent to qualify for the new provider exemption. If at any time during the three-year look back period the physical plant housed an institution or institutional complex that provided skilled nursing or rehabilitative services as an SNF, or its equivalent, those operations are considered in determining eligibility for an exemption.

3. An institution or institutional complex that operates, or operated as an SNF or its equivalent, must cease operation for three full years prior to the date the institution or institutional complex recommences operation as an SNF or its equivalent, to be granted a new provider exemption. If at any time during the three-year look back period the institution or institutional complex provided skilled nursing or rehabilitative services as an SNF, or its equivalent, those operations will be considered in determining eligibility for an exemption.

4. An institution or institutional complex that operates, or operated as an SNF or its equivalent, replaces, remodels, or enlarges its existing physical plant, either by new construction and/or the addition of long term care beds and/or the consolidation of long term care beds at the same location is not eligible for a new provider exemption if it has provided skilled nursing or rehabilitative services for three or more years, as a SNF or its equivalent.

5. An institution or institutional complex that operates, or operated as an SNF or its equivalent, replaces and relocates its existing physical plant which has been enlarged either through new construction and/or the addition of long term care beds and/or consolidation of long term care beds at a new location may qualify for the new provider exemption if it meets all the requirements set forth in Subsection B.3.

G. SNF and Its Equivalent Defined.--An SNF is defined in §1819(a)(1) of the Act as an institution or a distinct part of an institution that has or is engaged in providing skilled nursing care and related services for residents who required medical or nursing care, or rehabilitation services for the injured, disabled, or sick persons identified in 42 CFR 409.33(b) and (c). An SNF is not an institution or institutional complex that primarily cares and treats residents with mental diseases. These services include:

1. Skilled nursing services:
 - o IV or parenteral nutrition,
 - o Nasogastric or gastrojejunostomy tubes,
 - o Nasopharyngeal or tracheostomy suctioning,
 - o Foley or indwelling catheters,
 - o Administration of oxygen (i.e., respiratory therapy),
 - o Care of pressure ulcers,
 - o Intramuscular or subcutaneous injections,
 - o Application of dressings involving prescription medications and aseptic techniques,
 - o Heat treatments that are ordered by a physician and require skilled observation by nurses, or
 - o Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing (i.e., bowel and bladder training).
2. Rehabilitative services:
 - o Ongoing assessment of rehabilitation needs and potential,
 - o Therapeutic exercises or activities,
 - o Gait evaluation and training,
 - o Range of motion exercises,
 - o Maintenance therapy,
 - o Therapy modalities and treatments,
 - o Services of a speech pathologist or audiologist (restorative),
 - o Occupational therapy,
 - o Speech therapy, or
 - o Physical therapy.

The following are examples of institutions or institutional complexes that are considered to be equivalent to an SNF, but are not intended to represent all possible situations:

- a. An institution or institutional complex operated, or operated as a, nursing home not certified for Medicare, Medicaid, or title V, providing skilled nursing or rehabilitative services.
- b. An institution or institutional complex operated, or operated as a, Medicaid certified long term care facility providing skilled nursing or rehabilitative services (i.e., nursing facility as defined under §1919 (a) (1) of the Act).

The Omnibus Budget Reconciliation Act of 1987 includes the nursing home reform provisions that regulate the certification of long term care facilities under the Medicare and Medicaid programs. These provisions are effective for services rendered on or after October 1, 1990. Congress' intent in adopting these provisions was to establish uniform certification standards for all Medicare SNFs and Medicaid nursing facilities (NF). The result is that both Medicare SNFs and Medicaid NFs are required to provide directly or under arrangements the same basic range of services described in §1819 (b) (4) and §1919 (b) (4) of the Act in order to be certified for Medicare or Medicaid. This range of services includes those nursing services and specialized rehabilitative services needed to

attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being. Therefore, the range of services that a Medicaid NF must provide to be certified includes the same types of services offered in an SNF that is certified for Medicare.

c. The institution or institutional complex has operated or operated as a Medicare or Medicaid swing bed agreement, as defined in §1883 or §1913 of the Act.

Any hospital that has an agreement under §1886 of the Act may, subject to certain conditions, enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services. Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a SNF. Also, any hospital that has an agreement under §1883 of the Act may, subject to certain conditions, submit under its State plan a request under which its inpatient hospital facilities may be used for the furnishing of nursing facility services.

H. Effect of Increase in Bed Size on Approved Exemption.--In all instances, an exemption is approved only for the number of beds originally certified on the effective date of initial participation. If an institution or institutional complex increases the bed size of its participating unit, these beds are not automatically exempt. The institution or institutional complex must submit a request to HCFA to request that the additional beds be folded into the original approval by HCFA. This request must include:

1. A written request must be filed with the intermediary, in accordance with the instructions in §2531.1.

2. The approval by the Regional Office increasing the bed size of the certified unit from that on the effective date of initial participation to the part to which the distinct part certification is now to apply.

3. The written request submitted to the State Agency clearly describing the part to which the distinct part certification is to apply.

4. Answers to questions #1, #5, #6, #7, #8, #9, #10, and #11 included on Exhibit B for the institution or institutional complex.

5. If located in a State with a CON program for long term care facilities the institution or institutional complex must submit a copy of the CON application and the original certificate of need approval letter for the additional beds requested by the institution or institutional complex.

6. If located in a State without a CON program, the institution or institutional complex must submit a copy of the application for State licensure (not certification) for the additional beds submitted to the State for the institution or institutional complex.

7. Any other additional documentation as deemed necessary by the Intermediary or HCFA in order to make a determination.

The request will be approved depending on the outcome of the review performed by HCFA in accordance with the policies described in the examples found below.

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2533.1 (Cont.)

EXAMPLE: The overall institution originally consisted of 100 beds when initially approved for its exemption, of which 15 beds were certified to participate in the Medicare program. The institution has requested and been approved by the Regional Office for an increase in the bed size of the participating unit from 15 beds to 30 beds. It requests that these additional 15 beds included in the new provider exemption. HCFA finds that the institution has not increased its overall bed size nor has it undergone any type of CHOW. This request would be approved.

EXAMPLE: The overall institution originally consisted on 100 beds when initially approved for its exemption, of which 15 beds were certified to participate in the Medicare program. The institution has requested and been approved by the Regional Office for an increase in the bed size of the participating unit from 15 beds to 30 beds. It requests that these additional 15 beds be included in the new provider exemption. HCFA finds that the institution has undergone a CHOW (i.e., it purchased, leased, consolidated or reallocated long term care beds or merged with another entity) since being approved for an exemption. The outcome of this request will be determined in accordance with the policies found in Subsection E.2. Effect of a CHOW On an Approved New Provider Exemption.

Exhibit A-Fiscal Intermediary Review and Recommendation Checklist

Part 1: Documentation.--The request submitted to HCFA must contain the following documentation. Please check off all documentation included with the package submitted to HCFA for final decision.

- 1) Institution or institutional complex's letter requesting an exemption.
- 2) A copy of the SNF's Medicare Tie-In Notice.
- 3) A copy of the SNF's initial Form HCFA-671.
- 4) A copy of the certificate of need application and approval letter.
- 5) A copy of the application for State licensure.
- 6) Answers to all questions on Exhibit B.
- 7) A copy of the parent institution's Worksheet S-2 and Worksheet A for hospital-based facilities, for the three cost reporting periods prior to establishment of SNF.
- 8) A copy of the State licensure application for the hospital for hospital-based facilities, for the three years prior to establishment of the SNF.
- 9) Copies of any Notices of Program Reimbursement (NPRs), issued to the institution or institutional complex since becoming a Medicare certified SNF.
- 10) A statement from the Director of Nursing (DON) for the institution or institutional complex attesting to the truthfulness of the dates each skilled nursing or rehabilitative service was first performed by the institution or institutional complex included in response to the questions in Exhibit B.
- 11) A copy of each lease agreement, where an institution or institutional complex operates under a lease agreement, leases long term care beds, or leases spaces which houses the SNF or its equivalent.
- 11) Any other documentation deemed necessary to make a decision.
- 12) A copy of the OSCAR report identifying skilled nursing and/or rehabilitative services by survey date

Part 2: Submission and Recommendation.--The intermediary must submit a cover letter that includes all of the following information:

- o Name of institution or institutional complex,
- o Name of SNF from initial Form HCFA-1539,

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o Fiscal year end selected by SNF from initial Form HCFA-1539. If the year end has been changed from the initial Form HCFA-1539, please submit the letter from the institution or institutional complex requesting the change and the approval or denial letter sent by the FI in response to that request,

- o Date SNF was certified for Medicare from initial Form HCFA-1539,
- o Date of first patient admitted to SNF or its equivalent,
- o Date SNF or its equivalent performed first skilled nursing or rehabilitative service,
- o Number of beds certified to participate in Medicare on initial Form HCFA-1539, and
- o A recommendation to grant or deny the exemption based upon the documentation.

If your recommendation is to grant the exemption you must calculate the exemption period in accordance with the following instructions. An exemption ends with the first cost reporting period beginning at least two years after the institution or institutional complex accepts its first patient requiring skilled nursing or rehabilitative services.

EXAMPLE: A SNF has selected a fiscal year of December 31. The institution or institutional complex accepted its first patient requiring skilled nursing or rehabilitative services on December 1, 1995. The exemption would end with the cost reporting period ended December 31, 1998.

Exhibit B-SNF Exemption Questions

1. Name/Address(es) of Institution/Institutional Complex

Date of ORIGINAL construction for the institution or institutional complex

____/____/____

Total number of beds (operating and nonoperating) in the institution or institutional complex dedicated to long term care _____

If the institution or institutional complex is a Medicare certified hospital, indicate provider number/initial certification _____/____/____

Date of initial State licensure as a hospital ____/____/____

2. Has the institution or institutional complex operated, or operated as a nursing home not certified for Medicare, Medicaid, or title V in the three years prior to the establishment of the SNF this request pertains? _____ If yes, provide:

Date of initial State licensure as a nursing home ____/____/____

Date of first admission to the nursing home ____/____/____

3. Has the institution or institutional complex operated, or operated as a long term care facility certified for Medicare and/or Medicaid in the three years prior to the establishment of the SNF this request pertains? _____ If yes, provide:

Skilled nursing facility provider number/date of initial certification:

____/____/____

Date of first admission to SNF ____/____/____

Nursing facility provider number/date of initial certification:

____/____/____

Date of first admission to NF ____/____/____

4. Has the institution or institutional complex operated, or operated as a Medicare and/or Medicaid swing bed in the three years prior to the establishment of the SNF this request pertains? _____ If yes, provide:

Medicare swing bed provider number/effective date of swing bed agreement:

____/____/____

Date of first admission to Medicare swing bed ____/____/____

Medicaid swing bed provider number/effective date of swing bed agreement:

____/____/____

Date of first admission to Medicaid swing bed ____/____/____

5. Has the institution or institutional complex undergone a merger or a consolidation where more than one institution or institutional complex now operates under a single provider number? _____ OR

Has the institution or institutional complex undergone a merger where they retained their separate provider number and filed a home office cost report (chain)? _____ Provide home office number.

If yes to either of the above, what year did the merger take place? _____ What is the name and address of the other institution or institutional complex involved in the merger?

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Did the other institution or institutional complex involved in the merger operate, or operate as, in any of the three years prior to the establishment of the SNF this request pertains? (Check all that apply):

- ☐ A nursing home not certified for Medicare, Medicaid, or title V
☐ A long term care facility certified for Medicare and/or Medicaid
☐ A hospital with a swing bed certified for Medicare and/or Medicaid

If you checked any of the above, provide the provider number(s) and date(s) of initial certification or agreement, whichever is appropriate.

If the institution or institutional complex has or had a long term care facility certified as a Medicare SNF, has or had the SNF received an exemption to the SNF routine cost limits? ☐ If yes, when was the exemption approved and in what cost reporting period does or did it expire?

6. Did this institution or institutional complex buy a vacant building to utilize as its physical plant for the SNF to which this request pertains? ☐ If yes, what type of institution, if any, occupied this physical plant during the past 3 years, prior to its being purchased and used to operate as the SNF to which this request pertains?

If this physical plant was previously occupied by another health care institution, did it operate, or operate as? (Check all that apply):

- ☐ A nursing home not certified for Medicare, Medicaid, or title V
☐ A long term care facility certified for Medicare and/or Medicaid
☐ A hospital with a swing bed certified for Medicare and/or Medicaid

If you checked any of the above, provide the provider number(s) and date(s) of initial certification or agreement, whichever is appropriate

7. Did this institution or institutional complex purchase long term care beds (operating or nonoperating) to establish (in whole or in part) or to enlarge the SNF that this request pertains? ☐ If yes, were these long term care beds purchased from an institution or an institutional complex that operated, or operated as? (Check all that apply):

- ☐ A nursing home not certified for Medicare, Medicaid, or title V
☐ A long term care facility certified for Medicare and/or Medicaid
☐ A hospital with a swing bed certified for Medicare and/or Medicaid

How many beds were purchased? Indicate the name and address of the institution/institutional complex (may be more than one) from which the long term care beds were purchased.

8. Did this institution or institutional complex consolidate or reallocate long term care beds (operating or nonoperating) that it already owned to establish (in whole or in part) or to enlarge the SNF that this request pertains? ☐ If yes, were these long term care beds consolidated or reallocated from an institution or an institutional complex that operated, or operated as? (Check all that apply):

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- ☐ A nursing home not certified for Medicare, Medicaid, or title V
☐ A long term care facility certified for Medicare and/or Medicaid
☐ A hospital with a swing bed certified for Medicare and/or Medicaid

How many beds were reallocated or consolidated? _____ Indicate the name and address of the institution/institutional complex (may be more than one) from which these beds were consolidated or reallocated.

9. Did this institution or institutional complex lease long term care beds (operating or nonoperating) to establish (in whole or part) or to enlarge the SNF that this request pertains? _____ If yes, were these long term care beds leased from an institution or institutional complex that operated, or operated as? (Check all that apply):

- ☐ A nursing home not certified for Medicare, Medicaid, or title V
☐ A long term care facility certified for Medicare and/or Medicaid
☐ A hospital with a swing bed certified for Medicare and/or Medicaid

How many beds were leased? _____ Indicate the name and address of the institution/institutional complex from which the beds were leased.

10. Did this institution or institutional complex lease long term care beds (operating or nonoperating) that it already owned to establish (in whole or part) or to enlarge the SNF that this request pertains? _____ If yes, were these long term care beds leased from an institution or institutional complex that has operated, or operated as? (Check all that apply):

- ☐ A nursing home not certified for Medicare, Medicaid, or title V
☐ A long term care facility certified for Medicare and/or Medicaid
☐ A hospital with a swing bed certified for Medicare and/or Medicaid

How many beds that are owned were leased? _____ Indicate the name and address of the institution/institutional complex from which the beds were leased.

11. Did this institution or institutional complex enter into a CHOW transaction that is not covered in questions 5, 6, 7, 8, 9, or 10? If yes, please describe the CHOW transaction.

12. Has the institution or institutional complex been relocated? __ If yes, when was it relocated and from where (provide full address)?

13. Name of SNF that this request pertains to _____

14. Does the SNF that this request pertains or its equivalent operate under a lease agreement?

Does the SNF that this request pertains or its equivalent lease the space in which it is housed?

15. Is the SNF this request pertains to freestanding or hospital-based? _____ Has the SNF this request pertains to ever been previously classified as either a freestanding or hospital-based facility prior to its present classification?

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16. Has the SNF this request pertains to accepted a low Medicare volume prospective payment rate as defined in §1888(d) of the Act for any fiscal year(s)? ____ If yes, indicate FY(s):
17. On what date was the first patient admitted to the SNF to which this request pertains when it commenced operations for the first time after the date of original construction? ____/____/____

To determine the date the first patient requiring skilled nursing and/or rehabilitative services, was admitted to the institution or institutional complex, HCFA requires that the institution or institutional complex submit the date that each service identified below was performed for the first time, on any resident, regardless of payer source, in the institution or institutional complex since it began operating. In determining these dates, you must first determine if the institution or institutional complex operated, or operated as a nursing home not certified for Medicare, Medicaid, or title V, a long term care institution certified for Medicare and/or Medicaid, or a swing bed certified for Medicare and/or Medicaid in the three years prior to the establishment of the SNF this request pertains to ensure that the dates reflect the operation of the institution or institutional complex. These dates do not relate to the quantity or nature of that service (i.e., level of care requirements for coverage of Medicare extended care services), but only to the provision of that service.

SECTION 1: SKILLED NURSING SERVICES

- (1) Intravenous, hypodermoclysis or intravenous feeding.
Date first performed ____ / ____ / ____
- (2) Nasopharyngeal and tracheostomy aspiration.
Date first performed ____ / ____ / ____
- (3) Levin tube and gastrostomy feedings.
Date first performed ____ / ____ / ____
- (4) Insertion and sterile irrigation and replacement of catheters.
Date first performed ____ / ____ / ____
- (5) Treatment of decubitus ulcers or other widespread skin disorder.
Date first performed ____ / ____ / ____
- (6) Initial phases of a regimen involving administration of medical gases (i.e. respiratory therapy).
Date first performed ____ / ____ / ____
- (7) Intramuscular or subcutaneous injections.
Date first performed ____ / ____ / ____
- (8) Application of dressings involving prescription medications and aseptic techniques
Date first performed ____ / ____ / ____
- (9) Heat treatments that have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress.
Date first performed ____ / ____ / ____
- (10) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.
Date first performed ____ / ____ / ____

SECTION 2: REHABILITATION SERVICES

- (1) Physical therapy. Date first performed ____ / ____ /
- (2) Speech-language therapy. Date first performed ____ / ____ /
- (3) Occupational therapy. Date first performed ____ / ____ /
- (4) Ongoing assessment of rehabilitation needs and potential.
Date first performed ____ / ____ /
- (5) Gait evaluation and training. Date first performed ____ / ____ /
- (6) Range of motion exercises. Date first performed ____ / ____ /
- (7) Maintenance Therapy. Date first performed ____ / ____ /
- (8) Therapy modalities and treatments (i.e., ultrasound, short-wave and microwave therapy, hot pack, hydro collator, infrared treatments, or paraffin baths).
Date first performed ____ / ____ /

2534. REQUEST FOR EXCEPTION TO SNF COST LIMITS

2534.1 General.--Under the exception process a provider's limit may be adjusted to reflect additional costs that are the result of one or more of the circumstances identified in 42 CFR 413.30(f). The process for requesting an exception for atypical services or items is described in §2534.10. However, the mere existence of higher costs does not in and of itself justify an exception. An adjustment is made only to the extent costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

A request for an exception may be made for each cost reporting period in which a provider believes an exception is warranted. Each request is evaluated on its own merits with respect to the applicable schedule of limits. The evaluation of each request includes, but is not limited to, a determination as to whether all costs subject to the limits are reasonable when compared to similar costs of peer group providers. An exception may be granted if the provider demonstrates that its costs in excess of the cost limit are reasonable as such costs relate to the type of exception requested. The type of exception request must be based specifically on one or more of the circumstances identified in 42 CFR 413.30(f).

2534.2 Classification of Request: Interim vs. Final.--**A. Interim Exception Request.--**

1. When the cost reporting period has not ended, an interim exception may be granted if the provider expects to exceed the applicable cost limit. (See §2534.3.) However, after the cost reporting period has ended, interim exception amounts granted in this regard are subject to the following conditions:

- a. The provider files a cost report timely for the affected cost reporting period;
- b. The cost report is accompanied by all documentation that is necessary to determine the final exception amount for the period based on actual data (see subsection 2); and

c. The cost report is accompanied by a request from the provider to revise the interim exception amount to reflect actual data for the period covered by the report and a certification that there has been no change in the services provided or changes in its patient mix, which could reduce the amount of the exception. If the provider fails to meet any of these requirements, any interim exception amount that has been granted is revoked, and any payments made in excess of the provider's reasonable costs, as determined subject to the cost limits without the exception, is subject to recoupment under the usual rules.

These requirements are designed to protect the interests of the Medicare program, while at the same time lessen cash flow problems for providers with substantial Medicare utilization. While a final approval or denial of an exception is made by HCFA, interim exceptions may be tentatively approved and payments may be adjusted by an intermediary without prior approval from HCFA.

2. When a cost reporting period has ended but the cost report has not been settled and a NPR has not been issued, an interim exception may be requested based on actual costs incurred.

Interim exception amounts based on actual costs are subject to changes to reimbursable costs through the settlement of the cost report and issuance of an NPR. The intermediary revises the tentatively approved exception amount to reflect settlement adjustments and must notify HCFA as to the final recommended exception amount. HCFA then makes the final determination on the exception.

B. Final Exception Request.--A provider may file a request for an exception after the cost report has been settled and a NPR has been issued. However, the request must be filed within the time frames specified in §2531.1A.

2534.3 General Exception Request Requirements.--

A. Provider.--In addition to adhering to the general requirements listed in §2531.1, the provider must include the following information along with the data specifically related to the type of exception applied for as described in the following subsections.

1. In general, the provider must submit a cost report for the period for which an exception has been requested. If the request is filed by a provider that is a component of a chain organization, the provider must also include a copy of the home office cost statement.

2. When a cost report for the immediate preceding cost reporting period is available, the provider must include the cost report and a comparison of the per diem routine costs between the prior period and the period for which an exception has been requested. The provider must fully document and explain all substantial changes in per diem costs (more than 20 percent) even if the change occurs for a service not included in the exception request.

3. When the exception request is an initial request (i.e. no exception amounts granted in prior cost reporting periods), the provider must observe the following guidelines, where applicable:

a. If a cost report is available for the period for which an exception has been requested, it must be provided, as explained above.

b. If the request is for a period for which no cost report is available, the provider may submit the prior cost reporting period's cost

report if that cost report adequately reflects the circumstances in the period for which an exception has been requested. The required data, as described in §2534.10, must then also come from this prior cost reporting period. An exception based on these data is considered an interim exception as explained in §2534.2A.

c. If the request is for a period for which there is no cost report available and there is no cost report for the prior period, the provider must include a pro forma cost report based on 3 months of actual data from the period for which an exception has been requested. The required data, as described in §2534.10, must then also come from the period reflected by the pro forma cost report. An exception based on these data will also be considered an interim exception.

4. Repeat Requests.--If a provider has been granted an exception for a prior cost reporting period and is currently requesting an exception for the same circumstances, see §2534.11 for the documentation required. The provider must certify in writing that there has been no change in case mix or circumstances which could reduce the amount of the exception.

2534.5 Determination of Reasonable Costs in Excess of Cost Limit or 112 Percent of Mean Cost.--In determining reasonable cost, the provider's per diem costs in excess of the cost limit are subject to a test for low occupancy and are compared to per diem costs of a peer group of similarly classified providers.

A. Low Occupancy.--If a provider's occupancy rate is lower than the average occupancy rate of the providers used to develop the cost limits, an adjustment to the provider's per diem cost may be made. The average occupancy rate for all SNFs is approximately 92 percent with a standard deviation of approximately 9 percentage points. Accordingly, the threshold occupancy rate of 75 percent (the average less 2 standard deviations, rounded up to the next whole percentage point) is used to determine if an adjustment is necessary. If a provider's occupancy rate is below 75 percent, all fixed per diem costs, by cost center, are adjusted to reflect its per diem equivalent at the 75 percent occupancy rate. For the purposes of this adjustment, fixed costs are defined as those costs considered fixed by standard accounting practices and those costs that must be incurred by all SNFs in order to meet the conditions of participation in the Medicare program. The provider must identify and quantify all per diem costs, by cost center, that vary with occupancy and, accordingly, must be excluded from the adjustment for low occupancy. In the absence of a specific identification, all per diem costs are deemed fixed and adjusted accordingly. An example of HCFA's low occupancy adjustment is contained in the comprehensive example referred to in Appendix B.

B. Uniform National Peer Group Comparison.--The uniform national peer group data are based on data from SNFs whose costs are used to compute the cost limits. The peer group data are divided into four groups: Urban Hospital-based, Urban Freestanding, Rural Hospital-based, and Rural Freestanding. For each group, an average per diem cost (less capital-related costs) is computed for each routine service cost center (direct and indirect) that the provider reported on its Medicare cost report. For each cost center, a ratio is computed as the average per diem cost to total per diem cost. Those cost centers not utilized on the Medicare cost report must be eliminated and all ratios are revised based on the revised total per diem cost. If indirect costs are directly assigned (e.g. nursing administration (indirect cost) assigned to the direct cost center), the indirect cost elements must be identified and reassigned, for the purpose of constructing the peer group, to the indirect

cost center identified with the type of cost incurred. The ratios are then based on the averages for the cost centers reflecting the reassigned costs. However, maintenance of personnel, paramedical education, interns and residents, nursing school, etc. always have a ratio of 0.00 because HCFA's peer group does not contain a valid sample of providers incurring these costs. (See §2534.10.)

With cost reporting periods beginning prior to July 1, 1984, for each freestanding group and each hospital-based group, each cost center's ratio is applied to the cost limit applicable to the cost reporting period for which the exception is requested. For each hospital-based group with cost reporting periods beginning on or after July 1, 1984, the ratio is applied to 112 percent of the group's mean per diem cost (not the cost limit), adjusted by the wage index and cost reporting year adjustment factor applicable to the cost reporting period for which the exception is requested. The result is the provider's per diem cost is disaggregated into the same proportion of its peer group mean per diem cost for each cost center.

The SNF's actual per diem cost or, if applicable, the cost as adjusted for low occupancy for each applicable routine cost center (less capital-related costs) is compared to the appropriate component of the disaggregated cost limit or 112 percent of the hospital-based mean per diem cost. If the SNF's per diem cost exceeds the peer group per diem cost for any cost center, the higher cost must be explained. Excess per diem costs which are not attributable to the circumstances upon which the exception is requested and cannot be justified may result in either a reduction in the amount of the exception or a denial of the exception.

Pages 1 through 4 of Appendix A show the derivation of the per diem adjustment ratios (column (B)) applicable to each of the four peer groups. Page 5 of Appendix A shows the calculation of the hospital-based peer group mean cost.

Appendix B, pages 1 through 4, illustrates a comprehensive example of a hospital-based provider located in San Francisco, CA, which has low occupancy and has timely filed for an exception in accordance with §2531.1.A.2. The maximum exception that this provider can receive is \$78.44 per day assuming the requirements of §2534 for filing a request have been met.

2534.10 Atypical Services or Items.--Under 42 CFR 413.30(f)(1), an SNF may be eligible for an exception to the cost limits if it can show that (1) the actual cost of items or services furnished exceeds the applicable peer group cost because such items or services are atypical in nature and scope compared to the items or services generally furnished by its peer group; and (2) atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care. The provider must explain the nature and scope of the services it provides and how these services relate to the costs incurred.

The following is a list of exceptions that may be granted for atypical services or items.

A. Atypical Direct Cost.--In general, the classifications of direct costs include nursing service personnel which includes head/charge nurses, registered nurses (RNs), licensed practical and vocational nurses (LPNs), nursing aides, orderlies, and ward clerks. Personnel not included are administrative nursing personnel assigned to departmental offices, central supply, employee health services, or any other areas not providing general inpatient SNF care, and personnel performing activities that do not directly relate to the care of

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patients. Direct costs may also include non-salary costs such as routine medical supplies and drugs. In addition, direct costs may include directly assigned indirect costs such as nursing administration and social services. See §2534.5.B for instructions concerning the assignment of costs for purposes of constructing the peer group. The intermediary analyzes nursing service costs, nursing hours, and Medicare patient mix by types of care to ensure that the provider's direct salary costs in excess of the peer group direct salary costs are due to atypical nursing services and not a result of an excess number of nursing personnel. In no instance does HCFA grant an exception that includes direct patient care salary costs for more than 9.6 direct patient care hours per patient day. (This maximum was computed using a seven state staff time study developed for the Multi-State Nursing Home Case Mix and Quality Demonstration under authority of HCFA.)

If the intermediary determines that the provider has excessive personnel or the provider's direct patient care hours per patient day exceed 9.6, the intermediary eliminates the excessive costs from the provider's direct per diem cost for comparison to the peer group. For purposes of this determination, direct patient care hours do not include the hours for ward clerks or other personnel not providing direct hands on patient care. As part of its determination of the appropriateness of a provider's costs, the intermediary looks for instances where a provider is utilizing RNs or LPNs to perform the services of less costly aides or orderlies. This could be characterized by very low or no other nursing hours per patient day compared to the peer statistics referred to in §2534.10 A.5. If the provider cannot justify the utilization of more costly personnel, the intermediary adjusts the provider's direct per diem cost, for purposes of the peer group comparison, to reflect removal of the costs determined to be excessive.

When the nursing home has a distinct part SNF and the provider has allocated nursing hours on the basis of actual time, the intermediary verifies that the SNF has auditable records for recording and accumulating the number of nursing hours and costs allocated to the distinct part. In the absence of such records or if the available records are determined to be inadequate, costs are allocated in accordance with §2340. The provider must submit the same direct nursing service information described below for the non-participating portion of the facility as part of the supporting documentation.

When the SNF is a component of a chain organization and home office costs have been allocated to the SNF, the intermediary reviews home office costs, makes a determination as to their reasonableness in accordance with §§2150.2 and 2150.3 and makes adjustments as appropriate prior to determining an exception amount.

The provider must submit the following information for all initial requests for an exception for atypical nursing services. HCFA denies a request that does not include this information.

1. Complete breakdown of direct costs (Worksheet B, Part I, SNF participating line, column 0) including nursing salary cost breakdown by employee and/or contract classification, e.g., RN, LPN, nurse aides, breakdown of other than salary costs, e.g., routine medical supplies and drugs, and directly assigned indirect costs.
2. Complete breakdown of both productive and non-productive nursing personnel hours by classification of personnel and/or contracted nurses.
3. Peer group analysis comparing its per diem direct expenses to the peer group per diem direct expenses.

4. The provider must show the percentage of discharges (to home, to hospital, etc.) as related to the treatment of more complex cases. Other information may include, but is not limited to, the following factors as compared to peer providers: a shorter average length of stay for its patients, a higher incidence of ancillary services furnished to its patients, and/or higher than average Medicare utilization.

5. Summary of patient diagnoses and activities of daily living (ADLs) dependencies for a random sample of all patients in the Medicare certified facility. Based on the sample, the intermediary makes a determination on whether the SNF's staffing is excessive. If the intermediary determines that the staffing is excessive, the intermediary adjusts the SNF's direct per diem cost for comparison to the peer group.

The peer group direct per diem cost does not separately identify salary cost and non-salary cost. Accordingly, the provider's actual percent of salary and non-salary cost to total direct cost is applied to the peer group direct per diem cost. An exception is computed as the provider's direct salary per diem cost in excess of the peer group direct salary per diem cost.

When a provider has directly assigned any indirect costs (e.g., social services), it is necessary for the provider to separately identify the costs and for purposes of comparison to the peer group, compare this cost to the peer group amount.

In addition, separately identify the routine non-nursing direct cost, such as drugs and medical supplies, and for purposes of comparison to the peer group, compare these costs to the peer group amount for these cost centers. (For providers that have routine costs for central services/supplies and/or pharmacy in a separate general service cost center, see the instructions in subsection J.).

B. Atypical Employee Health and Welfare (EH&W) Cost.--An exception is granted for the portion of EH&W per diem cost associated with direct salary per diem costs considered to be atypical. The exception is computed as the lesser of the EH&W unit cost multiplier (UCM) less capital UCM times the atypical direct salary per diem costs or the provider's EH&W per diem cost in excess of the peer group EH&W per diem cost.

If a unit cost multiplier is not available from the cost report, directly assigned EH&W per diem costs less capital-related costs are divided by total routine salaries. Identify both EH&W cost and salaries in the direct cost breakdown that is required for computing atypical nursing services.

C. Atypical Administrative and General (A&G) Cost.--An exception is granted based on the portion of atypical direct and EH&W per diem costs (used, in part, as the statistical basis for allocation of A&G costs) related to atypical nursing services. The exception is computed as the lesser of the A&G UCM less capital UCM times the combined atypical nursing and related EH&W per diem cost or the provider's A&G per diem cost in excess of the peer group A&G per diem cost.

SNFs with fragmented A&G must add the fragmented A&G amounts less capital to compute an A&G per diem cost. In addition, the UCM for A&G must be computed (using Worksheet B, Part 1, SNF routine cost line) by dividing the combined A&G cost (including all fragmented portions less capital) by the accumulated cost of all cost centers prior to any of the fragmented A&G cost centers.

D. Atypical Plant/Maintenance (P&M) Cost.--An exception may be granted based on the demonstrated atypical dependency of special equipment (e.g., ventilators, beds to contain/prevent skin ulcerations, etc.). The exception is computed as the lesser of the cost of operating and maintaining atypical specialized equipment or machines or the provider's P&M per diem cost in excess of the peer group P&M per diem cost. Capitalized purchases are not included.

E. Atypical Housekeeping Cost.--An exception may be granted based on a demonstrated lower than average length of stay and/or higher than average number of incontinent patients. The exception is computed as the provider's housekeeping per diem cost in excess of the peer group housekeeping per diem cost.

F. Atypical Laundry Cost.--An exception may be granted if the provider can demonstrate (1) a higher than average number of incontinent patients; computed as the provider's laundry per diem cost in excess of the peer group laundry per diem cost, or (2) the rendering of rehabilitation care with a high percentage of patients discharged home which necessitates utilization of personal clothes that are cleaned by the provider. The exception is computed as the lesser of the percentage of Medicare patients receiving rehabilitation and utilizing personal clothing times the provider's laundry per diem cost or the provider's laundry per diem cost in excess of the peer group laundry per diem cost.

G. Atypical Dietary Cost.--An exception may be granted if the provider can demonstrate (1) kosher food costs in excess of non-kosher food costs, or (2) costs of foods with higher nutrition, pureed foods, or tube feeding mixtures (not considered ancillary costs) that are more expensive than regular non-specialized foods. The exception is computed as the lesser of per diem dietary costs in excess of the peer group or the separately identified dietary costs as referred to above.

H. Atypical Cafeteria Cost.--An exception is granted based on the amount of atypical direct nursing costs. The exception is computed as the lesser of the percent of atypical nursing costs per day to total nursing costs per day times the provider's cafeteria per diem cost or the provider's cafeteria per diem cost in excess of the peer group cafeteria per diem cost. For a freestanding provider that has routine cafeteria costs, the provider must compute the percentage of its routine cafeteria cost to its total routine cafeteria and routine dietary costs. For purposes of comparison to the peer group, the provider then applies the above percentage to the dietary base per diem amount (column A) included in its peer group.

I. Atypical Nursing Administration Cost.--An exception is granted based on the amount of atypical nursing hours. The exception is computed as the lesser of the percent of atypical nursing costs per day to total nursing costs per day times the provider's nursing administration per diem cost or the provider's nursing administration per diem cost in excess of the peer group nursing administration per diem cost.

J. Atypical Routine Central Service/Supplies and Atypical Routine Pharmacy Costs.--An exception is granted if the provider has demonstrated atypical direct nursing costs. The exception is computed as the amount that its routine costs exceeds the peer group amount.

K. Atypical Medical Records Cost.--An exception is granted based on a demonstrated lower than average length of stay and/or higher than average Medicare utilization. The exception is computed as the provider's medical record per diem cost in excess of the peer group medical record per diem cost.

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L. Atypical Social Service Cost.--An exception is granted based on a demonstrated lower than average length of stay and/or higher than average Medicare utilization. It is computed as the provider's social service per diem cost in excess of the peer group social service per diem cost.

M. Certain Other Atypical Costs.--The following indirect costs were not incurred by a sufficient number of providers to compute a valid peer group per diem cost. If a provider has incurred these costs and they have been separately identified and quantified, an exception is granted for the actual provider's per diem cost adjusted for capital-related costs.

(1) Maintenance of personnel costs certified by the intermediary as necessary and reasonable.

(2) Central services/supplies and pharmacy costs of non-routine nature but allocated to the routine service cost center where the provider had no charge structure for such costs thereby preventing such costs from being classified as ancillary costs. The intermediary verifies that costs are of non-routine nature and are reasonable.

(3) Interns/residents/nursing school/paramedical education under an approved program defined in 42 CFR §413.85. The intermediary verifies if the program is approved; if the provider is hospital-based, the hours per day for the SNF is equal to or lower than the hours per day for the hospital; and costs are reasonable.

2534.11 Continuing/Repeating Requests for Atypical Services or Items.--After HCFA has approved an initial exception, the intermediary performs the following analyses on requests for the current cost reporting period as compared to the previous cost reporting period when an exception was granted:

- o Changes in nursing hours per day by employee or contract classification;
- o Computes peer group analysis (where appropriate, adjusts provider's cost for occupancy rates below 75 percent); and
- o Changes in direct and indirect costs by cost center.

The intermediary reviews the provider's costs and nursing hours to ensure that any increases from the prior cost reporting period are appropriate and necessary given the provider's case mix and other relevant circumstances. If nursing hours per day in any classification differ by more than 25 percent and/or any individual per diem cost differs by more than 20 percent, the cost report and documentation must be reviewed by the intermediary as though the request was an initial request described in §2534.10. In addition, the provider must justify the causes for these substantial changes as they relate to patient care. Finally, the intermediary verifies any justification offered by the provider and forwards a recommendation to HCFA.

If the above nursing hours and cost thresholds have not been exceeded, the intermediary submits to HCFA only its recommendation, certification that the thresholds were not exceeded using the form below (the provider must include copy of the form below with its request), and a statement that the provider's request is based on existence of similar patient care as that rendered in the previous cost reporting period for which an exception was granted.

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Certification of Analysis for Exception to SNF Cost Limit

Provider Name:

Provider Number:

Fiscal Year Ending (FYE):

	<u>RNs</u>	<u>LPNs</u>	<u>Aides</u>
Nursing Hours			
Current FYE			
Prior FYE			
Percent change			

Per Diem Routine Costs

<u>Excluding Capital</u>	<u>Current FYE</u>	<u>Prior FYE</u>	<u>% Change</u>
--------------------------	--------------------	------------------	-----------------

Direct Expenses
 Employee Health & Welfare
 Admin. & General
 Operation/Maintenance
 Housekeeping
 Laundry
 Dietary
 Cafeteria
 Nursing Admin.
 Medical Records
 Social Services

Total Routine Service Cost	<u>Per Diem</u>
Compared to Cost Limit	\$
Cost Limit	\$
Per diem amount over limit	\$

Per Diem Exception	
Amount Recommended	\$

2534.13 Unusual Labor.--A provider may request an exception under 42 CFR 413.30(f)(8) when its percentage of routine labor costs differs by more than ten percent from the percentage used in promulgating the cost limits. The provider must verify its salary costs, the amount of other costs deemed to be labor related and the total amount of salary and labor related-costs allocated to SNF routine costs through the stepdown process. If the SNF documents that its labor related costs vary by more than ten percent from the percentage used to promulgate the limits, an exception for the variance in excess of ten percent is available. The exception is computed as shown in the following example utilizing the methodology in the Federal Register dated October 7, 1992 (57 FR 46177) for an urban freestanding SNF located in Bakersfield California whose fiscal year is October 1, 1992, through September 30, 1993.

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SNF A

Actual percentage of labor related costs	94.00	percent
Labor-related percentage in limit	83.10	percent
Plus 10 percent	8.31	percent
Total	91.41	percent

Variance in excess of 10 percent	2.59	percent
Plus labor-related percentage in limit	83.10	percent
Revised labor-related percentage	85.69	percent
Times limit	\$96.64	
Revised labor component	\$82.81	
Times wage index	1.0868	
Adjusted labor	\$90.00	
Revised non labor-related component		
(\$96.64 - \$82.81)	\$13.83	
Nursing home reform and OSHA per diem add-on	\$ 1.98	

SNF A's revised cost limit reflecting the exception for unusual labor costs	\$105.81
SNF A's original cost limit	<u>\$105.53</u>

Exception	\$.28
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2534.14 Extraordinary Circumstances.--Exceptions are available under 42 CFR 413.30(f)(2) for extraordinary circumstances beyond a provider's control. These include, but are not limited to, strikes, fire, earthquake, floods or similar circumstances of a short duration with substantial financial impact. The provider must document the impact the event has on its costs. However, these do not include circumstances which are in the control of management, such as, changed accountants, obsolete software, etc.

2535. ADJUSTMENT OF INTERIM RATE

The provisions of chapter 24, Payments to Providers, remain applicable in establishing the interim rate and need to be consulted for specific instructions on interim rates. The following provides a general description of the calculation of the interim rate.

Generally the interim rate is paid to SNFs on a per diem basis and is based on average cost or a percentage of charges. The portion of the provider's interim rate subject to the cost limits may not exceed the published limit applicable to the provider. When necessary, the intermediary reduces the portion of the interim rate that exceeds the cost limits. The interim rate may be increased when an interim or final exception has been granted by HCFA under 42 CFR 413.30(f).

A. Average Cost Method.--When the provider's interim rate is expressed as an average cost, the intermediary computes this average cost by dividing the lesser of the amounts shown in items 1 or 2 below by the provider's estimated Medicare days.

1. The provider's estimated Medicare reimbursable cost, or
2. When the lower of cost or charges provisions apply (see chapter 26), the estimated Medicare charges.

2536. OPERATIONAL REVIEW

Any provider that applies for an exception to the cost limits for any cost reporting period to which the limits apply agrees to an operational review at the discretion of HCFA. The findings from any such review may be the basis for recommendations for improvements in the efficiency and economy of the provider's operations. If such recommendations are made, any future exceptions are contingent on the provider's implementation of these recommendations.

A decision by HCFA to conduct an operational review does not have an effect on the granting of exception requests filed for fiscal years beginning prior to the issuance of findings and recommendations from the review. A provider requesting an exception to cost limits after an operational review must submit a detailed listing of the measures it has taken or a plan describing the measures it will take to improve the efficiency and economy of its operations. The purpose of the operational review is to study the provider's operations and to make appropriate recommendations for improvements to increase efficiency or economy. For example, the review may compare the provider's full time equivalent employees in the routine area with peer providers to determine if the provider's staffing ratio is contributing to the excess cost. The comparison takes into consideration factors other than the number of employees such as the case mix and the length of stay for the provider and peer providers.

2537. FORMAL APPEAL OF DETERMINATIONS ON REQUESTS FOR RECLASSIFICATION, EXCEPTIONS AND EXEMPTIONS

As with other reimbursement determinations, the provider is entitled to a formal appeal under 42 CFR 405.1801ff on issues of the provider's classification and requests for exceptions or exemptions if it disagrees with the determination. The request must be made within the time limits specified for making an appeal. However, the time required for HCFA to review the request is considered good cause for granting an extension of the time limit to apply to the Provider Reimbursement Review Board, as specified in 42 CFR 405.1841. The appeals process is discussed in chapter 29.

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Appendix A

APPENDIX A

Derivation of Uniform Peer Group by Adjusting Base Breakdown
Applicable to 1988 and 1989 SNF Cost Data

THIS SPACE RESERVED FOR PAGES 25-12.1O THRU 25-12.1S

APPENDIX B

THIS SPACE RESERVED FOR APPENDIX B PAGES 25-12.1T THRU 25-12.1W

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2540. SCHEDULE OF LIMITS FOR HOME HEALTH AGENCIES

A. General.--Effective with cost reporting period beginning on or after July 1, 1979, limits have been established on the reimbursable cost per visit for each type of home health service. The limits are also applicable to physical therapy or speech pathology visits furnished by home health agencies under the outpatient physical therapy benefit provisions of the law. The per visit limit amount includes the cost of medical supplies routinely furnished in conjunction with patient care visits, but excludes costs of medical appliances and supplies which are directly identifiable services furnished to individual patients.

B. Methodology.--An aggregate limit is applied to total allowable costs attributable to Medicare patient visits. This limit is computed for each home health agency by multiplying the number of program patient visits for each type of service furnished (e.g., skilled nursing, home health aide) by the respective per visit cost limit. The sum of these amounts is then compared to total allowable costs attributable to Medicare patient visits minus the costs of medical appliances and supplies not included in the per visit limit. Reimbursement is based on the lower of these two amounts.

Use the aggregate limit for cost reporting periods beginning on or after July 1, 1979, whether or not your current cost reporting method allows for application of separate limits.

2541. PROVIDER NOTIFICATION

Each home health agency is notified by its servicing intermediary of its limits at least 30 days prior to the start of a cost reporting period to which the limits are to be applied.

2541.1 Contents of Notice to HHA.--Each notice must contain:

- A. The home health agency's classification (see §2541.2) and applicable limits;
- B. If necessary, notification of an interim rate adjustment;
- C. A statement that, where the home health agency believes it has been incorrectly classified, it is the home health agency's responsibility to furnish evidence to the intermediary that establishes the classification is incorrect; and
- D. A statement regarding the home health agency's right to request an exception from the cost limits under the provisions of 42 CFR 405.460.

SAMPLE LETTER

TO: (Home Health Agency)

Our records indicate that, for purposes of the cost limits established under authority of Medicare regulations 20 CFR 405.460 and 405.461, your facility is classified as follows:

Cost reporting period begins:

SMSA (NECMA)/Non-SMSA:

Schedule of limits:

Calculation of Adjustment of the Interim Rate (If necessary).

If you believe the above classification is incorrect, please furnish us evidence that supports the classification you believe to be correct.

You are also advised that you may be entitled to an exception under the provisions of § 42 CFR 405.460. If you believe that your facility meets any of the conditions set forth in this section, you may request that our cost limitation be reviewed.

(Signature)

254l. 2 Classification of HHAs.--The criterion used to classify home health agencies is whether their main offices are located in an urban or nonurban areas of July 1, 1979. A main office of a home health agency which is located in a Standard Metropolitan Statistical Area (SMSA) or a New England County Metropolitan Area (NECMA) is considered urban. However, subunits of private agencies (i.e., agencies not operated by a State or local government) are classified according to the location of each subunit. Subunits of public agencies are classified according to the location of the main office of the parent agency. Branch offices are classified according to the location of the main office of the parent agency. Those areas located within SMSAs or NECMAs can be identified from the U.S. Department of Commerce publication: Federal Information Processing Standards Publication - Standard Metropolitan Statistical Areas.

254l.3 Intermediary Review of Provider Classification.--After receipt of the notice of classification, a home health agency may submit evidence that it has been incorrectly classified. If such evidence is satisfactory, the intermediary shall change the classification, notify the home health agency accordingly, and submit a copy of the notice of the change in classification to HCFA.

2544. PROVIDER REQUEST FOR EXCEPTION

A. Conditions.--Home health agencies are entitled to file a request for an exception from the costs limits for each cost reporting period under the following conditions:

1. The home health agency actually exceeds or expects to exceed the applicable limits, and
 2. it submits a request to its intermediary detailing the circumstances which it believes qualifies it for an exception and the effects of these circumstances on its costs. The circumstances which may entitle an agency to an exception are set forth in 42 CFR 405.460. The burden of justifying an exception to the cost limits is the responsibility of the provider.
- B. Intermediary Review.--Upon receiving the home health agency's request, the intermediary shall:
1. Review the request and make a recommendation and, if necessary, compute the amount of the exception.
 2. Include a copy of the latest desk-review cost report plus any later unreviewed
 3. Include a determination of the reasonableness of all the individual components of cost. This would include a comparison with peer home health agencies.
 4. Submit the request, recommendation, cost reports, and determination of reasonableness to the Bureau of Program Policy, HCFA.
 5. Not implement its recommendation pending receipt of Bureau of Program Policy advice.
- C. Bureau Action.--Upon receiving the information from the intermediary, the Bureau shall:
1. Review the request, intermediary's recommendation and determination of reasonableness.
 2. Affirm or otherwise advise the intermediary regarding the decision.
 3. Request additional information from the intermediary when the intermediary's recommendation does not contain sufficient documentation.

2545. ADJUSTMENT OF INTERIM RATE

While the provisions of Chapter 24, Payments to Providers, remain applicable in establishing the interim rate, the following methodologies are to be used for the purpose of adjusting the interim rate of home health agencies that exceed the aggregate cost limits.

2545.1 Average Cost Per Visit Method

A. Computation of Average Cost Per Visit.--When the home health agency's interim rate is expressed as an average cost per visit, the intermediary shall compute this average cost per visit by dividing the lesser of the amounts

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shown in 1, 2 or 3 below by the agency's estimated program visits.

1. The agency's estimated Medicare reimbursable cost (A home health agency that reports the cost of home health aid services on an hourly basis may continue to compute its allowable home health aide cost by multiplying the hourly rate by the number of program aide hours), or
2. The estimated Medicare charges, or
3. The estimated aggregate cost limit, plus the estimated cost of medical supplies and appliances that are directly identifiable services furnished to individual program patients.

B. Example

<u>Discipline</u>	<u>FYE 6/30/80 Estimated Visits</u>		<u>7/1/79 Limit Amount</u>		
Skilled Nursing	1,000	x	\$41.80	=	\$ 41,800
Physical Therapy	500	x	\$40.95	=	\$ 20,475
Speech Therapy	200	x	\$44.95	=	\$ 8,990
Home Health Aides	1,000	x	\$33.00	=	<u>\$ 33,000</u>
Aggregate Cost Limit					\$104,265
Medical Supplies and					
Appliances					<u>10,000</u>
					\$114,265

Cost Reporting Period Begins July 1, 1979

Estimated Reimbursable Cost = \$120,000

Estimated Charges = \$136,000

Estimated Aggregate Cost Limit = \$114,365

Estimated Number of Visits = 2,700

$\$114,265 \div 2,700 = \42.32 Average Cost Per Visit in effect 7/1/79

C. Computation of Home Health Aid Visits.--Where a home health agency does not report the number of home health aide visits, i.e., home health aides are reported on an hourly basis, the number of home health aide visits shall be computed by subtracting professional program visits (Schedule A-1 of HCFA-1728) of aid visits are not included in total visits on the statistical page, i.e., total visits equal profession visits on Schedule A-1, the number of aide visits shall be obtained from the provider's billing records.

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2545.2 Percentage of Charges Method.--When the home health agency's interim rate is expressed as a percentage of charges, the intermediary shall compute the interim rate by dividing the less of the agency's estimated program reimbursable costs or estimated aggregate cost limit, plus the estimated cost of medical supplies and appliances that are directly identifiable services furnished to individual program patients, by the agency's estimated Medicare charges.

Utilizing the example in § 2545.1, the home health agency's interim rate would be 84.02 percent (i.e., \$114,265 - \$136,000) effective July 1, 1979. Further adjustment of the interim rate may be made under either the average cost per visit method or the percentage of charges method if an agency's charge structure, costs, or visit mix changes.

2546. CHANGES IN UTILIZATION OR BILLING PRACTICES

Intermediaries shall be alert to changes in billing practices or changes in utilization of specified disciplines in HHAs whose interim rates are reduced because of implementation of the cost limits. Such changes may indicate an attempt to raise the cash flow from program sources to the level in effect prior to implementation of the cost limits. Claims from HHAs which exhibit changes in utilization or changes in billing practices shall be reviewed closely to assure that all claims for unnecessary care are denied.

2547. FORMAL APPEAL OF INTERMEDIARY DETERMINATIONS

As with other reimbursement determinations, after the submission of a cost report, the home health agency shall be entitled to a formal appeal under the regulations on the issues of provider classification and requests for exception if it disagrees with the intermediary's determination on these issues, even though the agency has been afforded a review as specified above. The agency's request for such a hearing must be made within the time limit specified for filing an appeal from an intermediary's notice of program reimbursement. (See § 2430.)

2548. PROVIDER CHARGES TO BENEFICIARIES FOR EXCESS COSTS

Information on the calculation and validation of provider charges to beneficiaries for excess costs can be found in § 2570.

2570. CHARGES TO BENEFICIARY

Section 405.461 of Regulations No. 5 permits a provider to charge the beneficiary where the provider's allowable costs (or, if less, the customary charges) in the second preceding cost reporting period exceed the applicable limits for such costs. The charge may not exceed the amount of such excess and may be made only if certain required conditions are met.

2570.1 Provider Charges to Beneficiaries for Excess Costs - General.--A provider may charge beneficiaries as noted in § 2570 for the excess cost of an item or service paid for by the program if all the following conditions are met:

A. The provider's allowable costs (or, if less, the customary charges) for the item or service in the second preceding cost period exceed the limits established for such items or services. (A new provider, as defined in § 2571.1B, which does not have a second preceding cost period will, subject to validation by the intermediary, estimate the current year cost and this amount will be adjusted to the equivalent of costs in the second preceding cost period by use of factors set forth in § 2571.1B to determine whether a charge is permissible.)

B. The intermediary determines that these charges for excess costs have been calculated in accordance with the provisions of this section.

C. The Health Care Financing Administration has provided notice to the public of the charges the provider is authorized to impose on Medicare beneficiaries because its costs for the items exceed the costs determined to be necessary in the efficient delivery of health services under title XVIII. (See § 2572.3.)

D. The provider has, in the manner prescribed in § 2573, identified such charges to the beneficiary or the individual acting on his behalf, as charge for excess costs.

E. The services are not emergency services as defined in § 2574.

F. The admitting physician has no direct or indirect financial interest in the provider. (See § 2575.)

Authorization to make charges for excess costs is effective only prospectively and does not extend beyond the end of the cost period for

which the cost limit is applicable. Thus, where all requirements for imposing charges for excess costs (e.g., public notice of the charges) are not met until after the beginning of the cost period for which such charges will be applicable, the charges can be made only for the remainder of the cost period.

2571. CALCULATION OF THE CHARGE TO THE BENEFICIARY

2571.1 Provider Inpatient General Routine Costs in Excess of the Schedule of Limits on Provider Inpatient General Routine Service Costs Effective July 1, 1974.--

A. Provider With a Second Preceding Cost Reporting Period.--Data obtained from appropriate pages of form SSA-2570 are to be used by all hospitals, including hospital-skilled nursing care complexes and subprovider components of general hospitals, to determine the allowable cost of and the customary charges for inpatient general routine services in the second cost reporting period immediately preceding the cost reporting period in which such charges are to be imposed. (The data used will be subject to adjustments made by the intermediary at settlement or initial desk review, whichever is last to occur before the provider request to charge is received.)

Charges to the beneficiary are calculated in the following manner:

1. The cost per day of inpatient general routine services applicable to Medicare including the inpatient routine nursing salary cost differential payment is the sum of the amounts obtained from lines l3 and l5 of page 5, form SSA-2570, completed for the hospital or subprovider, as appropriate. (The reimbursable return on equity capital is excluded from this computation.)

2. The customary charge for inpatient general routine services is the total Medicare charges for such services (obtained from the provider's records for the same cost reporting period as the allowable cost determined in Step 1) divided by the total number of Medicare inpatient days for general routine services obtained from form SSA-2570, page 1, line l2a, column 1, or column 3 and/or 4, as appropriate. (Do not include in this computation any inpatient days or charges applicable to special care units or ancillary services.)

3. The lower of the amounts determined in Steps 1 and 2 is compared with the hospital's applicable cost limit to determine if a charge may be imposed.

4. Where the amount determined in Step 3 exceeds the applicable cost limit, the charge, if imposed, may not exceed an amount equal to the excess cost.

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5. Examples:a. No Charge to Beneficiary Permitted.--

(1)	1973 Allowable Cost	\$80/Day
	1973 Customary Charge	\$85/Day
	1975 Cost Limit	\$90/Day

Provider may not charge beneficiary - 1973 allowable cost and charges less than 1975 cost limit.

(2)	1973 Allowable Cost	\$90/Day
	1973 Customary Charge	\$85/Day
	1975 Cost Limit	\$88/Day

Provider must not charge beneficiary - although 1973 allowable cost exceeds the 1975 cost limit, the 1973 customary charge is less than 1975 cost limit.

b. Provider Permitted to Impose Charge on Beneficiary.--

(1)	1973 Allowable Cost	\$95/Day
	1973 Customary Charge	\$100/Day
	1975 Cost limit	\$92/Day

Provider may charge beneficiary \$3/Day - excess of 1973 allowable cost over 1975 cost limit (\$95 - \$92).

(2)	1973 Allowable Cost	\$100/Day
	1973 Customary Charge	\$95/Day
	1975 Cost Limit	\$90/Day

Provider may charge beneficiary \$5/Day - excess of 1973 customary charge (less than 1973 allowable cost) over 1975 cost limit (\$95 - \$90).

B. New Provider With No Second Preceding Cost Reporting Period.--A new provider that does not have a second preceding cost reporting period will estimate the current year cost -- expressed as a per diem amount --for inpatient general routine services. The estimated current year per diem cost must be adjusted to an amount equivalent to general routine service costs in the second preceding year. The amount thus determined will be used in lieu of the prior period actual general routine service cost in determining the charge to the beneficiary.

For purposes of this provision, a new provider is defined as an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the program under present and previous ownership for less than 3 full years.

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The following table sets forth the factors which must be used to adjust estimated current year inpatient general routine service costs to an amount equivalent to such costs for the same reporting period 2 years earlier.

<u>Year</u>	<u>Cost Reporting Period Beginning Month</u>	<u>Adjustment Factor</u>
1974	July	82.3%
	August	82.2%
	September	82.1%
	October	82.0%
	November	81.9%
	December	81.9%
1975	January through June	81.9%

EXAMPLE: Hospital X's initial cost reporting period begins January 1, 1975, and the estimated cost for general routine services for the 1975 calendar year is \$100 per day. The cost limit for Hospital X's group for calendar year 1975 is \$80.

Computation of charge to beneficiary:

Estimated current year general routine service cost - 1975	\$100.00
Multiple by adjustment factor applicable to cost reporting periods beginning January 1975	<u>81.9%</u>
Adjusted per diem cost for general routine service applicable to Hospital X for calendar year 1973	<u>\$ 81.90</u>
1975 calendar year cost limit	\$ 80.00
Adjusted per diem cost used in lieu of 1973 actual cost	<u>81.90</u>
Amount Hospital X may charge beneficiary in calendar year 1975 for costs in excess of the limits	<u>\$ 1.90</u>

2572. PROVIDER REQUEST TO MAKE CHARGES

2572.1 Necessary Evidence.--To obtain consideration of a request to charge beneficiaries for costs in excess of the limits, the provider must submit to the intermediary a statement giving all pertinent information about all charges for excess costs for which it is seeking

validation, including the data and method used to determine the amount of each type of services for which a charge may be imposed. Such statement should include:

- A. Provider name and number;
- B. Identity of the class and prospective cost limit for the class in which the provider has been included;
- C. Amount of the proposed charge for each specified service or item, and the cost period during which the charges are to be imposed; and
- D. The cost and customary charge for each specified service or item in, and cost period ending date of, the second reporting period immediately preceding the cost reporting period in which the charge is to be imposed. (However, a new provider will include appropriate data used for the charge calculation computed in accordance with § 2571.)

The intermediary may request such additional information as it finds necessary to validate the charges the provider wishes to impose.

2572.2 Intermediary Action.--The intermediary will review the proposed provider charges to validate that they have been calculated correctly. If the charges are revised as a result of this review, the intermediary will obtain the written agreement of the provider to the revision. For purposes of giving the public notice described in § 2572 below, the intermediary will notify the regional office in writing of the validated charges, furnishing copies of the supporting documentation.

2572.3 Notice to the Public.--

A. Content.--Before charges can be made for covered services, the Social Security Administration must provide notice to the public that the provider is entitled to impose the charges on Medicare beneficiaries on account of costs in excess of the costs determined to be necessary in the efficient delivery of health services under title XVIII. The notice will be published in a local newspaper of general circulation serving the area where the provider is located. The following language will be used:

Notice is hereby given, in accordance with section 1866(a)(2)(B)(ii) of the Social Security Act, that (Name of Provider) is entitled to charge its Medicare patients during the period (Date at least 15 days after publication and not before beginning of applicable cost year) to (End of applicable cost year) for certain services in addition to the payment for such services made by the Medicare program. The charges have been approved by the Social Security Administration because the (Hospital, Skilled Nursing Facility, etc.) expects to incur cost which will exceed the costs determined

to be necessary for the efficient delivery of health care under the Medicare program. These charges may not be made, however, where the services furnished the patient are emergency services or where the physician admitting the patient has a direct or indirect financial interest in the (Hospital, Skilled Nursing Facility, etc.). The permissible charges, which are in addition to charges permitted for deductible, coinsurance, and noncovered services, are as follows:

(Example) Room & board, and other general routine services, \$5 per day.

Regional Representative
Bureau of Health Insurance
Social Security Administration

B. Obtaining Publication of Public Notice.--The regional office will obtain publication of the notice and advise the provider in writing, in advance, of the date the notice will be published. The regional office will also prepare and issue a press release in the provider's locality.

2573. IDENTIFICATION OF CHARGES TO BENEFICIARY BEFORE SERVICES ARE FURNISHED

A provider authorized to make charge for excess costs will, at the time it is first arranging for the individual's admission, outpatient services, or start-of-care, give or send him a schedule of all items and services which the individual might need and for which the provider imposes such charges, and the charge for each. Such schedule should be given or sent when arrangements are being made for admission or start of services or, if this is not feasible, as soon thereafter as practicable, but no later than the time of admission or initiation of services. The schedule should read as follows:

Provider Notice to Beneficiaries of Charges for
Excess Cost Services Covered Under Medicare

The Social Security Administration has determined that (Name of Provider) has higher costs for certain services covered by the Medicare program than most other comparable (hospitals, SNF's., etc.) in this area. For that reason, Medicare cannot pay or full costs for these services, but only the costs they determine to be necessary for these services, but only the costs they determine to be necessary for the efficient delivery of health care. Where the Medicare program cannot pay the full costs for a covered service, we are permitted to make an extra charge to the patient, except during a period when he or his is receiving hospital emergency services (or where the admitting physician has a direct

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or indirect financial interest in this (hospital, SNF)).* Emergency services are defined as services which are immediately necessary to prevent death or serious impairment of the patient's health and which are provided by the nearest hospital available and equipped to furnish such services.

For the period _____ to _____, we have been authorized to make the following extra charges for the services listed below:

(Example) Room, board and other general routine services--\$5 per day

These extra charges are your responsibility in addition to any Medicare deductible or coinsurance charges for which you are liable and charges for services not covered by Medicare.

If your or our representative believe these extra charges should not be made because the services are emergency services (or because you believe the admitting physician has a financial interest in this (hospital, SNF, etc.)),* you may ask for a determination from _____, the Medicare intermediary. We can assist you in making your request.

*To be used only for inpatient services.

Any deviation from the above wording is subject to intermediary approval.

2574. EMERGENCY SERVICES

A. Definition--A high-cost provider may not impose a charge for excess costs on a beneficiary for emergency services. Emergency services are those services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible participating hospital available and equipped to furnish such services. Where a beneficiary has been admitted as an inpatient to a high-cost participating hospital because of an emergency, the emergency will be deemed to continue until it becomes safe from a medical standpoint to move him to another hospital or other institution or to discharge him. The hospital may impose charges for excess costs beginning with the first day after the emergency ends.

The determination as to whether the high-cost hospital is the most accessible hospital in the emergency must take into account such matters as the relative distances of the high-cost hospital and other hospitals to the site of the emergency, the transportation facilities available to these hospitals, the quality of the roads to each hospital, the availability of beds at each hospital and the willingness of the other hospitals to accept the patient. The personal preference of the patient, his physician, or a member of his family, in the selection of the hospital, the nonavailability of staff privileges to the attending physician in other hospitals, or the location of previous medical records, will not be considered factors in the determination of accessibility.

B. Hospital Action.--The hospital's decision that the services it furnished were not emergency services will ordinarily be subject to review only if the decision is questioned by the beneficiary or his representative. If the decision is questioned, the hospital will obtain a written statement from the beneficiary or his representative as to why he thinks the services furnished are emergency services and will have the attending physician complete Form SSA-1771, Attending Physician's Statement and Documentation of Medical Emergency. (The reference to "participating hospital" or Hospital which participates under the Medicare program" should be changed to Hospital which makes no charges for excess costs.") A copy of the patient's hospital records, including a minimum history, physical examination doctor's orders, and all progress notes may be submitted in lieu of the SSA-1771. A statement that an emergency did not exist or the history or the diagnosis, without supporting information, is not sufficient. The statement concerning the character of the services is to be made by the physician attending the patient at the hospital. In exceptional situations-with appropriate justification the certification may be made by another physician having full knowledge of the circumstances at the time of admission, e.g., the attending physician is dead.

The hospital will forward the beneficiary's statement and the SSA-1771 or other evidence through its intermediary to the Bureau of Health Insurance Regional Office servicing its area with a request that a determination be made as to whether the services constitute emergency services under section 1866 of the Social Security Act, and a full explanation as to why it believes the services furnished were not emergency services within the definition in subsection A. The statement should deal not only with the existence of an emergency, but also with the question of whether there is another equally or more accessible participating hospital available which does not make charges for excess costs. The request will specify the services for which charges for excess costs were made, the charge per unit, the number of units, and the period during which the services were furnished (e.g., general routine services, \$5 per day, 12 days--March 10--March 21, 1975). If other services of the same character were not subject to charges, these should also be specified (e.g., general routine services, 7 days -- March 3 - March 9, 1975, emergency services).

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C. Regional Office Action.--The regional office will review the evidence submitted by the hospital concerning the services whose emergency character is in question and request any necessary additional evidence. The regional office will send the beneficiary notice of its determination and the provider a copy.

D. Effect of Determination.--If services are found to be emergency services as defines in A, the hospital will desist from further efforts to collect to charges and refund any amount collected for them.

2575. DIRECT OR INDIRECT FINANCIAL INTEREST

No charges may be made by the high-cost provider for excess cost for inpatient services where the physician admitting the patient has a direct or indirect financial interest in such provider. A physician will be considered to have such financial interest in a hospital or SNF in the following situation:

A. The physician is the sole owner of institution; or

B. The physician is a partner in the institution with a partnership interest equal to 5 percent or more of total ownership; or

C. Where the institution is operated by a corporation, the physician holds 5 percent or more of the outstanding stock; or

D. Where the institution is owned by a management or holding company, the physician has stock or other ownership in the management or holding company that gives him, in effect, 5 percent or greater interest in the institution.

It is the institution is owned by a management or holding company, the physician has stock or other ownership in the management or holding company that gives him, in effect, 5 percent or greater interest in the institution.

It is the responsibility of the provider not to make charges in these situations and to keep itself informed (by obtaining completion of a statement or questionnaire by the physician or by other means) as to the financial interest in the provider by admitting physicians.

2576. COMPLETION OF BILLING FORMS BY HIGH-COST PROVIDER

Where a provider makes charges for excess costs under § 2570, such charge information should not be shown on form SSA-l453.

2577. EFFECT OF REVISION OF COST LIMITS

Where a provider asks for review of the cost limits applicable in its case to an item or service, and the limit is subsequently raised as a result of this review, the provider is responsible for refunding to the beneficiary (or other person who paid the charges) amounts which, on the basis of the correction of the cost limit, were erroneously collected. Where the total erroneously collected on this basis from a beneficiary (or other person on a beneficiary's behalf) during the cost period is \$5 or less, the provider need not make a refund unless the payer requests

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it. However, any amounts which are not refunded, either because they are less than \$5 or because the provider is unable to locate the beneficiary, will be offset against program payment.