Medicare

Provider Reimbursement Manual
Part 1, Chapter 21, Cost Related to Patient Care

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Transmittal 493 **Date: March 31, 2023**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2104.3 - 2104.4	21-3.2 - 21-3.3 (2 pp.)	21-3.2 - 21-3.3 (2 pp.)

REPOSTED MATERIAL: This transmittal republishes chapter 21 to include page 21-3.2, issued in January 1976 as transmittal 139, that was inadvertently omitted when posted to the CMS website during an update. The transmittal communicates no new policies. All information in chapter 21 remains the same.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged.

CHAPTER 21

COST RELATED TO PATIENT CARE

Section

General

Principle 2100
Definitions 2102
Reasonable Costs 2102.1
Costs Related to Patient Care 2102.2
Costs Not Related to Patient Care 2102.3
Donations to a Provider of Produce, Supplies, Space, Etc. 2102.4
Prudent Buyer 2103

Costs Not Allowable

Unallowable Costs Related to Patient Care 2104
Ambulance Service 2104.1
Private-Duty Personnel 2104.2
Luxury Items or Services 2104.3
Dental Services 2104.4
Vocational and Scholastic Training Expense 2104.5
Unallowable Costs Not Related to Patient Care 2105
Noncompetition Agreement Costs 2105.1
Cost of Meals for Other Than Provider Personnel 2105.2
Cost of Reserving Beds or Services 2105.3
Costs of Unsuccessful Beneficiary Appeals 2105.4
Costs of Management Employee Meals 2105.5
Costs of Employee Travel 2105.6
Costs of Gifts or Donations 2105.7
Costs of Entertainment 2105.8
Costs of Employees' Personal Use of Motor Vehicles 2105.9
Costs of Fines or Penalties 2105.10
Costs of Spousal or Dependents Education 2105.11

Telephone, Television, and Radio Costs

Costs of Telephone, Television, and Radio 2106
General 2106.1
Combination Purpose Systems 2106.2

Parking Lot Costs

Parking Lot Costs 2107
General 2107.1
Treatment of Parking Revenue 2107.2

Provider-Based Physician Services

Reimbursement for Services by Provider-Based Physicians 2108
Professional and Provider Components 2108.1
Compensation Arrangements 2108.2
Methods Used to Determine the Reasonable Charge of Provider-Based Physicians 2108.3
Schedule of Charges 2108.4

Section

Effect of Physician's Assumption of Operating Costs (Lease or Concession Arrangement) 2108.5
Duties and Responsibilities of Provider and Intermediary in the Area of Provider-Based Physician Reimbursement 2108.6
Retroactive Adjustment of Certain Provider-Based Physician Payments 2108.7
Reimbursement for Provider-Based Physicians' Administrative, Teaching, and Direct Medical Care Services Where the Physicians Have Changed Their Compensation Arrangements With the Provider 2108.8
Reimbursement for the Services of Provider-Based Physicians Compensated Through the Provider and the Provider Bills the Program Under Combined Billing (on Forms SSA-1453 or 1483) or on Form SSA-1554 ..... 2108.9
Treatment of Provider Costs Related to the Provision of Physician Services to Nonprovider Patients 2108.10
Exhibits - Provider-Based Physicians 2108.11

Emergency Department Services

Reimbursement of Hospital Emergency Department Services When Physicians Receive Compensation for Availability Services 2109
General 2109.1
Definitions 2109.2
Allowability of Emergency Department Physician Availability Services Costs 2109.3
Methodology for Determining Allowable Emergency Physician Availability Service Costs 2109.4

Billing Costs

Billing Costs 2110
Contract Billing Services 2110.1
Treatment of Income Derived from Interest, Finance Charges, and Penalties on Delinquent Accounts Receivable 2110.2
Treatment of Income Derived from Billing Charges Imposed on Suppliers of Services Furnished Under Arrangements 2110.3
Physician Billing Costs 2110.4

Nonphysician Anesthetists' Services

Nonphysician Anesthetists' Services as Hospital Services 2112

Home Health Services

Home Health Coordination (or Home Care Intake Coordination) Costs - General 2113
Home Health Coordination Activities 2113.1
Patient Solicitation Activities 2113.2
Discharge Planning-Type Activities 2113.3
Education and Liaison Activities 2113.4
Home Health Coordination in the Provider-Based HHA 2113.5
Visiting Costs of HHAs 2114
Nonowners Compensation 2114.1
Transportation Costs 2114.2
Treatment of Medical Supply Costs in HHAs 2115
Non-Visiting Costs of HHAs 2116
Contracted Services Purchased by HHA 2117

COSTS RELATED TO PATIENT CARE

	Section
Services Furnished under Arrangements	
Cost of Services Furnished Under Arrangements	2118
Payment to the Provider	2118.1
Services Furnished Under Arrangements for Medicare Beneficiaries Only	2118.2
Cost of Drugs and Related Medical Supplies	2119
Services of Interns and Residents	
Reimbursement for Costs of Interns and Residents	2120
Taxes	
Taxes	2122
General Rule	2122.1
Taxes Not Allowable as Costs	2122.2
Employment-Related Taxes - Provider-Based Physicians	2122.3
Franchise Taxes	2122.4
Unemployment Compensation Insurance Costs for Nonprofit Providers Under Public Law 91-373	2122.5
Self-Insurance Program for Unemployment Compensation and Worker's Compensation Insurance Using a Reserve for Funding	2122.6
Review of Reasonable Costs, Including Taxes	2122.7
Oxygen	
Oxygen	2124
Blood	
Blood	2125
Utilization Review Costs	
Utilization Review	2126
Utilization Review in Hospitals	2126.1
Utilization Review in Skilled Nursing Facilities	2126.2
Community-Based Utilization Review Committee	2126.3
Utilization Review Cost; Provider Payment to Physicians for Rendering Utilization Review Services	2126.4
HHA Advisory Group	
Home Health Agency Advisory Group of Professional Personnel	2127
Training Costs	
Orientation and On-the-Job-Training	2128
Insurance Premiums	
Life Insurance Premiums	2130

Section

Start-Up Costs

Start-Up Costs 2132
General 2132.1
Applicability 2132.2
Cost Treatment for Medicare Reimbursement 2132.3
Sale of Institution 2132.4
Withdrawal from Program 2132.5
Effect on Equity Capital 2132.6

Organization Costs

Organization and Other Corporate Costs 2134
Organization Costs - General 2134.1
Cost Treatment of Organization Costs Under Medicare 2134.2
Amortization Period of 60 Months 2134.3
Amortization Period Less Than 60 Months 2134.4
Amortization Period Greater Than 60 Months 2134.5
Sale of Institution 2134.6
Withdrawal from Program 2134.7
Effect on Equity Capital 2134.8
Stockholder Servicing Costs 2134.9
Reorganization Costs 2134.10
Transfer of Assets to a Corporation 2134.11

Purchased Management and Administrative Support Services

Purchased Management and Administrative Support Services 2135
General 2135.1
Evaluation of the Need for Purchased Management and Administrative Support Services 2135.2
Determination of the Reasonable Cost of Purchased Management and Administrative Support Services 2135.3
Factors to Be Considered in Determining Reasonable Cost of Purchased Management and Administrative Support Services 2135.4
Documentation to Support Purchased Management and Administrative Support Services 2135.5

Advertising Costs

Advertising Costs - General 2136
Allowable Advertising Costs 2136.1
Unallowable Advertising Costs 2136.2

Membership Costs

Membership Costs - General 2138
Professional, Technical, or Business Related Organizations 2138.1
Civic Organizations 2138.2
Social, Fraternal, and Other Organizations 2138.3

	Section
Reasonableness of Provider's Participation in Approved Membership Activities	2138.4
Political and Lobbying Activities	
Political and Lobbying Activities	2139
Provider Political Activities	2139.1
Provider Lobbying Activities	2139.2
Organization Dues Related to Lobbying and Political Activities	2139.3
Deferred Compensation	
Deferred Compensation	2140
Definition	2140.1
Foreword	2140.2
Formal Plan	2140.3
Requirements to Fund Plan	2140.4
Reimbursement of Hospital-Based Physician Patient Care Services	2140.5
Guarantee Arrangements for Physician Emergency Room Services	2140.6
Defined Contribution Deferred Compensation Plans	
Defined Contribution Deferred Compensation Plans	2141
Definition	2141.1
Foreword	2141.2
Formal Plan	2141.3
Requirements to Fund Plan	2141.4
Reimbursement of Hospital-Based Physician Patient Care Services	2141.5
Guarantee Arrangements for Physician Emergency Room Services	2141.6
Effective Date	2141.7
Pension Plans	
Pension Plans	2142
Definition	2142.1
Section number reserved for future use	2142.2
Section number reserved for future use	2142.3
Section number reserved for future use	2142.4
Pension Costs	2142.5
Allowability of Payments	2142.6
Section number reserved for future use	2142.7
Fringe Benefits	
Fringe Benefits	2144
Definition	2144.1
Purpose	2144.2
Requirements for Recognition of Fringe Benefits	2144.3
Fringe Benefits Includable as Provider's Cost	2144.4
Fringe Benefits Includable in Determining Provider-Based Physician's Compensation	2144.5
Specific Costs Not Classified as Fringe Benefits	2144.6

	Section
Accounting for Fringe Benefits	2144.7
Sick Leave	2144.8
All-Inclusive Paid Days Off	2144.9
Cost of Meals for Provider Personnel	2145
Vacation Costs	
Vacation Costs	2146
Definition	2146.1
Reimbursement for Costs of Vacation	2146.2
Exception to the Requirement to Account for Vacation Costs on the Accrual Method	2146.3
Conversion from Cash Method to Accrual Method for Vacation	2146.4
Bilingual Service Costs	
Bilingual Services	2147
Cost of Physicians' Services in Teaching Hospitals	
Reimbursement for Physicians' Services Rendered in a Teaching Hospital by Physicians on the Hospital Staff and Reimbursement for Services Rendered in a Teaching Hospital by the Faculty of a Medical School or Organization Related Thereto - General	2148
Reasonable Cost of Direct Medical and Surgical Services Rendered by Physicians on the Hospital Staff in the Care of Individual Patients (Including Supervision of Interns and Residents Rendering Such Services)	2148.1
Reasonable Costs Incurred by a Teaching Hospital for the Services Rendered by a Medical School or Related Organization in the Hospital	2148.2
"Salary Equivalent" Payments for Direct Medical and Surgical Services in the Care of Individual Patients (Including Supervision of Interns and Residents Rendering Such Care) by Physicians on the Voluntary Staff of the Hospital (or Medical School or Organization Related Thereto)	2148.3
Allocation of Compensation Paid to Physicians in a Teaching Hospital	2148.4
Election to Receive Medicare Reimbursement on a Reasonable Cost Basis	2148.5
Home Office Costs	
Home Office Costs - Chain Operations	2150
General Limitation on Allowability of Costs	2150.1
Determination of Allowable Costs	2150.2
Allocation of Home Office Costs to Components in Chain	2150.3

Section

Home Office Equity Capital 2152
Computation 2152.1
Exclusions 2152.2
Allocation of Home Office Equity Capital 2152.3
Reporting of Home Office Costs and Equity Capital 2153

Planning Costs

Planning Costs 2154
General 2154.1
Definitions 2154.2
Planning Costs Where Facility is Completed 2154.3
Planning Costs Where Plans are Abandoned 2154.4

Abandonment of Construction

Abandonment of Construction-In-Progress 2155

Support Services Furnished to Governmental Providers

Allowable Costs of Governmental Support Services to State and Local Governmental Providers 2156
Unallowable Central Service Costs 2156.1
Allocation Bases 2156.2
Reporting Requirements 2156.3

Losses (Other Than from Sale of Assets)

Losses Arising from Other Than Sale of Assets 2160
Net Operating Losses 2160.1
Liability Losses 2160.2
Theft Losses 2160.3
Minor Losses 2160.4
Casualty Losses - General 2160.5
Insurance Costs 2161

Cost of Protection Against Malpractice Liability

Provider Costs for Malpractice and Comprehensive General Liability Protection, Unemployment Compensation, Workers' Compensation, and Employee Health Care Insurance 2162
Insurance with a Deductible or Coinsurance Provision 2162.1
Insurance Purchased from a Limited Purpose Insurance Company 2162.2
Self-Insurance 2162.3

Allowability of Actual Losses Related to Deductibles or Coinsurance 2162.5
Losses in Excess of Coverage 2162.6
Conditions Applicable to Self-Insurance 2162.7
Expenses Related to Losses Paid Out of Self-Insurance Fund 2162.8

Section

Reimbursement Principles Where a Provider Has Self-Insurance 2162.9
Treatment of Excess Reserves 2162.10
Effective Date and Retroactive Application 2162.11
Buy-Out Cost to Convert from a State- Administered Fund to a Self-Insurance Fund for Unemployment Compensation or Workers' Compensation Insurance 2162.12
Absence of Coverage 2162.13
Governmental Providers 2162.14

Post-Termination Administrative Costs

Administrative Costs Incurred After Provider Terminates Participation in Program..... 2176
Allowable Direct Administrative Costs to Be Included in Final Cost Report..... 2176.1
Allowable Direct Administrative Costs Incurred After Final Cost Report Is Filed 2176.2

Costs Related to Union Activities

Reimbursement for Costs Incurred in Relation to Union Activities..... 2180
Labor Union Organizing Activities 2180.1
Collective Bargaining 2180.2
Unallowable or Allowable but Not Reasonable Costs in Relation to Union Activities 2180.3

Physician Services Furnished in Providers

Services of Physicians in Providers 2182
General..... 2182.2
Allocation of Physician Compensation..... 2182.3
Conditions for Reasonable Charge Payment for “Physicians' Services” to Patients in Providers 2182.4
Determining Reasonable Charges for “Physicians' Services” in Providers..... 2182.5
Conditions of Payment for Costs of Physicians' Services to Providers..... 2182.6
Conditions for Payment of Charges - Anesthesiology Services 2182.7
Determining Reasonable Charges for Anesthesia Services 2182.8
Conditions for Payment of Reasonable Charges - Radiology Services..... 2182.9
Determining Reasonable Charges for Radiology Services..... 2182.10
Conditions for Payment of Charges - Physician Laboratory Services..... 2182.11
Blood Gas Studies..... 2182.12
Exhibits 2182.13

Appendix

Maximum Allowable Cost Limitation (MAC) Determinations for Drugs .....

2100. PRINCIPLE

All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries or, in the case of acute care hospitals, the prospective payment system (PPS). (See Chapter 28 on PPS.) Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

2102. DEFINITIONS

2102.1 Reasonable Costs.--Reasonable costs of any services are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs for individuals covered by the program are not borne by others not so covered and the costs for individuals not so covered are not borne by the program.

Costs may vary from one institution to another because of scope of services, level of care, geographical location, and utilization. It is the intent of the program that providers are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors. Utilization, for this purpose, refers not to the provider's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix - age of patients, type of illness, etc.).

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (See §2103.) If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

In the event that a provider undergoes bankruptcy proceedings, the program makes payment to the provider based on the reasonable or actual cost of services rendered to Medicare beneficiaries and not on the basis of costs adjusted by bankruptcy arrangements.

2102.2 Costs Related to Patient Care.--These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

2102.3 Costs Not Related to Patient Care.--Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

Such costs are not allowable in computing reimbursable costs and include, for example:

- o Cost of meals sold to visitors;
- o Cost of drugs sold to other than patients;
- o Cost of operation of a gift shop;

- Cost of alcoholic beverages furnished to employees or to others regardless of how or where furnished, such as cost of alcoholic beverages furnished at a provider picnic or furnished as a fringe benefit;

- Cost of gifts or donations;

- Cost of entertainment, including tickets to sporting and other entertainment events;

- Cost of personal use of motor vehicles;

- Cost of fines or penalties resulting from violations of Federal, State, or local laws;

- Cost of educational expenses for spouses or other dependents of providers of services, their employees or contractors, if they are not active employees of the provider or contractor;

- Cost of meals served to executives that exceed the cost of meals served to ordinary employees due to the use of separate executive dining facilities (capital and capital-related costs), duplicative or additional food service staff (chef, waiters/waitresses, etc.), upgraded or gourmet menus, etc.; and

- Cost of travel incurred in connection with non-patient care related purposes.

2102.4 Donations to a Provider of Produce, Supplies, Space, Etc.--If a provider receives a donation of produce, supplies, the use of space owned by another organization, etc., the provider may not properly impute a cost for the value of the donations and include the imputed cost in allowable costs. If an imputed cost has been included in the provider's costs, that amount is deleted in determining allowable costs. If the provider and donor organization are both part of a larger organizational entity, such as units of a state or county government, costs related to the donations are includable in the allowable costs of the provider. For example, if a county home health agency is given space to use in the county office building, costs related to that space may be included in the agency's costs, e.g., depreciation, costs of janitorial services, maintenance and repairs.

2103. PRUDENT BUYER

A. General.--The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost. This is especially so when the buyer is an institution or organization which makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases. In addition, bulk purchase of items or services often gives the buyer leverage in bargaining with suppliers for other items or services. Another way to minimize cost is to obtain free replacements or reduced charges under warranties for medical devices. Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them.

B. Application of Prudent Buyer Principle.--Intermediaries may employ various means for detecting and investigating situations in which costs seem excessive. Included may be such techniques as comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers, spot-checking, and querying providers about indirect, as well as direct, discounts. In addition, where a group of institutions has a joint purchasing arrangement which seems to result in participating members getting lower prices because of the advantages gained from bulk purchasing, any potentially eligible providers in the area which do not participate in the group may be called upon to justify any higher prices paid. Also, when most of the costs of a service are reimbursed by Medicare (for example, for a home health agency which treats only Medicare beneficiaries), examine the costs with particular care. In those cases where an intermediary notes that a provider pays more than the going price for a supply or service or does not try to realize savings available under warranties for medical devices or other items, in the absence of clear justification for the premium, the intermediary excludes excess costs in determining allowable costs under Medicare.

C. Examples of Application of Prudent Buyer Principle.--

1. Provider A consistently purchases supplies from supplier R and makes no effort to obtain the most advantageous price for its supplies.

Supplier W sells identical or equivalent supplies at a lower cost and is also convenient to A. Unless the provider can clearly justify its practice of purchasing supplies from R rather than W, the intermediary excludes any excess of R's charges over W's charges.

2. Supplier L supplies drugs to skilled nursing facility B and rents space from B to store the drugs to be used there. The rental paid by L to B for the space would generally constitute an indirect discount on the cost of drugs and must be reflected as a reduction of the cost of drugs supplied.

3. Dr. C, a hospital-based radiologist, purchases radiology equipment which he then leases to the provider where he is a staff member. Costs to the provider in this case are higher than if the equipment had been leased through competitive bidding from an outside source. The intermediary reimburses the provider only for those costs which a prudent and cost-conscious buyer would pay. Therefore, those costs which the provider pays for the equipment leased from the staff radiologist which are in excess of costs for equivalent equipment obtained through competitive bidding are denied.

4. Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits or payments available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment supplied.

2104. UNALLOWABLE COSTS RELATED TO PATIENT CARE

2104.1 Ambulance Service.--Ambulance service is covered under Part B of the Medicare program. A provider may furnish ambulance service directly or it may furnish the service under arrangements with a supplier of ambulance services. The cost the provider incurs to furnish ambulance service is paid by Medicare on a reasonable cost basis.

If a provider furnishes ambulance services with its own equipment and staff, the cost it incurs (depreciable cost of equipment, supplies, employee compensation, overhead, etc.) is its cost of the service for Medicare payment purposes. If it furnishes the service under arrangements, the charge to the provider by the ambulance company becomes the provider's direct cost of furnishing the service.

Medicare Part B carriers have established reasonable charge screens for a wide range of ambulance services furnished by suppliers of ambulance services for which claims are billed to the carriers. Medicare expects that the costs incurred by a provider for ambulance services furnished under arrangement with a supplier of ambulance services will not exceed the amount a carrier would pay the ambulance supplier for the same service. Therefore, if a provider furnishes ambulance service under arrangements, to the extent the provider's total costs of the services, direct costs and any indirect costs, exceeds what a carrier would pay a supplier of ambulance services for the same services in the same locality, the costs are unreasonable and cannot be paid by the provider's intermediary.

The next page is 21-3.2

2104.2 Private-Duty Personnel.-- The costs of private-duty nurses and other private-duty attendants are not included in allowable costs. Services of private nurses and attendants are specifically excluded from coverage by law.

2104.3 Luxury Items or Services.--

A. General.-- Where provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

B. Definitions.-- Luxury items or services are those that are substantially in excess of or more expensive than the usual items or services rendered within a provider's operation to the majority of patients. This provision should not be confused with the other provision dealing with limitations on coverage of costs as referenced in E below. Examples of luxury items or services are given below.

1. Luxury Room Accommodations.-- Some indications which tend to support a conclusion of the existence of luxury room accommodations are (a) the room size per bed is significantly larger than the usual room size per bed in the provider's operation and (b) the room charges are higher than the rates charged by the provider for its usual rooms. Other indications which may distinguish the luxury rooms from the usual rooms are the presence of refrigerators, special beds, and lavish bathing accommodations.

2. Luxury Food Items.-- Indications that would support a conclusion that certain food costs represent luxury items are (a) the provider maintains a separate kitchen for the preparation of special foods and (b) selected patients may order from a separate menu. Special diets ordered by a patient's physician or that permit a patient to continue with his already established dietary habits required for good cause are not considered luxury food items.

C. Application.-- Once it has been determined that luxury items or services have been furnished, allowable costs must be reduced by the difference between the costs of luxury items or services actually furnished and the reasonable costs of the usual less expensive items or services furnished by a provider to the majority of its patients. Where patients request luxury items or services, the provider may charge the patients for the excess costs involved.

(See §2106.1 for the proper handling of the full costs of items or services such as telephone, television, and radio which are furnished solely for the personal comfort of the patients.)

EXAMPLE:

Facts

A 300-bed hospital provides 50 private luxury room accommodations which are twice the size per bed as the size per bed of the remaining private accommodations. In addition, the luxury rooms are equipped with special beds, balconies, ceiling-to-floor length picture windows, color television sets, stereo equipment, and lavish baths. The hospital also offers special food service to patients occupying the luxury rooms.

Determination of Allowable Costs

Where a determination has been made that a provider furnishes luxury items or services, a single nonreimbursable cost center entitled "Luxury Routine Accommodations" must be established and the excess direct and indirect cost luxury items should be determined and eliminated through cost finding. However, where the intermediary determines that overhead costs applicable to the excess costs of luxury routine accommodations would be minimal, the adjustment to eliminate the excess costs need not be accomplished through cost finding. Also, the total costs of such items as the color television and stereo would be eliminated from allowable costs since they are for the sole personal comfort of the patients (§2106.1).

D. Effect on Medicare Program Charges.-- For the purpose of establishing proper interim reimbursement, program charges should not reflect the excess costs applicable to luxury routine accommodations. Rather, the portion of charges applicable to these excess costs should be billed as noncovered charges.

E. Effect on Other Provisions of Law.-- (1972 Amendments - Public Law 92-603, Section 223 and 233.) Where a provider furnishes luxury items or services to all patients in the facility, the provisions of this section do not apply. Rather, the provision dealing with limitations on coverage of costs (section 223) must be applied to such a provider. Also, for purposes of applying the limitation of program reimbursement to the lower of reasonable costs or customary charges (section 223), reasonable costs do not include the excess costs of luxury items or services and customary charges do not include the portion of the charges applicable to the excess costs of luxury items or services.

2104.4 Dental Services.-- Compensation paid to a dentist for services to or for an individual patient are not allowable provider costs and are nonreimbursable to the provider. The costs, however, of consultative services furnished by an advisory dentist to a provider are allowable costs, subject to the usual rules concerning reasonable costs incurred

by providers. Consultative services may include, for example, participating in the staff development program for nursing and other personnel and recommending policies relating to oral hygiene or dietary matters. For a detailed explanation of the coverage of inpatient services in connection with dental procedures, see §210.7 of the Hospital Manual (HCFA Pub. 10).

2104.5 Vocational and Scholastic Training Expense.-- The costs attributable to vocational, scholastic, or similarly oriented training activities conducted by providers on behalf of patients are not allowable costs. For example, costs incurred by a psychiatric facility in operating an elementary or secondary school for patients are unallowable costs.

2105. UNALLOWABLE COSTS NOT RELATED TO PATIENT CARE

2105.1 Noncompetition Agreement Costs.--Amounts paid to the seller of an ongoing facility by the purchaser to acquire an agreement not to compete are considered capital expenditures. Where the agreement covers a stated number of years and the provider amortizes the amount paid over the agreed number of years, the amortized costs for such agreements are not allowable costs under the program.

2105.2 Cost of Meals for Other Than Provider Personnel.--The cost of meals for other than provider personnel, whether served in a cafeteria, coffee shop, canteen, etc., is unallowable under the program because it is not related to patient care. (See §2102.3) Providers must maintain adequate cost data in order to determine the cost of these meals. (See §2300ff.)

2105.3 Cost of Reserving Beds or Services.--

A. Provider Making Payment to Reserve Beds or Services.--Providers may incur costs pursuant to a reserved bed agreement with another health care facility under which the provider receives guaranteed or priority placement for its discharged patients. For example, a hospital may pay a skilled nursing facility (SNF) to set aside a certain number of beds for the hospital's discharged patients. The cost incurred by a provider under a reserved bed agreement is not related to that provider's care of its patients and, therefore, is not an allowable cost.

B. Provider Receiving Payment for Reserving Beds or Services.--The revenue received by a provider for reserving its beds or services is not considered related to patient care. Therefore, the payments received are not required to be offset against the provider's operating costs.

C. Payment-In-Kind for Reserving Beds or Services.--If, under the terms of the agreement, a provider agrees to compensate another facility for reserving its beds by providing free or discounted services rather than by cash payments, neither the provider furnishing the services nor the provider receiving the services as payment-in-kind, is entitled to be reimbursed by Medicare for the cost of the services. (See §2328 F.)

D. Types of Agreements and Illustrations.--Providers are permitted to enter into reserved bed agreements, as long as the terms of that agreement do not violate the provisions of the statute and regulations which govern provider agreements which (1) prohibit a provider from charging the beneficiary or other party for covered services; (2) prohibit a provider from discriminating against Medicare beneficiaries, as a class, in admission policies; or (3) prohibit certain types of payments in connection with referring patients for covered services. A provider may jeopardize its provider agreement or incur other penalties if it enters into a reserved bed agreement that violates these requirements.

The following examples illustrate different types of reserved bed agreements and explain how each would be treated in terms of the provider agreement and reimbursement.

Illustration 1

A SNF reserves 10 beds for the exclusive use of a hospital's discharged patients. The hospital agrees to pay $75.00 per day per bed for each day a reserved bed is held vacant.

This agreement does not violate the SNF's provider agreement. The hospital cannot include the cost it incurs to reserve the SNF beds in its allowable costs. The SNF does not reduce its allowable costs by the payment received from the hospital in determining program reimbursement.

Illustration 2

A SNF reserves 10 beds for the exclusive use of a hospital's discharged patients. The hospital agrees to pay $75.00 per day per bed for each day a reserved bed is held vacant. The hospital further agrees to pay the difference between $75.00 and the Medicare reimbursement rate of $60.00 to the SNF for each day a reserved bed is occupied by one of the hospital's discharged Medicare patients.

This agreement violates the SNF's provider agreement. The additional payment of $15.00 per day paid by the hospital is a prohibited charge imposed by the SNF on another party for services that are covered by Medicare.

Illustration 3

A SNF agrees to reserve 10 beds for the exclusive use of a hospital's discharges. The hospital agrees to provide the SNF, without charge, a full-time registered nurse.

The agreement does not violate the SNF's provider agreement since the full-time nurse is provided for all patients and without regard to whether a Medicare patient is receiving services from the SNF. The hospital's reimbursement would not be affected except that any costs incurred by the hospital in providing the nurse should be adjusted out of the hospital's allowable costs for purposes of determining reimbursement for any services which are reimbursed on a reasonable cost basis. (See §2328F.) The adjustment is necessary because the nursing cost is not related to patient care of hospital patients. On

the other hand, the value of the nursing service received by the SNF is not considered revenue that is offset against its allowable costs in determining reimbursement. Similarly, the SNF may not impute the cost of the nursing services received for inclusion in its costs.

Illustration 4

A SNF agrees to reserve 10 beds for the exclusive use of a hospital's discharges. There is no charge for holding the beds vacant, although the hospital agrees to provide the SNF, without charge, a registered nurse for each of the three shifts whenever any of the reserved beds are occupied by a Medicare covered patient.

This agreement violates the SNF's provider agreement because the nursing services are provided only when a Medicare patient is in a reserved bed and, therefore, the services of the nurse are considered to be a payment-in-kind for providing services covered under Medicare.

Illustration 5

A SNF agrees to hold at least 5 beds on a priority basis for a hospital's discharges. The hospital agrees to provide, under arrangements, pharmacy, laboratory and radiology services for all of the SNF's patients. The agreement specifies no charge for laboratory and radiology services and provides a 30 percent discount for pharmacy.

The agreement does not violate the provider agreement of the SNF since free or discounted services are provided to all patients and without regard to whether a Medicare patient is receiving services from the SNF. The cost of providing free or discounted services is not an allowable cost for purposes of determining hospital reimbursement. Therefore, to assure that Medicare hospital patients do not share in the cost of the free or discounted services, the charges of the ancillary service centers are to be grossed-up to reflect the services provided to SNF patients. (See §2314.B.) There is no effect on the reimbursement of the SNF as a result of the free or discounted services furnished by the hospital. That is, the SNF may not impute any costs for the free services for inclusion in its cost report; it may only include the discounted charges (if reasonable) in its allowable costs for the discounted services.

Illustration 6

A SNF agrees to accept a hospital's “complicated care” patients on a priority basis. In return, the hospital agrees to provide free in-service education to the SNF's staff.

This agreement does not violate the SNF's provider agreement. The hospital's reimbursement is not affected except that any costs incurred by the hospital for providing the in-service training is adjusted out of the hospital's allowable costs for purposes of determining reimbursement for any services which are reimbursed on a reasonable cost basis. (See §2328.F.) The adjustment is necessary because the training cost is not related to patient care of hospital patients. On the other hand, the value of in-service training received by the SNF is not considered revenue that is offset against its allowable costs in determining reimbursement. Similarly, the SNF may not impute the cost of training received for inclusion in its costs.

2105.4 Costs of Unsuccessful Beneficiary Appeals.--Costs incurred by providers of services on or after October 21, 1986, representing beneficiaries in unsuccessful appeals are not allowable costs. Conversely, costs incurred by providers of services representing beneficiaries in successful appeals are allowable to the extent they are otherwise reasonable.

2105.5 Costs of Management Employee Meals.--Costs incurred by providers for meals served to executives or management employees in excess of the costs of meals served to ordinary employees are not allowable costs. Excessive costs of executive or management employees' meals are attributable to the use of separate dining facilities, duplicative or additional food service staff, and/or upgraded or gourmet menus. Conversely, the unrecovered costs related to meals served to executives or management employees from common menus in common employee dining facilities are allowable to the extent that they are otherwise reasonable.

2105.6 Costs of Employee Travel.--Costs incurred by providers in conjunction with employee travel are generally allowable to the extent that they are patient care related and reasonable. However, travel costs incurred in conjunction with non-patient care related employee travel are not allowable. Foreign travel costs are allowable only where the provider can clearly substantiate the reasonableness and patient care relatedness of the travel costs to the satisfaction of the Medicare fiscal intermediary.

2105.7 Costs of Gifts or Donations.--Costs incurred by providers for gifts or donations to charitable, civic, educational, medical or political entities are not allowable.

2105.8 Costs of Entertainment.--Costs incurred by providers for entertainment, including tickets to sporting or other events, alcoholic beverages, golf outings, ski trips, cruises, professional musicians or other entertainers, are not allowable. Costs incurred by providers for purposes of employee morale, specifically, for an annual employee picnic, an annual Christmas or holiday party, an annual employee award ceremony or for sponsorship of employee athletic programs (bowling, softball, basketball teams, etc.), are allowable to the extent that they are reasonable.

2105.9 Costs of Employees' Personal Use of Motor Vehicles.--Costs incurred by providers related to the personal use of provider vehicles are not allowable.

2105.10 Costs of Fines or Penalties.--Costs incurred by providers for fines or monetary penalties imposed for violations of Federal, State, or local laws are not allowable.

2105.11 Costs of Spousal or Dependents Education.--Costs incurred by providers related to the education of spouses or other dependents of owners or officers of providers of services, provider employees and provider contractors are not allowable when they are not active employees of the provider or contractor.

2106. COST OF TELEPHONE, TELEVISION, AND RADIO

2106.1 General.--The full costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of the patients (full costs include costs both directly associated with personal comfort items or services plus an appropriate share of indirect costs) are not includable in allowable costs of providers under the Medicare program. To illustrate, the full costs of telephones used solely for the personal comfort of patients include not only costs directly associated with these telephones, such as the rates billed by the public utility, but also an appropriate share of indirect telephone costs, e.g., operators' salaries, equipment, space-related costs of switchboard and other equipment, etc., as well as any other overhead that may be applicable thereto. The costs of television and radio services are includable in allowable costs where furnished to the general patient population in areas of providers other than patient accommodation, e.g., day rooms, recreation rooms, waiting rooms, etc.

The cost of a nurse-patient communication system that has no capability for other than communications between patient and nurse (or other facility employees) are includable in allowable costs. Similarly, cost of closed-circuit television monitoring systems used by providers for surveillance of patients or for security, teaching, or demonstration programs which serve purposes of patient care or which are otherwise needed for the provider's operations and have no capability beyond these stated purposes are includable in allowable costs.

The cost of television and radio located in lounges and other areas designated for the use of provider employees is includable in allowable costs.

2106.2 Combination Purpose Systems.--Some nurse-patient communication systems based on closed circuit television are used in part for bringing in outside entertainment. Likewise, some patient communication systems operate through the telephone line and such a system may also be used, in part, by the patient for making or receiving outside calls.

Where providers use the combined systems, the basic cost of the components designed and used for patient care communication is an allowable cost. Any incremental costs attributable to the additional components or capability for providing the patient's entertainment or convenience are not allowable and must be excluded. Where this distinction cannot be clearly made, particularly as it applies to maintenance, the intermediary may approve an allocation covering these incremental costs (usually nominal) based on an equitable sharing.

Occasionally, nurse call systems which do not provide closed circuit television for patient care services are tied by some adjunct linkage into the audio component of a television set. In such instances, the cost of the set and maintenance of the equipment providing the television capability is not an allowable cost, except to the extent the provider can demonstrate and the intermediary approves an equitable share (usually nominal) attributable directly to costs arising out of the adjunct linkage and use of the set for nurse call.

2107. PARKING LOT COSTS

2107.1 General.--The cost incurred for provider-owned or rented parking facilities, parking lots, and/or garages are allowable costs provided the parking facilities are for the use of patients, visitors, employees, and other provider purposes. Examples of allowable costs for a provider-owned parking facility include depreciation on the surface and structure (excluding land), interest on related loans, and other operating expenses. Costs related to the preparation of the land such as demolition of existing structures, clearing, and grading costs are added to the cost of the land and are unallowable.

The allowable costs for provider-rented parking facilities are limited to the reasonable rental paid on which the provider has a legal obligation to pay. Where the rental is paid to a lessor related to the provider through common ownership or control, the guidelines set forth in Chapter 10, “Cost to Related Organizations,” are applicable.

2107.2 Treatment of Parking Revenue.--Where a provider receives no revenue from parking lots, the allowable costs recognized under §2107.1 are reimbursed, subject to apportionment. Where, however, a provider elects to charge a fee for the use of these facilities, such revenue is treated under Medicare as follows:

A. Parking Revenue from Persons Other Than Employees and Physicians.--Where parking revenue is received from persons other than employees and physicians, the revenue is offset against parking lot costs attributable to such persons. If parking revenue exceeds the related costs, the excess revenue is not used to reduce employee and physician parking costs (or other provider costs) so long as the provider can demonstrate a reasonable and equitable basis for allocating parking costs between (1) employees and physicians, and (2) other persons. Where such an allocation is not determinable, the total allowable cost of provider-owned or rented parking facilities is reduced by all parking facility revenue.

B. Parking Revenue from Employees or Physicians.--Revenue from employees and physicians for parking must be used to reduce related allowable parking costs. If employee and physician parking revenue exceeds related costs (i.e., parking costs for employees and physicians), any excess revenue is applied against other parking costs, but not against other allowable costs.

2108. REIMBURSEMENT FOR SERVICES BY PROVIDER-BASED PHYSICIANS

A. General.-- These instructions apply where physicians perform services in a provider setting and have a financial arrangement under which they are compensated by or through a hospital (for both inpatient and outpatient services, or by or through a skilled nursing facility, a home health agency, clinic, rehabilitation agency, or public health agency. These physicians may also be receiving compensation from medical schools or other organizations which have arrangements with the provider for the services they render to provider patients (see §2108.2D2).

Further, these instructions apply where modifications of previously existing arrangements between providers and provider-based physicians permit the provider and physician to bill patients separately for their respective services. Such modifications may permit the physician to assume all or part of the departmental operating costs. These instructions do not apply to the services of interns and residents; their services are reimbursable to the provider on a reasonable cost basis. (See §2120.)

B. Noninterference by Federal Government.-- It is not the function of the health insurance program established under title XVIII of the Act to determine the arrangement into which a provider and provider-based physicians may enter for the compensation of the physicians, or to specify or influence the provisions of the contract or arrangement between the provider and provider-based physicians. The provider and physicians can continue to negotiate all aspects of their arrangement to their mutual satisfaction.

2108.1 Professional and Provider Components.--

A. Identification of Types of Services for Program Payments.-- Many providers retain physicians on a full-time basis in, for example, the fields of pathology, physiatry, anesthesiology, and radiology, and in many instances (especially in teaching hospitals) in other fields of medical specialization as well. Any one of these physicians may be engaged in a variety of activities including teaching, research, administration, supervision of professional or technical personnel, service on hospital committees, and other hospital-wide activities, as well as direct medical services to individual patients. The provider's arrangement may be with a single physician or with a group of physicians who assume joint responsibility for discharging agreed-upon duties.

To make payments under the health insurance program, it is necessary to distinguish between the medical and surgical services rendered by a physician to an individual patient, which are reimbursable under Part B on

a reasonable charge basis, and provider services (including a physician's services for the provider) which are reimbursable on a reasonable cost basis, generally under Part A. This is necessary because the payments are made from different trust funds, both fiscal intermediaries and carriers are involved in handling the claims, and the method of determining the payments for Part A benefits differs materially from those under Part B.

B. Distinguishing Between Professional and Provider Components.-- The services of provider-based physicians (e.g., those on a salary, or percentage arrangement, lessors of departments, etc., whether or not they bill patients directly) include two distinct elements, the professional component and the provider component.

1. Professional Component.-- The professional component of provider-based physician's services pertains to that part of the physician's activities which is directly related to the medical care of the individual patient. It represents remuneration for the identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or to his treatment.

2. Provider Component.-- The portion of the physician's activities representing services which are not directly related to an identifiable part of the medical care of the individual patient is the provider component. Reimbursement for provider component services can be made only to a provider on the basis of its allowable reasonable costs. Provider services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physician's provider service activities. Reimbursement for such services will always be made on a reasonable cost basis under Part A where they relate to inpatient services. Reimbursement is under Part B for outpatient services and for certain inpatient ancillary services where Part A coverage has been exhausted.

3. Allocation of Compensation.-- Ordinarily the compensation paid to the physician is for all services he performs, in proportion to the time he devotes to each activity. It is a primary obligation of the provider and provider-based physician to mutually agree upon the allocation of compensation for the provider-based physician to the time he spends in his various activities, and to communicate this information with supporting material to the provider's intermediary. The supporting material should include a written explanation of the basis for the allocation agreement. Where, however, the agreed-upon allocation is not consistent with similar arrangements between providers and provider-based physicians, the intermediary will obtain more detailed information, as necessary. Generally,

the remuneration a physician receives from a provider under an arrangement represents compensation for his services to the provider as well as for direct patient services.

C. The Provider-Physician Agreement as to Compensation Allocation.- In some institutions a physician may spend the bulk of his time in duties which benefit the entire patient population and a relatively small part of his time in performing services for individual patients. In other situations, the converse may exist. The arrangement between a provider and a provider-based physician does not generally support a 100 percent allocation of compensation for direct patient services. The allocation in each instance must be based on the facts of the individual case. Each case must be sufficiently documented to support the necessary determination, and should include a written agreement signed by both the provider and physician. (See Exhibit I.) If the allocation does not appear "reasonable" additional supporting documentation, such as the results of time studies, must accompany the signed agreement.

D. A Statement of Understanding Between the Provider and Physician.- There may be instances where a provider and the provider-based physician may be in substantial agreement as to the allocation of compensation between professional and provider services, but the physician is reluctant to sign a formal statement containing specific details about his compensation. In such cases, the provider's administrator may prepare a document outlining his own approximation of the time and activities of the physician and ask him to sign it as a "statement of understanding" regarding their mutual relationship. This "statement of understanding" may be accepted in lieu of the usual "physician agreement," where the Part A intermediary and Part B carrier are satisfied that it would not differ materially from the agreement itself.

E. Where an Agreement or Understanding Cannot Be Reached.- When a provider and physician are unable to reach an understanding as to the allocation of compensation between provider services and direct medical services, the intermediary and carrier will jointly try to resolve this question be meeting with the parties involved, suggesting methods for determining the allocation (e.g., time studies), and otherwise assisting the parties in reaching an accord. If the provider and physician fail to reach agreement within 30 calendar days after this meeting, the intermediary and carrier will jointly establish the required allocation based on their combined experience in comparable provider facilities. The parties will then be advised the (1) this allocation will be the basis for establishing a schedule of charges for the physician's professional services to the provider's patients for all prior and current billings, and (2) they have 30 calendar days to submit an agreement which more accurately reflects the required allocation. If an agreement is submitted within that time, and it is reasonable, it may be used for establishing a schedule of charges for current and prior billings.

2108.2 Compensation Arrangements.-- There are a variety of arrangements between providers and provider-based physicians, the more typical being the fixed compensation arrangement and the variable compensation arrangement. There are also many arrangements under which the physician assumes all or part of the costs of operating the provider department (e.g., lease or concession). Under any of these arrangements, the agreement could stipulate that the physician may bill through the provider for all or part of the services he renders, or that the physician and provider will bill separately for their respective services. It is necessary, therefore, in order to determine the appropriate amount of reimbursement for the services of a physician, to choose the appropriate method to develop the schedule of charges, establish the proper compensation base, and identify which elements of compensation are reimbursable under Part A and which are reimbursable under Part B.

A. The Fixed Compensation Arrangement.-- The fixed compensation, usually called a salary or stipend, consists of a specific dollar amount unrelated to volume. It generally covers the physician's provider services as well as his direct medical services to patients. When the computation is carried out, the physician is shown to receive an actual dollar amount which can be determined in advance.

In some cases, this compensation arrangement may be expressed in terms of a percentage of charges or collections reduced by a variety of actual or estimated costs of operation or other factors. When the intermediary and carrier evaluate a contract stated in these terms, they are to treat it as a fixed compensation contract where, in fact, it spells out a method for arriving at a fixed remuneration for the physician's services.

Regardless of the method of billing, the schedule of charges should be computed in the same manner as where the physician receives a fixed salary. Where there is a question as to the amount of compensation, the intermediary will refer to the provider records to ascertain the actual amount of compensation paid by the provider to the physician. However, such payment should be related to total departmental billing, not collections, in establishing program liability.

B. The Variable Compensation Arrangement.-- Under this type of arrangement, the provider and physician agree that the physician's compensation will be a percentage of departmental gross charges or of net collections. The actual compensation received by the physician will vary in proportion to the number of procedures performed and to the total charges made by the provider. The total compensation cannot be determined until the close of the accounting period. The percentage of the combined provider's charge represents the provider's reimbursement to the physician for all services he renders. (Where a physician has a variable income and chooses to use a uniform optional percentage as his schedule of charges, it is not necessary to translate his correct percentage amount into a fixed dollar amount before establishing the optional percentage. The physician's contract percentage multiplied by the professional component allocation will yield the optional percentage. See Exhibit IIA.)

C. Where Arrangements Are Modified to Permit the Physician to Bill Separately for His Professional Services.-- The objective in determining reasonable charges where a provider-based physician modifies his former compensation arrangements to permit him to bill directly is expressed in the regulations, i.e., ". . . to bring about as little change as possible (in the normal case) in the compensation the physician receives for his services in the hospital." Therefore, where modifications are made in an arrangement between a provider and physician, the customary charges for the physician's professional services should be related to his compensation prior to the modification. Also, where such contract changes permit the physician to independently bill Medicare patients only, the Part B carrier will ensure that the reasonable charges determined for the services rendered to Medicare beneficiaries are no higher than the charges generally made to the provider's other patients for similar services.

D. Additional Elements of a Provider-Based Physician's Compensation.-- The following are examples of elements which should be considered in determining the amount of compensation received by a physician for the purpose of establishing a schedule of charges:

1. Fringe Benefits.-- When fringe benefits inure to the benefit of the physician himself, they may be included as part of the physician's compensation. For example, group hospitalization and health insurance premiums paid or incurred by the provider for the benefit of the physician may be included in computing the physician's total compensation. However, is the provider is self-insured, the fringe benefit would accrue to the physician only to the extent of the cost incurred by the provider when health care is furnished. In this case, there would be no fringe benefit inuring to the physician if he receives no health care services from his self-insured employer. On the other hand, where a provider establishes a retirement plan for the benefit of its employees and supplements employee contributions to the fund, if any, with specific amounts that are assignable to individual employees, such amounts may be included in ascertaining the physician's compensation. (See §§2122.3 and 2144FF.)

2. Compensation from Other Sources.--Some providers have arrangements with medical schools or other organizations under which a physician receives compensation from such organizations for services which the physician renders to the provider patients.

The remuneration of a physician from such sources may be included in determining the total compensation he receives and in establishing the schedule of charges. This remuneration must be allocated between the professional and provider activities of the provider in the same manner as the compensation received from the provider. That portion of remuneration related to teaching or research activities at the medical school itself is not reimbursable under Medicare.

3. Bad Debts.-- Bad debts are not to be reflected in determining reasonable charges under the supplementary medical insurance program. The Medicare program reimburses 100 percent of the reasonable charges for inpatient hospital radiology and pathology services provided by a physician in the fields of radiology and pathology and 80 percent of the reasonable charges for all other medical services after the deductible has been met. The coinsurance amount and the deductible are considered liabilities of the beneficiary for physicians' services and the provider does not incur bad debts because of its failure to collect these amounts. (See §302.5.) Therefore, where a contract stipulates that the physician will receive a percentage of collections (charges minus bad debts), program liability should be determined as described in §2108.9.

2108.3 Methods Used to Determine the Reasonable Charge of Provider-Based Physicians.-- The amount of the physician's compensation representing the provider component will be reimbursed to the provider on the basis of reasonable costs by the Part A intermediary. The Part A intermediary will also reimburse the provider for medical services to individual patients, i.e., outpatient hospital services (except psychiatric) and inpatient radiology and pathology services where the physician and provider agree to use the combined method of billing. In all other situations, where direct physicians' services to patients are billed on forms SSA-1554 and SSA-1490, the Part B carrier will determine the amount of reimbursement.

A. Consideration Given to Customary and Prevailing Charges.-- Reasonable charges for the professional services of provider-based physicians will be determined for other physicians and suppliers. Consideration will be given to the customary charges of the provider-based physician for each item of service he renders (see the following sections for an explanation of how such customary charges should be determined) and the prevailing charge in the locality for similar services rendered a provider setting.

B. Where Providers Separately Identify Physicians' Charges.-- Where provider has customarily identified a physician's charges separately from charges for provider services, the physician's charges so established will be considered the customary charges for his professional services,

and will afford the basis for determining the reasonable charges for such services. In such cases, the physician's remuneration will not be a factor in establishing customary charges. It will still be necessary, however, to allocate the physician's compensation to professional and provider components so that proper cost payments can be made. (See §2108.1B.)

C. Where Providers Do Not Separately Identify Physicians' Charges.- Where, under an existing arrangement between a provider and physician's services and charges for provider services, a schedule of charges will need to be developed based on the physician's professional component. This schedule of charges will form the basis for establishing the customary charges for direct medical services to patients by the provider-based physician.

2108.4 Schedule of Charges.-- The schedule of charges must be designed to yield, in the aggregate, as nearly as may be possible, an amount equal to the portion of the physician's compensation represented by the professional component. There are several methods by which a schedule of charges may be developed based on the provider-based physician's professional component. Principally, these are the "optional," "item-by-item," and "per diem" methods. A variation from any of these methods is acceptable as long as it achieves the same results, i.e., it will yield in the aggregate an amount equal to or approximating the portion of a physician's compensation attributable to direct medical services to patients. Each provider department may use the method it finds most applicable (e.g., the use of the item-by-item method by one department does not prevent the use of the optional method or the per diem method by another department). Where there is more than one hospital-based physician rendering services in a single department, the schedule of charges should be developed for the department as a whole on the basis of the aggregate amount of compensation attributable to the professional components and the aggregate volume of procedures which all physicians in the department are expected to render. For establishing the professional component in a given department, see Exhibit II. To develop the schedule of charges, see Exhibits III, IV, and V.

A. The Optional Method.-- The optional method for establishing the physician's customary charges is appropriate for provider departments that perform a high volume of low-cost procedures, often rendered by technicians or by automated equipment, and find the item-by-item method neither feasible nor practical from an administrative viewpoint. Under the optional method, the schedule of charges for the physician's direct services to patients is determined by applying a uniform percentage to each charge made by a particular department. Exhibit III shows the development of the uniform optional percentage. (Where a hospital-based physician has a variable compensation arrangement and wishes to use the uniform optional percentage, see §2108.2B and Exhibit IIA.)

B. The Item-by-Item Method.-- This method can be implemented by using an appropriate relative value schedule and conversion factor assigned to unit values will result in reimbursement not in excess of the professional component of the physician's compensation arrangement, the first step in developing the data needed to establish the schedule of charges under the item-by-item method is to determine the amount of the provider-based physician's compensation attributable to direct patient services, reimbursable under Part B. (See Exhibit II.) The next step is to determine the total relative value units representing various procedures by particular provider departments. (See Exhibit IV.)

C. The Alternate Item-by-Item Method.--An alternate means for establishing a schedule of charges on an item-by-item basis is to assign to each procedure, on the basis of the time spent by the physician in performing the procedure, a percentage of the total amount of the physician's compensation on a departmental basis (see Exhibit V).

D. The Per Diem Method.-- The per diem method may be used where providers furnish health care services at an all-inclusive rate, or where there is no charge structure. It is most frequently, but not exclusively, applicable in long term or governmental facilities where both institutional and physician services are furnished at a fixed amount without regard to variations in the number and type of services the individual patient may receive and without distinction between the provider services and physician services furnished. Some providers use the per diem or per visit method only in connection with the services of certain departments (e.g., physiatry, outpatient) while charging on a fee-for-services basis in others. Establishing a schedule of charges through the per diem (or other units, such as per visit) method is limited to institutions or departments which make an identifiable uniform charge that constitutes the total expense the patient incurs for both provider and physician services. For detailed application of the per diem method, see Exhibit VI.

2108.5 Effect of Physician's Assumption of Operating Costs (Lease or Concession Arrangement).-

A. Where the Physician Bills Patients Directly.--

1. Basis of Reimbursement.-- Where a provider initially pays some or all of the operating expenses of a department (e.g., salaries of nonprofessional personnel, supplies and equipment), such operating expenses are reimbursable as reasonable costs to the provider even though the provider is subsequently reimbursed by the physician for the use of those items or services. Such operating expenses are not to be reflected in the reasonable charges of the physician. Any payments received by the hospital under an arrangement where the physician leases a department should be treated as a reduction of allowable costs for purposes of reimbursement

under the hospital insurance program. The application of this offset is not limited to the allowable costs for a single department. If the Medicare portion of the income realized by a hospital exceeds the Medicare portion of allowable costs of such department, any remaining income should be applied as a reduction of Medicare reimbursable costs for the other departments of the hospital.

Where a provider-based physician, himself, bears some or all of the costs of operation of a department, the costs which he bears may be reflected in his customary charges and considered in determining reasonable charges under supplementary medical insurance. However, these costs will need to be adjusted upward or downward where the provider has been bearing a cost significantly more or less than its own share of the proceeds of such charges, and the determination of reasonable charges should consider such adjustments.

2. Determination of Reasonable Charges.--

a. The customary charges of a physician who enters into a lease or similar arrangement with a provider, under which the physician assumes the costs of operating a department and bills patients directly, should be based upon: (1) the remuneration he received for his professional services to patients immediately prior to the leasing arrangement; and (2) his reasonable costs of operation, taking into account the provider's cost experience in providing such services. References to the remuneration formerly received by the physician from the provider are required because consideration must be given to the customary charges generally made by the physician for similar services. If, at the time the lease or similar arrangement became effective, the physician had no pattern of customary charges for his professional services to provider patients other than the compensation he received from the provider, such compensation serves to establish his customary charges.

b. Where a provider has been receiving, as its portion of the receipts for services rendered by a department, significantly more or less than the costs the provider has incurred in providing these services, this excess or shortage should not be transferred from the provider to the physician merely because he decided to bill directly. Such transfer would alter the total cost of patient hospital and medical care, a result which would conflict with the intent of the Medicare legislation.

c. Prevailing charges in nonprovider laboratories may be taken into account in determining reasonable charges for the services of a physician who has entered into a lease or concession arrangement with a provider. However, such charges should not be used as guides for determining reasonable charges in situations where they would produce an unreasonable result. The conditions found in a provider setting are frequently unique in that services are performed in large volume and consequently at low unit cost.

Where the Part A intermediary and the Part B carrier fail to agree as to the acceptability of the data supplied by the provider and its physicians, they will jointly submit a report to the health insurance regional office for clarification of outstanding issues.

B. Where Billing Is by or Through the Provider.-- Where a physician enters into a lease or concession arrangement and bills through the provider, the services of nonphysicians aiding the physician are reimbursable to the provider on a reasonable cost basis. The amount attributable to the physician's services to the patient is compensable under the supplementary medical insurance program. When submitting a bill to the provider for services rendered, the physician should separately identify in the bill the amounts representing the respective provider and physician components of his services.

2108.6 Duties and Responsibilities of Provider and Intermediary in the Area of Provider-Based Physician Reimbursement.--

A. Provider Responsibility.-- The effective implementation of provider-based physician reimbursement requires the closest coordination between the provider and its Part A intermediary. The provider is responsible for making available on a timely basis data on the financial and billing arrangements (including contracts, agreements, and other written documentation) it has with its provider-based physicians. This information is necessary to ensure that: (1) Medicare reimbursement for the services of these physicians is made from the appropriate trust funds; (2) the Medicare program does not make duplicate payments for the same service, once as a provider cost and again as a reasonable charge; and (3) the Part B reasonable charge properly reflects any deductible and coinsurance liability of the beneficiary. On a regular basis, the provider should supply the intermediary with any new or revised data which would affect the original reasonable charge determination.

B. Intermediary Responsibility.--

1. Whether reimbursement policies and guidelines are effectively implemented depends in large part on detailed information that the Part A intermediary obtains from providers. By signing section 1866 agreements to participate in the program, providers have consented to furnish all information which the intermediary and carrier require to make proper payments under the Act.

2. The Part A intermediary will obtain from the provider not only all data needed to determine reimbursable hospital costs, but also the data needed by the Part B carrier for establishing and reviewing the schedules of charges it will use to make reasonable charge determinations. Both the Part A intermediary and Part B carrier need to know:

a. The contents of agreements between provider-based physicians and providers. (Specific responsibilities of intermediaries in obtaining and reviewing these agreements are stated in §2108.1.)

b. The billing methods selected by the physicians and the detailed items of information pertaining to the specific method selected, shown in Exhibits I-VI. This information will need to be obtained in all

situations where physicians have a financial arrangement with a provider, whether or not they bill independently.

c. Where a laboratory director in a provider leases the department or has a concession arrangement, information will be needed to ascertain the portion of the operating costs to be reimbursable as provider costs to the provider, and the portion of the costs to be reimbursable as provider costs to the provider, and the portion of the costs to be reflected in the reasonable charge determination by the Part B carrier.

d. The circumstances under which physicians' services such as diagnostic and therapeutic X-rays, EKG's, and laboratory tests are rendered to the provider's patients, especially by a physician who is not associated with the provider's medical staff, to ensure that the provider is complying with regulations and policies concerning purchased services "under arrangement," so that Medicare reimbursement will be made from the appropriate trust fund. (The professional component of such services, except laboratory services obtained from an independent laboratory or from the laboratory of a hospital meeting at least the definition of emergency hospital, must be reimbursed under Part B.)

3. Where a hospital and its provider-based physicians have agreed to use the combined billing procedure, the Part A intermediary will need to assure that it has obtained all information necessary to support its reasonable charge determination (§2108.1) and that the provider has on file a current "Physician's Authorization for Hospital Billing" (see Hospital Manual, §400.3).

4. When the physician is based in a nonparticipating institution, the carrier will assume the responsibility for obtaining the data needed to make the determination of the reasonable charge for the physician's service.

C. Review of Schedules of Charges.-- Charges for physician services in provider departments (e.g., radiology, pathology, outpatient) can be billed to the program using either the combined billing procedure or form SSA-1554. Billings under either method are subject to year-end adjustments. When the combined billing procedure is used, there is no need to schedule a regular review of the schedule of charges for the provider-based physicians' Part B services. In form SSA-1554 cases there is no need to schedule a regular review of schedules of charges unless it is considered advantageous to the Medicare program to do so (e.g., the provider does not file timely cost reports, and Part B reimbursement for the physicians' services seems to be overstated). Where the provider-based physician bills the patient directly on form SSA-1490, regular reviews of the estimated factors used to develop schedules of charges are required whenever compensation-related charges are the basis for reimbursement. In these cases, the Part A intermediary will obtain from the provider at least quarterly a report disclosing the actual amount of departmental charges to date, the total reimbursement the schedule of charges was intended to

produce, and information necessary to permit a decision as to the accuracy of the estimates and projections. This report should provide the appropriate data pertaining to all factors on which the schedule of charges was based, whether the recording and billing method used is the item-by-item method, the uniform optional percentage or the per diem method. Copies of this material will be submitted to the Part B carrier servicing the physicians so that any required adjustments in the charge schedule can be made during the year.

2108.7 Retroactive Adjustment of Certain Provider-Based Physician Payments.-- With respect to cost accounting periods which began after June 30, 1971, and any earlier periods where the need for adjustment actions was identified, the Part A intermediary will take the action indicated in B below regarding retroactive adjustments of certain provider-based physician payments.

A. Applicability.-- Where a provider has been overpaid or underpaid for the patient care services of a provider-based physician, the Part A intermediary will make an appropriate adjustment as part of the provider's final cost settlement where:

1. The provider billed on form SSA-1554, and

2. The charges were based on the physician's compensation. (Where the combined billing method is used, Hospital Manual, §§400ff. apply.)

B. Procedure.-- Where there has been incorrect Part B reimbursement for the provider-based physician's services, i.e., carrier payments for patient care services differ from Medicare's proportionate share of the total costs for such services, the adjustment referred to above will be based on the Part A intermediary's review of the hospital's cost report, an examination of the factors used in establishing the professional component charges, and a review of the provider's record of SSA-1554 billings for the cost report period. Overpayments and underpayments will be corrected by the Part A intermediary by making an adjustment in the cost report in the same manner as it would adjust for any other incorrect payment. Whenever an overpayment or underpayment adjustment is made, or where total reimbursement was proper but inaccurately allocated to the trust funds, the Part A intermediary will prospectively adjust the factors it uses in making payment, and notify the Part B carrier of the adjustment by forwarding the new data on which the carrier is to base reimbursement (§2108.6C).

Each intermediary will furnish worksheets to be used by provider for the purpose of identifying incorrect payments for provider-based physician's services. Exhibit VII contains a sample format where the uniform optional percentage methodology is used.

2108.8 Reimbursement for Provider-Based Physicians' Administrative, Teaching, and Direct Medical Care Services Where the Physicians Have Changed Their Compensation Arrangements with the Provider.-- Situations may arise where physicians previously employed to perform both administrative and direct medical care services have terminated their employment relationship with providers and have organized and entered into arrangements with the providers to render administrative and teaching services at a greater level of compensation than was formerly received in the employment relationship for such administrative and teaching services. These organizations bill directly for the patient care services of their member physicians and such billings may exceed the estimated portion of the previous salary attributable to such services.

Where a provider which previously employed physicians on a salary basis to render administrative and/or teaching services as well as direct medical care services changes its arrangement to purchase only the administrative and/or teaching type services, program reimbursement to the provider would be limited to the cost previously incurred for such administrative and/or teaching services on a salary basis. An exception to such limitation could be granted where the provider demonstrates that, due to extraordinary circumstances, it is no longer able to engage physicians at the previous level of compensation to render the full range of services. Merely showing that the physicians previously employed were no longer willing to provide their services on this basis would not demonstrate that the provider is no longer above to engage physicians at the previous level of compensation. For the new financial arrangement to be accepted by the intermediary as reasonable costs, the provider would also have to demonstrate that, due to some new and special circumstances, it was no longer feasible to recruit replacements at the previous level of compensation.

Reasonable charges for the physicians' direct patient care services should initially be related as closely as possible to the portion of the compensation they received for such services prior to the change in the financial arrangement. These charges are subject to any applicable prevailing charge ceiling and will serve as the basis for program payment until: (1) the physician has established a pattern of customary charges which are billed to all patients and collected from the majority of his non-Medicare patients; and (2) the carrier has accumulated at least 3 months of charge data from the same base year used to establish reasonable charges for other physicians. When these criteria are met, the physician's reasonable charge will be determined in the same manner as other fee-for-service physicians. (Where a group of physicians uses a common schedule of charges, reasonable charges should be determined in this manner for the group.)

2108.9 Reimbursement for the Services of Provider-Based Physicians Compensated Through the Provider and the Provider Bills the Program under Combined Billing (on Forms SSA-1453 or 1483) or on Form SSA-1554.-- For the purpose of determining a provider's Medicare reimbursement based on

provider-based physicians' compensation where physicians are compensated through the provider, the intermediary must look to the actual amount of compensation received and retained by the physicians, i.e., the amount that the physicians have agreed to accept for their full range of services.

Where a provider-based physician agrees with the provider, whether in writing, orally, or in any way implied, to receive a reduced compensation or to remit a portion of his gross compensation back to the provider (other than amounts for the sole benefit of the physician, such as for a pension fund or health benefits plan), only the net amount received and retained by the physician represents the aggregate compensation, i.e., for both provider services and professional medical and surgical services, to be used in computing Medicare reimbursement to the provider. Clearly, the Medicare program does not intend for a provider to be reimbursed on a basis of gross compensation while effectively paying out a lesser amount. As an exception, a bona fide, voluntary contribution made by a physician to the provider is not a reduction of the physician's compensation for the purpose of computing Medicare reimbursement to the provider. A bona fide, voluntary contribution cannot exist where it is based on an agreement between the provider and physician whether in writing, orally, or in any way implied. The bona fide nature of the contribution must be established on the basis of all circumstances surrounding the contribution.

EXAMPLE: A contract provides that a provider-based pathologist will receive 30 percent of gross departmental charges less 5 percent of the gross charges for bad debts and courtesy allowances. During the provider's Medicare cost reporting period, the department had $200,000 in gross charges. The provider retains $6,000 of the pathologist's compensation for the physicians' pension fund. Of the amount received from the provider, the pathologist agreed to return $4,000 ($2,000 for the provider's equipment fund and $2,000 to be used for general purposes). In addition, the intermediary verified that the pathologist made a bona fide, voluntary contribution of $5,000 to the provider.

Calculation of Physician's Compensation to be Used in Computing Medicare Reimbursement to the Provider:

$50,000 -	Compensation received by the pathologist, including the $6,000 retained by the provider for the sole benefit of the pathologist ($200,000 in gross departmental charges x 25 percent 30 percent of gross departmental charges less 5 percent of the gross charges for bad debts and courtesy1).
- 2,000 -	Returned to provider by agreement for restricted fund of provider.

- 2,000 - Returned to provider by agreement for unrestricted use of provider.

$46,000 - Net amount received and retained by the pathologist to be used in computing the provider's Medicare reimbursement (to the further distinguished as to the amount representing professional medical and surgical services and the amount representing provider services).

The amount of the bona fide, voluntary contribution ($5,000) is not deducted from the pathologist's compensation for the purpose of computing Medicare reimbursement to the provider. However, to the extent that any of the contribution was designated by the pathologist to pay for specific operating expenses of the provider, such amount must be deducted from those specific operating expenses.

2108.10 Treatment of Provider Costs Related to the Provision of Physician Services to Nonprovider Patients.--Where direct medical services are rendered by a physician to nonprovider patients, all direct and indirect provider costs incurred by the provider in connection with the provision of such services should be identified and deducted from provider costs in arriving at allowable costs for Medicare purposes. Where the costs for rendering these services cannot be identified, reasonable estimates must be made of the costs incurred by the provider. Where the provider receives revenue that is related to such services, such estimated costs may not be less than such revenue.

2108.11 Exhibits - Provider-Based Physicians.--

Exhibit I	-	Hospital-Based Physician Allocation Agreement
Exhibit II	-	Determination of Amount of Provider-Based Physician Compensation Reimbursable Under Part B
Exhibit IIA	-	Determination of Uniform Optional Percentage
Exhibit III	-	The Uniform Optional Percentage
Exhibit IV	-	Item-by-Item Method - Relative Value Schedule
Exhibit V	-	Alternate Item-by-Item Method
Exhibit VI	-	Per Diem or Per Visit Method
Exhibit VII	-	Calculation of Reimbursement Settlement for Professional Services Rendered to Medicare Beneficiaries by Provider-Based Physicians Not Using Combined Billing

EXHIBIT I

HOSPITAL-BASED PHYSICIAN ALLOCATION AGREEMENT

The following schedule represents the distribution of time and activities of the physicians in the _____ department:

1. Activity, other than direct patient services	Percent of Time
(a) Teaching	5
(b) Research (including attendance at lectures, etc.)	10
(c) Administration	10
(d) Supervision of technical and other personnel	20
(e) Hospital service (committees, etc.)	5
(f) Services of general benefit to patients (quality control, etc.)	25
Total	75
2. Activity, direct personnel services to individual patients	25

The allocation of time by activity as shown above was based on (select one of the following):

1. Time study 2. Estimate 3. Other (attach explanation)

Signed _____ Administrator of Provider

Signed _____ Physician(s)

EXHIBIT II

Determination of Amount of Provider-Based Physician Compensation
Reimbursable Under Part B

1	2	3	4	5	6	
					Approved	
Department	Physicians	Compensation	Professional Component Allocation	Part B Amount	Carrier	Inter-mediary
Pathology	SMITH	$22,000	20%	$4,400		
	JONES	20,000	25%	5,000		
	GREEN	18,000	30%	5,400		
			Total-	14,800		

The method for determining the Part B component of the physician's compensation is demonstrated in Exhibit II. The data in each of the columns is as follows:

Column l - DEPARTMENT-- Indicate a single provider department with one or more provider-based physicians rendering a significant volume of professional services to Medicare beneficiaries.

Column 2 - PHYSICIANS-- List the name of each physician in this department rendering direct patient services.

Column 3 - COMPENSATION-- Show the annual remuneration for each physician receiving a fixed compensation. (Where a physician changed to direct billing subsequent to June 30, 1966, the compensation amount for the year prior to the change should be obtained and used. See §2108.2C.)

Column 4 - PROFESSIONAL COMPONENT ALLOCATION-- List the percentage of compensation attributable to direct patient services. (See §2108.1 and Exhibit I.)

Column 5 - PART B AMOUNT-- Multiply Column 3 (Compensation) by Column 4 (Professional Component Allocation) to obtain the portion of each physician's salary attributable to Part B services.

Column 6 - APPROVED-- By initialing and dating their action, the intermediary and carrier show approval of the determination.

EXHIBIT II A

Determination of Uniform Optional Percentage

(Compensation Arrangement Stipulates Percentage of Gross Charges or Collections)

1	2	3	4	5	6	
					Approved	
Department	Physicians	Contract Percentage	Professional Component Allocation	Uniform Optional Percentage	Carrier	Intermediary
Pathology	SMITH	35	20	7.0		

Where a physician has a variable compensation arrangement (see §2108.2B for exception) and wishes to use the uniform optional percentage, enter the appropriate data in the columns of Exhibit II A as follows:

Column l - DEPARTMENT-- Indicate a single provider department with one or more provider-based physicians rendering a significant volume of professional services to Medicare beneficiaries.

Column 2 - PHYSICIANS-- List the name of each physician in this department rendering direct patient services.

Column 3 - CONTRACT PERCENTAGE-- Show the contract percentage.

Column 4 - PROFESSIONAL COMPONENT ALLOCATION-- List the percentage of compensation attributable to direct patient services (see §2108.1 and Exhibit I).

Column 5 - UNIFORM OPTIONAL PERCENTAGE--Multiply Column 3 (Contract Percentage) by Column 4 (Professional Component Allocation) for each physician. This amount (rounded to the nearest one-half percent) is the uniform optional percentage. The physicians' Part B charge for each service is derived by applying this uniform optional percentage to the provider's established charge for each service.

Column 6 - APPROVED-- By initialing and dating their action, the intermediary and carrier show approval of the determination.

EXHIBIT III

The Uniform Optional Percentage

1	2	3	4	5	6	
			Estimated Gross	Uniform	Approved	
Department	Part B Amount	Contract Percentage	Department Charges	Optional Percentage	Carrier	Intermediary
Pathology	$14,800	35	$200,000	7.5%		

After completing Exhibit II, where a physician has a fixed compensation and desires to use the uniform optional percentage, enter additional data in the appropriate columns of Exhibit III as follows:

Column l - DEPARTMENT--Show one provider department with provider-based physicians who render identifiable direct patient services.

Column 2 - PART B AMOUNT--The Part B amount was derived in Exhibit II, Column 5. Enter that amount in this column.

Column 3 - ESTIMATED GROSS DEPARTMENT CHARGE--Enter the estimated gross departmental charges for the year.

Column 4 - UNIFORM OPTIONAL PERCENTAGE--Divide Column 2 (Part B Amount) by Column 3 (Estimated Gross Department Charges) to obtain the uniform optional percentage. This percentage is applied to all departmental billings, and will yield in the aggregate an amount equal to the Part B Amount (Column 2). (This percentage may be rounded where such action will not result in reimbursement of an amount appreciably different from the amount in Column 2.)

Column 5 - APPROVED-- By initialing and dating their action, the intermediary and carrier indicate approval of the determination.

EXHIBIT IV

Item-by-Item Method - Relative Value Schedule

Pathology (Department)									
1	2	3	4	5	6	7	8	9	
Procedure	Provider's Established Charge	Percent Physician's Service	Relative Numerical Value	Estimated Procedures (Annual)	Total Units	Conversion Factor	Part B Charge	Approved Carrier	Approved Inter-mediary
U	$ 5.00	50%	2.5	2,000	5,000	$\frac{14,800}{29,900} = 5$		1.25	
V	10.00	3							
W	15.00	20	3.0	1,800	5,400			1.50	
X	20.00	10	2.0	2,500	5,000			1.00	
Y	25.00	80	20.00	200	4,000			10.00	
Z	30.00	10	3.0	3,500	10,000			1.50	

After completion of Exhibit II, in order to determine the Part B charge for the various procedures performed in a provider department, enter the appropriate data in the column of Exhibit IV as follows:

Column l - PROCEDURE--List each procedure with significant physician involvement performed in the provider department.

Column 2 - PROVIDER'S ESTABLISHED CHARGE--Show the provider's charge for each procedure shown in Column 1.

Column 3 - PERCENT - PHYSICIAN'S SERVICE--For each procedure show the percentage which represents the extent of physician involvement in rendering direct patient services. (Examples: For procedure "U" it is estimated that 50 percent of the provider charge represents physician involvement each time the procedure is performed. For procedure "V" physician involvement is negligible and the procedure is not used in obtaining the Part B charge.)

Column 4 - RELATIVE NUMERICAL VALUE--Multiply Column 2 (Provider's Established Charge) by Column 3 (Percent - Physician's Service) to obtain the Relative Numerical Value.

Column 5 - ESTIMATED ANNUAL PROCEDURES--Show the estimated number of times each procedure will be rendered during the year.

Column 6 - TOTAL UNITS-- The total relative value units for each procedure represent the estimated aggregate value of the physician component for each procedure and are obtained by multiplying Column 4 (Relative Numerical Value) by Column 5 (Estimated Procedures--Annual). The total units for each procedure are added to obtain the aggregate number of units for the department.

Column 7 - CONVERSION FACTOR-- Divide the Part B Amount (Exhibit II, Column 5) by the aggregate number of units, Column 6 (Total Units). (Round the answer to nearest tenth.)

Column 8 - PART B CHARGE-- Multiply Column 7 (Conversion Factor) by Column 4 (Relative Numerical Value) to obtain the Part B component charge for each procedure.

Column 9 - APPROVED-- By initialing and dating their action, the intermediary and carrier indicate approval of the determination.

NOTE: If an existing relative value schedule is to be used, complete Column l, and omit Columns 2 and 3. Enter in Column 4 the appropriate relative numerical value for each procedure as indicated in the existing relative value schedule. Complete Columns 5 through 7 as described in the instructions for Exhibit IV.

EXHIBIT V

Alternate Item-by-Item Method

Pathology (DEPARTMENT)						
1	2	3	4	5	6	
Procedure	Professional Component Percentage	Part B Compensation	Estimated Procedures (Annual)	Part B Component Charges	Approved	
					Carrier	Intermediary
M	15%	$ 2,220	1,100	$ 2.00		
N	10	1,480	200	7.50		
O	5	740	55	13.50		
P	20	2,960	300	10.00		
Q	25	3,700	1,700	2.00		
R	5	740	100	7.50		
S	10	1,480	150	10.00		
T	10	1,480	200	7.50		
	(100%) Total =	$14,800				

After completing Exhibit II, where the physicians in a single provider department elect to use the alternate item-by-item method, enter the following data in the appropriate columns:

Column l - PROCEDURE-- List each procedure performed in the department with significant physician involvement.

Column 2 - PROFESSIONAL COMPONENT PERCENTAGE-- Show the percentage of time which the physicians collectively spend performing each procedure. (The total time spent should equal 100 percent of the time devoted to direct patient services.)

Column 3 - PART B COMPENSATION-- Multiply the amount shown in Exhibit II, Column 5, by each percentage in Column 2.

Column 4 - ESTIMATED ANNUAL PROCEDURES-- Estimate the number of times each procedure will be performed in the coming year.

Column 5 - PART B COMPONENT CHARGES-- The physician Part B charge is derived by dividing Column 3 (Part B Compensation) by Column 4 (Estimated Procedures--Annual) rounded to nearest 50 cents.

Column 6 - APPROVED-- By initialing and dating their action, the intermediary and carrier indicate approval of the determination.

EXHIBIT VI

Per Diem or Per Visit Method

THE METHOD - TABLE A

1	2	3				4	
Department	Total Physician Compensation	Division of Compensation				Inpatient-Compensation for Direct Patient Services	
		Outpatient		Inpatient			
Radiology	$ 52,000	50%	$26,000	50%	$26,000	60%	$ 15,600
Pathology	40,000	35	14,000	65	26,000	40	10,400
Anesthesiology	42,000	10	4,200	90	37,800	85	32,130
Internal – Med.	150,000	35	52,500	65	97,500	90	87,750
Surgery	155,000	30	46,500	70	108,500	90	97,650
		Total - $143,200				Total - $243,530	

INPATIENT RATE - TABLE B

	Direct Patient Service Dept.	Part B Amount	Inpatient Days	Per Diem Rate	Approved	
					Carrier	Intermediary
HOSPITAL	RADIOLOGY PATHOLOGY	$ 26,000	100,000	(26) 25		
	ALL OTHER DEPARTMENTS	217,330	100,000	(2 18) 2 20		
ALL OTHER PROVIDER SETTINGS	ALL DEPTS.	243,530	100,000			

OUTPATIENT RATE - TABLE C

	1	2	3	4	5	
	Direct Patient Service Dept.	Part B Amount	Inpatient Days	Per Diem Rate	Approved	
					Carrier	Intermediary
ALL PROVIDER SETTINGS	ALL DEPTS	$143,200	41,000	(3 49) 3 50		

In developing the per diem (or per visit) method of reimbursement, enter the pertinent information in the appropriate columns in Exhibit VI. Separate tables are presented to show the basic data necessary (Table A) and its utilization in deriving the inpatient rate (Table B) and the outpatient rate (Table C).

Under this method, only compensation paid to physicians who normally render services to Medicare patients should be included in the computation. Thus, the compensation of obstetricians, pediatricians, and other physicians who do not normally render services to Medicare beneficiaries should not be included. In addition, the patient days attributed to the departments of the institution which do not usually provide services for Medicare patients should also be excluded from the per diem computation.

It should also be noted that some physicians who render services to Medicare patients also render services that are not covered under the program. For example, dentists and podiatrists provide covered services as well as noncovered services to beneficiaries. In such cases, the physicians' compensation allocated to those noncovered services should be omitted from the per diem computation.

Table A	The Method
Column l	DEPARTMENT-- List each provider department in which a significant number of services for Medicare patients are rendered.
Column 2	TOTAL PHYSICIAN COMPENSATION--On a departmental basis show the total physician compensation.
Column 3	DIVISION OF COMPENSATION--On a departmental basis show the percentage and amount of the total physician compensation (Column 1) attributable to outpatient and inpatient services, and enter the aggregate total for outpatient services in the space provided in Column 3.
Column 4	INPATIENT - COMPENSATION FOR DIRECT PATIENT SERVICES--Of the inpatient compensation (Column 3) show the percentage and amount attributable to direct patient services to inpatients. Enter the aggregate total compensation attributable to inpatient direct patient services in the space provided in Column 4.

Table B	The Inpatient Rate
Column l	DIRECT PATIENT SERVICES - DEPARTMENT--In the hospital setting it is necessary to separate the radiology and pathology department compensation from other compensation because the direct patient services of these specialty departments are reimbursable without application of the coinsurance and deductible provisions. In other provider settings, all departments are considered together.
Column 2	PART B AMOUNT--This item corresponds to the total of Table A, column 4. In the hospital setting the amount attributable to the radiology and pathology departments must be shown separately.
Column 3	INPATIENT DAYS--Indicate the estimated total number of inpatient days for the year.
Column 4	PER DIEM RATE--The rate is obtained by dividing column 2 (Part B Amount) by column 3 (Inpatient Days) and rounding to the nearest multiple of $.05.
Column 5	APPROVED--The carrier and intermediary will signify their approval of the determination by initialing and dating their action.

Table C	The Outpatient Rate
Column l	DIRECT PATIENT SERVICES - DEPARTMENT--No differentiation among departments is necessary.
Column 2	PART B AMOUNT--This item corresponds to the total of Table A, column 3 (Outpatient).
Column 3	OUTPATIENT VISITS--Indicate the estimated total number of outpatient visits for the year.
Column 4	PER VISIT RATE--Divide column 2 (Part B Amount) by column 3 (Outpatient Visits) and round to the nearest multiple of $.05.
Column 5	APPROVED--The carrier and intermediary will signify their approval of the determination by initialing and dating their action.

RESERVED FOR EXHIBIT VII

RESERVED FOR EXHIBIT VII (Cont.)

2109. REIMBURSEMENT OF HOSPITAL EMERGENCY DEPARTMENT SERVICES WHEN PHYSICIANS RECEIVE COMPENSATION FOR AVAILABILITY SERVICES

2109.1 General.--Wide variations can occur in the utilization of hospital emergency department services and hospitals cannot always schedule physician staffing at a level commensurate with the actual volume of services rendered. As a result, emergency department physicians may spend a portion of their time in an availability status awaiting the arrival of patients. Alternatively, hospitals may need to arrange for emergency department physician coverage for evenings, weekends or holidays, when staff or community physicians are not available. Since these periods frequently generate inadequate physician revenue through charges for professional services due to lower utilization, hospitals may have to offer physicians supplemental compensation or minimum compensation guarantees to secure coverage of emergency departments.

When emergency department physicians are compensated on an hourly or salary basis or under a minimum guarantee arrangement (§2109.2E) providers may include a reasonable amount in allowable costs for emergency department physician availability services subject to limitation through the application of Reasonable Compensation Equivalents (RCEs). Availability costs will be recognized only in the emergency department of a hospital, and only as described in this section.

2109.2 Definitions.--

A. Physician Availability Services.--Physician availability services consist of the physical presence of a physician in a hospital under a formal arrangement with the hospital to render emergency treatment to individual patients as and when needed.

B. Reasonable Compensation Equivalent .--A Reasonable Compensation Equivalent (RCE) is the limitation on the cost which a provider can claim for compensation of services furnished by physicians to providers. At present, the RCEs apply only to services which are reimbursable on a reasonable cost basis. The limitation is expressed as a dollar amount for a full work year of 2080 hours ("work-year hours"), and is published in the Federal Register. It is differentiated by physician specialty with variations for rural areas, metropolitan areas of less than 1,000,000 population, and metropolitan areas of greater than 1,000,000 population. Details on the RCE limitation are provided in §2182.6, Conditions of Payment for Costs of Physicians' Services to Providers.

C. RCE Base.--The RCE base is the physician compensation amount that the program will recognize for provider services and availability services, whether compensation for availability services is calculated under an hourly rate or salary arrangement, or based on a minimum guarantee amount calculated for a specified number of direct patient care service hours under a minimum guarantee arrangement. The RCE base is determined by applying the RCE limitation to the provider services, availability services or direct patient care services hours specified in the applicable provider/physician allocation agreement.

D. Adjusted RCE Base.--The RCE base amount may be adjusted to reflect the addition of allowances for the costs of physician membership in professional associations,

continuing medical education and malpractice insurance. The allowance for membership in professional associations and continuing medical education is limited to the lesser of actual cost or 5 percent of the applicable RCE base amount. The allowance for malpractice insurance is limited to the proportionate share of actual reasonable physician malpractice insurance cost attributable to the provider services, availability services or direct patient care services hours (under a minimum guarantee arrangement) subject to the RCE limitation.

E. Minimum Guarantee Arrangement.--A minimum guarantee arrangement is a financial arrangement between a physician or a group of physicians and a provider where the physician(s) is (are) guaranteed a minimum level of compensation (the minimum guarantee amount) for availability services. The physician(s) may receive more than the minimum amount guaranteed if they generate charges for services to individual patients in excess of the minimum guarantee amount. If the charges fall short of the minimum guarantee amount, the provider is obligated to pay the physician(s) the difference to make up the guaranteed amount. A minimum guarantee arrangement may also contain provisions for compensating physicians for performing provider services such as supervision of the emergency department, administration, etc.

F. Unmet Guarantee Amount.--An unmet guarantee amount is the amount by which the minimum guarantee amount exceeds total physician charges for services to individual patients during the cost reporting period. Total physician charges include imputed charges for services performed but not billed. Total physician charges, not collections, must be included in the computation.

2109.3 Allowability of Emergency Department Physician Availability Services Costs.--Emergency department physician availability services costs will be allowable only in special circumstances, as follows:

A. No Feasible Alternative Way to Obtain Physician Coverage is Available.-In order for physician availability services costs to be allowable, the provider must demonstrate that it explored alternative methods for obtaining physician coverage but was unable to do so. An alternative might include negotiating a straight fee-for-service arrangement. Evidence of such an effort could consist of advertisements for emergency physicians, to be compensated on a fee-for-service basis, placed in appropriate professional publications. It is not necessary for a provider to demonstrate that it explored alternative methods for obtaining emergency physician coverage annually. The requirement is applicable prior to the renegotiation of expiring arrangements or the initiation of new arrangements for physician coverage of the emergency department.

B. Physicians Provide Immediate Response to Life-Threatening Emergencies.-The physician must be on the hospital premises in reasonable proximity to the emergency department. The physician cannot be “on call.”

C. Documentation.--A claim for Part B hospital costs or Part A and Part B hospital costs must be supported by the following data maintained by the hospital:

1. A signed copy of the contract between the hospital and the physician(s).

2. A written copy of the allocation agreement and supporting data depicting the distribution of the physician's time between services to the provider, services to individual patients and services not reimbursable under Medicare.

3. A permanent record of payments made to the physician(s) under the agreement.

4. A record of the amount of time the physician was physically present on the hospital premises to attend to emergency patients.

5. A permanent record of all patients (Medicare and non-Medicare) treated by the physician, copies of all physician bills generated for such services and a record of imputed charges for services for which no billing was made by the hospital or physician.

6. A schedule of physician charges.

7. Evidence that the provider explored alternative methods for obtaining emergency physician coverage before agreeing to physician compensation for availability services.

2109.4 Methodology for Determining Allowable Emergency Physician Availability Service Costs --

A. General.--When a provider compensates emergency physicians for being available to render physician services to individual patients in the emergency department, the provider may be reimbursed Medicare's share of the allowable costs incurred by the provider to the extent that the costs are determined reasonable. Provider reimbursement will be based on the lesser of the actual compensation paid to the physician or the reasonable compensation determined through the application of the RCE limits to the hours of emergency department availability stipulated in the approved provider/physician allocation agreement. If the required allocation agreement does not specify the availability services hours for which the provider compensates the physician, availability services costs will not be allowable unless the conditions of §2109.4 C. are met with respect to minimum guarantee arrangements.

The limit on allowable cost for a physician's services to the provider is calculated by dividing the total hours of services to the provider (including both availability and provider services) by 2,080 “work-year hours” and multiplying the result by the applicable RCE limit to determine the RCE base. The RCE base may be increased by the lesser of actual costs or 5 percent of the RCE base to reflect costs incurred by the provider for emergency physicians' membership in professional associations and continuing medical education. Additionally, the RCE base may be increased to reflect an allowance for the proportionate share of actual reasonable physician malpractice insurance cost incurred by the provider.

Emergency physician availability services costs are reimbursable under Part A if attributable to inpatient services and Part B if attributable to outpatient services in the emergency department. Both are processed by the Part A intermediary. The costs should be included in the emergency department cost center. The portion of the cost attributable to emergency physician services rendered in the inpatient routine areas should then be reclassified from the emergency department cost center to the inpatient routine cost center on the cost report. The allocation to the inpatient routine cost center is accomplished by dividing emergency department physician charges for inpatient routine emergencies by total emergency department physician charges and applying the result to allowable availability services cost as follows:

$$\frac{\text{Emergency Department Physician Charges for I/P Routine Areas}}{\text{Total Emergency Department Physician Charges (Billed and Imputed)}} \times \text{Allowable Availability Services Cost} = \text{Inpatient Availability Services Costs}$$

When a contract requires the physician to render duties other than direct patient care services, such as teaching, administrative, supervising technical personnel, which are of general benefit to all patients, and the hospital incurs allowable physician compensation costs for such activities, these costs will be allocated between the Part A and Part B programs in the same ratio that the inpatient charges and the outpatient charges for the emergency department bear to total charges. Where the hospital is reimbursed under the prospective payment system, the Part A inpatient costs are reimbursed on the basis of the DRG payment.

B. Allowable Availability Service Costs Under Hourly Rate or Salary Arrangements.--Where the agreement between a provider and emergency physician specifies that payment for availability services will be made on an hourly rate or salary basis, the provider will be reimbursed Medicare's share of incurred physician availability services costs subject to the RCE limitation. The following illustration demonstrates the methodology for determining allowable emergency physician compensation costs when the physician is compensated on an hourly rate or salary basis for availability, supervisory and administrative services.

ILLUSTRATION

Dr. A agrees to work in the emergency department of XYZ Hospital providing general emergency department physician services on weekends, holidays and evenings. The hospital agrees to compensate Dr. A at the rate of $20 per hour for emergency physician availability services, supervisory and administrative duties. The hospital also agrees to pay $250 towards the cost of Dr. A's membership in professional associations, $1,500 for continuing medical education costs and $4,000 of Dr. A's annual malpractice insurance cost. Dr. A bills and retains all professional fees. He has agreed not to bill for services rendered to hospital inpatients and employees. The allocation agreement developed by XYZ Hospital and Dr. A indicates that Dr. A will expend his time, for which he is compensated by the hospital, as follows:

	Percentage
Availability Services	50%
Supervision and Administrative Services	50%
TOTAL	100%

During the year Dr. A renders 300 hours of supervisory, administrative and availability services, bills $29,000 in professional fees, furnishes the equivalent of $1,000 in emergency services to hospital inpatients and $2,000 in emergency services to hospital employees, is compensated $3,000 for supervisory and administrative services, and receives additional compensation of $3,000 for availability services. The compensated hours worked by Dr. A are allocated as follows:

	Hours
Availability Services (50% of 300)	150
Supervisory and Administrative Services (50% of 300)	150
TOTAL	300

The reasonable cost of the supervisory, administrative and availability services time is computed as follows:

1. Determine the Applicable RCE Base

Total Hours (Supervisory, Administrative and Availability Services) / Work Year Hours (2080)		RCE (for illustrative purposes we selected the 1983 RCE/ Total figure for non-metropolitan areas)	=	RCE Base
$\frac{300}{2080}$	X	$87,600	=	$12,635

2. Determine the Limit on the Allowance for Membership in Professional Associations and Continuing Medical Education

RCE Base				Limit
$12,635	X	.05	=	$632

3. Provider Payments for Membership in Professional Associations and Continuing Medical Education = $1,750
($250 Membership in Professional Associations + $1,500 Continuing Medical Education)

4. Malpractice Insurance Expense = $4,000

5. Adjusted RCE Base = $17,267
(Sum of #1 ($12,635) + the Lesser of #2 or #3 ($632) + #4 ($4,000))

6. Actual Provider Payments

Supervision and Administration	$ 3000	
Availability	3000	
Membership in Professional Associations	250	
Continuing Medical Education	1500	
Malpractice	4000	
		$11,750

7. Amount Includable in Allowable Costs = $11,750
(Lesser of #5 or #6)

8. Allocation of Allowable Costs

Billed Charges (Emergency Department)	$29,000
Imputed Employee Charges	2,000
Total Outpatient Charges	$31,000
Imputed Inpatient Charges	1,000
Total Charges	$32,000

Outpatient Charges / Total Charges	X	Allowable Provider Costs	=	Allowable Part B Costs
31,000 / 32,000	X	$11,750	=	$11,383
Inpatient Charges / Total Charges	X	Allowable Provider Costs	=	Allowable Part A Costs
1,000 / 32,000	X	$11,750	=	$367

C. Allowable Unmet Guarantee Amounts Under Minimum Guarantee Arrangements.--The allowable cost of an unmet guarantee amount is determined by subtracting total charges for physician services to individual patients from the lesser of (1) the minimum guarantee amount specified in the provider/physician arrangement or (2) the reasonable compensation amount which is arrived at by applying the RCE limits (as adjusted for any appropriate additional allowances) to the physician's total hours allocated for individual patient care. The charges billed by or for the physician must be appropriate to the patient care services rendered and not merely token charges. If the agreement between the provider and physician restricts the physician from billing charges for designated groups of patients (e.g., inpatients, provider employees), charges for such services must be imputed, and included in the total physician charge figure. Total physician charges (billed and/or imputed) must be used in this computation whether or not collected. When physicians are required to perform services which are of general benefit to all provider patients, as well as direct patient care services, under a minimum guarantee arrangement, the RCE limits are applied separately in determining the allowable costs of the unmet guarantee amount and compensation for provider services such as administration or supervision. If the provider also incurs costs for physician membership in professional associations, continuing medical education and malpractice insurance premiums, such costs are allocated between provider payments for unmet guarantee amounts and provider payments for physician compensation for provider services on the basis of the respective ratios of allocated direct patient care service hours and provider service hours to total hours worked. This allocation is necessary in order to determine the provider's actual payments for unmet guarantee amounts and physician compensation for provider services. Allowable unmet guarantee costs are reimbursable under Part A if attributable to inpatient services and Part B if attributable to outpatient services in the emergency department and are processed by the Part A intermediary. The costs for an unmet guarantee amount should be allocated between Part A and Part B in the same manner as those for availability services compensated under hourly rate or salary arrangements. (See §2109.4A.)

ILLUSTRATION

Dr. X contracts to work 1,000 hours during the year in the emergency department of ABC Hospital providing general emergency department physician services on weekends, holidays and evenings. ABC Hospital guarantees Dr. X $50,000 in charges for physician services to individual patients and agrees to compensate Dr. X at the rate of $20 per hour for supervisory and administrative duties. The hospital also agrees to pay $500 for the cost of Dr. X's membership in professional associations, $2,500 for continuing medical education and $5,000 of Dr. X's annual malpractice insurance cost. Dr. X bills and retains all professional fees. He has agreed not to bill for services he renders to inpatients and employees of the hospital. The allocation agreement developed by ABC Hospital and Dr. X indicates that Dr. X will expend his time as follows:

	Percentage
Professional Services to Individual Patients (includes inpatients and employees) and Availability Services	90%
Supervision and Administrative Services	10%
TOTAL	100%

During the year Dr. X bills $29,000 in professional fees, furnishes the equivalent of $1,000 in professional services to hospital inpatients and $2,000 in professional services to hospital employees. Dr. X is compensated $2,000 for supervisory and administrative services, and $21,000 for an unmet guarantee amount. The hours worked by Dr. X are allocated as follows:

	Hours
Professional Services to Individual Patients and Availability Services	900 (90% of 1,000)
Supervision and Administrative Services	100 (10% of 1,000)
TOTAL	1,000

Computation of Reasonable Allowable Cost for Supervisory and Administrative Duties

1. Determine the Applicable RCE Base

Total Hours (Supervisory and Administrative Services) / Work Year Hours (2080)		RCE (for illustrative purposes we selected the 1983 RCE/ Total figure for non-metropolitan areas)		RCE Base
100/2080	X	$87,600	=	$4,212

2. Determine the Limit on the Allowance for Membership in Professional Associations and Continuing Medical Education

RCE Base				Limit
$4,212	X	.05	=	$211

3. Determine Actual Provider Payment for Membership in Professional Associations and Continuing Medical Education Applicable to Supervisory and Administrative Services

Total Hours (Supervisory and Administrative Services) / Total Hours Worked		Total Payments for Membership in Professional Associations and Continuing Medical Education		
100/1000	X	$3,000	=	$300

4. Determine the Allowance for Malpractice Insurance (Supervision and Administration)

Supervisory and Administrative Hours / Total Hours Worked	X	Total Payment for Malpractice Insurance		
100/1000	X	$5,000	=	$500

5. Adjusted RCE Base for Supervision and Administrative Services (Sum of #1 ($4,212) + the Lesser of #2 or #3 ($211) + #4 ($500)) $4,923

6. Determine Provider Payments Attributable to Supervision and Administrative Services $2,800

Supervision and Administration (100 hours X $20)		$2,000
Membership in Professional Associations	(100/1000 X $500)	50
Continuing Medical Education	(100/1000 X $2500)	250
Malpractice Insurance Premiums	(100/1000 X $5000)	500
		$2,800

7. Amount Includable in Allowable Costs (Lower of #5 or #6) $2,800

Computation of Reasonable Allowable Costs for an Unmet Guarantee Amount

8. Determine the Applicable RCE Base

Total Hours (Professional and Availability Services) / Work-Year Hours (2080)	X	RCE (for illustrative purposes we selected the 1983 RCE/ Total figure for non-metropolitan areas)	=	RCE Base
900/2080	X	$87,600	=	$37,904

9. Determine the Limit on the Allowance for Membership in Professional Associations and Continuing Medical Education

RCE Base		.05		Limit
	$37,904 X	.05	=	$1,895

10 Determine Actual Provider Payment for Membership in Professional Associations and Continuing Medical Education Applicable to Professional and Availability Services

Total Hours (Professional and Availability Services) / Total Hours Worked		Total Payments for Membership in Professional Associations and Continuing Medical Education		
900/1000	X	$3,000	=	$2,700

11. Determine the Allowance for Malpractice Insurance (Professional and Availability Services)

Total Hours (Professional and Availability Services) / Total Hours Worked		Total Payment for Malpractice Insurance		
900/1000	X	$5,000	=	$4,500

12. Adjusted RCE Base (Sum of #8 ($37,904) + the Lesser of #9 or #10 ($1,895) + #11 ($4,500)) $44,299

13. Actual Minimum Guarantee Amount $50,000

14. Reasonable Minimum Guarantee Amount (Lower of #12 or #13) $44,299

15. Total Charges $32,000

Billed Charges	$ 29,000
Imputed Inpatient Charges	1,000
Imputed Employee Charges	2,000

16. Reasonable Unmet Guarantee Amount (#14 Less #15) $12,299

17. Summary of Allowable Provider Costs *$15,099

Supervisory and Administrative Svcs	$ 2,800
Reasonable Unmet Guarantee Amount	12,299
	$ 15,099

*Total allowable provider costs of $15,099 are allocated between Part A and Part B in the same manner as the preceding example.

2110. BILLING COSTS

In the cost finding process, billing costs are generally allocated to the various cost centers as part of administrative costs. Medicare then reimburses providers for its proportionate share of these costs as determined in the apportionment of the costs of the various cost centers.

2110.1 Contract Billing Services.--Where a provider contracts for billing services to be performed by another organization, the contract costs of such services are allowable costs subject, of course, to the provisions of Chapter 10, Cost to Related Organizations. These costs are administrative costs and are subject to cost allocation and apportionment even though the billings contracted out are Medicare billings.

2110.2 Treatment of Income Derived from Interest, Finance Charges, and Penalties on Delinquent Accounts Receivable.--Where a provider derives income from interest, finance charges, or penalties on delinquent accounts receivable, the actual cash received must be used as a deduction from allowable administrative and general costs. The provider may not remove the related costs of preparing, billing, and collecting all accounts receivable balances, or costs of only those accounts which generated the income, from allowable costs to avoid this income offset requirement.

2110.3 Treatment of Income Derived from Billing Charges Imposed on Suppliers of Services Furnished Under Arrangements.--Where a provider imposes a charge for billing or any other administrative services on a supplier of services furnished under arrangements, the amount of the charge is treated, for Medicare purposes, as a discount for the services rendered. It may not be considered as income from billing or other administrative services. Accordingly, the amount of allowable cost for any service furnished under arrangements is the net amount paid by the provider.

2110.4 Physician Billing Costs.--If you incur costs providing billing services to provider-based physicians for direct medical and surgical services rendered to individual patients, the physician billing costs are generally not allowable. Physician billing costs incurred by you billing for direct medical and surgical services rendered to individual patients by provider-based physicians are recognized as allowable provider costs only when incurred on behalf of compensated provider-based physicians for services rendered before January 1, 1992, and where payment for the services is made to you by the carrier on a compensation related customary charge basis. Unallowable physician billing costs must be identified by you and offset against your total direct and indirect billing costs. Reasonable estimates of unallowable physician billing costs, inclusive of direct and indirect costs, as well as a representative portion of overhead, are acceptable, subject to review and approval by your servicing Medicare fiscal intermediary. Physician billing costs are best estimated if your billing staff is segmented into provider and physician billing components. This facilitates the more exact determination of direct physician billing costs and results in more accurate and, thus, more acceptable overall estimates of physician billing costs. In situations where it is impractical to segment the billing staff, estimates of physician billing costs may be based upon ratios of physician bills processed to total bills processed by the billing staff applied to total billing costs. Acceptable estimates of physician billing costs may also be based on time studies where the average processing time for a physician bill is determined and that average time is multiplied by the number of physician bills processed by the billing staff to determine total direct time expended on physician billing. The ratio of direct physician billing time to total billing time may then be applied to total billing costs to determine an acceptable estimate of physician billing costs.

2112. NONPHYSICIAN ANESTHETISTS' SERVICES AS HOSPITAL SERVICES

When a nonphysician anesthetist is a salaried member of the staff of a hospital, the services furnished by such an individual in connection with the administration of anesthetic agents are covered in the same manner as the services of other nonphysician hospital employees. Such services to hospital inpatients are covered under Part A as inpatient hospital services. When provided for outpatients, these services are covered under Part B as hospital services incident to a physician's services to outpatients. In either situation, reimbursement for the services furnished is made to the hospital on a reasonable cost basis.

When a nonphysician anesthetist who is not a salaried member of the hospital staff provides services to the hospital's inpatients on a fee-for-service basis, such services are covered in the same manner as the services of a salaried nonphysician anesthetist, provided the following conditions are met. The nonphysician anesthetist must be contractually authorized to furnish such services and the services are made available under arrangements where payment to the hospital for the services discharges the liability of the patient or any other individual to pay for the services. While the charges for equivalent services of the anesthetist must be uniform for Medicare and non-Medicare patients, billing practices of the nonphysician anesthetist need not be identical for both Medicare and non-Medicare patients. Where the arrangement under which services are furnished meets the requirements specified in guidelines published by HCFA, these services may be furnished for Medicare beneficiaries even if the nonphysician anesthetist bills directly for non-Medicare beneficiaries. Anesthetist services provided under arrangements by which the hospital bills for the services will be reimbursed to the hospital on a reasonable cost basis. Services billed directly by a nonphysician anesthetist to an individual patient are not covered under Medicare.

If a hospital imposes a charge for billing or other administrative services on a nonphysician anesthetist who is not a salaried member of the hospital staff and who is furnishing services under arrangements, the amount of such charge is a discount from the cost of the services. It may not be treated as income by the hospital. Thus, the amount to be recognized as cost by the hospital is the net amount paid to the non-physician anesthetist.

2113. HOME HEALTH COORDINATION (OR HOME CARE INTAKE COORDINATION) COSTS - GENERAL

Home health coordination, also known as intake coordination, is intended to manage and facilitate the transfer of patients from a hospital or skilled nursing facility (SNF) to the care of a home health agency (HHA). This involves arranging for the uninterrupted continuing medical care of the patient and assisting in the organization of family resources for the effective care of the patient, reducing the psychological apprehensions inherent in returning the patient to his/her residence. These duties may be performed at various locations; e.g., at hospitals or other health care institutions such as SNFs, or on the HHA's premises. The costs of performing these services are allowable under Medicare as described in §2113.1.

However, the costs of services performed by HHA personnel which constitute patient solicitation activities or activities duplicative of the institution's discharge planning responsibilities are not allowable. These activities are described in §§2113.2 and 2113.3.

The following sections define home health coordination and these other activities so that the time spent by HHA personnel in hospitals and SNFs can be divided among the various activities to determine allowable costs. The fact that a service is performed in a hospital or SNF, rather than on HHA premises, does not necessarily make the cost of that service unallowable, but such costs should be carefully assessed to assure they are related to allowable services. HHAs must be able to produce supporting records such as time logs to substantiate their statements pertaining to the time spent by HHA personnel in the various activities.

2113.1 Home Health Coordination Activities.--The cost of coordination activities, which ease the patient's transition from hospital or SNF to the home under the care of an HHA, are allowable. Coordination activities take place once the patient's physician has determined that the patient requires home health services as evidenced by the patient's medical record, and the specific HHA that is to render the services has been chosen by the patient and/or his family (possibly with hospital or SNF assistance). The cost of activities performed prior to the determination that home health services are needed and the selection of one HHA to perform the services is not an allowable home health cost since an agency cannot coordinate the care of a nonpatient. In some cases, generally infrequently, a referred patient does not actually become a patient of the agency, either because of a subsequent decision that home care is not needed or because the agency selected cannot meet the patient's needs. In such cases, the cost of coordination activities would be allowable as if the patient had been accepted by the HHA.

Coordination activities may be performed on the premises of the HHA, or in a hospital or SNF. They may be performed by a nurse, medical social worker, or other health professional. For example, coordination for a specific patient might be performed by the nurse who will provide skilled nursing services to the patient once he/she is discharged. Coordination activities are of the type listed below. They are allowable unless the activities are found to be unnecessary for patient care or a duplication of services already properly performed by the hospital or SNF. To the extent that coordination activities can be performed simultaneously with evaluation visit activities, separate visits to the same patient would be excessive.

Coordination Activities

A. Explaining the agency's policies to patients and responsible family members following referral.

B. Assisting in establishing a definitive home care plan prior to discharge, including assessment of the appropriateness of the requested services, medical supplies, and appliances.

C. Assuring that the HHA is ready to meet the patient's needs at the time of discharge. This entails making arrangements for any special medical supplies or appliances, making arrangements for training agency personnel regarding unfamiliar procedures or problems pertaining to the patient's care, and communicating information regarding the patient to agency personnel.

2113.2 Patient Solicitation Activities.--Costs incurred by a home health agency for personnel performing duties in the hospital or SNF which are primarily directed toward patient solicitation are unallowable costs for Medicare reimbursement purposes. (See HCFA Pub. 15-1, §§2136ff.) Visits made by HHA personnel to patients which have not yet been referred to the HHA (as evidenced by the patient's medical record) in order to persuade the patient to request the HHA's services are considered patient solicitation, as would visits to physicians to obtain referrals. Obtaining referrals by means of a cooperating hospital or SNF employee, or by reviewing patient records to identify potential patients for the HHA, are also considered patient solicitation. Any costs incurred for these activities are unallowable. These costs include not only the compensation and transportation costs of the HHA personnel engaged in the activity, but also any costs the HHA incurs for meals, entertainment, gifts, etc., given to influence these parties to refer patients to the HHA.

2113.3 Discharge Planning-Type Activities.--A hospital or SNF must perform discharge planning for its patients as a part of the utilization review plan it is required to have in effect in order to meet the Medicare conditions of participation. Since implementation of a utilization review plan is the responsibility of the hospital or SNF, no cost attributable to this activity can be recognized as an allowable cost of an HHA.

Therefore, the costs an HHA incurs because one or more of its employees performs patient discharge planning activities cannot be recognized as an allowable cost to the HHA. For example, costs incurred by an HHA to screen and review hospital files individually or during staffing or discharge planning, for the purpose of determining the level of care a patient will require upon discharge, are not allowable costs to the HHA regardless of whether the HHA employee performs this assistance at the hospital or elsewhere.

Rather than having its own staff perform the required discharge planning activities, a hospital or SNF could arrange to have these services provided by HHA employees and pay the HHA for these services. These costs would be allowable to the hospital or SNF as discharge planning costs, and would be reimbursable to them to the extent they are reasonable in amount and do not duplicate services already provided by hospital or SNF staff. The HHA must specifically identify and deduct the costs. However, if the costs cannot be determined, the HHA may deduct the revenue it receives for these services from its costs.

2113.4 Education and Liaison Activities.--Education and liaison activities permit the HHA to establish ties with the rest of the health care system. These activities are allowable to the extent that they are necessary for patient care and do not duplicate services which are or should be performed by the hospital or SNF. (See §§2136ff.) The activities include:

A. Serving as an educational resource to the hospital or SNF concerning home health services. This includes conducting training for hospital or SNF staff and serving as a consultant to the hospital or SNF for establishing home care policies and practices.

B. Educating physicians concerning the range of home care services available.

2113.5 Home Health Coordination in the Provider-Based HHA.--In provider-based HHAs the hospital or SNF and the HHA are part of the same complex, and the reasonable costs of discharge planning services performed by HHA personnel are allowable when the costs are properly classified as costs of the hospital or SNF and do not represent a duplication of services performed by other personnel. Include the costs in the hospital's or SNF's discharge planning costs. Instruct the provider-based HHA to maintain records to substantiate time spent in various activities.

2114. VISITING COSTS OF HHAS

Costs related to patient care visits are allowable HHA costs. Visiting costs are incurred when a staff member of the HHA or others under arrangements made by the HHA make a personal contact to provide a covered home health service to a beneficiary in his/her place of residence.

Costs related to outpatient visits made by a patient to a hospital, SNF, rehabilitation center, or outpatient department affiliated with a medical school to receive covered HHA services are allowable costs if:

- The HHA made arrangements for the services; and
- The services involve the use of equipment which cannot be made readily available to the patient in his/her place of residence.

Visiting costs include all incurred costs related to making the visits, such as preparation for the visits, telephone calls or conferences about the patients, maintaining the patients' records, travel to the patients, and treating the patients.

2114.1 Nonowners Compensation.--Compensation paid to a nonowner employee, which is computed under the procedural guidelines contained in Chapter 9, is included in the allowable costs of the HHA. Following these procedural guidelines is necessary when applying the substantially out of line test in §2102.1. This test determines whether the compensation costs are substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors.

2114.2 Transportation Costs.--Transportation costs incurred by an HHA may be included in the allowable costs of the HHA if the costs are reasonable (as defined in §2102.1), and necessary (as defined in §2102.2). Generally, transportation costs are incurred for either the use of an employee's vehicle or the use of the HHA's vehicle, whether owned or leased.

A. Use of An Employee's Vehicle: Include the amount paid to an employee for necessary patient care transportation in the allowable costs of the HHA if it does not exceed either the amount recognized under current IRS guidelines or the amount based on the standard GSA mileage rate (see §1412.6). Classify any excess amount as a fringe benefit and include in the employee's compensation.

B. Use of An HHA's Vehicle, Whether Owned or Leased: Reasonable costs of owned or leased vehicles incurred by an HHA to render necessary patient care are included in allowable costs of the HHA. When an HHA vehicle is used for personal and HHA patient care activities, the HHA must maintain documentation of the number of miles that the vehicle is used for each purpose. Use of the vehicle for commuting between the employee's place of residence and the HHA is considered a personal activity. The costs of the vehicle attributed to personal activities (based on the ratio of personal mileage to total mileage applied to the vehicle's costs) must be included in the employee's compensation as a fringe benefit to the extent that the employee does not reimburse the HHA for the costs.

2115. TREATMENT OF MEDICAL SUPPLY COSTS IN HHAs

All HHAs are expected to separately identify in their records the cost of medical supplies that are not routinely furnished in conjunction with patient care visits and which are directly identifiable services to an individual patient. Exclude the cost of medical supplies for which a separate charge is made, in addition to the per visit charge, from the per visit costs if:

- The common and established practice of comparable HHAs in the area is to charge separately for the item;
- The HHA follows a consistent charging practice for Medicare and non-Medicare patients receiving the item;
- Generally, the item is not frequently furnished to patients;
- The item is directly identifiable to an individual patient and its cost can be identified and accumulated in a separate cost center; and
- The item is furnished at the direction of the patient's physician and is specifically identified in the plan of treatment.

Do not separately classify the cost of those minor medical and surgical supplies which are not expected to be specifically identified in the physician's plan of treatment, or for which a separate charge is not made. It must be included in the per visit cost. These supplies (e.g., cotton balls, alcohol prep) are items which are frequently furnished to patients or utilized individually in small quantities (even though these items in certain situations may be used in greater quantity). For proper cost report treatment of medical supply costs in HHAs, see PRM-2, §404.

2116. NON-VISITING COSTS OF HHAs

Non-visiting costs are not allowable costs under Medicare. Non-visiting costs are costs related to activities of the HHA other than home visiting or visits by the patients as an outpatient to a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school for covered home health services. (See §2114.) These costs include costs incurred for the operation of school visit programs, meals-on-wheels programs, well-baby clinics, etc.

2117. CONTRACTED SERVICES PURCHASED BY HHA

A. Applicable Contracts.--The contracts for services referred to in these instructions include administrative services such as purchased management services and patient care services such as purchased therapy services. They do not include contracts to purchase products such as medical supplies or rental space even if a coincidental service (e.g., maintenance and repairs) is provided under the contract.

B. Contracts Exceeding Five Years.--The total costs incurred by a HHA pursuant to a contract entered into after December 5, 1980 for any services furnished on or after April 1, 1982 for, or on behalf of, the agency are unallowable where the contract is entered into for a period exceeding 5 years. Included in this category are the following:

- Contracts with a stipulated term exceeding 5 years;

- Contracts with an initial term of 5 years or less, but which, in the absence of specific action by the parties to the contract, are automatically renewable for a period(s) which together with the initial term exceeds 5 years.

The following are not included in the category of contracts exceeding 5 years:

- Contracts with terms exceeding 5 years or potentially exceeding 5 years through automatic renewals and which are subject to termination at any time by either party.

- Contracts which could exceed 5 years only through renewals requiring a specific election by the HHA.

- Contracts of indefinite duration which, under applicable State law, are subject to termination.

- Contracts which provide for an unspecific change in the amount of consideration at an interval of 5 years or less, and which, under applicable State law, are construed as having a tenure not exceeding the point in time when the change occurs.

Penalty or other fees incurred by a HHA to terminate a contract with a stipulated term exceeding 5 years (as explained), which was entered into after December 5, 1980 for any services furnished on or after April 1, 1982 for, or on behalf of the agency, are unallowable.

Costs of a contract for services entered into after December 5, 1980 for services furnished prior to April 1, 1982 are reimbursable to the extent that the costs are otherwise allowable and reasonable in amount.

C. Contracts Where Payment is on a Percentage Basis.--The total costs incurred by a HHA pursuant to a contract entered into after December 5, 1980 for any services furnished on or after April 1, 1982 and prior to September 3, 1982 for, or on behalf of, the agency where the amount payable by the HHA under a contract is based on a percentage of the agency's reimbursement or claim for reimbursement are unallowable. Included in this category are contracts where payment or any portion of the payment by a HHA is based on a percentage of the agency's revenue or profit, a percentage of the agency's Medicare, Medicaid or other third-party reimbursement, a percentage of billed charges, or other similar arrangements. Costs of a contract for services entered into after December 5, 1980 for services furnished prior to April 1, 1982 and on or after September 3, 1982 are reimbursable to the extent that the costs are otherwise allowable and reasonable in amount.

D. Contracts Entered into On or Before December 5, 1980.--Costs which are incurred by a HHA pursuant to a contract for services entered into on or before December 5, 1980 may be reimbursed to the extent that the costs are otherwise allowable and reasonable in amount. However, a contract entered into on or before December 5, 1980 that is renewed subsequent to December 5, 1980 at the specific election of a HHA is subject to the provisions of §§2117 A, B and C.

E. Applicable HHAs.--These instructions apply to all free-standing HHAs. Provider-based HHAs are also subject to these instructions where the contract applies only to the HHA component of the health care complex. In this circumstance, the costs applicable to the HHA component must be appropriately identified and disallowed by reason of the above stated conditions.

2118. COST OF SERVICES FURNISHED UNDER ARRANGEMENTS

The term under arrangements refers to a manner of furnishing services by a provider in which payment to the provider for the services with respect to which the individual is entitled to have payment made by the program discharges the individual's liability to pay for the services. Providers may furnish services under arrangements with outside suppliers, including other providers. The amount charged by the supplying organization and paid by the provider for the services rendered then becomes a cost to the provider. This amount is includable in the provider's allowable cost for Medicare purposes to the extent that the costs of such purchased services are determined to be reasonable, subject to the provisions of Chapter 10, Cost to Related Organizations. The reasonableness of the amount is determined by the going rate charged to others for such services within the general community. The services are treated as though they were furnished directly to the provider.

2118.1 Payment to the Provider.--Where services are provided "under arrangements," the supplier bills, and is paid by, the provider for the services actually rendered. Under these circumstances, the Medicare program cannot directly reimburse the supplier of services. Payment for such services is made as a part of provider costs. Provider cost in this instance is limited to the net amount actually paid the supplier. If the provider imposes a charge for billing services or other administrative services on the supplier, such amount must be treated as a discount to the provider. It may not be treated as income by the provider.

A. Routine Services.--(See §§2202.6, 2202.7, and 2203.1.) The costs of items purchased under arrangements that are considered as a part of covered routine inpatient services are includable in the provider's overall allowable cost for routine services. The costs of routine services will then be apportioned over all patients in accordance with the apportionment method selected. The provider should not bill the program for these purchased services on an individual patient basis, even though the service is actually secured for a specific patient.

B. Ancillary Services.--(See §§2202.8 and 2203.2.) The supplier should bill the provider for the services purchased under arrangements which are actually rendered, itemizing such services by individual patient, the date of service, and, where appropriate, the related charge for each service and the quantity of service provided. This bill then provides the supporting documentation for the cost to be included in the provider's allowable cost. The detailed information is then used by the provider to bill the Medicare program for the services provided to each Medicare patient.

2118.2 Services Furnished Under Arrangements for Medicare Beneficiaries Only.--While charges for equivalent services of a supplier of services "under arrangements" must be uniform for Medicare and non-Medicare patients, billing practices of such a supplier need not be identical for both Medicare and non-Medicare patients. Where the arrangement under which services are furnished meets the requirements specified in guidelines published by HCFA, these services may be furnished for Medicare beneficiaries even if the supplier bills directly for non-Medicare beneficiaries.

Where a supplier furnishes services "under arrangements" only for Medicare beneficiaries and bills directly for non-Medicare beneficiaries, the costs of such services should not be commingled with other provider costs. Rather, the cost of such services should be included in total Medicare costs after cost finding and apportionment. (See Part II, §§240.1 and 340.1)

2119. COST OF DRUGS AND RELATED MEDICAL SUPPLIES

A. Reasonable Cost and Maximum Allowable Cost Limitation (MAC).--The cost of drugs and related medical supplies furnished by providers to Medicare beneficiaries are reimbursed by the program on a reasonable cost basis. To meet the test of reasonableness, the cost of the drug or related medical supply may not exceed the amount a prudent and cost-conscious buyer would pay for the same item.

A reasonable cost limitation will be set on certain multiple-source drugs that involve the expenditures of significant amounts of Federal funds and are purchased at significantly different prices. This maximum allowable cost limitation, called the "MAC" for a particular drug, will be based on the lowest unit price at which the drug is widely and consistently available to pharmacists from any formulator or labeler, and the most frequently purchased package size. Final MAC determinations will be published in the Federal Register. These MAC determinations are also published as an appendix to this chapter. This appendix includes the MAC limitation and its effective date, the generic name of the drug, and a listing of the most frequently purchased brand names of the drug.

For purchases made on or after the effective date of the final MAC determinations, the allowable cost for any multiple-source drug for which a MAC has been established may not exceed the lowest of:

(1) the actual cost,

(2) the amount which would be paid by a prudent and cost-conscious buyer for the drug if obtained from the lowest-priced

source that is widely and consistently available within a provider's service area, whether sold by generic or brand name, or

(3) the MAC.

B. Prescription Drugs

1. Drug Purchases.--Providers have their own pharmacy are expected to purchase drugs in bulk, where possible, from manufacturers or recognized wholesale outlets to gain economies from quantity purchasing.

Providers not having their own pharmacies generally purchase drugs under arrangements with local pharmacies rather than from manufacturers or wholesalers. Where the drugs are purchased under arrangements, the charges to the provider by the supplier become the provider's pharmacy costs. In such cases, these providers should pay no more than the going rate for prescription drugs and, in addition, should seek to minimize their pharmacy costs by obtaining discounts, either direct or indirect, from the supplier. It is not expected that a provider will utilize the services of a higher charge pharmacy for its normal prescription needs merely because the pharmacy provides 24-hour emergency services. Of course, the Medicare program will recognize the costs of services when a prescription is required at a time when the provider's normal source of prescription is not available, even though this pharmacy may have higher charges than and may not be the same as the one with which the regular prescription orders are placed.

2. Consultant Services.--A pharmacist's fee for consultant services should not be included in the price of the prescriptions. If the extent of the consultant services is such that the pharmacist believes it necessary to make a charge for these services, then it would be appropriate for the pharmacist to make a separate charge to the provider. The charge for the consultant services may be included in the provider's administrative costs, to the extent reasonable. The provider should document the extent of these services received so that any payment for them may be evaluated under the prudent buyer policy.

C. Exception to the MAC Limit.--The MAC limit for a particular drug will not apply where a physician certifies that in his medical judgment a specific brand name drug is medically necessary for a particular patient. The individual patient's name and the particular drug prescribed must be clearly identifiable. This certification must be in the physician's own handwriting. Merely checking a box on a form or stamping a prescription will not be considered an acceptable certification. Written certifications must be retained in the provider's records.

Example of physician certification statement:

“This brand is medically necessary--dispense as written.”

It is not necessary to forward the certification statement to the pharmacist. Written certifications may be made on patient charts with the pharmacist receiving some form of notification on the drug order that a properly executed physician certification is on file. This exception, however, does not waive the requirement that the cost of the drug may not exceed the amount a prudent and cost-conscious buyer would pay for the drug prescribed.

D. Charges to Beneficiaries.--If the amount determined to be allowable in accordance with paragraph A is less than the amount charged the provider by an outside supplier, the beneficiary cannot be charged for the excess. The provider's agreement with the Secretary prohibits charging the Medicare patient for covered items and services (Section 1866(a)(1)(A) of the Social Security Act).

E. Provider Record keeping Requirements.--In addition to maintaining the physician certifications described in paragraph C, the provider, as part of its financial record keeping responsibility under the program, must have on supplier invoices all needed cost verification information--i.e., name, brand, quantity, form and strength of the drugs supplied and the provider's actual cost. Otherwise, the intermediary, in accordance with section 1815 of the Social Security Act and section 405.453 of the regulations, will be required to deny charges for unlabeled drugs because of inadequate records. Any cost reductions received on drug purchases, such as discounts (cash, trade, purchase and quantity), rebates, etc., must also be clearly reflected on the individual invoices or related documentation.

F. Nonprescription Drugs and Medical Supplies.--Wherever feasible and to the extent permitted by State law, providers should also purchase their nonprescription drugs and medical supplies in bulk to get more reasonable prices and take advantage of quantity and other discounts. (See §2203.1 concerning routine drugs in SNF's.)

G. Survey Results to Determine Scope of Audit.--The results of intermediary surveys for evaluating the cost of drugs and other related medical supplies will be one of the factors considered in the scope of audit determinations.

H. Audit Adjustments.--

1. Drugs Purchases from Manufacturers or Recognized Wholesale Outlets.--If a MAC has been established for a drug that appears on an invoice reviewed by the intermediary, a comparison will be made between the cost incurred by the provider in purchasing the drug and the allowable cost based on the MAC limit. (See example.)

Adjustments to allowable costs will be made based on this comparison where the cost of one or more drugs exceeds the applicable MAC limitation. Make such adjustments even if the provider has purchased other drugs at costs below the

limitation. An adjustment will also be made where the cost of a drug is below the applicable MAC limitation yet exceeds the amount that would be paid by a prudent and cost-conscious buyer for the drug if obtained from the lowest-priced source that is widely and consistently available, whether sold by generic or brand name. If the provider has a substantial number of physician certifications (see paragraph C) on file to justify the purchase of drug products priced above the MAC limit and above the "lowest-priced source" limit, the audit adjustments described above may be waived. The allowable cost for the higher-priced products may not, however, exceed the amount that would be paid by a prudent and cost-conscious buyer for the same items.

Example:

Invoice shows the provider purchased from a recognized wholesale outlet a widely distributed brand-name version of drug X as follows:

Assume the MAC for drug X, 250 mg. capsules, is set at 2.2 cents/capsule. 100 bottles, 100 capsule size @$3.90 per bottle.

Total invoice price	$390
Deduct:	
Total maximum allowable cost (2.2 cents x 100 x 100)	-220
Excess =	$170

The $170 excess above the MAC amount will be deducted from the provider's total allowable drug costs.

2. Drugs Purchased under Arrangements with Local Pharmacies.--Drug surveys will be conducted by the intermediary based on a sample review of Medicare billings (forms HCFA-1453) and the supporting invoices. Where the total costs incurred by the provider for the sampled drugs (which may include drugs for which a MAC has been established) are substantially in excess of the "going price" for the drugs, as determined by the intermediary, and adjustment to reimbursable drug costs will be made initially. If subsequent drug surveys indicate a pattern of substantially out-of-line drug costs, adjustments to total allowable drug costs will be made based on the survey results. Initial adjustments are made to reimbursable cost, rather than total allowable cost, because in the absence of a pattern of substantially out-of-line drugs costs, it cannot be assumed that the results of a single drug survey adequately reflect the provider's overall purchasing practices with regard to prescriptions obtained from local pharmacies.

I. Appeals.--A provider may appeal the amount of program reimbursement made for drugs in accordance with the requirements and procedures described in §§2425ff. However, the provisions of §§2425ff do not apply to disputes concerning the inclusion of a specific drug on the published MAC list or the MAC limitation established for a specific drug. For disputes involving these issues, provisions of the Department's MAC regulations shall apply (45 CFR 19.6).

2120. REIMBURSEMENT FOR COSTS OF INTERNS AND RESIDENTS

For information on coverage of services performed by interns and residents, refer to the appropriate manuals listed below:

Hospital Manual - §§210.6, 237
Skilled Nursing Facility Manual - §212.7
Home Health Agency Manual - §206.4

A. Reimbursement under Part A.--The cost of services of interns and residents provided an inpatient of a hospital with an approved teaching program or a skilled nursing facility with a hospital approved program and a transfer agreement with the hospital are includable in allowable costs under Part A. (See §§404 and 404.1 for an explanation of approved programs.)

Where home health services are furnished by residents or interns under approved teaching programs of the hospital with which the home health agency is affiliated of under common control, the visiting costs incurred by the interns or residents of the hospital for visits to home health beneficiaries are included in the allowable costs of the home health agency.

B. Reimbursement Under Part B.--The following types of services performed by interns or residents are reimbursable under Part B on a reasonable cost basis:

1. Services rendered to inpatients of hospitals by interns and residents not in approved training programs,

2. Services performed for hospital outpatients,

3. Services which would otherwise be covered under Part A, but for which the patient is not eligible under Part A (e.g., inpatient hospital benefit eligibility is exhausted),

4. Services performed for SNF patients which are not covered under Part A, and

5. Services performed for home health patients which are not covered under Part a home health plan.

The cost of Part B residents' and interns' services to inpatients should be calculated on a per diem basis by the hospital in consultation with the intermediary. The total cost of such services (including fringe benefits, etc.) should be apportioned between inpatient and outpatient services on the basis of the time spent on each. The inpatient per diem figure is then obtained by dividing the total annual inpatient cost for these services by the estimated annual number of inpatient days for all patients.

For patients who are enrolled under Part B, as indicated by the Reply to the Notice of Admission, the provider will be reimbursed for 80 percent of the cost of providing these services. The provider should collect 20 percent of the per diem rate for the services of residents and interns covered under Part B times the number of inpatient days provided. As long as the patient is entitled to Part A benefits, no determination of the patient's deductible liability need be made for inpatient Part B interns' and residents' services.

Patients not enrolled under Part B will be liable for the entire cost of Part B interns' and residents' services. The provider must maintain a record of the inpatient days of these individuals so that this cost may be excluded from the amount of program obligation at the time of retroactive cost adjustment.

2122. TAXES

2122.1 General Rule.--The general rule is that taxes assessed against the provider, in accordance with the levying enactments of the several States and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax expense should not include fines and penalties. Taxes are allowable costs to the extent they are actually incurred and related to the care of beneficiaries.

Whenever exemptions to taxes are legally available, the provider is expected to take advantage of them. If the provider does not take advantage of available exemptions, the expenses incurred for such taxes are not recognized as allowable costs under the program.

2122.2 Taxes Not Allowable as Costs.--Certain taxes which are levied on providers are not allowable costs. These taxes include:

A. Federal income and excess profit taxes, including any interest or penalties paid thereon (see §1217).

B. State or local income and excess profit taxes (see §1217).

C. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

D. Taxes from which exemptions are available to the provider.

E. Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives.

F. Taxes on property which is not used in the rendition of covered services.

G. Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider.

H. Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc.

2122.3 Employment-Related Taxes--Provider-Based Physicians.--Employment-related taxes, i.e., FICA, Workers' Compensation and Unemployment Compensation, which are paid by a provider on behalf of a provider-based physician, are considered business expenses of the employer and not fringe benefits (§2108.3C1). Hence, they are includable in their entirety as part of the administrative cost of the provider, without allocation to the physician's professional component, and reimbursable to the provider on a reasonable cost basis.

2122.4 Franchise Taxes.--A franchise tax is a periodic assessment levied by a State or local taxing authority on the operation of a business within the borders of that governmental entity. The basis used to compute the amount of the franchise tax varies among taxing authorities. Where the amount of the franchise tax is based upon the net income of the provider,

with a minimum amount stated, the following criteria will be used to determine whether and in what amount a franchise tax is an allowable cost:

A. Where a provider has no net income but is required to pay a minimum franchise tax, the franchise tax is an allowable cost.

B. Where a provider realized net income which is not sufficient to incur a tax in excess of the minimum tax and the minimum tax is levied, then only the difference between the minimum franchise tax and the tax computed on net income is allowable cost. For example, if the minimum tax is $500 and the tax computed on the net income is $400, then the $400 is an income tax and only the excess ($500 - $400) or $100 is an allowable cost.

C. Where a provider has net income sufficient to incur a tax greater than the minimum franchise tax, the entire tax is considered and income tax and no part of the tax is an allowable cost. For example, if the minimum tax is $500 and the tax computed on income is $600, then the entire $600 is a nonallowable cost.

D. Where the amount of the franchise tax is based upon several criteria, one of which is net income, the amount of the franchise tax computed on net income is not an allowable cost. For example, if the minimum tax is $500, the tax computed on net income is $400, and the tax levy on capital stock is $600, then $400 remains an income tax and only the excess ($600 - $400) or $200 is an allowable cost.

2122.5 Unemployment Compensation Insurance Costs for Nonprofit Providers Under Public Law 91-373.--

A. General.--Under PL 91-373, most nonprofit providers and State hospitals are required to cover certain employees under their respective State unemployment compensation laws.

This Federal law also provides that each nonprofit provider must be permitted by State law the option of (1) paying regular State unemployment compensation taxes, or (2) reimbursing the State direct, on a dollar-for-dollar basis, for unemployment compensation benefits paid to former employees attributable to service with the provider--a form of self-insurance. Those providers which elect to pay benefits direct by self-insuring must also be allowed to participate in a joint program with other nonprofit organizations to establish a pool for reimbursing the State. See §2162ff for provisions governing pool arrangements for unemployment compensation and workers' compensation insurance coverage.

B. Payment of the State Tax.--Where a nonprofit provider elects to pay regular State unemployment compensation taxes, such payments are recognized as an allowable cost.

C. Self-Insurance Program.--Where a nonprofit provider chooses to self-assure by establishing its own reserve account, contributions to this reserve account are not allowable costs under the Medicare program. Where a nonprofit chain organization (or related organization) centrally operates an unemployment insurance reserve fund for some or all of its member (related) providers, the fund is considered a self-insurance program and payments made to it by the participating providers are not allowable costs under the Medicare program. This is because such a fund is simply an arrangement among related providers with the chain maintaining control over the fund. Thus, payments to the fund are not actually incurred costs, but rather a provision for establishing a central reserve from which unemployment costs are met as they are incurred. Moreover, any income earned from investment of the funds of the reserve account must be used to offset a provider's allowable interest expense under the Medicare program.

Certain costs associated with a self-insurance program are allowable, whether paid from the fund or directly by the provider. They are:

1. Any amounts paid to reimburse the State for unemployment compensation payments actually made by the State to the former employees of the provider.

2. Any premium costs for the purchase of commercial insurance which protects against catastrophic loss, provided the type, extent, and cost of coverage are not substantially out of line with those of other similar institutions in the same area.

3. The fees paid to an outside individual or firm (if any) to administer the program, to the extent such fees are considered reasonable for the services rendered. Such administration may consist of completing the claims forms from the State unemployment office, representing the provider at the appeals level, etc.

4. Any other reasonable administrative costs incurred by the provider in establishing and administering the program.

These costs are allowable for a chain organization program to the extent the costs are properly allocated among the providers which incurred them, e.g., unemployment compensation payments should be directly allocated to the provider whose unemployed employees were paid. (See §2162ff for other self-insurance provisions.)

2122.6 Self-Insurance Program for Unemployment Compensation and Workers' Compensation Insurance Using a Reserve for Funding.--Where a provider or a group of providers, whether proprietary or nonprofit and whether related or not, chooses to self-insure against unemployment compensation and/or workers' compensation risks by establishing its own reserve account, the provisions of preceding §2122.5C apply. See §2162.7, which explains the self-insurance requirements that must be met before payments made into a trust can be included in allowable costs.

2122.7 Review of Reasonable Costs, Including Taxes. -- In general, reasonable costs claimed by a provider, including taxes, must be actually incurred. While a tax may fall under a category that is generally accepted as an allowable Medicare cost, the provider may only treat the net tax expense as the reasonable cost actually incurred for Medicare payment purposes. The net tax expense is the tax paid by the provider, reduced by payments the provider received that are associated with the assessed tax. Contractors will continue to determine whether taxes and other expenses are allowable based on reasonable cost principles set forth in the Medicare statute and regulations.

2124. OXYGEN

Oxygen is classified as a medical supply under both Part A and Part B of the Medicare program, and providers are reimbursed for it on the basis of reasonable cost. When oxygen is furnished to a Medicare inpatient by a participating hospital or skilled nursing facility, or by another under arrangements with such a provider, the cost of oxygen is an allowable Part A cost. Oxygen furnished by a participating hospital is incident to physicians' services to outpatients is an allowable Part B cost. For cost finding purposes, oxygen is classified as a medical supply, part of the ancillary services furnished to inpatients under Part A.

The cost of oxygen furnished by a home health agency is covered under Part A or Part B as a home health service. Under the provisions for rental or purchase of durable medical equipment this cost is allowable only if oxygen is essential to the effective use of the durable medical equipment, it has been prescribed by the beneficiary's physician, and the equipment, it has been prescribed by the beneficiary's physician, and the equipment has been determined to be medically necessary for the treatment of the patient's condition.

Oxygen is covered under Part B when administered in connection with ambulance services. When the ambulance services are furnished by a provider, payment is made on a reasonable cost basis for the costs of the oxygen in addition to the cost of the ambulance service.

2125. BLOOD

Blood Replacement Practices.--Implicit in the determination of the reasonable cost of blood is that providers must afford Medicare patients the same opportunity as non-Medicare patients for reducing or eliminating blood fees. In situations where the provider deals with an independent blood supplier, the provider must assure itself that the blood supplier does not similarly discriminate by affording non-Medicare patients greater opportunities to reduce or eliminate their blood fees than is possible for Medicare beneficiaries. Thus, for example, providers (or their blood suppliers) must not limit the number of replacement credits accepted for Medicare patients to an amount equal to the Medicare blood deductible requirement while imposing no limitation on the number of replacement credits accepted for non-Medicare patients. This nondiscrimination rule also applies in situations where the provider (or its blood supplier) allows blood replacement credits to reduce or eliminate blood derivative fees and blood processing fees.

There is an exception to this general rule, however. In situations where allowing full blood replacement opportunity would diminish a beneficiary's blood reserve available for meeting future blood deductible requirements, full replacement (i.e., replacement beyond the Medicare blood deductible requirement) is not required. This occurs

most often with beneficiaries who are members of blood plans that limit the number of replacement credits available to the number of units deposited by (or on behalf of) the member. Because providers typically deal with only one or two blood suppliers on a regular basis, providers are expected to be familiar with the replacement credit policies (i.e., limited vs. unlimited) of the suppliers with which they deal.

A refusal by providers (or their blood suppliers) to accept replacement blood from Medicare patient not only increases the overall cost of blood to providers (because replacement blood must be obtained elsewhere) but also disproportionately increases Medicare's share of the cost of blood. Similarly, failure of a provider to accept medically sound replacement blood on behalf of Medicare patients to reduce blood processing costs or blood derivative costs to the Medicare program is neither a consistent nor a cost-conscious practice. Therefore, if these discriminatory replacement practices exist, the consequent excess provider costs for blood, blood derivatives, or blood processing must be disallowed in the determination of Medicare reimbursement. The costs that are considered excess are those costs that could have been reduced or eliminated had the provider sought and accepted all available replacement credits. In addition to the cost adjustment, the provider must make corresponding reductions in the charges billed for replacement blood which was rejected by the provider or its blood bank.

B. Adjustments to Provider Charges for Blood Replaced and Blood Not Used.-Often, a provider's blood supplier will not notify the provider of a patient's total blood replacement credits until after the provider bills that patient's charges. This occurs, for example, when the patient arranges for a donor(s) to replace blood at some time after the provider has already billed the charges for blood unreplaced at the time of billing. In situations such as this, the provider must adjust its charges to reflect credits for the blood replacement. Providers should follow current manual instructions (Hospital Manual (HIM-10), $460 and Skilled Nursing Facility Manual (HIM 12), §417) in submitting corrected bills to the Medicare program.

Another situation requiring blood credits occurs when a provider bills a patient's account for blood prepared for transfusion but, for whatever medical reason, all or part of the blood is not transfused. This occurs, for example, when a surgeon anticipates the need for five units of blood, which are prepared for transfusion, and the patient's account is charged for the blood. The patient's medical condition requires that only three units be transfused and the unused blood is returned to storage. In situations such as this, the patient's account must be credited for the amount of unused blood, because the blood was not furnished to the patient. However, any necessary crossmatch or preparation fees may be charged to the patient's account even though the blood was not used. Blood which cannot be returned to storage due to the addition of medication or thawing in preparation for transfusion should not be charged to the patient's account. Rather, the cost of such blood should be transferred to a blood processing, storing, and administration account to be shared proportionately by all patients.

Moreover, if the provider's blood supplier gives a larger credit for blood replaced by nonbeneficiaries than it gives for blood replaced by beneficiaries, the larger credit will be applied to reduce provider charges and costs for all patients. Of course, provider charges for blood must be uniformly applied to beneficiaries and nonbeneficiaries.

C. Application of the Prudent Buyer Principle to Blood Procurement and Replacement Policies.--Blood is unique among provider furnished items, because unlike other items, it can be replaced by patients or by persons acting on the patients' behalf. The development of organizations supplying blood to providers has been such that the charging practices of these organizations vary not only nationwide, but also within limited geographical areas. For example, within a local geographical area, one blood supplier may charge a provider both a processing fee and a charge for the flood, while another supplier may charge only a processing fee. These circumstances require careful application of the prudent buyer principle.

In applying the prudent buyer principle under these circumstances, the provider must look to the net charge for the blood. For example, assume the following facts. A provider has a choice between obtaining blood from Supplier A for a processing fee only of $30 per unit, or obtaining blood from Supplier B for a processing fee of $10 and a charge for the blood itself of $25, a combined charge of $35 per unit. Supplier A allows no credit for blood replaced; whereas, Supplier B allows a credit of $25 for blood replaced on a unit-for-unit basis. The provider anticipates a usage of 2100 units of blood for the upcoming contract period. Experience of local blood suppliers has shown an average of one-third to be the prevailing replacement rate in the locality (i.e., on the average, one out of every three units used is replaced). Putting all these facts together, the provider's anticipated blood costs for the upcoming contract period would be $63,000 (2100 x $30) if obtained from Supplier A. However, the provider's anticipated blood costs would be $56,000 (2100 x $10) plus (1400 x $25)1 if obtained from Supplier B. The provider, in seeking to minimize its costs under the prudent buyer principle, would obtain the blood from Supplier B.

Moreover, if a provider enters into an arrangement with a blood supplier which precludes obtaining blood from other sources at a lower charge, the provider could be found to be acting in violation of the prudent buyer principle within the meaning of §2103, Prudent Buyer. However, such a contractual arrangement would not necessarily violate the prudent buyer principle if the provider can demonstrate to the satisfaction of the intermediary that the arrangement is absolutely compelling to assure an adequate, reliable source of blood supply.

Although the cost of whole blood is used in the above example, it would be appropriate for a provider to consider the totality of its blood product needs in evaluating a purchase decision for prudence. In addition, it is appropriate for a provider to consider nonfiscal (service) components, such as physician consultation or 24-hour service, in evaluating the costs of blood from alternative sources. Of course, for an occasional purchase, allowable blood cost may be higher than normally incurred to meet an immediate medical need.

2126. UTILIZATION REVIEW

Utilization review is a provider function and reimbursement for utilization review can be made only as a part of the provider's reasonable costs. No payment for utilization review can be made by the program directly to physicians or to utilization review committees. (Section 2126.3). Costs incurred by the provider in connection with utilization review are includable in reasonable costs as set forth in the following sections.

2126.1 Utilization Review in Hospitals.--

A. Physicians' Services.--Where utilization review covers the entire patient population of a hospital, payments made to physicians for their services on utilization review committees are allowable as costs. Allowable costs are limited to payment of a reasonable compensation to the physician. Such costs are then apportioned among all of the users of the hospital as part of administrative costs. However, where utilization review covers only Medicare beneficiaries, payments made to physicians for their services on utilization review committees are not allowable as costs.

B. Costs Other Than for Physicians' Services.--All reasonable costs of utilization review other than for physicians' services are allowable costs and are apportioned among all of the users of the facility. Included in these costs are costs related to the services of professional personnel other than physicians, report writing, etc. Utilization review costs other than for physicians' services are allowable whether or not the utilization review covers the entire patient population.

2126.2 Utilization Review in Skilled Nursing Facilities.--

A. Physicians' Services.--Payments made to physicians for their services on utilization review committees are allowable as costs, whether or not the utilization review covers the entire patient population of the skilled nursing facility. Allowable costs are limited to the payment of a reasonable compensation to the physician.

Where utilization review covers only Medicare beneficiaries, compensation to physicians for their utilization review services is reimbursable 100 percent by the Medicare program.

If the scope of a SNF utilization review committee's activity does not include all patients but does extend to services furnished to patients under other health care programs--such as Medicaid--the SNF's (or committee's) records of activities and compensation paid to the physician members of such a committee should be sufficient to serve as the basis for a proper apportionment of these costs between programs. Where, in the judgment of the intermediary, these costs are apportioned correctly, Medicare should reimburse 100 percent of the portion allocated to the Medicare program. However, where the utilization review committee activities apply to more than Medicare covered services but a valid allocation between Medicare and the other programs is not supported by documentation, all utilization review costs should be apportioned among all users of the skilled nursing facility.

B. Costs Other Than for Physicians' Services.--Administrative costs related to utilization review and costs of professional personnel other than physicians are allowable costs allocated as a part of the administrative costs of the facility. Generally, these costs are apportioned among all the users of the SNF, whether or not utilization review covers the entire patient population.

However, if the SNF is a distinct part of a larger facility (as defined in HCFA Pub. 12, §201.1) and the utilization review is performed only for patients in the distinct part, the costs may be totally charged to the distinct part if they are specifically identifiable (in accordance with §§2126.4 ff) to the distinct part. The costs would then be apportioned among the users of the distinct part SNF.

2126.3 Community-Based Utilization Review Committee.--Community-based utilization review committees are those which operate external to the SNF. They are formed primarily by local medical societies or by the intermediary and furnish utilization review services to more than one SNF.

Where this is the case, the organization furnishing the services must bill the SNF for the services. The SNF pays the committee and includes the payment to the committee in its allowable costs under the program. The billing from the committee must be separated into two parts for services furnished. One part should indicate the payment made to physicians for their services on the utilization review committee; this part would be treated in accordance with §2126.2A. The second part should cover all other services and would be treated in accordance with §2126.2B.

2126.4 Utilization Review Cost; Provider Payment to Physicians for Rendering Utilization Review Services.--Experience has indicated that many physicians rendering utilization review services do not charge providers for such services. These physicians

view this activity as a community service, as part of a professional education responsibility, or as a responsibility flowing from staff membership. However, where a charge is made by a physician, providers utilize a variety of methods for compensating for these services. A substantial plurality of providers use an hourly scale as the basis for such payment. Because of the statutory mandate to pay reasonable cost (§1814(b) of the Act) it is necessary to have sufficient information to determine the reasonable cost of utilization review in all cases where reimbursement is sought from Medicare.

A. Utilization Review Records Necessary to Establish Allowable Cost of Compensation.--Section 1815 of the Act states that a provider must maintain adequate records for reasonable cost determination purposes. Consequently, for utilization review compensation received by physicians or other persons to be recognized as an allowable cost, a provider must keep adequate records to determine the reasonableness of its payments for services identified as being exclusively related to utilization review activities. Only the actual time spent in rendering utilization review services should be recorded. Time spent in travel to and from the point of review should be excluded from the time calculation for reimbursement. The record-keeping requirement may be met in either of the following ways:

1. Hourly Rate.--Where payment to a physician or other person by a provider for utilization review services is based on an hourly rate, the provider should regularly record the name, hourly rate, and number of hours of services rendered by the individual; or

2. Other Payment Base.--Where payment to a physician or other person by a provider is based on some measure other than an hourly rate, the provider should prepare a schedule of payments for each cost period for which reimbursement is claimed showing: the name, number of hours of utilization review services rendered, and total payments made to each individual in the cost period. The total payment should then be converted into an hourly rate for each individual. The supporting data for this schedule should be available for verification by the intermediary.

B. Records of Provider Using Community-Utilization Review Group.--Where a community-based group functions as the utilization review committee for more than one institution, each provider must have in its records: (1) a description of the services furnished on its behalf, (2) an explanation of the rationale for apportioning any costs among the various institutions using the same community-based utilization review group, and (3) for each cost period for which such costs are claimed by a provider, the total hours and cost for each significant category of service (e.g., physician service, secretarial service, etc.), rendered to the provider by the utilization review committee so the intermediary may determine whether the share of the community-based group's costs apportioned to the provider is reasonable.

C. Retainer Fees.--Payments by a provider to a physician or other person to be available for participation on a utilization review committee, such as retainer fees, are not allowable costs.

D. Administrative Costs.--In hospitals and SNFs, the reasonable costs of administrative services necessary for utilization review are allowable costs. These costs are apportioned among all users of the institution (they are classified as administrative and general expenses on the cost report) without regard to whether the plan applies only to Medicare beneficiaries. Examples of such allowable costs are:

1. Expenses incurred for the purchase of data from organizations that compile statistics and make profiles and studies of utilization of health care facilities and services.

2. Expenses incurred for clerical and other administrative services including the services of nonphysician personnel.

3. Expenses incurred in traveling outside the individual's normal commuting area or in traveling from institution to institution because of necessary and proper activities related to utilization review, such as transportation expenses incurred by a physician in traveling to a provider outside his local area to participate in utilization review activities.

E. Administrative Costs Related to Community-Based Utilization Review Committee.--Payments for services obtained from a community-based utilization review group for administrative duties pertinent to utilization review in such facilities (such as scheduling meetings, providing coordination between the committee and providers, supervising maintenance of records, as well as clerical, record keeping and associated activities described in D above) are allowable costs. The measure of the reasonableness of such costs is the remuneration that would be paid an employee performing comparable services in the area.

F. Studies.--Costs incurred by a provider in the purchase of data and statistics concerning health care utilization that are necessary for the purpose of comparing them with other data related to patients for whom the utilization committee is responsible are allowable costs.

The reimbursement mechanism under title XVIII of the Social Security Act, however, is not meant to support studies in health care utilization beyond the requirements of §1861(k) of the Act or the conditions of participation as set forth in §405.1035 and §405.1137 of Regulations No. 5 of the Social Security Administration. Thus, costs related to evaluation by the committee of care furnished patients under the purview of the committee are allowable costs. (Examples of such care are length of stay, patterns of stay, patterns of care by diagnostic categories, and medical services or practices, such as drug prescribing.) However, if a provider agrees to participate in studies extending beyond the care furnished patients under the committee's purview, any costs incurred are not allowable.

2127. HOME HEALTH AGENCY ADVISORY GROUP OF PROFESSIONAL PERSONNEL

A. General.--A home health agency participating in the Medicare program is required to have a group of professional personnel to serve in an advisory capacity to the agency or organization. The function of this advisory group is to approve and review, on a regular basis, the agency's policies governing skilled nursing and other health care services.

Generally, the costs incurred by the home health agency in connection with advisory group services are includeable in allowable costs and must be apportioned among all the users of the facility in determining program reimbursement. Payments to physicians for their direct medical services to individual patients are not allowable home health agency costs. No payment for advisory group services may be made by an intermediary directly to any physician or other member of the advisory group.

B. Costs for Services of Professional Personnel.--Where compensation is paid to a member of the advisory group, including nonemployee professional personnel, the reasonable compensation is includable in the allowable costs of the home health agency.

However, where a member of the advisory group is also an owner of the agency, any separate compensation paid for participation in the advisory group meetings should be considered in evaluating the reasonableness of his total compensation. For a determination to be made on the reasonableness of the compensation paid to a physician or other professional person, the home health agency must maintain adequate records. These records must contain the following minimum information for each meeting of the advisory group: the date of the meeting, the name and occupation of each participant to whom compensation is paid, the hourly rate or other payment base for each of these individuals, and the number of hours of services rendered by each participant.

C. Administrative Costs.--The reasonable cost of administrative services incurred in connection with the activities of the advisory group are also allowable costs. Examples of such allowable costs are expenses for supportive clerical and other administrative services, and expenses for purchase of necessary data and statistics on health care facilities and services.

2128. ORIENTATION AND ON-THE-JOB TRAINING

The costs of orientation and on-the-job training are recognized as normal operating costs and are allowable. Ordinarily, such training would be imparted within the provider setting. If, however, the training requires outside instructions, costs of such training are allowable.

2130. LIFE INSURANCE PREMIUMS

In general, premiums related to insurance on the lives of owner(s), officer(s), key employee(s) and provider-based physician(s) where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured individual, the insurance proceeds are payable directly to the provider. A provider is an indirect beneficiary when another party receives the proceeds of a policy through an assignment by the provider to the party or other legal mechanism but the provider benefits from the payment of the proceeds to the third party.

An exception to these requirements is permitted where (1) a provider as a requirement of a lending institution must purchase insurance on the life of an owner(s), officer(s), key employee(s) or provider-based physician(s) to guarantee the outstanding loan balance (2) the lending institution must be designated as the beneficiary of the insurance policy, and (3) upon the death of the insured, the proceeds will be used to pay off the balance of the loan. The insurance premiums allowable are limited to premiums equivalent to that of a decreasing term life insurance policy needed to pay off the outstanding loan balance. In addition, the loan must be related to patient care and meet the necessary and proper requirements of section 200ff, Interest Expense. Where other than decreasing term policies are purchased (e.g., whole life, or convertible term), only that portion of the premium which can be equated to the premium for a similar face amount of a decreasing term life policy may be included in allowable costs.

The life insurance premiums allowable are reimbursable for cost reporting periods beginning on or after April 15, 1983.

Premiums related to insurance on the lives of owner(s), key employee(s) and provider-based physician(s) where the individual relative(s) or his/her estate is the beneficiary are considered to be compensation to the individual and are allowable costs to the extent such total compensation is reasonable.

2132. START-UP COSTS

2132.1 General.--In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they must be capitalized as deferred charges and amortized over a number of benefiting periods.

Start-up costs include, for example, administrative and nursing salaries; heat, gas, and electricity; taxes; insurance; mortgage and other interest; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as organization costs or capitalizable as construction costs must be appropriately classified as such and excluded from start-up costs.

Amortized start-up costs may be charged only to the "Administrative and General" cost center unless these costs can be specifically identified with a cost center or component of a provider, in which case the amortized costs must be directly assigned to the applicable cost center or component.

Unless otherwise specified herein, the provisions of this section are effective for providers after June 30, 1976.

2132.2 Applicability--Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient, whether Medicare or non-Medicare, is admitted for treatment, or, where the start-up costs apply only to nonrevenue-producing patient care functions or non-allowable functions, to the time the areas are used for their intended purposes. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility should be accumulated in a single deferred charge account and should be amortized when the first patient is admitted for treatment. However, if a provider intends to prepare portions of its facility on a piecemeal basis (i.e., preparation of a floor or wing of a provider's facility is delayed), start-up costs should be capitalized and amortized separately for the portion(s) of the provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the intermediary need not be capitalized, but rather, may be charged to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the intermediary, these costs need not be capitalized, but may be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first patient is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction (see §118). Where portions of the provider's facility are prepared for patient care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a patient care area, depreciation should start with the month the first patient is admitted for treatment. If the portion of the facility is a nonrevenue-producing patient care area or nonallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major movable equipment, however, should be depreciated over the useful life of each item starting with the month the item is placed into operation, subject to §118.

2132.3 Cost Treatment for Medicare Reimbursement.--

A. Operations Begin Upon Entrance into the Program (Providers Entering Program After June 30, 1976).--

1. Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratably over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment.

2. Where a provider prepares portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time.

EXAMPLE:

Facts: On July 1, 1976, the provider entered the program with a new three-floor facility. The first two floors of the facility were prepared and available for patient care services at the time the provider entered the program; however, preparation of the third floor for patient care services was deferred until July 1, 1977. The first patient was admitted to the first two floors on July 5, 1976, while the first patient was admitted to the third floor on October 15, 1977. Start-up costs of $60,000 were capitalized for the first two floors from the time preparation began on these floors for the rendition of patient care services to July 5, 1976. Start-up costs of $25,000 were also capitalized for the third floor from July 1, 1977 to October 15, 1977.

With the above facts, the provider would accumulate the start-up costs of $60,000 attributable to the first two floors separately from the start-up costs of $25,000 attributable to the third floor. The start-up costs of $60,000 would be amortized at the rate of $1,000 per month beginning in July 1976 and ending 1981. The start-up costs of $25,000 attributable to the third floor would be amortized at the rate of $417 per month from October 1977 to September 1982.

B. Operations Begin Prior to Entrance into the Program (Providers Entering Program After June 30, 1976).--Where a provider enters the program more than 60 months after its first patient is admitted for treatment, start-up costs unamortized at the time the provider enters the program will not be allowable. However, where a provider enters the program within 60 months after its first patient is admitted for treatment and has capitalized start-up costs, the portion of start-up costs unamortized at the time the provider enters the program may be included in allowable costs using a 60-month amortization period starting with the month the provider admitted its first patient for treatment. In these situations, if a provider chooses to include amortized start-up costs in its allowable costs, the costs must be recomputed as follows:

EXAMPLE 1:

Facts: A provider enters the program on July 1, 1976, 30 months after it admitted its first patient; start-up costs were capitalized in the amount of $30,000; and amortization is based on a 120-month period.

	Per Books	Medicare
Original amount of start-up costs to be amortized	$30,000	$30,000
Amount amortized as of July 1, 1976 ($\frac{30}{120}$ x $30,000)	$ 7,500	
Unamortized start-up costs as of July 1, 1976	$22,500	
Amount which would have been amortized over 60 months ($\frac{30}{60}$ x 30,000)		$15,000
Amount to be amortized under the program over a 30-month period		$15,000

EXAMPLE 2:

Facts: A provider enters the program on July 1, 1976, 24 months after it admitted its first patient; start-up costs were capitalized in the amount of $36,000; and amortization is based on a 36-month period.

Original amount of start-up costs to be amortized	$36,000	$36,000
Amount amortized as of July 1, 1976 ($\frac{24}{36}$ x 36,000)	$24,000	
Unamortized start-up costs as of July 1, 1976	$12,000	
Amount which would have been amortized over 60 months ($\frac{24}{60}$ x 36,000)		$14,400
Amount to be amortized under the program over a 36-month period		$21,600

If a provider enters the program within 60 months after admitting its first patient for treatment, start-up costs may be capitalized retroactively (reduced for any periods already elapsed from the time the first patient was admitted for treatment) where the provider did not initially capitalize start-up costs (or has written off such costs in the period(s) incurred) before entering the program and the provider can establish these costs to the satisfaction of the intermediary.

C. Providers Entering Program Before July 1, 1976.--Where a provider enters the program before July l, 1976, and capitalizes start-up costs incurred before July 1, 1976, the provider may continue to amortize the start-up costs ratably over a period of up to 60 consecutive months, but not less than 36 consecutive months, beginning with the month the first patient is admitted for treatment or, in the case of a nonrevenue-producing patient care area or nonallowable area, beginning with the month the area is opened for its intended purpose. Where a provider enters the program before July 1, 1976, and incurs start-up costs after June 30, 1976, start-up costs must be treated in the manner described in §2132.3A. Start-up costs that are considered to be immaterial by the intermediary may be included in allowable costs in the cost reporting period(s) incurred.

2132.4 Sale of Institution.--Where a provider institution is sold before the expiration of the amortization period, the portion of start-up costs amortizable through the month of sale is includable in allowable costs. If the unamortized balance of start-up costs at the time of sale represents a value reflected in the selling price to the purchaser and contained in the sales agreement, this value will be limited to the lesser of the sales price attributed to the start-up costs or the unamortized balance of start-up costs on the books of the seller. If the purchaser becomes a provider, the unamortized start-up costs subject to the above limitation (reduced for any period in which the purchaser operates the facility before becoming a provider, unless this period is represented by a delay in certification caused by the program) transferred in the sale may be amortized and included in allowable costs over the remaining portion of the period established for amortization by the seller-provider. If the unamortized balance of the start-up costs at the time of sale is not identified in the sales price (the sales agreement does not allocate a portion of the sales price to this unamortized balance), the seller-provider may include the unamortized costs in its allowable costs for the last cost report submitted to the program.

2132.5 Withdrawal from Program.--Where a provider withdraws from the program, start-up costs amortizable through the month of withdrawal are includable in allowable costs. Unamortized start-up costs adjusted through the month of withdrawal are applicable to services provided after the month of withdrawal and, therefore, are not includable in allowable costs. However, where the provider ceases to provide health care services on withdrawal from the program, the unamortized costs at termination may be included in the provider's allowable costs for the last cost report submitted to the program.

2132.6 Effect on Equity Capital.--Unamortized start-up costs allowable for program purposes are includable in the equity capital of a provider.

2134. ORGANIZATION AND OTHER CORPORATE COSTS

2134.1 Organization Costs--General.--Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the cost of future periods of operation.

A. Allowable Organization Costs.--Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to States for incorporation.

B. Unallowable Organization Costs.--The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate State or Federal Authorities, stamp taxes, etc.

Unless specified otherwise herein, the provisions of this section are effective for providers after June 30, 1976.

2134.2 Cost Treatment of Organization Costs under Medicare--.

A. Providers Entering Program After June 30, 1976.--Allowable organization costs should generally be capitalized by the organization. However, if in the opinion of the intermediary, these costs are not material when compared to total allowable costs, they may be included in allowable costs for the initial cost reporting period. Otherwise, allowable organization costs are amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

If the provider enters the program after 60 months, starting with the month the first patient is admitted for treatment, no organization costs are recognized. Organization costs can be capitalized retroactively (reduced for any periods already elapsed from the time the first patient was admitted for treatment) where a provider (1) did not initially capitalize organization costs (or has written off such costs in the period(s) incurred) before entering the program; (2) can establish these costs to the satisfaction of the intermediary; and (3) enters the program within 60 months after the first patient was admitted for treatment.

B. Providers Entering Program Before July l, 1976.--Where a provider enters the program before July l, 1976, and capitalizes organization costs, the provider may continue to amortize the organization costs ratably over a period of 60 consecutive months beginning with the date of organization. However, if the organization costs were considered to be immaterial by the intermediary, the costs may be included in the provider's allowable costs in the cost reporting period(s) incurred.

2134.3 Amortization Period of 60 Months.--Where a provider is newly organized upon entering the program and has capitalized organization costs, these costs must be amortized ratably over a 60-month period starting with the month the first patient is admitted for treatment. Where a provider admitted its first patient for treatment within a 60-month period prior to entry into the program and has capitalized organization costs using a 60-month amortization period, no change in the rate of amortization is permitted. In this instance, the unamortized portion of organization costs is allowable under the program and is amortized over the remaining part of the 60-month period.

2134.4 Amortization Period Less Than 60 Months.--Where a provider has entered the program within 60 months after the first patient is admitted for treatment, has capitalized organization costs, but has used an amortization period of less than 60 months, an adjustment will be necessary if the provider chooses to include amortized organization costs in its allowable costs. The unamortized amount of organization costs must be recomputed using a 60-month period starting with the month the first patient is admitted for treatment. The recomputed unamortized portion of organization costs as of the month the provider enters the program is recognized as an asset under the program and may be amortized over the remaining months of the 60-month period.

EXAMPLE: A provider enters the program 24 months after the first patient is admitted for treatment; organization costs were capitalized in the amount of $12,000; amortization is based on a 36-month period.

	Per Books	Medicare
Organization costs to be amortized	$12,000	$12,000
Amount amortized to date ($\frac{24}{36}$ x $12,000)	8,000	
Book balance unamortized as of date of entry into program	4,000	

	Per Books	Medicare
Amount which would have been amortized on a 60-month basis		
($\frac{24}{60}$ x $12,000)		4,800
Total amount to be amortized under the program		$ 7,200

2134.5 Amortization Period Greater Than 60 Months.--Where a provider has entered the program within 60 months after the month the first patient is admitted for treatment, has capitalized organization costs, but used an amortization period longer than 60 months, an adjustment will be necessary if the provider chooses to include amortized organization costs in its allowable costs. The unamortized amount of organization costs must be recomputed as of the date of entry into the program using a 60-month period starting with the month the first patient was admitted for treatment. The unamortized amount so computed will be recognized for program purposes and may be amortized over the remaining part of the 60-month period.

EXAMPLE: A provider enters the program 36 months after the first patient is admitted for treatment; organization costs were capitalized in the amount of $10,000; amortization is based on a 120-month period.

	Per Books	Medicare
Organization costs to be amortized	$10,000	$10,000
Amount amortized to date		
($\frac{36}{120}$ x $10,000)	3,000	
Book balance unamortized as of date of entry into program	$ 7,000	
Amount which would have been amortized on a 60-month basis		
($\frac{36}{60}$ x $10,000)		6,000
Total amount to be amortized under the program		$ 4,000

2134.6 Sale of Institution.--Where a provider institution is sold before the expiration of the amortization period, the portion of organization costs amortizable through the month of sale is includable in allowable costs. If the unamortized balance of organization costs at the time of sale represents a value reflected in the selling price to the purchaser and contained in the sales agreement, this value will be limited to the lesser of the sales price attributed to the organization costs or the unamortized balance of organization costs on the books of the seller. If the purchaser becomes a provider, the unamortized organization costs subject to the above limitation (reduced for any period in which the purchaser operates the facility before becoming a provider, unless this period is represented by a delay in certification caused by the program) transferred in the sale may be amortized and included in allowable costs over the remaining portion of the 60-month period established for amortization by the seller-provider. If the unamortized balance of organization costs at the time of sale is not identified in the sales price (the sales agreement does not allocate a portion of the sales price to the unamortized balance), the seller-provider may include the unamortized costs in its allowable costs for the last cost report submitted to the program.

2134.7 Withdrawal from Program.--Where a provider withdraws from the program, the portion of organization costs amortizable through the month of withdrawal is includable in allowable costs. The unamortized balance of organization costs is not allowable under the Medicare program but is considered applicable to services provided after the month of withdrawal. However, where the provider ceases to provide health care services on withdrawal from the program, the unamortized costs at termination may be included in the provider's allowable costs for the last cost report submitted to the program.

2134.8 Effect on Equity Capital.--The unamortized portion of organization costs determined to be allowable for program purposes is includable in the equity capital of the provider. Those expenditures not considered allowable organization costs as described in §2134.1B are excluded from the computation of the return on equity capital.

2134.9 Stockholder Servicing Costs.--The following types of costs relevant to proprietary and equity interests of the stockholders, but not related to patient care, are excluded from allowable costs: costs incurred primarily for the benefit of stockholders or other investors, including, but not limited to, the costs of stockholders' annual reports and newsletters, annual meetings, mailing of proxies, stock transfer agent fees, stock exchange registration fees, stockbroker and investment analysis, and accounting and legal fees for consolidating statements for SEC purposes.

2134.10 Reorganization Costs.--Within the scope of this section, reorganization costs are the types of costs addressed in §2134.1A (impacting on, but not limited to ownership/equity, tax status, financial structure, debt, assets, or asset valuation) with regard to recreating, reestablishing, or otherwise rearranging an entity.

Reorganization costs are unallowable because they duplicate an entity's original organization costs. Therefore, any costs of studies, surveys, etc., associated with or leading to a reorganization are also unallowable. It is not the intent of the Medicare program to reimburse an entity, i.e., a provider or provider component, more than once for its organization costs.

Costs not within the scope of this section include:

1. Costs associated with improving the efficiency of an entity by rearranging or reconfiguring the management hierarchy (sometimes referred to as reengineering), but having no impact on ownership/equity, tax status, financial structure, debt, assets, or asset valuation. These types of costs are allowable. (See §§506 and 2102.2.) Therefore, to the extent that the provider can identify costs of activities aimed at improving and making provider administration and operation more efficient (see §506), i.e., costs outside the scope of this section, those costs are allowable.

2. Costs related to or associated with the initial organization of an entity, as covered in §2134.1A.

2134.11 Transfer of Assets to a Corporation.--Costs connected with the transfer of assets to a corporation must be capitalized as part of the cost of the asset. (See §104.10.) The acquisition of capital stock of a provider does not constitute a transfer of assets to a corporation and, therefore, costs associated with such a transaction are not allowable.

2135. PURCHASED MANAGEMENT AND ADMINISTRATIVE SUPPORT SERVICES

2135.1 General.--Providers often purchase from other organizations various services which are necessary for proper management and administrative operations. These services, depending on the individual needs of the provider, may be used in lieu of, or support of, in-house staff in performing their duties. Services may be purchased in a package from a single contractor or separately from different contractors. One method of purchasing the services is through a full-service management contract in which the management contractor provides a complete package of services, has overall day-to-day management responsibility for the operation of the provider, and is accountable only to the governing board (or delegated representative) of the provider. Another method is through a limited service management or administrative service contract in which a contractor provides certain specific services to a provider and is responsible for only those specific services.

While these guidelines are primarily directed toward determining the reasonableness of the cost of full-service contracts, they are applicable to any contracted service. Their application must be tempered by the circumstances and by the type of service purchased. For example, intermediaries should not expect providers to routinely obtain competitive bids or maintain the level of documentation contemplated in these instructions for all limited service contracts, particularly those that are nominal in amount.

These guidelines are not intended to dissuade providers from seeking or utilizing alternatives to in-house services. Rather, providers should always consider the most appropriate means for obtaining services needed for the ongoing rendition of patient care. This requires an initial determination of whether the services the provider needs can be obtained more effectively using in-house staff or through outside contractors. After evaluating all factors, a provider should choose the most prudent manner of performing the services. If the determination is made to purchase management and administrative support services, the following sections provide guidelines for evaluating the reasonableness of the costs incurred in purchasing these services. Other sections of the manual provide general and specific guidance in evaluating the reasonableness of the cost of services performed in-house.

2135.2 Evaluation of the Need for Purchased Management and Administrative Support Services.--In claiming reimbursement for purchased management and administrative support services, a provider must demonstrate its operational need and the cost effectiveness of its expenditures vis-a-vis available alternatives for obtaining the necessary services. Factors to be considered include the types and ranges of purchased services being offered; the need for improved quality of services; the qualifications, experience and reputation for efficiency of available contractors; and the cost of comparable services among contractors. Generally, a provider is prudent to solicit competitive bids. Therefore, in the absence of competitive bidding which would otherwise be appropriate in the circumstances, the provider must be able to demonstrate the manner in which it searched the marketplace for the most appropriate and effective means of obtaining the services. (For general guidance in evaluating comparable costs generated by in-house operations see §§2102 and 2103 or the manual section pertaining to the cost in question, e.g., §2144 for fringe benefits or Chapter 9 for evaluating compensation of owners.)

A. Terms of a Contract.--A provider should be careful that it does not enter into a contract containing any provision(s) which in any way prevents it from fulfilling its ongoing responsibilities as a prudent buyer. While such provision(s) may have no immediate effect upon the provider's reimbursement, it may subsequently affect reimbursement; e.g., a contract may have an extremely punitive termination penalty which would result in nonreimbursable expenses.

The responsibilities and authority delegated to the contractor, and the parameters and limitations to this authority, should be specified. Where control of the provider's policies and operations is not retained by the provider, the contractor and provider may be found to be related organizations. (See Chapter 10.)

The duration of the relationship between provider and contractor should be carefully considered. Reimbursement is allowable only so long as the services are both necessary and effective for provider operations. Although the duration of the relationship is determined by the provider based on its particular needs, a provider should carefully consider the advantage of short-term contracts to allow it opportunity to renegotiate based on its most current requirements. A contract might include a mutually protective termination clause to permit both provider and supplier to dissolve the relationship upon specified conditions. However, the provider should bear in mind that if it is found to be imprudent in continuing to incur a cost for services for which a need no longer exists, neither the costs for such services nor excessive penalties can be included in allowable costs.

A contract should contain a detailed listing of services to be received and those which are available on an as-needed or standby basis. The amount of the fee and the base upon which the fee is computed should be specified and, for the services to be reimbursable, the intermediary must be satisfied that the computation yields a reasonable fee for the services actually furnished by the supplier.

B. Operations Under the Contract.--During the operational periods, the provider should maintain records showing the services actually received and should document the continuing need and cost effectiveness of the services. This documentation should include the assessment of the provider's governing body or its delegated representative(s) on an annual or more frequent basis, as incorporated into the Board minutes or other records.

2135.3 Determination of the Reasonable Cost of Purchased Management and Administrative Support Services.--Generally, purchased management and administrative support service costs are reasonable if the costs incurred are comparable with marketplace prices for similar services, or provide for a total guaranteed cost equal to or less than the provider's current cost for such department or service.

Factors which will be considered by the intermediary in its evaluation of the reasonable cost of purchased management and administrative support services include:

A. Whether the contract results from competitive bids that are reasonable within industry norms for similar services; and

B. Whether the contract is between unrelated parties (chapter 10); and

C. Whether the contract provides for services that are designed to accomplish within a prescribed time frame clearly stated goals and objectives based on needs identified by the provider (see §2135.2); and

D. Whether the provider maintains adequate documentation of the services rendered and the status of the accomplishment of the stated goals and objectives.

Where the supporting evidence does not permit a presumption of reasonableness, the intermediary will consider any factors, including those discussed below, and request any supporting documentation (see §2135.5) to the extent it believes necessary to satisfy itself of the reasonableness of the costs. In its evaluation, the intermediary will consider the circumstances and the needs of the provider at the time the services were purchased.

1. Evaluation of Services Purchased.--The number and type of services furnished under a contract will influence the manner in which the services are evaluated. The cost of contracts providing for a package of services, such as a full-service management contract, will be compared if possible against a comparable package of services, including those which might have submitted competitive bids. Where that is not feasible, or where the intermediary finds that this unilateral approach is insufficient to determine whether the costs incurred were, in fact, reasonable, it may be necessary to divide a package of services into separate components so that they can be evaluated with comparable services provided in the marketplace.

Alternatively, where a package of services is essentially comparable among contractors bidding to furnish the services, only those components which vary may need to be individually evaluated. A unique or highly specialized service which does not lend itself to comparability in the marketplace may be evaluated based on whether the service is at least as cost effective as could be furnished by the provider in-house. The intermediary may, for example, encounter situations in which all bids actually made seem to be very costly, given the nature of the actual services rendered. The objective of evaluating individual components of a package is to provide the same assurance as can be provided in other situations by a comparison of services in the aggregate, that the total cost of the necessary services is not substantially out of line with services which can be purchased elsewhere. Therefore, if certain individual components are more expensive than could be purchased elsewhere, the unreasonable cost of these components will not be disallowed if the cost of the aggregate services is not substantially out of line with a comparable package of services available in the marketplace.

2. Standby Services.--A contract fee may provide for the availability of services on an as needed or standby basis (e.g., access to national purchasing programs) which may or may not be utilized. Ordinarily, costs for standby services will be recognized if reasonable in amount and related to patient care.

3. Computation of Fee.--A supplier's fee may be computed in a number of ways, e.g., a fixed periodic payment for a group of specific services or a separate fee for each service rendered, or some other basis. Regardless of the computation method, the fees should be evaluated in relation to the services furnished.

4. Evaluation of Fees Over More Than One Cost Reporting Period.--Reasonableness of fees may in some cases be evaluated over more than one cost reporting period. For example, where a provider is receiving purchased management and administrative support services under a contract covering more than one cost reporting period, the provider's incurred costs based on the contractor's fees during one period may be less than the value of the services actually received during the same period. In this situation, where the provider can demonstrate that the costs incurred and the services received are reasonable in total, the reasonable costs for such services can be recognized in a subsequent cost-reporting period(s).

2135.4 Factors to Be Considered in Determining Reasonable Cost of Purchased Management and Administrative Support Services.--Whether or not the presumption of reasonableness can be made, intermediaries will consider the following factors in their reasonable cost determinations.

A. Preopening Services.--When a provider has purchased startup or preopening services such as those related to establishing a provider and its facilities, the cost associated with these services will be reviewed and treated separately from the cost associated with services for ongoing operations. The reasonable cost is determined through comparison with marketplace prices for similar services and will be capitalized and amortized in accordance with the Medicare principles of reimbursement.

B. Unallowable Costs.--Rights to a logo, noncompetition clauses or exclusive franchise rights to a particular territory, promotion or sale of a franchise, etc., are not related to a provider's patient care activities and, therefore, are not allowable. Non-covered Medicare services furnished under a contract represent an unallowable cost to a provider. The cost of purchased management and administrative support services which constitute duplication of services also furnished in-house is not allowable. (This does not refer to situations where the purchased services augment, rather than duplicate, the provider's activity.)

C. Costs of Terminating a Contract.--Where a contract is terminated prematurely, the provider would normally incur expenses which are not directly related to the services or supplies received under the contract. These costs generally include penalties, interest or lump sum payments to the contractor. If the termination is disputed, the provider could also incur legal fees,

accounting fees, court costs, and out-of-court settlement costs related to the arbitration of the dispute between the provider and contractor. Those costs incurred to terminate a contract would be included in allowable costs where they are reasonable in amount and incurred in an attempt to comply with the prudent buyer guidelines. In assessing the reasonableness of the costs allowed, the intermediary will consider the extent that the termination costs could have been avoided if the provider had been more prudent in entering into the contract.

D. Recognition of the Fee as a Liability.--After a determination is made as to the reasonableness of the fee for these services, Medicare's share of the fee is reimbursable, provided it has been paid or, if an accrued liability, can reasonably be expected to be paid. Where a provider has contested its liability and the intermediary therefore cannot be assured that accrued fees will actually be paid, no amount can be included in the cost report for that cost reporting period. If only part of the liability is contested, the uncontested amount may be included in the cost report. When the fee is actually paid or the liability is no longer contested, the amount will be recognized as allowable. This amount will be included in the appropriate cost centers of the current period cost report.

2135.5 Documentation to Support Purchased Management and Administrative Support Services.--Records must be available which will support the cost of purchased management and administrative support services. Such support could include some or all of the following, depending upon the scope and type of contract:

A. A copy of the contract(s) and any amendments;

B. Periodic progress reports submitted by the management organization;

C. An analysis showing the efforts of the provider to comply with the prudent buyer principle guidelines in assessing its needs, establishing the goals to be attained, evaluation of the available alternatives, and choosing the terms of the contract (see §2135.2);

D. Board minutes or other documentation to show continued reassessment of the effectiveness of the services (see §2135.2);

E. Detailed identification of the services actually received during the period (see §2135.2); and

F. Any other documentation available such as visit or contact reports, minutes of committee meetings, evaluations, cost/benefit analyses, etc., which would support the receipt of services and substantiate the attainment of the goals and objectives which are desired and the reasonableness of the fees paid.

2136. ADVERTISING COSTS--GENERAL

The allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing covered services to Medicare beneficiaries by providers of services. In determining the allowability of these costs, the intermediary should consider the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions. To be allowable, such costs must be common and accepted occurrences in the field of the provider's activity.

2136.1 Allowable Advertising Costs.--Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples are: visiting hours information, conduct of management-employee relations, etc. Costs connected with fund-raising are not included in this category (see §2136.2).

Costs of advertising for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in patient care activities or in the development and maintenance of the facility.

Costs of advertising for procurement of items or services related to patient care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.

Costs of advertising incurred in connection with obtaining bids for construction or renovation of the provider's facilities should be included in the capitalized cost of the asset (see Chapter 1, §104.10).

Costs of advertising incurred in connection with bond issues for which the proceeds are designated for purposes related to patient care, i.e., construction of new facilities or improvements to existing facilities, should be included in “bond expenses” and prorated over the life of the bonds.

Costs of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. Such contacts make known what facilities are available to persons who require such information in providing for patient care, and serve other purposes related to patient care, e.g., exchange of medical information on patients in the provider's facility, administrative and medical policy, utilization review, etc. Similarly, reasonable production and distribution costs of informational materials to professional groups and associations, such as those listed above, are allowable if the materials primarily refer to the provider's operations or contain data on the number and types of patients served. Such materials should contribute to an understanding of the role and function of the facility as a provider of covered health care in the community.

Costs of informational listings of providers in a telephone directory, including the "yellow pages," or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry.

Costs of advertising for any purpose not specified above or not excluded below may be allowable if they are related to patient care and are reasonable.

2136.2 Unallowable Advertising Costs.--

Costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.

Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable. See section 2136.1 for allowability of professional contact costs and costs of advertising for the purpose of recruiting physicians as members of the provider's salaried staff.

Costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are not allowable.

Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective. While it is the policy of the Health Care Financing Administration and other Federal agencies to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients.

2138. MEMBERSHIP COSTS--GENERAL

Providers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary provider operating costs.

Some of those organizations promote objectives in the provider's field of health care activities. Others have purposes or functions which bear little or no relationship to this activity. In order to determine, for Medicare purposes, the allowability of costs incurred as a result of membership in various organizations, memberships have been categorized into three basic groups: (1) professional, technical or business related; (2) civic; and (3) social, fraternal, and other.

2138.1 Professional, Technical, or Business Related Organizations.--The Medicare program classifies organizations in this category if their functions and purposes can be reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services. Memberships in these organizations, while not restricted to providers, are generally comprised of provider, provider personnel, or others who are involved or interested in patient care activities.

Costs of memberships in such organizations are allowable for purposes of program reimbursement. These costs include initiation fees, dues, special assessments, and subscriptions to professional, technical or business-related periodicals. (See §2139.3 regarding lobbying activities.) Also included are costs related to meetings and conferences, such as meals, transportation, registration fees and other costs incidental to those functions, when the primary purpose of such meetings and conferences is the dissemination of information for the advancement of patient care or efficient operation of the facility.

2138.2 Civic Organizations.--These organizations function for the purpose of implementing civic objectives. Reasonable costs of initiation fees, dues, special assessments, and subscriptions to periodicals of civic organizations are allowable. (See §2139.3 regarding lobbying activities.) Also allowable are those reasonable costs related to meetings and conferences, such as meals, transportation, registration fees, and other costs incidental to these functions when the primary purpose of such meetings and conferences is the promotion of civic objectives.

2138.3 Social, Fraternal, and Other Organizations.--Generally, these organizations concern themselves with activities unrelated to their members' professional or business activities. Their objectives and functions cannot be considered reasonably related to the care of beneficiaries. Consequently, provider costs incurred in connection with memberships in social, fraternal, and other organizations are not allowable.

2138.4 Reasonableness of Provider's Participation in Approved Membership Activities.--The program looks to comparable providers, as well as to the justification by the individual provider, in determining the reasonableness of the number of organizations in which the provider maintains memberships and the claimed costs of such memberships.

2139. POLITICAL AND LOBBYING ACTIVITIES

Provider political and lobbying activities are not related to the care of patients. Therefore, costs incurred for such activities are unallowable.

2139.1 Provider Political Activities.--Costs of political activities are unallowable. These activities include, but are not limited to, provider involvement with political parties, candidates/incumbents of political parties, and political action committees or similar committees or associations. Likewise, contributions made directly to political parties or candidates or contributions made indirectly, e.g., through other individuals, committees, or associations, are unallowable. (See §2139.3 regarding dues to trade or other organizations related to such organizations' lobbying or political activities.)

2139.2 Provider Lobbying Activities.--

A. Lobbying Activities.--Lobbying is any activity whereby a directed effort is made to influence legislation. Costs of lobbying activities are unallowable. The policy applies whether the lobbying involves Medicare activities or activities unrelated to Medicare and whether the provider lobbies with its own employees or engages others, directly or indirectly, to lobby on its behalf.

Government agencies other than HCFA have developed specific policies regarding lobbying. While other agencies may apply their policies and procedures differently or use different nomenclature than HCFA, e.g., in the case of the Internal Revenue Service (IRS), by means of nondeductible business expenses rather than unallowable costs, the general intent behind policies of those agencies and of HCFA is the same. Costs of lobbying are costs in which the government does not participate. HCFA does not intend providers to be subject to varying rules on lobbying costs among government agencies, resulting in nonuniform treatment of the costs and additional provider recordkeeping. Therefore, if a non-HCFA agency, e.g., the IRS, has developed policies and procedures defining lobbying activities and addressing the costs, HCFA does not expect providers to follow different rules in determining Medicare payment. Rather, providers subject to rules of non-HCFA agencies on lobbying can follow those rules in determining payment under Medicare to the extent such rules are in accordance with Medicare policy which disallows any costs of lobbying activities.

B. Activities Which Are Not Lobbying.--Contacts by a provider with HCFA or other government agencies with which it has business dealings is not lobbying unless the contacts are determined to be directed toward influencing legislation. For example, if a provider, group of providers, or provider trade organization comments on a HCFA proposal, that activity is not lobbying. Or, if a provider disputes a point of Medicare policy or its application or has a suggestion regarding policy, contact with HCFA or an intermediary by the provider or an organization to discuss such issues is not lobbying.

2139.3 Organization Dues Related to Lobbying and Political Activities.--Trade or other organizations and associations often engage in lobbying and political activities as part of their activities. Therefore, in accordance with the policy in §§2139.1 and 2139.2, the portion of an organization's dues or other payments related to these activities, including special assessments, is an unallowable cost.

For cost reporting periods beginning on or after January 1, 1996, this policy requires identification and disallowance of the portion of dues related to lobbying and political activities. For prior periods, the policy does not require identification but requires disallowance of any identified portion.

The policy in §2139.2 permitting providers to follow the rules of other government agencies on lobbying activities in determining unallowable lobbying costs under Medicare applies also to dues. In particular, for Federal income tax purposes, §13222 of the Omnibus Budget Reconciliation Act of 1993 generally requires tax-exempt organizations to report to their members the nondeductible portion of dues related to an organization's lobbying and political activities. The reporting required under that provision satisfies Medicare's requirement for identification of the portion of an organization's dues related to lobbying and political activities. If an organization is not required to report to its members for tax purposes, for Medicare purposes, the portion of dues for lobbying and political activities remains unallowable as if the organization were required to report. In such cases, a provider will need to request the information from the organization in order to report for Medicare purposes only the portion not related to lobbying and political activities.

In light of policy by CMS and other agencies requiring identification of the lobbying and political activities portion of an organization's dues, CMS believes it unlikely a provider will be unable to, or choose not to, identify such portion. However, if a portion is not identified for Medicare payment purposes and the intermediary is aware of the organization's ongoing lobbying or political activities, all costs associated with the provider's dues to the organization are unallowable unless the provider can document the unallowable portion for lobbying and political activities.

This policy is not limited to dues incurred by a provider on its own behalf. It applies also to dues a provider pays, as a business or fringe benefit expense, on behalf of its employees and officers in professional, trade, or other organizations to which they belong, e.g., associations of nurses, therapists, administrators, or accountants. Only the portion of the dues not related to lobbying or political activities of the organizations is an allowable cost.

2140. DEFERRED COMPENSATION

2140.1 Definition.--Deferred compensation is remuneration currently earned by an employee but which is not received until a subsequent period, usually after retirement. Accordingly, a deferred compensation plan defers the receipt of income beyond the year in which it is earned. The type of deferred compensation plan considered herein is not considered a qualified plan under Internal Revenue Service requirements. (See subchapter D, Internal Revenue Code of 1986, as amended, and regulations thereunder.) Qualified deferred compensation plans that meet the definition of a defined benefit pension plan are treated under §2142ff. Qualified deferred compensation plans that meet the definition of a qualified defined contribution deferred compensation plan are treated under §2141ff.

2140.2 Foreword.--Provider contributions for the benefit of employees under a deferred compensation plan are reimbursable when, and to the extent that, such costs are actually incurred by the provider. Such costs are found to have been incurred only if the requirements of §2140ff. are met. The requirements of this section are applicable not only to provider costs but also to direct patient care services furnished by hospital-based physicians who receive their remuneration from the hospital. (See §2140.5.) As a condition for provider reimbursement, deferred compensation plans must be funded. Provider payments

under unfunded deferred compensation plans are considered an allowable cost only when actually paid to the participating employees, or their beneficiaries, and only to the extent considered reasonable. Also, only where deferred compensation is funded is the deferred portion of the hospital-based physician's total compensation included in determining a Part B reasonable charge for the physician's services to patients.

2140.3 Formal Plan.--In order to establish a formal deferred compensation plan, the provider is required to adequately communicate the proposed plan to all eligible employees, enabling them to make an informed decision on whether to participate in the plan. A formal plan is one that is provided for in a written agreement executed between the provider and the participating employees. It is a permanent plan which:

- o Prescribes the method for calculating all contributions to the fund established under the plan;
- o Is funded in accordance with the provisions of §2140.3B;
- o Provides for the protection of the plan's assets;
- o Designates the requirements for vested benefits;
- o Provides the basis for the computation of the amount of benefits to be paid; and
- o Is expected to continue despite normal fluctuations in the provider's economic experience.

A. Contributions.--Contributions to the plan may be made by the provider only, or by the provider and the employee. The provider's contribution is established by the terms of the deferred compensation agreement and made for the sole benefit of participating employees. An employee's contribution is generally a voluntary contribution to the fund established under the plan in addition to the provider's required contribution. For example, an employee may agree to a division of his $15,000 salary so that $12,000 is received as immediate remuneration, $1,000 is designated as a voluntary employee contribution, and the provider also contributes $2,000 to the deferred compensation plan on behalf of the employee. Of course, the employee's total compensation ($15,000 in the example) must be reasonable in relation to the services rendered by the employee to be allowable. Also, contributions by a provider to a deferred compensation plan on behalf of an employee-owner of a provider are considered to be a part of the owner's compensation and are subject to the test of reasonableness. (See §902.3.)

B. Funding of Deferred Compensation Plans.--

1. Provider Reimbursement for Deferred Compensation Plans.--A funded plan is one in which contributions are systematically made as a specific provision of the plan to a funding agency for the purpose of meeting retirement benefits. For Medicare purposes, a funding agency is a trustee, an insurance company, or a custodial bank account which provides for the accumulation of assets to be used for the payment of benefits under the deferred compensation plan. Accordingly, both provider and employee contributions to the deferred compensation plan must be used either to purchase an insured plan with a commercial insurance company, to establish a custodial bank account, or to establish a trust fund administered by a trustee. Past service costs are allowed in accordance with the provisions of §2142.5.

Regardless of the funding mechanism utilized, all provider and employee contributions to the fund established under the deferred compensation plan and income therefrom must be used for the sole benefit of the participating employees.

a. Commercial Insurance as a Funding Mechanism.--A provider's cost for a funded deferred compensation plan is recognized when there is an actual expenditure of funds by the provider to a commercial insurance company for the sole benefit of the participating employees. (See §2140.4.) There are various types of insurance policies which are recognized as a funding medium for deferred compensation plans. However, the purchase of an ordinary life insurance contract is not a deferral of compensation and will not be recognized as a funding mechanism. Ordinary life insurance contracts include whole life, straight life, and other permanent life insurance policies that provide life insurance protection for the life of an employee and some accumulation of cash value in return for regular premium payments. Nor will such a contract be recognized even though it is convertible at the normal retirement date specified in the policy to an annuity payable over the remaining life of the employee, because this arrangement is essentially a variation of life insurance rather than deferred compensation.

(1) Retirement Annuity Contract.--A retirement annuity contract (which insurance companies have given various names) is recognized as a funding medium for deferred compensation plans. A retirement annuity contract generally provides for an accumulation of premiums and interest less expenses to a predetermined date, usually the annuitant's retirement age. The amount accumulated is used to purchase a contract in which annuity payments are made to the retired employee or his survivor.

(2) Retirement Income Policy.--A retirement income policy (which insurance companies have also given various names) is recognized as a funding medium for deferred compensation plans. A retirement income policy usually combines the features of ordinary life and endowment policies. Upon reaching a stipulated age (usually retirement age), the insured receives a pension for a period of years consisting of periodic payments varying in amount dependent upon the principal sum of insurance. This contract provides, as a secondary feature, a designated amount of insurance protection during the lifetime of the insured.

(3) Deferred Group Annuity Contract.--A deferred group annuity contract is also recognized as a funding medium for deferred compensation plans. Under this plan, a paid-up unit of annual income at normal retirement age is purchased for each employee at the end of each year of employment. The unit purchased is expressed as a percentage of the earnings of the employee in that year. For example, an employee who has worked 30 years for a provider under a 1 1/2 percent benefit plan receives an annual pension at retirement of 45 percent (i.e., 30 times 1 1/2 percent) of his/her average annual salary.

b. Trust Fund as a Funding Mechanism.--When a provider establishes a trust fund for a deferred compensation plan, the trustee(s) are appointed by the executive board or a committee of the provider to protect the fund's assets and its distribution to the beneficiaries under the plan. The trustee may be either a member of the provider's organization or a third-party trustee.

c. Custodial Bank Account as a Funding Mechanism.--Generally, a custodial bank account results from an administrative and custodial arrangement between a provider and a bank under which the provider transfers deferred compensation amounts to the bank. As custodian of the deferred compensation funds, the bank is responsible for the safekeeping of the funds. A custodial

bank account may be an acceptable funding mechanism for deferred compensation plans provided that: (1) all assets in the custodial account, including any annuity, endowment, and other insurance policies, are registered and held in the name of the custodian until distributed to the participants pursuant to the terms of the deferred compensation agreements, and (2) the terms of the custodial contract specify that no part of the funds in the custodial account may be used for or diverted to purposes other than for the exclusive benefit of the participating employees or their beneficiaries as required by the deferred compensation agreement.

d. Trustee and Custodial Fees.--Reasonable trustee or custodial fees paid by the provider are allowed as an administrative cost. However, the cost of such fees is not allowed to the provider when the deferred compensation plan provides that they are paid out of the corpus or earnings of the fund.

C. Plan's Assets.--

1. Transactions.--All transactions involving the deferred compensation fund must be made under conditions comparable to arm's length transactions. The provider cannot transfer, either by sale or exchange, its securities and other property to the deferred compensation fund at more than adequate consideration. Likewise, a deferred compensation fund cannot sell its assets either to a provider or a third party at less than adequate consideration. All assets accumulated by the plan must be distributed exclusively to the participating employees or their beneficiaries.

2. Earnings.--The plan must specify that the interest, capital gains and losses, and dividends earned from the investment of the fund's assets will be added to or deducted, as applicable, from the corpus of the deferred compensation fund. Actuarial gains and losses, which are adjustments need to reflect actual experience and to revise at intervals the actuarial assumptions to be used in the future, should be utilized in a rational and consistent manner to adjust a provider's cost for a deferred compensation plan.

3. Loans Made from the Deferred Compensation Fund.--The deferred compensation fund may make a loan out of either corpus or income to a provider on the conditions that the fund receive adequate security and a reasonable rate of interest on the loan. Adequate security means something of value in addition to, and supporting, a promise to pay, which is so pledged to the deferred compensation fund that it may be sold, subject to foreclosure, or otherwise disposed of in default of repayment of the loan. It also requires that the asset pledged as security for the loan must not be subject to prior and/or superior liens of other creditors in an amount which would negate the value and liquidity of such security for the loan from the fund. Therefore, a provider's evidence of indebtedness, regardless of what the document is called, is, by itself, not security for a loan. Interest paid by the provider on loan from the deferred compensation fund would be an allowable cost if the necessary and proper requisites were met. (See §§202.2 and 202.3.) Whether a rate of interest is reasonable would be determined by comparing it with the rates that would be charged by a bank or other lending institution in the same community on a similar loan. To be similar, the loans should be alike with respect to such factors as amount, duration, and security.

Since income earned on loans to the general fund of the deferred compensation fund is not income to the provider, it will not be offset against a provider's allowable interest expense. (See §224.2.) However, before such loans are made, the reasons for such loans should be carefully reviewed to assure that the

deferred compensation plan is not serving any purpose other than that for which it was intended; i.e., for the exclusive benefit of participating employees. In addition, a loan from the deferred compensation fund to a provider to meet a funding requirement (deferred compensation, pension, or depreciation) would not be deemed proper under this section.

D. Vested Benefits.--The deferred compensation plan must specify the time and the manner in which the benefits are to become vested; e.g., after a predetermined number of years of employment, or after a specific age is attained, or some combination of the two. The schedule of benefits which accrue to an employee or his survivors upon the employee's retirement, termination of services because of disability, death, or other reasons, must be incorporated into the plan.

The immediate vesting of benefits is not required. However, the deferred compensation plan must provide that vesting of provider contributions occur on or before the normal retirement age established by the provider and defined in the plan.

The unconditional vesting of benefits will not be required. Unconditional vesting of benefits means that once a participant's benefits are vested in accordance with the normal vesting schedule, there are no conditions incorporated in the plan which would deprive the participant of such benefits. Accordingly, the forfeiture of an employee's benefits for cause (as defined in the deferred compensation plan) will be recognized provided that such forfeited amounts are used to reduce the provider's subsequent contributions to the deferred compensation plan. However, employee contributions to the deferred compensation fund are always nonforfeitable. If no subsequent provider contributions are to be made to the plan, then other provider costs must be offset to the extent of such forfeitures.

Employee benefits must become fully vested upon any of these occurrences: (a) the normal retirement age established by the provider, (b) termination of the deferred compensation plan, (c) complete discontinuance of contributions under the deferred compensation plan, (d) the termination of the provider's participation in the Medicare program, or (e) change of ownership of the provider where the successor provider is unwilling or unable to continue the deferred compensation plan or alters the existing plan in any way. Should the provider decline to vest the provider contributions upon the occurrence of any of these events, then the funds must be used to reduce the provider's allowable costs.

Excess funds arising from the termination of a deferred compensation plan are to be recouped in the year of the plan termination (or the year in which the actuarial surplus is determined, if later) only against the cost center(s) in which the provider reported its deferred compensation plan contributions, usually administrative and general (A&G). The recoupment of the excess funds is treated on the cost report in the same manner for both cost reimbursed providers and prospective payment providers, although the payment impact upon prospective payment providers is limited to cost reimbursed activities. Excess funds exceeding the amount in the A&G (or other) cost center are not further offset in the current or subsequent years. The date of the official notice to the provider that the terminated plan has generated an actuarial surplus, e.g., notice by the Pension Benefit Guaranty Corporation (PBGC), or similar entity, of the surplus amount, represents the year in which the actuarial surplus is determined. The Medicare share of the reversion is based on the Medicare utilization rate in the year the reversion occurs (or the year the actuarial surplus is determined), and not Medicare's utilization in the years the

contributions to the plan were made. Investment income earned on a fund after its termination but prior to liquidation of the fund's assets and distribution to the provider is offset against the provider's allowable interest expense, as provided in §202.2.

E. Benefits to be Paid.--If an employee terminates his participation in the deferred compensation plan before his rights are vested, the applicable non-vested funds cannot be applied to increase the benefits of the surviving participants, but must be applied to reduce the provider's subsequent contributions to the plan. If subsequent provider contributions to the plan are not made, then provider costs will be reduced to the extent of such non-vested funds. The plan may provide that a refund of a terminated employee's contributions include interest. If an employee terminates his participation after his rights are vested, then the final payment to the employee will be made according to the terms of the plan.

2140.4 Requirements to Fund Plan.--A provider must make payment of its liability to the fund established for the deferred compensation plan in accordance with the provisions covering liquidation of liabilities established in §2305. This section requires full liquidation of the liability within 1 year after the end of the cost reporting period in which the liability is incurred. An extension, not to exceed 3 years beyond the end of the cost reporting period in which the liability was incurred, may be granted by the intermediary for good cause if the provider, within the 1-year time limit, furnishes to the intermediary sufficient written justification (based upon documented evidence) for non-payment of the liability.

Payment to the deferred compensation fund in excess of the provider's incurred liability is not includable in allowable costs, but may be carried forward and considered as payment against the liability of a future period.

Payment must be made by check or other negotiable instrument, cash, or legal transfer of assets such as stocks, bonds, real property, etc. Where payment is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the time limit specified in this section. The valuation of stocks, bonds, real property, etc., transferred to the deferred compensation fund would be determined as of the date of transfer by the provider.

2140.5 Reimbursement of Hospital-Based Physician Patient Care Services.--Contracts or agreements between hospital-based physicians and hospitals involve a variety of arrangements under which the physician is compensated by the hospital for the full range of his services within the institution. The allocation of the hospital-based physician's compensation (including any portion subject to deferment) between services benefiting the institution and direct patient care is subject to the review and approval of the hospital's intermediary and the Part B carrier. (See §§2108.2C and 2108.2D.) Medicare will not, however, accept an allocation which attributes the physician's deferred compensation entirely to one type of service and his current compensation to the other. The amount deferred must be allocated in the same ratio that physician's total compensation is allocated between the two types of service.

Where the arrangement between the physician and provider results in the provider reimbursing the physician from its own funds, then a deferred compensation arrangement can occur which will be recognized by Medicare. Recognition will require that all the provisions of §2140ff be met.

Recognition of a deferred compensation arrangement does not mean that a provider will incur a cost, which is allowable. For example, payments to a fund for a physician's direct patient care services are not an allowable provider cost. However, where the arrangement is recognized by the program, and the physician's compensation is determined to be reasonable in terms of the prudent buyer principles, then deferred compensation can be included in the physician's total compensation in determining his reasonable charge. However, if the deferred compensation is not recognized because it fails to meet all provisions of §2140ff, e.g., it is not funded, then deferred compensation cannot be included in the physician's compensation in determining his reasonable charge.

The Medicare program will not recognize an arrangement between the physician and the provider in which the physician is reimbursed from patient charges, but the provider does the billing, as a deferred compensation arrangement. For example, where the employment relationship between the provider and the provider-based physician is such that the provider is merely acting as the billing agent for the physician whose remuneration is derived from billing for his patient care services, the Medicare program will not recognize a deferred compensation plan for such remuneration. In order to be recognized as a deferred compensation plan, the compensation costs must be initially borne by the provider, i.e., the funds must not be dependent upon patient billings. As an example, if the hospital has agreed to pay a physician $30,000 for his services in the emergency room, the program would recognize a deferred compensation plan which defers a portion of the $30,000. The difference in recognition is that in the first example, the hospital is merely the conduit for a physician's billings for patient care; whereas, in the second example, the hospital has to pay the physician $30,000 regardless of the number of patients he treats.

In all matters affecting provider-based physician reimbursement, close coordination between the provider, the intermediary and the Part B carrier is necessary. The intermediary is responsible for insuring that the provider complies with the overall requirements of this section and for providing the carrier with data needed in determining reasonable charges.

2140.6 Guarantee Arrangements for Physician Emergency Room Services.--A provider may agree to guarantee a physician a specified amount of compensation for rendering emergency room services. Under the guarantee, the provider makes up any difference between the amount guaranteed and the total amount of physician's charges to all patients for services actually rendered. (See §2109.) Only the amount the provider pays to satisfy the guarantee is recognized as a provider cost.

Deferred compensation arrangements which are included in such guarantee arrangements are recognized by Medicare when (1) the terms of both the guarantee arrangements and the deferred compensation plan establish the amounts to be included at the beginning of the provider's accounting period, (2) the amount of deferred compensation is included in the guaranteed amount, and (3) the provider contributes to the fund established under the deferred compensation plan from its own funds.

The amount of deferred compensation, which the program recognizes, however, is limited to the amount by which the guarantee, including deferred compensation, exceeds the total billed by the provider to all patients for the physician's patient care services. The amount recognized may not exceed the amount of deferred compensation specified in the agreement. When the physician's charges to all patients equal or exceed the amount guaranteed by the provider, the

program does not recognize a deferred compensation payment because the funds are not provider generated. (It is the physician's charges to all patients, not the collections, which measure the guarantee.)

The following example illustrates how the amount of deferred compensation the program recognizes under guarantee arrangements can be determined in the three situations presented.

Provider A has an arrangement with Dr. X guaranteeing him/her $25,000 per year for emergency room patient care services. Under a deferred compensation agreement, up to $5,000 of the amount paid to meet the guarantee is considered deferred compensation.

	Situation A	Situation B	Situation C
Guaranteed Amount	$25,000	$25,000	$25,000
Total Services Billed (by physician or by provider)	$20,000	$23,000	$30,000
Amount Recognized by Program as Deferred Compensation	$ 5,000	$ 2,000	---

If the guarantee arrangements require the physician to render administrative services which are recognized as provider costs under Medicare, then the deferred compensation must be apportioned between Part A and Part B in the proportion that each bears to the total guarantee.

2141. DEFINED CONTRIBUTION DEFERRED COMPENSATION PLANS

2141.1 Definition.--Defined contribution deferred compensation plans include profit sharing, stock bonus, and other such defined contribution deferred compensation plans that meet Internal Revenue Service (IRS) or Employee Retirement Income Security Act (ERISA) requirements as qualified plans and have been so approved by the IRS. The plans provide for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to the participant's account. These deferred compensation plans, as well as the non-qualified deferred compensation plans described in §§2140ff, provide for the deferral of remuneration currently earned by an employee until a subsequent period (usually after retirement).

2141.2 Foreword.--Provider contributions for the benefit of employees under a defined contribution deferred compensation plan are allowable when, and to the extent that, such costs are actually incurred by the provider. Such costs may be found to have been incurred only if the requirements of this section are met.

2141.3 Formal Plan.--In order to establish a formal deferred compensation plan, the provider is required to adequately communicate the proposed plan to all eligible employees, enabling them to make an informed decision on whether to participate in the plan. No provision of the plan may discriminate in favor of certain employees, e.g., employees who are stockholders, supervisors, or highly paid personnel. A formal plan is one that is maintained by the provider and is provided for in a written agreement executed between the provider and the participating employees. It is a permanent plan which:

o Prescribes the method for calculating all contributions to the fund established under the plan;

o Is funded in accordance with the provisions of §2140.3B;

o Provides for the protection of the plan's assets;

o Designates the requirements for vested benefits;

o Provides the methods and procedures for payment to the employee of the amount in the employee's account; and

o Is expected to continue despite normal fluctuations in the provider's economic experience.

A. Contributions.--The provisions of §2140.3A must be met.

B. Funding of Deferred Compensation Plans.--The provisions of §2140.3B must be met.

C. Plan's Assets.--

1. Transactions.--The provisions of §2140.3.C.1 must be met.

2. Individual Participant's Account.--The plan must provide for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account. This includes any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to each participant's account.

3. Loans Made from Deferred Compensation Fund.--The provisions of §2140.3.C.3 must be met.

D. Vested Benefits.--The deferred compensation plan must specify the time and the manner in which the benefits are to become vested, e.g., after a predetermined number of years of employment, after a specific age is attained, or some combination of the two. The benefits that accrue to an employee upon retirement, termination of services due to disability, or other reasons (or that accrue to the employee's survivor in case of death) must be incorporated into the plan.

The immediate vesting of benefits is not required. However, the deferred compensation plan must provide that vesting of provider contributions occurs on or before the normal retirement age established by the provider and as defined in the plan.

The unconditional vesting of benefits is not required. Unconditional vesting of benefits means that once a participant's benefits are vested in accordance with the normal vesting schedule, there are no conditions incorporated in the plan which deprives the participant of such benefits.

Employee benefits must become fully vested upon any of these occurrences:

o The normal retirement age established by the provider;

o Termination of the deferred compensation plan;

- Complete discontinuance of contributions under the deferred compensation plan;

- Termination of the provider's participation in the Medicare program; or

- Change of ownership of the provider when the successor provider is unwilling or unable to continue the deferred compensation plan or alters the existing plan in any way.

Excess funds arising from the termination of a deferred compensation plan are subject to the provisions of §2140.3.D.

2141.4 Requirements to Fund Plan.--The provisions of §2140.4 must be met.

2141.5 Reimbursement of Hospital-Based Physician Patient Care Services.-- Contracts or agreements between hospital-based physicians and hospitals involve a variety of arrangements under which the physician is compensated by the hospital for the full range of services within the institution. The allocation of the hospital-based physician's compensation (including any portion subject to deferment) between services benefiting the institution and direct patient care is subject to the review and approval of the hospital's intermediary. Medicare does not accept an allocation, which attributes the physician's deferred compensation entirely to one type of service and the current compensation to the other. The amount deferred must be allocated in the same ratio that physician's total compensation is allocated between the two types of service.

Arrangements between the physician and the provider in which the physician is compensated solely from patient charges, although the provider, serving merely as a billing agent, does the billing, cannot include a deferred compensation arrangement, which will be recognized by the program. In order to be recognized as a deferred compensation plan, the compensation costs must be initially borne by the provider.

2141.6 Guarantee Arrangements for Physician Emergency Room Services.--The provisions of §2140.6 must be met.

2141.7 Effective Date.--The provisions of this section are effective for defined contribution deferred compensation plans established in cost reporting periods beginning on or after March 1, 1976.

2142. DEFINED BENEFIT PENSION PLANS

2142.1 Definition.--A defined benefit pension plan is a type of deferred compensation plan, which is established and maintained by the employer primarily to provide definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Pension plan benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by the employees. This section applies only to defined benefit pension plans which are qualified pension plans under Section 401 (a) of the Internal Revenue Code. A qualified pension plan is for the exclusive benefit of employees or their beneficiaries and qualifies for special tax benefits, such as tax deferral for employer contributions. Defined benefit pension plans which are not qualified plans are treated as deferred compensation plans under §2140.

2142.2 Removed and Reserved - Section content deleted and the section number is reserved for future use.

2142.3 Removed and Reserved - Section content deleted and the section number is reserved for future use.

2142.4 Removed and Reserved - Section content deleted and the section number is reserved for future use.

2142.5 Pension Costs.—

A. Current Period Pension Cost.--The current period pension cost is the sum of the provider contribution payments made to a defined benefit pension plan during the current cost reporting period in accordance with §2142.6(A) plus any carry forward contributions determined in accordance with §2142.5(E), such total for the current year may not exceed the pension cost limitation described in §2142.5(B).

B. Pension Cost Limitation.--Except as provided in §2142.5(D), the current period pension cost may not exceed 150% of the provider's average contribution payments made to the plan during the three (3) consecutive cost reporting periods out of the last five (5) consecutive cost reporting periods (ending with the current reporting period) which produce the highest average.

(1) For purposes of determining the pension cost limitation, provider contribution payments for each applicable cost reporting period shall be determined on a cash basis in accordance with §2142.6(A), without regard to any pension cost limitation determined under §2142.5(B) for the period during which the contributions were made, and excluding any contributions deposited in a prior period and treated as carry forward contributions under §2142.5(E).

(2) The averaging period used to determine the pension cost limitation shall be determined without regard to a provider's period of participation in the Medicare program. Periods which are not Medicare cost reporting periods (e.g. periods prior to the hospital's participation in the Medicare program) shall be defined as consecutive twelve-month periods ending immediately prior to the provider's initial Medicare cost reporting period.

(3) The averaging period used to determine the pension cost limitation shall exclude all periods ending prior to the initial effective date of the pension plan (or a predecessor pension plan in the case of a merger as explained in 2142.5(C)).

C. Multiple Pension Plans and Successor Plans.--In general, the current period pension cost and pension cost limitation shall be computed and applied separately for each defined benefit pension plan offered by a provider. In the case of a plan merger, the contribution payments made by a provider to a predecessor pension plan and reflected in the assets subsequently transferred to a successor plan shall be treated as contribution payments made to the successor plan.

D. Request for Adjustment to Pension Cost Limitation.--A provider may request an adjustment to the pension cost limitation otherwise determined under section §2142.5(B) for the current period by submitting documentation, prior to the filing deadline for its current period cost report, to show that all or a portion of the contributions in excess of the pension cost limitation are reasonable and necessary to satisfy a current period's actuarially determined pension liability. Examples of situations when an adjustment to the pension cost limitation may be justified would include, but are not limited to, excess contributions required by law or to avoid benefit restrictions under ERISA. Requests for a limitation adjustment and any documentation should be sent to Pension@cms.hhs.gov with a copy to the Medicare contractor. The CMS central office will approve or disapprove these requests.

(1) For purposes of determining the pension cost limitation, provider contribution payments for each applicable cost reporting period shall be determined on a cash basis in accordance with §2142.6(A), without regard to any pension cost limitation determined under §2142.5(B) for the period during which the contributions were made, and excluding any contributions deposited in a prior period and treated as carry forward contributions under §2142.5(E).

(2) The averaging period used to determine the pension cost limitation shall be determined without regard to a provider's period of participation in the Medicare program. Periods which are not Medicare cost reporting periods (e.g. periods prior to the hospital's participation in the Medicare program) shall be defined as consecutive twelve-month periods ending immediately prior to the provider's initial Medicare cost reporting period.

(3) The averaging period used to determine the pension cost limitation shall exclude all periods ending prior to the initial effective date of the pension plan (or a predecessor pension plan in the case of a merger as explained in 2142.5(C)).

C. Multiple Pension Plans and Successor Plans.--In general, the current period pension cost and pension cost limitation shall be computed and applied separately for each defined benefit pension plan offered by a provider. In the case of a plan merger, the contribution payments made by a provider to a predecessor pension plan and reflected in the assets subsequently transferred to a successor plan shall be treated as contribution payments made to the successor plan.

D. Request for Adjustment to Pension Cost Limitation.--A provider may request an adjustment to the pension cost limitation otherwise determined under section §2142.5(B) for the current period by submitting documentation, prior to the filing deadline for its current period cost report, to show that all or a portion of the contributions in excess of the pension cost limitation are reasonable and necessary to satisfy a current period's actuarially determined pension liability. Examples of situations when an adjustment to the pension cost limitation may be justified would include, but are not limited to, excess contributions required by law or to avoid benefit restrictions under ERISA. Requests for a limitation adjustment and any documentation should be sent to Pension@cms.hhs.gov with a copy to the Medicare contractor. The CMS central office will approve or disapprove these requests.

E. Carry Forward Contributions.--Carry forward contributions represent contributions made in a prior cost reporting period which were not allowable pension costs in any prior cost reporting period. Carry forward contributions may be included as a current period pension cost in accordance §2142.5(A).

F. Data Required.--The provider must have available data to show the amount(s) and date(s) of contribution payments made to a defined benefit pension plan during the current reporting period and any applicable prior periods. If the pension costs included in the cost report for a period differ from the pension contribution payments made during the reporting period (i.e., as a result of carry forward contributions), the provider must also have data available to track and reconcile the difference.

Inserted blank page

2142.6 Allowability of Payments.--

A. Payment Requirements.--Provider contribution payments made to a defined benefit pension plan are allowable only to the extent that costs are actually incurred by the provider. Such costs are found to have been incurred only if paid directly to participants or beneficiaries under the terms of the plan or paid to a pension fund which meets the applicable tax qualification requirements under Section 401(a) of the Internal Revenue Code.

Provider payments to a pension plan for a cost reporting period shall be measured on a cash-basis without regard to §2305. Payment must be made by check or other negotiable instrument, cash, or legal transfer of assets such as stocks, bonds, real property, etc. A contribution payment shall be deemed to occur on the date it is credited to the fund established for the pension plan, or for provider payments made directly to a plan participant or beneficiary, on the date the provider's account is debited.

B. Reasonable Compensation.--The payments made by the provider together with all other compensation paid to the employee must be reasonable in amount.

2142.7 Removed and Reserved - Section content deleted and the section number is reserved for future use.

2144. FRINGE BENEFITS

2144.1 Definition.--Fringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee, his/her dependent (as defined by IRS), or his/her beneficiary derives a personal benefit before or after the employee's retirement or death. In order to be allowable, such amounts must be properly classified on the Medicare cost report, i.e., included in the costs of the cost center(s) in which the employee renders services to which the fringe benefit relates and, when applicable, have been reported to IRS for tax purposes. Where claimed items are in dispute, the provisions of §115 of the Provider Reimbursement Manual, Part II, apply.

2144.2 Purpose.--Fringe benefits inure primarily to the benefit of the employee. However, there may also be some intrinsic benefit to the provider, such as increasing employee work efficiency and productivity, reducing personnel turnover, or increasing employee morale. It is necessary to recognize all costs which are properly classified as fringe benefits since the designation of a particular cost as a fringe benefit could affect the computation of items such as the value of services of nonpaid workers. However, see §2102.3 for items not related to patient care (specifically, alcoholic beverages furnished as a fringe benefit).

2144.3 Requirements for Recognition of Fringe Benefits.--The costs of fringe benefits must be reasonable, as defined in §2102.1, and related to patient care, as defined in §2102.2.

2144.4 Fringe Benefits Includable as Provider's Cost.--Following are examples of fringe benefits:

- Provider contributions to certain deferred compensation plans (see §2140ff);
- Provider contributions to certain pension plans (see §2142ff);
- Paid vacation (see §2146), paid holidays, sick leave (see §2144.8), all-inclusive paid days off (see §2144.9), voting leave, court or jury duty leave, all of which generally are included in employee earnings;
- Provider-paid educational courses benefiting the employee's interest;
- Provider's unrecovered cost of meals (see §2145) and room and board furnished employees for the employees' convenience;
- Provider's unrecovered cost of medical services rendered to employees (see §332.1); and
- Cost of health and life insurance premiums paid or incurred by the provider if the benefits of the policy inure to the employee or his/her beneficiary.

2144.5 Fringe Benefits Includable in Determining Provider-Based Physician's Compensation.--Fringe benefits for the personal benefit of the provider-based physician are includable as part of his/her total compensation. (See §2108.2.D.1.)

2144.6 Specific Costs Not Classified as Fringe Benefits.--Fringe benefits do not include items furnished to the employee for the convenience of the provider. These include items which advance only the provider's interest, which may include the provider's cost of meals, payment of room and board, perquisites (uniforms and laundry), operating day care centers for the children of employees, and provider-paid educational courses. Although these costs are not classified as fringe benefits, they may be included in a provider's allowable cost to the extent they are reasonable in amount as defined in §2102.1 and related to patient care as defined in §2102.2.

2144.7 Accounting for Fringe Benefits.--Some providers' accounting systems are not designed to currently accumulate on a departmentalized or cost center basis the various employee fringe benefits incurred by the provider. Such providers may accumulate fringe benefits for all employees in one account during the cost reporting period, usually the administrative and general account. If a provider does not charge the cost of fringe benefits directly to the department or cost center where the employee is assigned, then the cost reimbursement forms, which are used to determine Medicare reimbursement, provide the mechanism for the allocation of fringe benefits to the appropriate cost centers.

2144.8 Sick Leave.--

A. Reasonable Costs.--The reasonable cost of sick leave taken (or payment in lieu of sick leave taken) by an employee of a provider is recognized as a fringe benefit and includable in allowable cost in the cost reporting period when paid. If the sick leave is vested and funded, contributions to the fund are allowed under the applicable provisions of §2140ff (deferred compensation). However, where the provider's sick pay plan grants employees the right to demand cash payment for unused sick leave at the end of each year, the pertinent accruals are includable in allowable costs, without funding, in the cost reporting period when earned.

B. Conversion from Cash Method to Accrual Method for Sick Pay.--

1. General.--When a provider changes its sick pay cost accounting from a cash method to an accrual method, the adjustments determined to be necessary solely because of such change must be taken into account in order to prevent costs from being duplicated or omitted in computing allowable costs for the cost reporting period in which the change is effected.

Allowable costs in the year of conversion include the accruable amount of costs for all sick pay earned and not paid as of the end of the year of conversion (either funded

under the applicable provisions of §2140ff, or not funded when employee has the right to demand cash for unused sick leave at the end of the year), plus sick pay costs paid in the year of conversion that were earned in both the year of conversion and in prior periods under Medicare. The accrual must be based on the sick pay policy as established by the provider.

As part of the conversion, an adjustment will be made to Medicare reimbursable costs in the year of conversion by subtracting the product of the amount of sick pay costs included in allowable costs in the first year the provider entered the Medicare program that applied to prior periods and the Medicare utilization in the year the provider entered the Medicare program.

2. Example.--A cash basis calendar year provider entered the Medicare program on January 1, 1982, and files its first cost report for the period ended December 31, 1982. The provider adopted the accrual method of accounting in accordance with regulations section 405.453(e), except for sick pay benefits. However, in July and August 1982, the provider paid sick pay benefits in the amount of $50,000 that were earned and properly accruable in prior periods. The provider included this amount in allowable costs for the year ended December 31, 1982. Allowable costs were not adjusted to exclude this amount, and the provider continued to include sick pay in allowable costs when paid.

As of the end of 1983, the provider accrued sick pay costs in the amount of $100,000. The provider also paid sick pay costs in the amount of $75,000 during 1983 that were earned in 1983 and in prior periods under Medicare.

a. Accruable amount as of December 31, 1983, and amounts paid in 1983 that were earned in both 1983 and in prior periods under Medicare	$175,000
b. Amount paid or funded in 1982 that applied to prior periods ($50,000 x 25% - percentage of Medicare reimbursement to total allowable costs for the period ended 12/31/82)	$12,500

3. Notes to Example.--Item a. represents an element of allowable costs subject to apportionment to Medicare in the year of conversion. Item b. represents an adjustment to Medicare reimbursement in the year of conversion and, therefore, should be separated between Part A and Part B costs and "included" (below the line on the settlement pages of the cost forms) with other Medicare reimbursement determined through apportionment. The proportions of reimbursable provider Part A costs and reimbursable provider Part B costs to the sum of both in the first year the provider entered the Medicare program must be used as the basis to allocate between Part A and Part B, with Part B reimbursed at 80 percent. This may be accomplished in the following manner:

Part A = Gross* Reimbursable Provider Part A Costs / Gross Reimbursable Provider Costs (Part A and Part B) X Sick Pay Cost Adjustment

Part B = Gross* Reimbursable Provider Part B Costs / Gross Reimbursable Provider Costs (Part A and Part B) X Sick Pay Cost X 80% Adjustment

* "Gross" refers to reimbursable costs before inclusion of deductible and coinsurance.

2144.9 All-Inclusive Paid Days Off (P.D.O.).--

A. Definition.--A formal plan under which all employees earn accrued vested leave -or payment in lieu of leave taken - for an unallocated combination of occasions such as illness, medical appointments, holidays, vacations, family bereavement, and taking care of a sick child, based on actual hours worked. (Note: An approved P.D.O. replaces a provider's other vacation and sick pay plans.)

B. Reimbursement.--The reasonable cost of P.D.O. is recognized as a fringe benefit and included in allowable costs. The provisions contained in §2146.2ff relative to vacation costs are incorporated by reference herein and adapted to all-inclusive paid days off by substitution of "P.D.O." each place the term "vacation" appears.

2145. Cost of Meals for Provider Personnel.--Any reasonable unrecovered cost of a provider's personnel meals is allowable when deemed a fringe benefit (see §2144.4E) related to patient care. Also, any reasonable unrecovered cost of a provider's personnel meals when deemed solely for the provider's benefit and related to patient care is allowable under the principle in §2102.2. An example of the latter is the cost of meals served to selected personnel who must remain on call to provide patient care on the provider's premises during mealtime and the cost of the meals is not deemed a fringe benefit.

Where a provider maintains multiple food services, e.g., a coffee shop or restaurant, in addition to a food service facility for provider personnel, and the additional food services are determined to be unnecessary for such personnel, the applicable unrecovered cost is unallowable. Some conditions under which the additional food services may be determined as necessary are the following:

1. The provider personnel food service facility (e.g., personnel cafeteria) has the capacity for serving all provider personnel meals;

2. It would be economically feasible to extend the hours of the personnel food service facility to serve meals to provider personnel on another work shift;

3. The type of food services offered in the additional facility could be offered in the provider's personnel food service facility.

On the other hand, where additional food service facilities are determined to be necessary to provide personnel meals, the reasonable unrecovered cost of these meals is allowable when deemed to be a fringe benefit or deemed to be for the provider's benefit, as explained above.

2146. VACATION COSTS

2146.1 Definition.--A vacation benefit is a right granted by an employer to an employee (a) to be absent from his job for a stipulated period of time without loss of pay, or (b) to be paid an additional salary in lieu of taking the vacation. (See §2144.9 for all-inclusive paid-days-off plans.)

2146.2 Reimbursement for Costs of Vacation.--Vacation costs must meet all of the following conditions to be included in allowable costs:

A. These costs must be included in the cost reporting period in which they are earned by the employee and must be computed from actual payroll records as related to each employee.

B. Where the provider's vacation policy is consistent among all employees, the vacation must be taken - or, if the employee elects to be paid in lieu of taking a vacation, the payment must be made - within the period consistent with the vacation policy established by the provider. Where the policy is not consistent among all employees, the vacation must be taken - or payment in lieu of vacation must be made - within 2 years after the close of the cost reporting period in which the vacation is accrued.

If payment is not made within the required period of time or in those instances where the vacation benefits accrued and included in allowable costs are forfeited by the employee for cause, the current year cost report must be adjusted. However, the intermediary may require the provider to file an amended cost report if necessary under our policy for amended cost reports. The time limitation in this section for payment as part of owners' compensation made for either vacation taken or for amounts in lieu of vacation taken supersedes the time limitation for payment specified in §906.4, Unpaid Compensation, of Chapter 9, Compensation of Owners.

C. Amounts allowed for vacation benefits must be reasonable in themselves and, together with other compensation, result in reasonable compensation for services rendered.

Employer payroll taxes applicable to vacation, such as F.I.C.A., must not be accrued in the period when the vacation costs are accrued, but treated as a cost in the period when the vacation costs are paid.

2146.3 Exception to the Requirement to Account for Vacation Costs on the Accrual Method.--Where a provider has been accounting for vacation costs on a cash basis and the intermediary determines that using such a method for vacation costs will yield results reasonably equivalent to the accrual method, a cash basis for vacation costs is allowed.

2146.4 Conversion from Cash Method to Accrual Method for Vacation.--

A. General.--When a provider changes its vacation cost accounting from a cash method to an accrual method, the adjustments determined to be necessary solely because of such change must be taken into account in order to prevent costs from being duplicated or omitted in computing allowable costs for the cost reporting period in which the change is effected.

Allowable costs in the year of conversion will include the accruable amount of vacation costs for all vacation earned and not paid as of the end of the year of conversion plus vacation costs paid in the year of conversion that were earned in both the year of conversion and in prior periods under Medicare. The accrual must be based on the vacation policy as established by the provider. No accrual will be allowed where an employee forfeited a vacation under the provider's vacation policy and for which the provider did not incur a liability. Moreover, in any event, the vacation accrual in the year of conversion must be limited to those vacations consistent with §2146.2B above.

As part of the conversion, an adjustment will be made to Medicare reimbursable costs in the year of conversion by subtracting the product of the amount of vacation costs included in allowable costs in the first year the provider entered the Medicare program that applied to prior periods and the Medicare utilization in the year the provider entered the Medicare program.

B. Example.--A cash basis calendar year provider entered the Medicare program on January 1, 1967, and filed its first cost report for the period ended December 31, 1967. The provider adopted the accrual method of accounting in accordance with Regulations section 405.453(e) except for vacation benefits. However, in July and August 1967, the provider paid vacation benefits in the amount of $50,000 that were earned and properly accruable in prior periods. The provider included this amount in allowable costs for the year ended December 31, 1967. Allowable costs were not adjusted to exclude this amount, and the provider continued to include vacations in allowable costs when paid.

As of the end of 1970, the provider accrues vacation costs in the amount of $100,000. The provider also paid vacation costs in the amount of $75,000 during 1970 that were earned in 1970 and in prior periods under Medicare.

1. Accruable amount as of December 31, 1970, and amounts paid in 1970 that were earned in both 1970 and in prior periods under Medicare	$175,000

2. Amount paid in 1967 that applied to prior periods ($50,000 x 25% - percentage of Medicare reimbursement to total allowable costs for the period ended 12/31/67) $12,500

C. Notes to Examples.--Item 1 represents an element of allowable costs subject to apportionment to Medicare in the year of conversion.

Item 2 represents an adjustment to Medicare reimbursement in the year of conversion and, therefore, should be separated between Part A and Part B costs and included (below the line on the settlement pages of the cost forms) with other Medicare reimbursement determined through apportionment. The proportions of reimbursable provider Part A costs and reimbursable provider Part B costs to the sum of both in the first year the provider entered the Medicare program must be used as the basis to allocate between Part A and Part B, with Part B reimbursed at 80 percent. This may be accomplished in the following manner:

Part A = Gross* Reimbursable Provider

$$\frac{\text{Part A Costs}}{\text{Gross Reimbursable Provider Costs (Part A and Part B)}} \times \text{Vacation Cost Adjustment}$$

Part B = Gross* Reimbursable Provider

$$\frac{\text{Part B Costs}}{\text{Gross Reimbursable Provider Costs (Part A and Part B)}} \times \text{Vacation Cost Adjustment} \times 80\%$$

*"Gross" refers to reimbursable costs before exclusion of deductible and coinsurance.

2147. BILINGUAL SERVICES

The costs incurred for bilingual services are allowable provider costs to the extent that the costs are reasonable both as to amount and in relationship to the extent of need for the services. They include, but are not limited to, the costs of translators for communication between the provider and patients, printed provider informational material distributed to patients, and special personnel recruitment efforts designed to recruit bilingual employees. For purposes of Medicare reimbursement, the term bilingual includes the ability to communicate with the deaf through sign language. Providers are encouraged to make bilingual services available to patients wherever the services are necessary to adequately serve a multilingual patient population.

2148. REIMBURSEMENT FOR PHYSICIANS' SERVICES RENDERED IN A TEACHING HOSPITAL BY PHYSICIANS ON THE HOSPITAL STAFF AND REIMBURSEMENT FOR SERVICES RENDERED IN A TEACHING HOSPITAL BY THE FACULTY OF A MEDICAL SCHOOL OR ORGANIZATION RELATED THERETO--GENERAL

Where the hospital exercises the election provided for in §2148.5, direct medical and surgical services, including supervision of interns and residents in the care of individual patients, rendered to Medicare patients in a teaching hospital by physicians on the hospital staff will be reimbursed as a provider service on a reasonable cost basis; and reasonable costs of direct medical and surgical services, including supervision of interns and residents in the care of individual patients, rendered to Medicare patients in a teaching hospital by physicians on the faculty of a medical school or organization related thereto may be reimbursed to the hospital by the program. These services are covered under Part A of the program when rendered to inpatients (unless Part A coverage has expired or is not available; in such case the inpatient could be covered under Part B of the program) and are covered under Part B of the program when rendered to outpatients.

Reasonable costs incurred by a medical school or organization related thereto in rendering other than direct medical and surgical services to Medicare patients in the hospital may be reimbursed to the hospital by the program . Reimbursement could also be made to a fund (see §2420) for physicians' volunteer direct medical and surgical services, including supervision of interns and residents in the care of individual patients, rendered on a regularly scheduled basis in a teaching hospital.

2148.1 Reasonable Cost of Direct Medical and Surgical Services Rendered by Physicians on the Hospital Staff in the Care of Individual Patients (Including Supervision of Interns and Residents Rendering Such Services).--Reasonable costs incurred by a teaching hospital in compensating physicians for direct medical and surgical services to patients, including supervision of interns and residents in the care of individual patients, are reimbursable by the program to the hospital. Such costs are not subject to cost finding as described in Chapter 23. Rather, these costs are separately accumulated and apportioned in accordance with the Aggregate Per Diem Method of apportionment. (See §2218.) For purposes of this section, reasonable costs are defined as the direct salary paid to such physicians plus applicable fringe benefits. Other allowable costs incurred by the provider related to the services described in this section are reimbursable subject to the requirements pertaining to all other provider services, including cost finding.

2148.2 Reasonable Costs Incurred by a Teaching Hospital for the Services Rendered by a Medical School or Related Organization in the Hospital.--

A. Direct Medical and Surgical Services (Including Supervision of Interns and Residents in the Care of Individual Patients).--Reasonable costs incurred by a teaching hospital for direct medical and surgical services rendered by a medical school (or an organization related to the medical school) in the hospital are reimbursable to the hospital by the program, provided that such costs would be reimbursable if incurred

directly by the hospital rather than under such arrangement. In situations where the medical school (or organization related to the medical school) and the hospital are related by common ownership or control in accordance with Chapter 10, the costs of such services are allowable costs to the hospital under the provisions of that chapter and the reimbursable costs to the hospital are determined under the provisions of this section in the same manner as the costs incurred for physicians on the hospital staff and without regard to payments made to the medical school by the hospital. For purposes of the preceding sentence, the allowable costs to the medical school or organization related thereto is defined as the physicians' direct salaries, applicable fringe benefits, employer's portion of FICA taxes, Federal and State unemployment taxes, and workmen's compensation. Such costs are subject to substantiation by the hospital with appropriate documentation showing that these costs are related to the rendition of patient care services in the hospital.

The Medicare program will recognize additional costs only if necessary and directly related to the rendition of the services; however, in the following situations, any costs incurred by the medical school that would represent duplications of costs incurred by the hospital, would not be recognized by the program, i.e., where: (1) the hospital maintains a medical library; (2) the hospital has its own administrative structure; and (3) the hospital maintains physician office space and clerical support. Such costs are also subject to substantiation by the hospital and/or medical school or organization related thereto. The costs of the physicians' direct salaries plus applicable fringe benefits are not subject to cost finding as required by Chapter 23. Rather, these costs are separately accumulated and apportioned in accordance with the Aggregate Per Diem Method as described in §2218. Allowable costs other than direct salaries and applicable fringe benefits are subject to the cost finding and apportionment methods required for all provider services (excluding physicians' direct medical and surgical services rendered to patients).

Where the medical school and the hospital are not related organizations, (see Chapter 10), and the hospital makes payment to the medical school for the costs of direct medical and surgical services rendered to all patients in the hospital by the medical school or organization related thereto, reimbursement will be made by the health insurance program to the hospital for the reasonable costs incurred by the hospital for its payments to the medical school for services to Medicare patients. Costs incurred under such an arrangement must be allocated to the full range of services provided to the hospital by physicians of the medical school on the same basis as provided for under §2148.4 and costs of physicians' direct salaries plus applicable fringe benefits so allocated to direct medical and surgical services to hospital patients must be apportioned to Medicare patients in accordance with §2204. Allowable costs other than direct salaries and applicable fringe benefits are subject to the cost finding and apportionment methods required for all provider services.

Where the medical school and the hospital are not related organizations (see Chapter 10) and the hospital makes payment to the medical school for the costs of direct medical and surgical services rendered only to Medicare patients, the allowable costs to the medical school may not exceed 105 percent of the sum of physicians' direct salaries, applicable fringe benefits, employer's portion of FICA taxes, Federal and State unemployment taxes, and workmen's compensation paid by the medical school or organization related thereto. Such allowable medical school costs must be allocated to the full range of services rendered by the physicians of the medical school or organization related thereto as provided in §2148.4 and all the costs defined in this paragraph so allocated to direct medical and surgical services to hospital patients must be apportioned to program beneficiaries as provided in §2204. Such costs are reimbursable only where (1) there is a written agreement between the hospital and the medical school or organization related thereto specifying the types and extent of services to be furnished by the medical school and specifying that the hospital must pay the medical school at least an amount equal to the reasonable costs (as defined in this paragraph) of providing such services to Medicare patients, (2) such costs are paid to the medical school by the hospital no later than the date on which the cost report covering the period in which the services were rendered is due, and (3) payment for such services furnished under such arrangement would be made by the program to the hospital had such services been furnished directly by the hospital.

B. Reasonable Costs of Other Than Direct Medical and Surgical Services.-Reasonable costs incurred by a medical school (or organization related thereto) in rendering other than direct medical and surgical services in the hospital will be reimbursed by the program to the hospital in the same manner as in paragraph A above except that where the medical school (or organization related thereto) incurs costs for these services rendered to both Medicare and non-Medicare patients, these costs are subject to the cost finding and apportionment methods for all provider services (excepting physicians' direct medical and surgical services rendered to patients). Where the medical school (or organization related thereto) incurs costs for these services rendered only to Medicare patients, then the costs are not subject to cost finding and must not be included in the hospital's total allowable costs. Nevertheless, Medicare's portion must be determined on the basis of the Medicare ratio(s) used in the apportionment of all other provider costs (excepting physician's direct medical and surgical services rendered to patients) applied to the allowable costs incurred by the medical school (or organization related thereto) for the services rendered to all patients in the hospital. An example of these services is supervisory laboratory services rendered by a member of the medical school faculty.

2148.3 "Salary Equivalent" Payments for Direct Medical and Surgical Services in the Care of Individual Patients (Including Supervision of Interns and Residents Rendering Such Care) by Physicians on the Voluntary Staff of the Hospital (or Medical School or Organization Related Thereto).--Payments will be made to a fund for direct medical and surgical services rendered on a regularly scheduled basis to Medicare patients by physicians on the unpaid voluntary medical staff of the hospital (or medical school or organization related thereto under arrangement with the hospital) provided that the conditions outlined in §2420 are met. Such payments represent compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a reimbursable basis. Payments for volunteer services are determined by applying to the regularly scheduled contributed time an hourly rate not to exceed the equivalent of the average direct salary (exclusive of fringe benefits) paid to all full-time salaried physicians (other than interns and residents) on the hospital staff, or where the number of full-time salaried physicians is minimal in absolute terms or in relation to the number of physicians on the voluntary staff, to physicians at like institutions in the area. This "salary equivalent" is a single hourly rate, covering all physicians regardless of specialty, and is applied to the actual regularly scheduled time contributed by the physicians in rendering direct medical and surgical services to Medicare patients including supervision of interns and residents rendering such care. The amount applicable to program beneficiaries and payable to a fund will be determined in accordance with the Aggregate Per Diem Method (see §2218). (See §2420E on the use of benefits by a fund.)

A physician who receives any compensation from the hospital, or a medical school related to the hospital by common ownership or control, for direct medical and surgical services rendered to any patient in the hospital will not be considered an unpaid voluntary physician for purposes of this paragraph. Where, however, a physician receives compensation from the hospital or related medical school (or organization related thereto) only for services which are other than direct medical and surgical services, a salary equivalent payment for his regularly scheduled direct medical and surgical services to Medicare patients of the hospital may be imputed but such amount for volunteer services when added to his actual compensation from the hospital and the related medical school (or organization related thereto) may not exceed the amount that would have been imputed if all of his hospital and medical school services (compensated and volunteer) had been volunteer services or at the rate of $30,000 per year, whichever is less.

The following examples assume that the average salary equivalent hourly rate is equal to the hourly rate for the individual physician's compensated services:

EXAMPLE l: Dr. Jones receives $3,000 a year from Hospital X for services other than direct medical and surgical services to all patients, e.g.,

utilization review, administrative services, etc. Dr. Jones also voluntarily rendered direct medical and surgical services to Medicare patients. The imputed value of the volunteer services amount to $10,000 for the cost reporting period. The full imputed value of Dr. Jones' volunteer direct medical and surgical services would be allowed since the total amount of the imputed value ($10,000) and the compensated services ($3,000) does not exceed $30,000.

EXAMPLE 2: Dr. Smith received $25,000 from Hospital X for services as a department head in a teaching hospital. Dr. Smith also voluntarily rendered direct medical and surgical services to Medicare patients. The imputed value of the volunteer services amounted to $10,000. Only $5,000 of the imputed value of volunteer services would be allowed since the total amount of the imputed value ($10,000) and the compensated services ($25,000) exceeds the $30,000 maximum amount allowable for all his services.

COMPUTATION

Maximum amount allowable for all services performed by Dr. Smith for purposes of this computation	$30,000
Less compensation received from Hospital X for other than direct medical and surgical services to individual patients	$25,000
Allowable amount of imputed value for the volunteer services rendered by Dr. Smith	$ 5,000

EXAMPLE 3: Dr. Brown is not compensated by Hospital X for any services rendered in the hospital. Dr. Brown voluntarily rendered direct medical and surgical services to Medicare patients for a period for six months and the imputed value of these services amounted to $20,000. The allowable amount of the imputed value for volunteer services rendered by Dr. Brown would be limited to $15,000 ($\frac{6 \text{ months}}{12 \text{ months}}$ = 50% x $30,000).

The amount of the imputed value for volunteer services applicable to Medicare patients and payable to a fund will be determined in accordance with the Aggregate Per Diem Method described in §2204.

2148.4 Allocation of Compensation Paid to Physicians in a Teaching Hospital.--In determining reasonable cost under this section, the compensation paid by a teaching hospital, to physicians in a teaching hospital must be allocated to the full range of services implicit in the physicians' compensation arrangements and for which they are not otherwise compensated. (However, see §2148.3 for the computation of the

"salary equivalent" payments for volunteer services rendered to patients.) Such allocation must be made and must be capable of substantiation on the basis for the proportion of each physician's time spent in rendering each type of service to such hospital and/or medical school or organization related thereto.

2148.5 Election to Receive Medicare Reimbursement on A Reasonable Cost Basis.-For cost reporting periods beginning after June 30, 1973, and before July l, 1976, a teaching hospital may elect to receive reimbursement on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of any payment on the basis of reasonable charges which might otherwise be payable for such services. A hospital may make this election to receive cost reimbursement only where all physicians who render services in the hospital which are covered under the Medicare program agree in writing not to bill charges for such services (or where all the physicians are employees of the hospital and as a condition of employment they are precluded from billing for such services).

A. Current or Future Periods.--Where the election to receive cost reimbursement is for a current or future period, each physician who provides services to Medicare beneficiaries must agree in writing (except where the employment restriction discussed above exists) not to bill charges for services provided to Medicare beneficiaries. However, where each physician agrees in writing to abide by all the rules and regulations of the medical staff or the hospital (and, as appropriate, the fund), such an agreement will suffice if the agreement is required as a condition of staff privileges, and the rules and regulations of the hospital or fund clearly preclude physician billing for the services for which cost benefits are payable. A copy of the rules or regulations or a copy of the standard agreement used by the hospital or fund should be furnished to the fiscal intermediary, and the signed agreements must be maintained on file by the provider and are subject to periodic review by the intermediary. The intermediary must advise the carrier, where a hospital elects cost reimbursement for physicians' services, and supply the carrier with a list of all physicians who provide services in the facility. These actions must be completed before any cost payments under this provision may be made.

B. Past Periods.--Where an election to receive cost reimbursement for physicians' services is made for a past period, it is not necessary to obtain the signed agreements discussed above. However, the cost payment made by the intermediary will be reduced by an amount equal to the aggregate reasonable charges applicable to any services reimbursed by the carrier during the period in question. Since the period for filing claims for reasonable charge reimbursement differs somewhat from the period for filing hospital cost reports, the hospital (or the fund, as appropriate) is required to agree to further adjust if Part B claims are received and paid by the carrier subsequent to the time for which cost payments are made.

2150. HOME OFFICE COSTS--CHAIN OPERATIONS

A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care. (See §§1002.2 and 1002.3 for definitions of common ownership and control.)

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicare program is that of a related organization to participating providers. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.

Very often the home office of a chain organization charges the providers in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, except where §1010 is applicable, and such fees must be deleted from the provider's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the provider. The instructions for preparation of a home office cost statement containing schedules for the determination of home office costs and equity capital, and their allocation, are set forth in §2153.

Section 2150 is not applicable to franchise fees (see §2135ff), management fees or fees for other services paid by a provider where there is no common ownership or control between the provider and the franchisor or other service organization, or where the exception to the related organization principle applies (see §1010).

2150.1 General Limitation on Allowability of Costs.--Where a provider is furnished services, facilities, or supplies from an organization related to it by common ownership or control, the costs allowed are subject to the provisions of chapter 10. Thus, allowable cost is limited to the lower of (1) allowable costs properly allocated to the provider, except as indicated in §1010, or (2) the price for comparable services, facilities, or supplies that could be purchased elsewhere, taking account of the benefits of effective purchasing that would accrue to each member provider because of aggregate purchasing on a chainwide basis.

2150.2 Determination of Allowable Costs.--

A. General.--Home office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.) are allowable to the extent they are reasonable (see §2102.1). Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. For example, certain advertising costs (see §2136.2), some franchise taxes and other similar taxes (see §2122.4), costs of noncompetition agreements (see §2105.1), certain life insurance premiums (see §2130), certain membership costs (see §§2138.3 and 2138.4) or those costs related to nonmedical enterprises are not considered allowable home office costs. In addition, where an owner of the provider, as defined in chapter 9, received compensation for services provided by the home office, the compensation is allowable only to the extent that it is related to patient care (see §902.2) and to the extent that it is reasonable (see §902.3).

B. Organization, Start-Up, and Other Corporate Costs.--

1. Organization Costs.--The organization costs of a home office (except those referred to below) are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions in §2134ff. Section 2134.1B describes costs which are not considered allowable organization costs. In addition, reorganization costs (see §2134.10) and stockholder servicing costs (see §2134.9) are not allowable organization costs. These unallowable organization costs are excluded from the computation of the home office equity capital.

2. Start-Up Costs.--Start-up costs of a home office are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions of §2132ff.

3. Costs of Corporate Acquisitions.--Costs related to the acquisition of the capital stock of a provider, whether or not such facilities are participating or subsequently will participate in the Medicare program, are not allowable (see §2134.11). Additionally, costs connected with the transfer of assets to a chain are not allowable as organization costs but instead must be capitalized as part of the cost of the asset (see §104.10).

C. Interest on Loans Between Home Office and Components of Chain.--Where the home office makes a loan to, or borrows money from, one of the components of the chain, the interest paid is generally not an allowable cost and the interest income earned from such a loan is not used to reduce allowable interest expense. (See §218 for the general rule and §§218.2 and 220 for exceptions to the general rule.)

D. Interest on Loans from Unrelated Sources.--Interest expense (see §200ff) is allowable to the extent that the proceeds of the related loan, mortgage, bond issue, etc., are used either to acquire assets for use in patient care activities (capital related) or to provide funds for operations related to patient care (noncapital related). The interest expense must be reduced by investment income as defined in §202.2. For the allocation of interest expense and investment income, refer to §2150.3.E. Where proceeds of a loan, mortgage, bond issue, etc., are used to acquire stock ownership (as opposed to assets and liabilities) of additional facilities, the interest expense is not allowable.

E. Home Office Planning Costs.--This policy is effective for all cost reporting periods beginning on or after June 1, 1976.

1. Expanding, Rebuilding, or Relocating Existing Providers.--When a home office incurs planning costs as described in §§2154.1 and 2154.2 to purchase or construct a new facility, to expand, rebuild, or relocate a provider which is a member of a chain organization, such costs are allowable when:

a. They are reasonable and prudent as defined in §2103;

b. They have been included in the historical cost of the completed facility;

c. The facility has been certified to participate in the Medicare program; and

d. The facility has been approved under §1122 of the Social Security Act. (See §2422ff.)

Any planning costs incurred to purchase land become part of the historical cost of the land and are not included in the historical cost of the depreciable assets of the completed facility. If a home office incurs planning costs for both land and a facility, and such costs cannot be specifically identified with either the land or facility, the planning costs must be allocated between the land and facility based on the cost of each to the total cost.

If a home office abandons plans, the abandoned planning costs are treated as provided for in §2154.4. Any allowable abandonment costs must be directly allocated to the appropriate provider.

2. Expansion of the Chain Operation.--

a. Allowable.--If a home office incurs planning costs to construct a new facility or to purchase an existing facility (excluding land) to expand a chain organization and not to expand an existing provider, such costs are recognized when the requirements enumerated in subsection 1. above are met.

b. Nonallowable.--If a home office abandons plans described in a. above, the costs of the abandoned plans are considered an investment loss and are not allowable. Also, where plans involving the acquisition of land are abandoned, the costs of such plans are not allowable.

F. Malpractice and Comprehensive General Liability, Unemployment and Workers' Compensation Insurance Coupled with Second Injury Coverage.--Payments by a home office of a chain for its providers, or individually by members of a chain to an independent fiduciary for malpractice and comprehensive general liability insurance coverage, as well as unemployment and workers' compensation, coupled with second injury coverage, will be recognized if made to a fund established in accordance with the requirements in §2162ff.

2150.3 Allocation of Home Office Costs to Components in Chain.--

A. Procedure.--Starting with its total costs, including those costs paid on behalf of providers (or other components in the chain), the home office must delete all costs which are not allowable in accordance with program instructions. The remaining costs (total allowable costs) will then be identified as capital-related costs and noncapital-related costs and allocated as stated below to all the components--both providers and non-providers--in the chain which received services from the home office.

Where the home office incurs costs for activities not related to patient care in the chain's participating providers, the allocation bases used must provide for the appropriate allocation of costs such as rent, administrative salaries, organization costs, and other general overhead costs which are attributable to nonpatient care activities, as well as to patient care activities. All activities and functions in the home office must bear their allocable share of home office overhead and general administrative costs.

B. Costs Directly Allocable to Components.--The initial step in the allocation process is the direct assignment of costs to the chain components. Allowable costs incurred for the benefit of, or directly attributable to, a specific provider or nonprovider activity must be allocated directly to the chain entity for which they were incurred. For example, where such costs are paid by the home office, interest expense is allocated to the facility for which the loan was made; salaries are allocated to the facility to whose employees they apply; etc. Home offices may simplify the allocation of costs to the chain components in the cost finding process by transferring the costs which are directly allocable to the components through the intercompany accounts. The transfers should be made at the time the costs are incurred.

C. Costs Allocable on a Functional Basis.--The allowable home office costs that have not been directly assigned to specific chain components must be allocated among the providers (and any nonprovider activities in which the home office may be engaged) on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the entities in the chain. Chain home offices may provide certain centralized services, such as central payroll or central purchasing, to the chain components. Where practical and the amounts are material, these costs must be allocated on a functional basis. For example, costs of a central payroll operation could be allocated to the chain components based on the number of checks issued; the costs of a central purchasing function could be allocated based on purchases made or requisitions handled. Any residual allowable home office costs remaining after a functional cost allocation has been completed must be included as pooled costs and allocated as described in subsection D. below. The functions, or cost centers used to allocate home office costs,

and the unit bases used to allocate the costs, including those for the pooled costs described in subsection D., must be used consistently from one home office accounting period to another.

However, if the home office wishes to change its allocation bases and believes the change will result in more appropriate and more accurate allocations, the home office must make a written request, with its justification, to the intermediary responsible for auditing the home office cost for approval of the change no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The intermediary's approval of a home office request will be furnished to the home office in writing. Where the intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods unless the intermediary approves a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made.

D. Pooled Costs in Home Office.--In each home office there will be a residual amount, or "pool," of costs incurred for general management or administrative services which cannot be allocated on a functional basis. For home office accounting periods beginning before November 1, 1976, these costs may be allocated to the components in the chain on the basis of beds, bed days, or other basis, provided the basis used equitably allocate such costs. Revenues are not generally appropriate for distributing these costs. Where the home office cannot determine its costs by functions and allocate them on a functional basis, the home office must allocate its costs as one cost center of pooled costs.

1. For home office accounting periods beginning on or after November 1, 1976, but beginning before January 1, 1983, the pooled costs of the home office must be allocated to the chain components in accordance with the following:

a. Where the chain consists solely of health care facilities, the pooled costs must be allocated to the components based on either inpatient days or total costs. If inpatient days are used, each facility would share in the pooled costs in the same proportion that its inpatient days bear to the total inpatient days of all the facilities in the chain. The basis of inpatient days can be used only if the entire chain consists solely of inpatient health care facilities. If the chain consists of both inpatient and noninpatient type of facility, total costs must be used as the basis of allocation. If total costs are used, each facility would share in the pooled costs in the same proportion that its total costs (excluding home office costs) bear to the total costs of all facilities in the chain. Total costs are costs before Medicare adjustments are made.

b. Where the chain consists of health care facilities and organizations carrying on other types of activities, such as pharmacies, construction companies, etc., the pooled costs may be allocated to the health care facilities and non-health care organizations on an appropriate basis, depending upon the organization of the chain. The

intermediary would be responsible for reviewing and approving the basis used. After this initial allocation, the pooled costs allocated to the health care facilities must then be allocated to each separate facility as set forth in a. above.

2. For home office accounting periods beginning on or after January 1, 1983:

a. Pooled home office costs must be allocated on the basis of inpatient days, provided the entire chain consists solely of comparable inpatient health care facilities (e.g., the entire chain is composed solely of short-term inpatient hospitals). Where this situation exists, each facility in the chain would share in the pooled costs in the same proportion that its total inpatient days bears to the total inpatient days of all the facilities in the chain.

b. Pooled home office costs must be allocated to chain components on the basis of total costs if the chain is composed of either unlike health care facilities (e.g., a combination of short-term hospitals, long-term hospitals, and home health agencies) or a combination of health care facilities and non-health care facilities (i.e., facilities engaged in activities other than the provision of health care). Under this basis, all chain components will share in the pooled home office costs in the same proportion that the total costs of each component (excluding home office costs) bear to the total costs of all components in the chain. Total costs are costs before Medicare adjustments are made.

Where a chain consists of health care facilities and organizations carrying on other types of activities, pooled costs can be initially allocated to the health care facilities and non-health care facilities on an appropriate basis depending upon the organization of the chain, subject to intermediary approval as explained in the following paragraph. After this initial allocation has been performed, the pooled costs allocated to the health care facilities must then be distributed to these chain components in accordance with the requirements of paragraphs a. or b. above, as appropriate.

If evidence indicates that the use of a more sophisticated allocation basis would provide a more precise allocation of pooled home office costs to the chain components, such basis can be used in lieu of allocating on the basis of either inpatient days or total costs. However, intermediary approval must be obtained before any substitute basis can be used. The home office must make a written request with its justification to the intermediary responsible for auditing the home office cost for approval of the change no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The intermediary's approval of a home office request will be furnished to the home office in writing. Where the intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods, unless the intermediary approves a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made.

E. Allocation of Interest Expense and Investment Income of Chain Operations.--Interest expense incurred by the home office must be appropriately assigned and/or allocated in accordance with subsections 2150.3.A-D. As required in §2150.3.A., interest expense must be separately identified between capital-related and noncapital-related.

Similarly, all home office investment income which is subject to offset (see §202.2) against allowable interest expense must be appropriately assigned and/or allocated in accordance with the methodology of subsections 2150.3.A-C, and separately identified between capital-related and noncapital-related. Any investment income which cannot be allocated in accordance with subsections A-C must be allocated in the same proportion that the total capital related or noncapital related interest expense of each component bears to the total interest expense of all components in the chain. The net amount of capital-related interest expense and investment income (whether positive or negative) so determined, at the home office level for each chain provider, must be appropriately included with that chain provider's costs as described in F. below. Also, the net amount of noncapital-related interest expense and investment income (whether positive or negative) so determined at the home office level, for each chain provider, must be appropriately included with that chain provider's costs as described in F., below.

F. Inclusion in Provider Costs.--Home office costs directly allocated to the chain providers should be included in each appropriate account in the provider's trial balance and then allocated through the provider's cost-finding process. The provider's share of the home office's allowable costs is included in the provider's adjusted trial balance with the provider's own allowable costs. This amount, like other costs, must be allocated between patient care and nonpatient care activities.

The provider's share of the net amount of home office capital-related interest expense and investment income is subject to offset by the provider's own capital-related investment income and included with the provider's capital-related costs. If the provider's share is a negative amount, it should be added to the provider's capital-related investment income and the combined amount used to reduce the provider's capital-related interest expense.

The provider's share of the net amount of home office noncapital-related interest expense and investment income is subject to offset by the provider's own noncapital-related investment income and included with the provider's Administrative and General costs. If the provider's share is a negative amount, it should be added to the provider's noncapital-related investment income and the combined amount used to reduce the provider's noncapital-related interest expense.

Although the share of the home office costs allocated to each provider may thereby become allowable costs under the program, the allowed costs of providers in a chain should not exceed the cost allowed for similar institutions not so affiliated. Thus, the costs of a chain provider (including any allowable home office costs) are not recognized or allowed to the extent they are found to be out of line with similar institutions in the same area. (See §2102ff.)

G. Interperiod Allocation of Home Office Costs.--When the home office accounting period differs from the cost reporting period of a chain provider, the allowable home office costs of the provider for the period covered by the home office cost statement should be included in the provider's cost report as indicated above and then allocated through the cost-finding process. An amount of allowable home office costs and equity capital for the provider for the portion of its reporting year not covered by the home office statement will be tentatively projected at a rate not in excess of the previous year's home office costs and equity capital as set forth in the applicable home office cost statement.

Example:

The home office has an accounting year ending August 31, 1974. For that year, home office costs of $120,000 were allocated to Provider A and $84,000 to Provider B. Provider A's reporting year ends on December 31; Provider B's reporting year ends on March 31.

Of the $120,000 costs allocated to Provider A, $40,000 applies to its reporting year ended 12/31/73, covering the period from 9/1/73 to 12/31/73; and $80,000 applies to its reporting year ending 12/31/74, covering the period from 1/1/74 to 8/31/74. Therefore, in its cost report for the year ending 12/31/74, Provider A may include home office costs of $40,000 projected for the period 9/1/74 to 12/31/74, which is not covered by the home office cost statement ($10,000 per month x 4 months).

Of the $84,000 allocated to Provider B, $49,000 applies to its reporting year ending 3/31/74, covering the period from 9/1/73 to 3/31/74; and $35,000 applies to its reporting year ending 3/31/75, covering the period from 4/1/74 to 8/31/74. Therefore, in its cost report for the year ending 3/31/75, Provider B may include home office costs of $49,000 projected for the period 9/1/74 to 3/31/75, which is not covered by the home office cost statement ($7,000 per month x 7 months).

A similar procedure would be followed for projecting an amount of home office equity capital. Then, the following year, when actual costs and equity capital are determined, the projected amounts will be adjusted to agree with the actual amounts, and appropriate adjustments made to the provider's reimbursement.

2152 HOME OFFICE EQUITY CAPITAL

2152.1 Computation.--Where a chain provider received services from the home office and the program recognizes the costs of such services for reimbursement purposes (see §2150.1), the provider must include in its equity capital computation its proportionate share of the equity capital of the home office which is related to patient care as defined in §1202.l. In the determination of home office equity capital, assets and liabilities not related to patient care activities are excluded in the computation.

The equity capital of the home office is computed generally in the same manner as for providers (see chapter 12). That is, a calculation is made at the end of the home office's accounting period to analyze the equity capital and changes therein during the period and to determine the amounts of home office equity capital at the end of each month in the period. However, where a negative amount is shown in the home office equity capital balance for any month, the actual negative amount of equity capital is included for that month in the provider's cost reports to determine the provider's average equity capital.

2152.2 Exclusions.--

A. Loans and Other Intercompany Transfers.--Loans to (or from) the home office or other components of the chain from (or to) the provider cannot be considered as assets or liabilities in computing the equity capital of the home office or of the provider where interest payments are not allowable (see §1210). In addition, amounts due to (or from) the home office or other component in the chain from (or to) the provider as a result of transfers of assets between the components of the chain or as a result of other intercompany transactions are not includable in computing the equity capital of the home office or of the provider.

B. Assets Leased from Home Office.--Where assets are leased by the provider from the home office (or other related organization) and the owner's equity in the leased assets is included in the equity capital of the provider under §1212, the owner's equity in the asset may not be included in the equity capital of the home office. The equity in the leased asset must be computed and included in the provider's equity capital in the same manner that home office equity capital is included; that is, on a month-by-month basis with negative amounts, if any, carried over to the provider from the home office. (See §2152.1.)

C. Investment in Capital Stock of Provider.--The home office's investment in the capital stock of the provider or of any other component in the chain and loans made to finance the purchase of such investments are not includable in the equity capital of the home office.

2152.3 Allocation of Home Office Equity Capital.--After the home office equity capital is determined in accordance with §§2152.1 and 2152.2, the home office equity capital must be allocated to the providers and other components in the chain (including non-health care areas) which receive services from the home office. Any assets and liabilities on the financial records of the home office, and includable in equity capital of the home office, which are directly attributable of a particular provider or other entity in the chain, must be allocated directly to the particular provider or other entity in the chain and included in that entity's equity capital. For example, where the equity in the equipment must be directly allocated to that provider. In the same manner, if the home office borrowed funds to finance the purchase of the equipment, the liability must also be allocated directly to the provider and included in the provider's equity capital computation.

Where borrowed and internally generated funds are transmitted by the home office to the providers or other entities in the chain and the funds have become so commingled as to preclude separate identification, the liability for the borrowed funds is allocated to the providers and other entities in the chain in the proportion that the funds received by that provider or other entities bear to total funds disbursed.

The equity in those assets and liabilities which are directly allocable to a particular provider must be included in the computation of the average equity capital of the provider on a monthly basis. The effect of this would be the same as if the provider itself owned the assets and owned the liabilities. Home offices can simplify the computation of home office equity capital and the allocation of equity capital to the chain components in the cost finding process by transferring the assets and liabilities which are directly allocable to the components through the intercompany accounts. The transfers should be made at the time the assets and/or liabilities become directly allocable.

The remaining home office equity capital, or “pooled” equity capital, related to patient care and computed under §2152 must be allocated to each provider and other entity in the chain. The basis used for the allocation of pooled equity capital is the ratio that the portion of home office costs allocated to each provider or other entity bears to total home office costs. Home office costs which are directly allocable to a provider or other component in the chain (see §2150.3B) should be excluded from the allocation base used to allocate “pooled” equity. The ratio developed for the allocation of home office equity capital must be applied to the amount of equity capital computed at the end of each month in the computation of average equity capital of the home office. In effect the home office equity capital is considered as a group of net assets used to provide services to the providers and other entities in the chain.

The costs of these services allocated to the providers are considered to be a measure of the degree to which the related equity capital is used for the benefit of the providers. Each provider must include its

allocated share of the pooled equity capital of the home office at the end of each month in the computation of its total equity capital for each respective month to determine its combined average equity capital upon which the return on equity capital is based.

2153. REPORTING OF HOME OFFICE COSTS AND EQUITY CAPITAL

Each intermediary servicing a provider in a chain must be furnished with a detailed home office costs statement as a basis for reimbursing the provider for home office costs and equity capital. The home office cost statement must be prepared as of the end of the home office accounting year, setting forth home office costs and equity capital for the accounting year then ended. Only one copy of the cost statement is required for each intermediary regardless of the number of providers in the chain the intermediary is servicing. The home office cost statement may be obtaining either from the chain provider or from the chain home office.

The home office cost statement constitutes the documentary support required of the provider to be reimbursed for home office costs and equity capital in the provider's cost report. The financial records of the home office, in turn, are the necessary support for the data in the home office cost statement. Preparation of, and furnishing, the home office cost statement then is a home office responsibility. If a provider or the home office does not furnish a home office cost statement to the intermediary, the intermediary will not have adequate data to support payments for home office costs and equity capital and must delete home office costs and equity capital allocations from reimbursement. Corresponding changes would be made to interim rates of reimbursement affected by the deletion of home office costs.

Since the intermediary must have an acceptable home office cost statement before it can reimburse the provider for home office costs and equity capital, the cost statement should be furnished to the intermediary within 90 days after the close of the home office accounting year. Timely furnishing of the home office cost statement will facilitate the intermediary's settlement of the provider's cost report and reimbursement for the home office costs and equity capital.

To be acceptable, the home office cost statement must be prepared in a format which contains detailed schedules of the determination of home office costs and equity capital and their allocation.

A. Home Office Costs.--The determination of allowable costs of the home office should begin with the total costs of the home office, by cost centers, as shown by the home office general ledger trial balance; should show the reductions for those costs which are not allowable; and should then show the adjusted trial balance of total allowable costs. The reductions for unallowable costs should be identified and explained on a supporting schedule.

A schedule (or schedules) for the allocation of the allowable costs to all of the entities serviced by the home office must be included showing each related entity in the chain and the amount of home office costs allocated to each related entity, based on the procedures set forth in section 2150. Where services are provided by the home office to nonrelated entities, such as to hospitals serviced under management contracts, the allocations of costs for these entities may be consolidated on the cost statement. However, detailed working papers should be maintained by the home office to support the allocations of costs consolidated on the statement. The costs allocated to each provider would then be included in the provider's cost report for reimbursement by the Medicare program.

B. Home Office Equity Capital.--The determination of home office equity capital should be made on a schedule similar to Supplemental Worksheet F, Part I, Form SSA-2552G, Return on Equity Capital of Proprietary Providers. The equity capital is determined based on the assets, liabilities, and capital account balances as set forth in the home office's balance sheet as of the end of its accounting year. Those assets and liabilities which are not includabel should be deleted to arrive at an adjusted balance sheet for equity capital purposes under Medicare. The adjustments made to delete assets and liabilities not includable in equity capital should be identified and explained on an attached schedule. An adjusted balance sheet for the determination of equity capital for Medicare purposes must be made for both the beginning and end of the first year in the program, and at the end of each accounting year, thereafter.

A schedule similar to Supplemental Worksheet F, Part II, FormSSA-2252G, must be prepared to calculate the monthly balance of the home office equity capital, in accordance with section 2152. The monthly balances of equity capital must then be allocated to the providers and other entities in the chain. The amounts of home office equity capital allocated to each provider for each month in the accounting period must be combined with the provider's own equity capital for the corresponding month in its own calculation. Where negative amounts of home office equity capital have been computed, the actual negative amounts of home office equity capital have been computed, the actual negative amounts are brought forward to the provider's cost report for inclusion in its computation.

C. Bases for Allocations.--a statement must be included explaining the various home office allowable costs. Where the home office has departmentalized its home office costs by functions, i.e., accounting, personnel, purchasing, etc., and allocates such costs on an appropriate unit basis, the home office cost statement should contain a full explanation of the unit basis used in each case. Also, where specific items of home office assets and liabilities are allocated directly to a particular provider or other entity, the statement should contain an

explanation for, and the basis of, such direct allocation. The intermediary responsible for the home office audit will determine the appropriateness of the method of allocation used, in addition to the appropriateness of the bases of allocation used.

However, where "pooled" home office costs and equity capital are concerned, the bases for allocating such amounts are limited to specific ratios. (See §§2150.3D and 2152.3.)

Where the chain provider has a cost reporting period ending date extending beyond the ending date of the home office's accounting year, the home office costs and equity capital included in the provider's cost report for a portion of the reporting period will not be supported by a cost statement. In such cases, the intermediary may reimburse the provider tentatively for amounts of home office costs and return on equity capital projected at a rate not in excess of the previous year's home offices costs and return on equity capital as set forth in the related home office cost statement. When the current year's home office cost statement is submitted, the projected amount will be adjusted to the actual amounts which should be included.

2154. PLANNING COSTS

2154.1 General.--When a provider plans for any physical plant construction or plans to purchase an existing facility or land to expand, rebuild, or relocate its present facility, it generally incurs planning costs. The planning costs may include feasibility studies, engineering studies, architect fees, finder's fees, etc., and usually involve the provider's staff and/or the use of outside consultants. The planning may either be initiated by a provider or required by an area planning agency.

Planning costs generally become part of the historical cost of a completed facility. (See §2154.3 for specifics.) However, where a provider abandons its plans, the abandoned planning costs are allowable where the provider had planned to expand its present facility by adding new wings, departments, or buildings, which would have been included under its present certification, and such costs were reasonable.

On the other hand, where a provider plans to open a new facility which would be separately certified under the program, while continuing to perform services at the present location, it would not be expanding its facility, but would be investing in a capital asset which would not be related to patient care until the new facility was certified. Consequently, the costs of any abandoned plans would not be allowable under the program. This policy is effective for all cost reporting periods beginning on or after June l, 1976.

2154.2 Definitions.--

A. Expand.--To increase the size of a provider's facility. This includes the purchase or construction of wings, departments, and/or buildings that will be included in a provider's existing certification.

B. Rebuild.--To make extensive improvements; to restore to a previous state; to make extensive changes, to remodel; to tear down an existing provider's facility and build a new facility in the immediate proximity of the old facility.

C. Relocate.--To move an existing provider to a new location and close the old provider.

2154.3 Planning Costs Where Facility is Completed.--These costs are recognized under Medicare when:

A. They are reasonable and prudent as defined in §2103,

B. They become part of the historical cost of the completed facility, and

C. The facility is certified to participate in the Medicare Program.

Any planning costs incurred to purchase land become part of the historical cost of the land and are not included in the historical cost of the depreciable assets of the completed facility. If a provider incurs planning costs for both land and a facility, and such costs cannot be specifically identified with either the land or facility, the provider must allocate the planning costs between the land and the facility based on the cost of each to the total cost.

2154.4 Planning Costs Where Plans Are Abandoned.--

A. Allowable.--If a provider abandons its plans to construct or purchase a facility, the cost of such plans is allowable if the planning was for the purpose of expanding, rebuilding, or relocating the operations of the certified facility. (See §2155 for abandoned construction in-progress.) Plans are deemed abandoned when there is no remaining discernible benefit to a provider. If a facility is completed, all feasibility studies and preliminary plans related to the building project have a discernible benefit to a provider since they are used as part of the decision-making process on whether to build the facility. Thus, such plans, even if they are not directly used in the building of the facility, are not considered abandoned. The costs of such plans should be included in the historical cost of the facility when it is completed. (Effective for all cost reports open on or after June 1, 1978.)

Providers have the option of including the cost of the abandoned plans in allowable cost either in the year of abandonment or by amortizing them over a 3-year period. In addition, if a provider received a restricted gift, grant, etc. for construction on purchase of a facility, both the principal and income from such gift, grant, etc. must be offset against the allowable cost of abandoned plans. (See §1218.11 for treatment of return on equity capital.)

B. Nonallowable.--Costs of abandoned plans are not allowed when:

1. A provider plans to continue to operate its present facility and plans to construction or purchase a new facility which will be separately certified under the program. For example, if a participating hospital plans to construct or purchase a skilled nursing facility and abandons such plans, such costs are not allowable; or

2. Such costs are for the purchase of land to be used either for facilities or parking lots.

2155. ABANDONMENT OF CONSTRUCTION-IN-PROGRESS

Where a provider begins construction of a new facility to expand, rebuild, or relocate its present certified facility and then later abandons the partially completed asset, the cost of this abandoned asset, excluding planning costs described in §§12154ff, is an investment loss and is not allowable under the Medicare program. If a provider abandons a partially constructed asset which would have become a newly certified facility, the loss, including abandoned planning costs, is not allowable.

2156. ALLOWABLE COSTS OF GOVERNMENTAL SUPPORT SERVICES TO STATE AND LOCAL GOVERNMENTAL PROVIDERS

Agencies and departments of State and local governments often furnish providers operated by such government with facilities and services necessary to the operation of those providers. These facilities and services included such items as motor pool, legal counsel, procurement personnel administration, data processing payroll, maintenance and operation of plant, accounting, budgeting, auditing, and mail and messenger services. The costs of such facilities and services are includable in the allowable costs of the provider to the extent they are (1) reasonable, (2) related to patient care, (3) allowable under Medicare regulations, and (4) allocated on an acceptable basis.

Allowable services may also include an allocable share of supportive and supervisory time directly present in furnishing the service to the provider. They should not include supervision of a general nature such as that of a department head or staff assistants not directly involved in specific operations.

Any grants, Federal or private or gifts received by State and local government for operating expenses must be offset against allowable costs.

2156.1 Unallowable Central Service Costs.--The following expenses are unallowable: (1) general administrative costs of State and local governments-such as the general expenses of State and local governments in carrying out the coordinating, fiscal and administrative functions of government, and public services such as fire, police, sanitation, tax administration and collection, and water, (2) chief executive officer's expenses-the salaries and expenses of the office of the Governor of a State or the chief executive of a political subdivision, (3) legislative expenses--salaries and other expenses of the State legislature or similar local governmental lawmaking bodies such as county supervisors, city council, etc., and (4) tax anticipation warrants and property tax functions.

2156.2 Allocation Bases.--Costs allocated to a provider from a servicing governmental unit must fairly represent benefits received by the provider. Therefore, for the following types of services, the following allocation bases are recommended:

TYPE OF SERVICE	BASIS FOR ALLOCATION
Accounting	Time spend on number of transactions processed
Auditing	Direct audit hours

Budgeting	Direct hours of identifiable services of employees of central budget
Data Processing	Machine hours
Disbursing Service	Machine hours
Employee Retirement System Administration	Dollar contributions to fund or number of employees contributing
Fidelity Bonding Program	Employees subject to bond
Health Services	Number of employees
Legal Services	Direct hours
Local Telephone	Number of telephone instruments
Mail and Messenger Service	Number of documents handled or employees serviced
Motor Pool Costs (including automotive management)	Miles driven or days used
Office Machine and Equipment Repairs	Direct hours
Office Space Use and Related Costs (i.e., janitorial service, etc.)	Square foot of occupied space
Payroll Service	Number of employees
Personnel Administration	Number of employees or salaries and wages
Printing and Reproduction	Number of hours, job basis, printed pages, etc.
Procurement Services	Total dollar volume or number of transactions processed

If a provider cannot use the above recommended bases, it may use alternative bases after obtaining the approval of the intermediary. Costs of allowable services other than those listed maybe allocated to providers on any reasonable allocation bases subject to prior intermediary approval.

2156.3 Reporting Requirements.--Providers must attach a supporting schedule to their cost reports listing the type of service, amount, allocation base, and the cost center to which the government overhead cost is allocated.

2160. LOSSES ARISING FROM OTHER THAN SALE OF ASSETS

A. General.--A provider participating in the Medicare program is expected to follow sound and prudent management practices, including the maintenance of an adequate insurance program to protect itself against likely losses, particularly losses so great that the provider's financial stability would be threatened. Where a provider chooses not to maintain adequate insurance protection against such losses, through the purchase of insurance, the maintenance of a self-insurance program described in §2161B, or other alternative programs described in §2162, it cannot expect the Medicare program to indemnify it for its failure to do so. Where a provider chooses not to file a claim for losses covered by insurance, the costs incurred by the provider as a result of such losses may not be included in allowable costs.

If a provider is unable to obtain a particular type of insurance coverage, excluding malpractice and comprehensive general liability coverage in conjunction with malpractice coverage or malpractice liability coverage only (see §2162A), and it sustains losses at a time of noninsured status, the cost of such losses will be considered allowable costs where the provider submits evidence to establish the unavailability of the coverage. If a provider is unable to obtain malpractice coverage, it must select one of the self-insurance alternatives in §2162 to protect itself against such risks. If one of these alternatives is not selected and the provider incurs losses, the cost of such losses and related expenses are not allowable.

B. The Deductible Clause.--Certain types of insurance policies are subject to a customary deductible. To purchase these policies without the deductible feature would result in a substantially higher premium and thus would not be in keeping with sound business practice. Therefore, losses incurred for such amounts attributable to the customary deductible clause are considered allowable costs under the Medicare program except for deductibles for malpractice and comprehensive general liability in conjunction with malpractice coverage or for malpractice liability only or for unemployment and workers' compensation insurance coupled with second injury coverage which are subject to certain funding requirements as described in §2162.5.

2160.1 Net Operating Losses.--Because operating losses are not costs, a net operating loss sustained by a provider is not an allowable cost.

2160.2 Liability Losses.--Liability damages paid by the provider , either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Insurance against a provider's liability for such payments to others would include, for example, automobile liability insurance; professional liability (malpractice, negligence, etc.); owners, landlord and tenants liability; and workers' compensation. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the limits of the provider's policy, as well as the reasonable cost of any legal assistance connected with

the settlement or award are includable in allowable costs, provided the provider submits evidence to the satisfaction of the intermediary that the insurance coverage carried by the provider at the time of the loss reflected the decision of prudent management. Also, the reasonable cost of insurance protection, as well as any losses incurred because of the application of the customary deductible feature of the policy, are includable in allowable costs.

Losses in excess of the limits of and/or related to the customary deductible feature of the provider's policy, applicable to damages awarded by a court or amounts paid to an injured party for an out-of-court settlement for an event that occurred prior to the provider's participation in the Medicare program, where the actual liability was unknown and could not be determined at the time of the event, are includable in allowable costs, provided the determination and actual payment of the damages are made subsequent to the provider's entry into the program.

2160.3 Theft Losses.--Protection against theft losses is generally covered by two types of insurance--fidelity bonds and burglary insurance. Fidelity bonds provide protection against losses resulting from all types of theft by employees and corporate officers. Burglary insurance protects against losses resulting from thefts not involving employees. The costs of both types of theft insurance are allowable costs, as are losses incurred because of the application of a customary deductible feature.

Where a provider exercises prudent management by purchasing adequate theft insurance, theft losses over and above the coverage limits of the insurance would be includable in allowable costs, subject to the following conditions:

A. The provider must purchase an adequate amount of theft insurance based on the amount of coverage recommended by insurance companies and based on the provider's theft loss experience, if any. The premium must be at a competitive rate. The provider must support the adequacy of its theft insurance with documentation which would include, but is not limited to, written competitive bids from insurance companies, formulas used in computing the amount of coverage, and a narrative of its theft loss experience;

B. The provider must maintain adequate internal controls against theft. These would include, but are not limited to, the use of appropriate accounting controls and the maintenance of appropriate physical security measures, e.g., guards, locks, and employee badges;

C. The provider must document the theft loss by including evidence such as, but not limited to, insurance company reports and police reports.

This policy is effective with losses incurred in cost reporting periods beginning after December 31, 1977.

2160.4 Minor Losses.--In the ordinary course of operations, a provider may incur a number of losses of minor equipment or supplies which are generally not covered by insurance because of their low cost or the frequency of the occurrences of loss. These include such losses as the disappearance of linen, supplies, food and silverware; the breakage of equipment, and the spoilage of drugs and food. Where such losses are generally not insured, the program will recognize them as allowable costs to the extent that the provider can establish proof of loss. Such minor losses are to be adjusted in accordance with one of the three methods selected by the provider for writing off the cost of minor equipment (see §106). If there is evidence of theft and the items are covered by the provider's insurance contract, the policy described in §2160.3 is applicable.

2160.5 Casualty Losses - General.--For Medicare reimbursement purposes, a casualty is defined as the complete or partial destruction of property resulting from an identifiable event of sudden, unexpected or unusual

nature. Casualty losses include, but are not limited to, damage from a hurricane, tornado, storm, fire, flood, accident, earthquake, and vandalism. A provider, as part of its insurance program, is expected to protect its depreciable assets against casualty losses. As stated in the following sections, actual losses sustained by a provider which are not compensated by insurance proceeds received, generally are not included in allowable costs where the lack of insurance coverage reflects imprudent management.

Losses which are not considered casualty losses, such as reduction in the value of property resulting from a nearby disaster, etc., are not included in allowable costs.

EXAMPLE: A public bridge which provided the most direct access to the provider facility, was completely destroyed by a flood. The bridge was not replaced because of the high cost of reconstruction in view of its limited utility. The only other access to the facility involved a lengthy and more circuitous route through undesirable areas. This inconvenience of access resulted in a reduction in the economic value of the property, a loss which is not includable in allowance costs.

A. Special Deductible Clause.--A special type of deductible clause is written for earthquake insurance, with the deductible being stated in terms of a percentage of the property rather than in a dollar amount. In certain States, the form of the deductible clause contains a minimum mandatory deductible of 5 percent of the insured value of the property, and ,for some buildings, the clause may require a deductible as high as 15 percent. In these cases, even though the deductible is not a nominal amount, the deductible clause is considered standard coverage in the particular area, and losses resulting from the application of this deductible clause are included in allowable costs.

B. Coinsurance Clause.--The coinsurance feature of insurance policies was developed to encourage the insuring of a high percentage of property value by offering a reduced rate to the insured. The coinsurance clause stipulates that the insured maintain insurance equal to an agreed percentage (usually 80 percent or more) of the replacement cost of the asset, regardless of the undepreciated cost basis (book value) of the asset. If the insured fails to maintain insurance at the agreed fixed percentage of the replacement cost of the property, the provider then becomes a coinsurer with the insurance company and, in the event of loss, shall, to the extent of the deficit, bear is proportion of the loss. Losses resulting from the application of the coinsurance clause are not allowable costs to the extent that the provider has failed to maintain insurance at the agreed fixed percentage of the value of the property to be considered fully insured.

EXAMPLE: A provider insures a piece of equipment for $3,000 but its replacement cost is $5,000. The policy contains an 80 percent coinsurance feature. If the property sustains $l,000 worth of damage, the

provider receives only $750 from the insurance company, computed as follows:

$$\frac{\text{amounts of insurance}}{\text{amount of insurance required to meet 80 percent requirement}} \quad \frac{(\$3,000)}{(\$4,000)} \times \text{loss } (\$1,000) = \text{settlement } (\$750)$$

The provider sustains a $250 loss which is not allowable since it is due to the fact the provider has underinsured its property. If the provider had maintained $4,000 insurance on the asset (80 percent of the replacement cost), the settlement would have been $l,000.

C. Underinsurance.--A loss which is in excess of the amount of insurance carried by the provider is considered to result from underinsurance and is not reimbursed by the program. For example, if a provider insures an asset having a replacement cost of $12,000 for $8,000 and the asset is completely destroyed by fire, the provider receives $8,000 from the insurance company. Where the undepreciated cost basis of the asset is $10,000, the provider incurs a loss of $2,000 which cannot be claimed as an allowable cost since it results from the asset being underinsured.

D. Excess Insurance.--Where a provider receives insurance proceeds in excess of the undepreciated cost basis of the asset, the provider has a gain, which is treated in accordance with instructions contained in §132. If the insurance proceeds exceed the undepreciated cost basis of the asset, the gain reduces the amount of allowable depreciation allowed for the asset under the program.

E. Extraordinary Casualty Losses.--Sound and prudent management practices include purchasing adequate insurance to provide protection against losses from the usual casualties and losses which would threaten the institution's financial stability. However, coverage against every possible type of loss would not be prudent or feasible. Thus, a provider may have an insurance program which would be considered adequate to insure against those risks that the institution could not afford to assume and yet sustain an uninsured loss from an unexpected quarter. This can occur because the failure to purchase insurance coverage for a highly improbable type of loss, e.g. earthquake insurance in an area where earthquakes seldom occur, would not be considered imprudent management. Where such casualties occur, the amount of the casualty loss (see §133.2 for computation of the loss) less the amounts that were received from insurance and from local, State, Federal grants or other sources, if any, will be recognized as a deferred charge to be amortized over the expected subsequent useful life of the restored or replaced asset. If the decision is made that the provision of patient care service through use of the asset should cease when the asset is damaged, no amount of the loss is includable in allowable costs.

F. Total Casualty Losses.--Where an asset is entirely destroyed by fire or other casualty to the point of being unrepairable, the loss is generally considered an unallowable cost for Medicare reimbursement purposes, except where the loss related to the deductible factor of the insurance policy or the loss was such that the risk would not ordinarily be insured in adequate insurance programs. The provision of §133.l, rather than §132, applies when depreciable assets are totally lost as a result of fire or other casualty.

G. Partial Casualty Losses.--Where an asset is partially destroyed or damaged as a result of fire or other casualty, the loss, as in the case of the total casualty loss, is generally considered an unallowable cost for Medicare reimbursement purposes, except where the loss relates to the deductible factor of the insurance policy or the loss is such that it is not ordinarily insured against an adequate insurance program. See §133.3 for the procedure to follow in adjusting the cost basis of the depreciable asset to reflect the amount of the casualty losses, even though the loss is not an allowable cost for purposes of Medicare reimbursement.

2161. INSURANCE COSTS

A. Purchased Commercial Insurance.--The reasonable costs of insurance purchased from a commercial carrier or a nonprofit service corporation and not from a limited purpose insurer (see §2162.2) are allowable if the type, extent, and cost of coverage are consistent with sound management practice. Insurance premiums reimbursement is limited to the amount of aggregate coverage offered in the insurance policy.

(See §§2122.5 and 2162 regarding unemployment compensation insurance payments.) Generally, in meeting these criteria, the following types of insurance are recognized;

l. Property Damage and Destruction.--This type of insurance covers losses due to the damage to, or the destruction of, the provider's physical property. Coverage is available to insure against losses resulting from fire or lightning, windstorm, earthquake, sprinkler leakage, water damage, automobile damage, etc.

2. Liability.--This insurance includes professional liability (malpractice, error in rendering treatment, etc.), unemployment compensation, worker's compensation, automobile liability, etc. See §2162 for alternatives to insurance for malpractice and comprehensive general liability losses, as well as losses from unemployment and worker's compensation insurance coupled with second injury coverage.

3. Consequential Loss or Indirect Loss.--There are various indirect losses a provider may incur in connection with property damage or other occurrences which interrupt the normal operation of the institution. The cost of business interruption or other similar insurance is allowable; however, the premium cost for “guaranteeing profits” is not allowable.

4. Theft Insurance.--This generally includes fidelity bonds and burglary insurance. (See §2160.3.)

Where a provider has purchased insurance without the customary deductible feature and, as a result, is charged a substantially higher premium, the amount of the insurance premium which exceeds the insurance premium with the customary deductible clause is not an allowable cost.

5. Employee Health Care.--This type of insurance covers health care expenses of a provider's employees. Premiums paid by the provider to purchase this coverage usually represent a fringe benefit to the covered employees as specified in §2144.4.G.

If the health care services are rendered by a provider to its own employee and the provider is remunerated for these services under the provisions of the purchased insurance plan, the provider should not offset the reimbursement received from the insurance company against either the cost of the services rendered to the employee or the premium cost incurred to purchase the insurance coverage. Instead, the cost of services rendered by a provider to its own employee in this situation will be excluded from Medicare reimbursement by requiring the provider to include the charges and/or days related to the services rendered to its employee among total charges and/or days used to apportion costs.

B. Self-Insurance.--Where a provider maintains a self-insurance program for other than malpractice and comprehensive general liability coverage in conjunction with malpractice coverage, as well as unemployment compensation and workers' compensation insurance coupled with second injury coverage, or employee health-insurance coverage, provided it meets the requirements of §2162.7, contributions to a self-insurance reserve fund referred to below are not includable in allowable costs. (See §1218.9 for the effect on equity capital.) Although contributions to the self-insurance reserve fund are not allowable, a reserve fund established under the conditions of this section need not be considered available for patient care in determining the necessity of borrowing under §202.2. However, where such a program meets the following conditions, any allowable loss cannot exceed the amount of the fund as of the date of the loss; that is, the date a claim is actually paid.

1. The provider must maintain a self-insurance reserve fund to meet any actual losses that are sustained. In the event of a loss, the amount allowable will be limited to the balance in the reserve fund at the date of the loss.

2. The provider must furnish to the intermediary pertinent details about the specific assets that are to be covered by the self-insurance reserve fund.

3. The reserve must be maintained in a segregated account and the funds must not be commingled with any other funds.

4. The self-insurance reserve must be sufficient to meet losses of the type and to the extent that they would ordinarily be covered by insurance.

5. Contributions to the reserve must be made not less frequently than annually.

6. The provider's total allowable interest expense under the Medicare program will be offset by income earned by invested insurance reserve funds.

7. Where appropriate, the provider must demonstrate the ability to effectively replace the inspection service, the loss-handling service, and the legal defense service of the insurance companies.

8. The treatment of casualty losses sustained by the self-insurance fund shall follow the procedure provided in §§133ff.

2162. PROVIDER COSTS FOR MALPRACTICE AND COMPREHENSIVE GENERAL LIABILITY PROTECTION, UNEMPLOYMENT COMPENSATION, WORKERS' COMPENSATION, AND EMPLOYEE HEALTH CARE INSURANCE

A. General.--Where provider costs incurred for protection against malpractice and comprehensive general liability, or for protection against malpractice liability only, unemployment compensation, workers' compensation coupled with second injury coverage, and employee health care insurance, do not meet the requirements of §2161.A, costs incurred for that protection under other arrangements will be allowable under the conditions stated below. Costs incurred for comprehensive general liability coverage not in conjunction with malpractice liability coverage are allowable only under the provisions of §§2160 or 2161.

Usually coupled with workers' compensation laws are second injury laws which provide that the employer shall be liable only for the disability resulting from an injury to an employee incurred during his/her current employment without regard to a preexisting handicap. Where reference is made to workers' compensation coverage, it also includes second injury coverage where such liability is incurred by the provider.

The following illustrates alternatives to full insurance coverage from commercial sources which providers, acting individually or as part of a group or a pool, can adopt to obtain malpractice, and comprehensive general liability, unemployment compensation, workers' compensation, and employee health care insurance protection:

1. Insurance purchased from a commercial insurance company which provides coverage after a deductible or coinsurance provision has been met;

2. Insurance purchased from a limited purpose insurance company (captive);

3. Total self-insurance; or

4. A combination of purchased insurance and self-insurance.

The conditions for Medicare reimbursement stated below are for provider malpractice liability and comprehensive general liability coverage in conjunction with malpractice coverage or for malpractice liability coverage only, unemployment compensation, workers' compensation insurance, and employee health care insurance, not for liability coverage costs such as automobile liability, fire, theft, or general liability only.

B. Effect on Interns, Residents, and Other Provider-Based Physicians.--The cost of malpractice coverage that a provider incurs for its employee interns and residents is allowable, subject to the provisions of §2120. However, the cost of malpractice coverage incurred by a provider for the personal risks of physicians other than interns and residents for direct medical care rendered to patients is not allowable except where the provider incurs such cost for its hospital-based physicians as described in Regulations No. 5, §405.480(f) and §2108ff of this manual. This cost incurred by the provider for its hospital-based physicians must be considered part of the physicians' total compensation. Regulations No. 5, §405.484, requires that this total physicians' compensation must be apportioned between the services rendered to the institution (Part A) and the services rendered to patients (Part B). The portion of the physicians' compensation for services rendered to the institution is an allowable provider cost. The portion of the physicians' compensation for services rendered to patients is reimbursed under the supplementary medical insurance program through the appropriate billing or cost-apportionment mechanism.

C. Documentation Required Where Type of Insurance Changes.--A provider usually selects the type of arrangement which is most reasonable and prudent, taking into account all pertinent facts and circumstances related to its organization and operation. When a change is made from commercial insurance as described in §2161 to one of the alternatives or from one alternative to another, the provider must document a comparative analysis which shows that the provider's choice results in a reasonable cost for the coverage offered and that the extent of coverage is consistent with sound management practices. The provider's comparative analysis should be performed on a periodic basis, usually every 3 to 5 years, to assure consistent application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider should retain these analyses to assist its intermediary in determining the reasonableness of the insurance costs. These analyses should show the following information:

o The administrative cost for the arrangements, including the cost for the maintenance of a fund by a fiduciary, legal cost, cost of a risk management program, cost of claims management program, actuarial costs, and other related costs.

o The necessary contributions to the fund based on an actuarial determination (as described in §2162.7C) of anticipated losses for malpractice, comprehensive general liability coverage in conjunction with malpractice, unemployment compensation, workers' compensation, and employee health care insurance. The determination of necessary contributions to the fund may also be made by a governmental agency for unemployment compensation and workers' compensation.

o The cost of any insurance to supplement self-insurance, like stop-loss insurance.

o The comparative commercial insurance premium.

2162.1 Insurance with a Deductible or Coinsurance Provision.--If you purchase an insurance policy with a deductible or coinsurance provision from a commercial insurance company, the cost of the insurance coverage for losses in excess of the deductible or coinsurance is an allowable cost, to the extent that the amount of coverage is consistent with sound management practices. (See §2162.5 for the discussion of losses related to deductibles or coinsurance.)

2162.2 Insurance Purchased from a Limited Purpose Insurance Company.--

A. Premium Costs.--Some providers, groups of providers, and State hospital associations have established limited purpose insurance companies (often known as captive insurance companies) to insure themselves against malpractice and, in some instances, comprehensive general liability losses as well as unemployment and workers' compensation insurance and employee health care costs. The regular premiums (other than the supplemental premiums) paid to such companies for provider malpractice and comprehensive general liability coverage in conjunction with malpractice coverage, or for malpractice liability coverage only, as well as unemployment insurance costs paid to the Federal Government and to the States, workers' compensation insurance costs paid to commercial insurance companies, and employee health benefit premiums paid to such companies are allowable costs if they are not in excess of the cost of available comparable commercial insurance premiums and meet the reasonable cost provisions of §2100. If comparable insurance premiums are not available, the captive insurance company must obtain an evaluation of the adequacy and reasonableness of its insurance premium by an independent actuary, commercial insurance company, or broker as described in §2162.7 C. The allowable premium may not exceed the amount which such evaluation determines to be reasonable.

In addition, supplemental premiums which are assessed by limited purpose insurers to build reserves against contemplated losses, as distinguished from capital costs, are allowable costs if, when added to the regular premium, the total premium costs do not exceed a commercial insurance premium for comparable coverage. The supplemental premiums must have the essential characteristics of normal insurance premiums, i.e., they must stand at risk against potential losses and must be available to support losses. Any excess premiums are allowed in a subsequent cost reporting period to the extent that, when added to premiums paid to the captive insurance company in that period for comparable coverage, the total premium costs do not exceed the comparable commercial insurance premiums for that period. Premiums paid to a limited purpose insurance company are recognized in your allowable costs only if all of the conditions of this section are met.

Any funds returned to the insured by the insurer (rebates, distributions, etc.) must be offset against the costs in the year you receive them. Such returned funds must be offset against the costs of the Employee Health and Welfare Cost Center for employee health care and against the costs of the Administrative and General Cost Center for other than employee health care. However, if a captive insurance company is liquidated, no offset is required for the return of capitalization costs previously paid by providers receiving the rebate. If payments are made to other than providers, e.g., the home office of a chain organization, appropriate adjustment of your cost is still necessary. Proper allocation of distributions by the home office to you must be made based on the appropriate facts in each situation.

The premium paid by you for hospital-based physicians is subject to the requirements in §2162 B.

The captive insurance company must have an adequate claims management and risk management program and, in cases where the captive insurance company is designed to cover employee health care insurance, it is suggested that a coordination of benefits program be employed as described in §2162.7 D. In cases where a limited purpose insurance company has both Medicare and non-Medicare participating providers paying premiums, such premiums must be determined so that Medicare providers do not share in premium costs that must be borne by the non-Medicare providers, and non-Medicare providers do not share in premium costs that must be borne by Medicare providers.

If a provider or group of providers is related to the insurer through ownership or control, as defined in Chapter 10, the following additional provisions apply:

1. The captive insurance company must be established in and meet the appropriate insurance laws of one of the United States, District of Columbia, or foreign government, if it is formed offshore.

2. The excess of actuarially determined loss reserves and related operating expenses over actual losses and related operating expenses and gains and losses from investments must be taken into account in establishing reasonable premium levels which do not reflect a profit factor.

3. If you terminate from the Medicare program, you must obtain a final determination of the adequacy of premium reserves as of the date of termination. This determination must be obtained from an independent actuary, commercial insurance company or broker as described in §2162.7. Any reserves that are deemed excessive at the date of termination must be offset against your allowable costs in your final cost report. If reserves are deemed inadequate, additional premium payments subsequent to the date of termination are not allowable provider costs.

4. RESERVED

5. Loans or any transfer of funds by the insurance company to policy holders, owners of providers, or parties related to them are prohibited.

B. Capitalization Costs.--The initial or any subsequent capital payments, as distinguished from supplemental premiums as described in subsection A, made by you to establish or maintain limited purpose (captive) insurance companies, including companies established by State hospital associations or others, are not allowable under Medicare. Such payments include the purchase of stock or surplus certificates (mutual insurance company), or other payments to establish capitalization levels such as special dues assessments paid by you to a hospital association which then establishes a captive insurance company.

2162.3 Self-Insurance.--You may believe that it is more prudent to maintain a total self-insurance program (i.e., the assumption by you of the risk of loss) independently or as part of a group or pool rather than to obtain protection through purchased insurance coverage. If such a program meets the conditions specified in §2162.7, payments into such funds are allowable costs.

2162.4 Combination of Purchased Insurance and Self-Insurance.--You may believe it appropriate to self-insure some of the risk independently or as part of a group or pool and purchase insurance for the remainder of the risk. Where you decide to fund all or some of the risk covered through self-insurance, payments into a fiduciary fund are allowable costs if you or the pool sets up a program which meets the conditions specified in §2162.7. The cost of the insurance is also an allowable cost subject to the conditions of §2161.

2162.5 Allowability of Actual Losses Related to Deductibles or Coinsurance.--Where you, at your option, are willing to commit your resources toward meeting first dollar losses through a deductible (as defined below), losses relating to the deductible are allowable costs in the year paid without funding if the aggregate deductible is no more than the greater of 10 percent of your (or, if appropriate, a chain organization's) net worth--fund balances as defined for Medicare cost reporting purposes--at the beginning of the insurance period or $100,000 per provider. The same rule applies where you coinsure with an insurance carrier. This requirement is deemed a reasonable test as to whether you are acting prudently in this regard. So long as you stay within the above limitations, you can be assumed to be exercising sound judgment in deciding to meet first dollar losses or coinsurance payments out of available resources. This requirement also permits you to pay reasonable losses without incurring costs to fund such payments. If your deductible or coinsurance exceeds the above requirements and the provider does not make payments into a fiduciary fund as required by §2162.7, any losses paid by the provider in excess of the greater of 10 percent of the provider's or, if applicable, a chain organization's net worth, or $100,000 per provider, are not allowable.

For purposes of this section, a "deductible" refers to the amount of first dollar losses not covered by a purchased insurance policy, a funded self-insurance program, or a combination of both.

2162.6 Losses in Excess of Coverage.--Where a provider incurs losses which are in excess of purchased commercial and/or limited purpose insurance coverage or actuarially determined funded contributions to an approved self-insurance fund in meeting specified deductibles, coinsurance provisions, or total self-insurance, such costs are allowable in the year paid where the provider submits evidence to the satisfaction of the intermediary that the insurance coverage or funding levels reflected the decisions of prudent management.

Losses in excess of coverage for events that occurred prior to the provider's participation in the Medicare program, where the actual amount of the loss was unknown and could not be determined at the time of the event, are allowable, provided the determination and actual payment of the losses are made subsequent to the provider's entry into the program, and assuming that the required evidence of prudent management in establishing insurance coverage or funding levels has been submitted.

2162.7 Conditions Applicable to Self-Insurance.--

A. Definition of Self-Insurance.--Self-insurance is a means whereby a provider(s), whether proprietary or nonproprietary, undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities.

If a provider enters into an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party, such an agreement shall be considered self-insurance. For example, any agreement designed to provide administrative services only shall be considered self-insurance and must meet the requirements specified below. If administrative services agreements do not meet these requirements, any amounts funded as part of the agreement will not be allowed. Payments from the fund, however, will be treated on a claim-paid basis as specified in §2162.3.

There may be situations in which there is a fine line between self-insurance and purchased or commercial insurance. This is particularly true of "cost-plus" type arrangements. As long as there is at least some shifting of risk to the unrelated party, even if limited to situations such as provider bankruptcy or employee termination, the arrangement will not be considered self-insurance.

B. Self-Insurance Fund.--The provider or pool establishes a fund with a recognized independent fiduciary such as a bank, a trust company, or a private benefit administrator. In the case of a State or local governmental provider or pool, the State in which the provider or pool is located may act as a fiduciary. The provider or pool and fiduciary must enter into a written agreement which includes all of the following elements:

1. General Legal Responsibility.--The fiduciary agreement must include the appropriate legal responsibilities and obligations required by State laws.

2. Control of Fund.--The fiduciary must have legal title to the fund and be responsible for proper administration and control. The fiduciary cannot be related to the provider either through ownership or control as defined in Chapter 10, except where a State acts as a fiduciary for a State or local governmental provider or pool. Thus, the home office of a chain organization or a religious order of which the provider is an affiliate cannot be the fiduciary. In addition, investments which may be made by the fiduciary from the fund are limited to those approved under State law governing the use of such fund; notwithstanding this, loans by the fiduciary from the fund to the provider or persons related to the provider are not permitted. Where the State acts as fiduciary for itself or local governments, the fund cannot make loans to the State or local governments.

3. Payments by Fiduciary.--The agreement must provide that withdrawals must be for malpractice and comprehensive general liability or unemployment or workers' compensation insurance losses, or employee health benefits coverage only and those expenses listed in §2162.8. Any rebates, dividends, etc., to the provider from the fund will be used to reduce allowable cost. Furthermore, evidence of a practice of payments from the fund for purposes unrelated to the proper administration of the fund may result in a withdrawal of recognition of the self-insurance fund by the Medicare program. In such instances, payments into the fund will not be considered an allowable cost. Intermediaries will submit incidents of impropriety to the appropriate regional office.

4. Termination.--The agreement must state that upon termination from the Medicare program, the provider must obtain a determination of the adequacy of the fund balance as of the date of termination from an independent actuary, insurance company, or broker (as defined in B below). Any reserves that are deemed excessive must be offset against the provider's allowable costs in the provider's final cost report. If the reserve fund is deemed inadequate, additional contributions to the fund subsequent to the date of termination are not allowable.

5. Reporting.--The agreement must require that a financial statement be forwarded to the provider or pool members by the fiduciary no later than 60 days after the end of each annual insurance reporting period. This statement must

show the balance in the fund at the beginning of the period, current period contributions, and amount and nature of final payments, including a separate accounting for claims management, legal expenses, claims paid, etc., and the fund balance. This report and fiduciary's records must be available for intermediary review and audit.

6. Income Earned.--The agreement must provide that any income earned by the fund must become part of the fund and used in establishing adequate fund levels.

C. Soundness of the Fund.--The provider submits to the intermediary an annual certified statement from an independent actuary, insurance company, or broker that has actuarial personnel experienced in the appropriate field of medical malpractice and general liability insurance, unemployment compensation, workers' compensation or employee health care insurance. To be independent, there must not be any financial ownership or control, as defined in Chapter 10, either directly or indirectly in the provider.

The actuary, insurance company, or broker shall determine the amount necessary to be paid into the fund. The fund should include reserves for losses based on accepted actuarial techniques customarily employed by the section of the insurance industry writing the type of insurance coverage the fund is designed to provide, and expenses related to the self-insurance fund as specified in §2162.8. The actuary, insurance company, or broker shall also provide for an estimate of the amounts in the fund that are in excess of what is reasonably needed to support anticipated disbursements from the fund. This excess amount must be treated as specified in §2162.10. Where funds have been established to cover employee health care, the actuary, insurance company or broker must limit fund payments to the cost of insurance premiums for comparable purchased coverage at the same level offered by the fund. Fund payments exceeding this amount will be treated as excess payments.

The actuary, insurance company, or broker must state the actuarial basis and the coverage period used in establishing reserve levels. Reserves will not be recognized as allowable Medicare costs for losses specifically denied by other subsections of §§2160, 2161, and 2162. Thus, reserve payments will not be recognized for items such as:

1. Losses in excess of the greater of 10 percent of a provider's net worth or $100,000 where a provider elects to pay losses directly in lieu of establishing a funded self-insurance fund (§2162.5);

2. Losses in excess of coverage levels which an intermediary deems do not reflect the decisions of prudent management (§2162.6).

The actuary, insurance company, or broker must provide its workpapers to Medicare intermediaries upon request.

There must be separate accountability to reflect all operations within each fund.

D. Claims Management, Risk Management, and Coordination of Benefits Program. -A provider or pool has an ongoing claims process and risk management program. The provider or pool must demonstrate to the intermediary that it has an ongoing claims process to determine whether malpractice and comprehensive general liability, unemployment and workers' compensation insurance liabilities, and the liability for employee health care insurance exist, their causes where applicable, and the cost of claims. A provider or pool may either utilize its qualified personnel or an independent contractor, such as an insurance company, to adjust claims. In addition, a provider or pool must obtain adequate legal assistance in carrying out its claims process. Each provider must also have an adequate risk management program to examine the cause of losses and to take action to reduce the frequency and severity of them. Such risk management program has the essential characteristics of programs required by insurers which currently insure providers for these risks. Therefore, a provider must have an ongoing safety program, professional and employee training programs, etc., to minimize the frequency and severity of malpractice and comprehensive general liability, as well as workers' compensation insurance incidents.

For funds established to cover employee health care, the provider, or its fiduciary, should consider the institution of an effective coordination of benefits program. A program of this nature would seek to determine whether any beneficiary of the fund is partly or fully covered by another insurance plan, such as a family plan provided to a spouse as a fringe benefit of employment or a private insurance plan held by the beneficiary with a commercial insurance company. A program of this type would assure that each health plan pays its appropriate share of the expenses related to the beneficiary's illness, thus reducing the liability for full payment by the provider's fund.

E. Trust Mechanism Applicable to Employee Health Care.--If the provider wishes, the program will recognize the establishment of self-insurance funds for employee health care in accordance with the provisions of §501(c)(9) of the Internal Revenue Code. This code section grants a tax-free exemption to funds established in trust, provided the funds are used to pay for life, sick, accident or other employee benefits.

Application of this Internal Revenue procedure would allow a provider to establish its employee health care self-insurance fund without relinquishing legal title to the fund to an independent fiduciary. In addition, fund trustees may also be employees of the provider, as long as the employees act independently in their administration of the trust. All other conditions applicable to self-insurance elicited in this manual section, however, will be applicable to employee health care trusts established under this Internal Revenue procedure, i.e., payments by fiduciary, termination, reporting, soundness of the fund, etc.

2162.8 Expenses Related to Losses Paid Out of Self-Insurance Fund.--The following expenses will be considered costs attributable to a self-insurance fund established by a provider or pool: expenses of establishing the provider fund or pool, expenses for administering the claims management program, expenses involved with maintenance of the fund by the fiduciary, legal expenses, actuarial expenses, excess insurance coverage (if purchased by the fiduciary or pool), risk management (if performed by the fiduciary or

pool), and a coordination of benefits program (if performed by the fiduciary pool or provider) to the extent that such expenses are related to the provider's self-insurance program. All other expenses will not be considered costs attributable to the fund, but should be included in provider administrative and general costs in the year incurred.

2162.9 Reimbursement Principles Where a Provider Has Self-Insurance.--

A. Medicare's participation in the fund contributions will be limited to actual funded payments made by a provider into the fund and only to the extent of the amounts permitted by §2162.7C. Accruals of payments to be made into the fund are allowable costs in the year of accrual if paid within 75 days after the end of a provider's cost reporting period. Payments made after the 75th day will be deemed allowable in the reporting period paid, provided the total contributions made in that period do not exceed the amount prescribed by the actuary as necessary for the adequacy of the fund.

B. Total fund contributions for employee health care are included in the Employee Health and Welfare Cost Center and for other than employee health care in the Administrative and General Cost Center and allocated in the cost-finding process in the same manner as commercial insurance premium costs.

C. Medicare's share of allowable contributions to a fund which meets the conditions in §2162.7 will be included in the calculation of the regular interim reimbursement. The interim rate will be based on the payments required by the actuary, insurance company, or broker for the current year under the agreement setting up the fund.

D. Interim reimbursement for actual losses related to deductibles or coinsurance which are not covered by a funded self-insurance program as described in §2162.5 will be based on the provider's estimate of Medicare's share of total paid claims to be made the coming year. Factors such as the provider's previous years' claims paid experience, claims pending, etc., should be used in establishing the estimated losses for interim payment purposes.

2162.10 Treatment of Excess Reserves.--Contributions or pool payments for any period in excess of the amount required by §2162.7C as needed to support disbursement are not allowable costs for such period but may be allowed in the subsequent reporting period to the extent that, when added to contributions paid in the subsequent year, the sum does not exceed the prescribed amount.

2162.11 Effective Date and Retroactive Application.--

A. Malpractice and Comprehensive General Liability.--The provisions of this section are effective with payments for malpractice and comprehensive general liability protection in conjunction with malpractice protection or malpractice liability protection only, beginning April 1, 1977. If a provider did not have full coverage under commercial insurance after December 31, 1974, and disbursed funds for such protection under alternative arrangements, such costs of protection are allowable when:

1. The disbursement was made after December 31, 1974;

2. The intermediary determines that the arrangement and cost for securing such protection were reasonable; and

3. The provider conforms to the provisions of this section before:

a. November 1, 1977, for arrangements other than through purchase of protection from a captive insurance company; or

b. July 1, 1978, for protection purchased from a captive insurance company.

Where a provider or group of providers included self-insured losses and related expenses in allowable costs after December 31, 1974, and before April 1, 1977, in accordance with §2161.B, such providers may request reopening and revision of cost reports for applicable cost reporting periods to recognize reasonable disbursements for such protection in lieu of the costs previously allowed, if the self-insurance arrangement met the provisions of this section before November 1, 1977. Such reopening and revision are not mandatory for periods prior to April 1, 1977.

If a provider has made payments to a self-insurance fund or a pool during the period after December 31, 1974, and before April 1, 1977, an independent actuary, insurance company, or broker must review the adequacy of the payments made by the end of the cost reporting period ending on or after November 1, 1977. If the actuary, insurance company, or broker believes that the payments made are excessive, then reimbursement will be limited to the amount determined necessary by the actuary, insurance company, or broker. Any excess amounts may be carried forward and included in the subsequent year's contribution to the extent that, when added to contributions paid in the subsequent year, they do not exceed the amount determined necessary by the actuary, insurance company, or broker.

In a self-insurance or pool arrangement, contributions must be paid into the fund within 75 days after the end of a cost reporting period for the contributions to be recognized as an allowable cost for that cost reporting period. Any withdrawals from the fund for other than malpractice losses or comprehensive general liability losses in conjunction with

malpractice coverage and related expenses must be offset against allowable contributions to the fund. In addition, all income earned by the fund must become part of the fund and used to establish adequate fund levels. Any income earned and used for other than this purpose must be offset against allowable payments in the year earned.

B. Unemployment and Workers' Compensation Insurance Coupled with Second Injury Coverage.--The provisions of this section are effective with payments for unemployment and workers' compensation coupled with second injury coverage beginning January 1, 1979. If a provider did not have full coverage under commercial insurance for any cost report that can be reopened in accordance with 42 CFR 405.1885 and disbursed funds for such protection under alternative arrangements, such costs of protection are allowable when:

1. the disbursement applies to January 1, 1976, or later; and

2. the provider conforms to the provisions of this section before January l, 1980.

Where a provider or group of providers included self-insured losses and related expenses in allowable costs in accordance with §§2161.B or 2122.5C for open years, such providers may request reopening and revision of cost reports for applicable cost reporting periods to recognize reasonable disbursements for such protection in lieu of the costs previously allowed if the self-insurance arrangement meets the provisions of this section before January 1, 1980. Such reopening and revisions are not mandatory.

Where a provider has made payments to a self-insurance fund or a pool during the period after December 31, 1975, and before January 1, 1979, an independent actuary, insurance company or broker must review the adequacy of the payments made by the end of the first cost reporting period ending on or after June 30, 1979. If the actuary, insurance company or broker believes that the payments made are excessive, then reimbursement will be limited to the amount determined necessary by the actuary, insurance company, or broker. Any excess amounts may be carried forward and included in the subsequent year's contribution to the extent that, when added to contributions paid in the subsequent year, they do not exceed the amount determined necessary by the actuary, insurance company or broker.

In a self-insurance or pool arrangement, contributions must be paid into the fund within 75 days after the end of the cost reporting period for the contributions to be recognized as an allowable cost for that cost reporting period. Any withdrawals from the fund for other than unemployment or workers' compensation premiums or claims and related expenses must be offset against allowable contributions to the fund. In addition, all income earned by the fund must become part of the fund and used to establish adequate fund levels. Any income earned and used for other than this purpose must be offset against allowable payments in the year earned.

C. Employee Health Care Insurance.--The provisions of this section related to insurance purchased from a limited purpose insurance company (captive), total self-insurance or a combination of purchased insurance and self-insurance are effective with cost reports settled on or after January 15, 1983, and cost reports under appeal as of or subsequent to January 15, 1983. Prior to this date, payments made to a captive insurance company or to a self-insurance fund designed to provide employee health care coverage shall not be considered an allowable cost at the time the payment was made. Cost recognition for periods prior to the effective date shall be limited to the premium cost of commercial insurance purchased to provide this coverage or to the actual cost of the health expenses paid on behalf of the employee at the time such expenses were actually incurred.

2162.12 Buy-Out Cost to Convert from a State-Administered Fund to a Self-Insurance Fund for Unemployment Compensation or Workers' Compensation Insurance.--The charge made by a governmental agency for the cost of pending and expected claims of employees of a business entity which discontinues purchasing insurance coverage from the governmental agency is considered a buy-out cost. Where a provider or group of providers or chain of providers incurs a liability representing a "buy-out" cost to enable those providers to set up their own self-insurance fund for unemployment compensation or workers' compensation coverage, the liability is an allowable cost of the year incurred to be proportionately spread among the providers which are part of the buy-out arrangement in an amount directly related to the provider's claims to be assumed by the State. Where the State permits payment over a period greater than 1 year and issues an annual assessment of the amount due, then the amount to be included in allowable costs cannot exceed the assessment. This assessment establishes the annual liability which the provider must pay to the State. See §2305 where the amount is accrued on the books.

2162.13 Absence of Coverage.--Where a provider, other than a governmental (Federal, State, or local) provider, has no insurance protection against malpractice or comprehensive general liability in conjunction with malpractice, either in the form of a limited purpose or commercial insurance policy or a self-insurance fund as described in §2162.7, any losses and related expenses incurred are not allowable.

2162.14 Governmental Providers.--For all governmental providers (Federal, State, or local), Medicare will reimburse its proportionate share of actual losses in the year paid, without funding or subject to the deductible provisions of §2162.5, but only if the provider demonstrates to its intermediary that it has a claims management and risk management program as described in §2162.7D.

2176. ADMINISTRATIVE COST INCURRED AFTER PROVIDER TERMINATES PARTICIPATION IN PROGRAM

When a provider terminates its participation in the program, either voluntarily or involuntarily, or a change of ownership occurs (see Health Insurance Regulations section 405.626), administrative costs associated with the preparation and settlement of costs reports with an intermediary and other third parties will be incurred after the effective date of termination. The direct administrative costs that are reasonable and related to the settlement of reimbursement for patient care rendered while the provider was participating in the program and bad debts resulting from coinsurance and deductibles billed to Medicare patients are allowable. Examples of allowable direct administrative costs are salaries and those costs associated with such salaries, i.e., fringe benefits, workmen's compensation insurance, and payroll taxes; accounting benefits, workmen's compensation insurance, and payroll taxes; accounting and legal fees which are incurred for bill preparation, bill processing, and cost report preparation; and, where applicable, hearing fees and expenses incurred for settlement with an intermediary and other third parties (see exception below). However, legal fees and related costs incurred in the sale of the facilities, costs incurred on or after the effective date of termination for the operation or maintenance of closing of the facility are not allowable. (See §2414.2B for patient care services rendered after the effective date of termination and §132A for gains or losses incurred on the disposal of depreciable assets within 1 year after the date of termination.)

EXCEPTION: When a provider terminates its participation in the program more than 1 month before the end of its cost reporting year and continues to operate a health care facility for more than 1 month beyond the effective date of termination, the costs incurred for the preparation and settlement of a cost report that may be required by other third parties will not be allowable.

EXAMPLE:

Provider's cost reporting year	10/1 - 9/30
Effective date of termination	5/31
Provider continues to operate health care facility after 6/30	
Due date of Medicare cost report	7/15

In the above example, only the costs associated with the preparation and settlement of the Medicare cost report and costs incurred for preparation of bills to be submitted to other third parties for services rendered prior to the effective date of termination are all allowable. Such costs are to be included in the cost reporting period ending 5/31 and are subject to cost allocation and apportionment.

2176.1 Allowable Direct Administrative Costs to be Included in Final Cost Report.--The allowable direct administrative costs, to the extent they are necessary, proper, and reasonable, are to be included in the provider's final cost report for the period ending with the date of termination of its participation in the program or change of ownership and are subject to cost allocation and apportionment. The provider must maintain adequate records to enable the intermediary to identify and verify such costs that are included in the final cost report. For the due date of the final cost report, see §2413.

2176.2 Allowable Direct Administrative Costs Incurred After Final Cost Report is Filed.--When a provider incurs additional allowable direct administrative costs after filing a final cost report, the provider should notify the intermediary. The intermediary may adjust the final cost report or required the provider to file an amended cost report, depending on the materiality of the adjustments. When a provider is required to fill an amended cost report, such report is due within 45 days after the date of notification by the intermediary.

2180. REIMBURSEMENT FOR COSTS INCURRED IN RELATION TO UNION ACTIVITIES

2180.1 Labor Union Organizing Activities.--Reasonable costs incurred by providers in activities consistent with the National Labor Relations Act (NLRA) may represent allowable costs of operation, provided such costs are not directly related to influencing employees with respect to unionization and further provided such costs are not unreasonable in amount. The NLRA imposes responsibilities and limitations on both management and labor. Management must have the knowledge and skill to deal with their employees and the wide range of labor relations issues in order to maintain an effective working environment. These rights and responsibilities of management encompass various activities such as written and oral communication with employees, consultations with attorneys or management advisors, and collective bargaining with union representatives. Unless the provider's activities are unauthorized or prohibited by the NLRA or these guidelines, or unless the costs incurred for such activities are unreasonable in amount or unnecessary, they will be allowable.

Reasonable costs incurred to keep employees informed of issues and to keep the lines of communication open between employees and employers are usually necessary and proper as they are part of normal personnel management and, therefore, may be allowable costs, provided such costs are not directly related to influencing employees with respect to unionization.

Costs incurred for activities directly related to influencing employees respecting unionization or related to attempts to coerce employees or otherwise interfere with or restrain the exercise of employee rights under the NLRA are not allowable costs for program purposes. Such costs are unallowable whether such activities are performed directly by the provider or through an independent contractor, consultant or outside attorney.

With respect to allowable costs for services furnished, only the reasonable portion of the total costs incurred will be considered for reimbursement purposes. Expenses which are extraordinary in amount or kind, or unreasonably exceed expenditures common in the health care field for activities related to unionization, are not allowable costs.

Example: Reasonable costs incurred to furnish literature to employees or management personnel explaining their rights and responsibilities under the NLRA are allowable costs. Costs incurred to furnish literature designed to influence employees respecting unionization or to teach techniques for influencing employees respecting unionization are not allowable costs.

Example: Consultants and/or attorneys retained by a provider may be needed at times to familiarize supervisors and employees with labor laws. Therefore, reasonable costs incurred by a provider in seeking legal advice or counsel specifically on union activity matters, such as informing provider management and supervisory personnel regarding their legal rights and responsibilities under the NLRA with regard to union organizing, are a necessary part of operations and are allowable costs.

Example: Reasonable costs incurred by a provider in providing training to supervisory personnel on union activity matters which is a part of normal personnel management are necessary and proper as part of the business operations of a provider and, therefore, are allowable costs, provided such training is not designed or timed to influence employees with respect to unionization.

Example: Provider activities which impact on wage or benefit programs, because they are designed to influence employees with respect to unionization are not related to patient care and, therefore, are not allowable costs for Medicare program purposes.

2180.2 Collective Bargaining.--Reasonable expenses incurred by a provider for collective bargaining and related activities, unless disallowed under §2180.1 are allowable costs, provided the activities are permitted by the NLRA. Contract negotiations and any procedures which flow from enforcement of contract terms, whether in a collective or individual setting, are necessary to maintain the continued operation of the provider, and, thus, are a precondition for the delivery of health services.

Example: The cost of the services of management's representative in good-faith collective bargaining activities is an allowable cost.

Example: Consultants and/or attorneys' fees associated with collective bargaining activities in violation of the NLRA are not allowable costs.

2180.3 Unallowable or Allowable But Not Reasonable Costs in Relation to Union Activities.--Costs incurred for activities directly related to influencing employees respecting unionization or related to attempts to coerce employees or otherwise interfering with or restraining the exercise of employee rights under the NLRA are not allowable costs for program purposes. Such costs are unallowable whether such activities are performed directly by the provider or through an independent contractor, consultant or outside attorney.

Example: Costs incurred for activities directly related to expressing management's opinions for purposes of influencing employees not to organize and to form a union are not allowable costs.

With respect to allowable costs for services furnished, only the reasonable portion of the total incurred costs will be considered for payment purposes where expenses are extraordinary in amount or in kind, or which unreasonably exceed expenditures common in the health care field for activities related to unionization.

2182. SERVICES OF PHYSICIANS IN PROVIDERS
(Effective for Services Performed on or After October 1, 1983)

2182.1 General.--These sections govern reimbursement for services physicians furnished in providers of services, including hospitals, skilled nursing facilities and comprehensive outpatient rehabilitation facilities. If the physicians are compensated for their services by the provider or another entity, the compensation they receive must be allocated among the various types of services they furnish. Payment for the services they furnish to the provider is made on either a reasonable cost basis or as a component part of prospective payment. These payments are made by the Part A intermediary. Reimbursement for the services physicians furnish to individual patients in providers is made under Part B on a reasonable charge basis by the carrier. However:

A. Reimbursement for physician services furnished in teaching hospitals that elect cost reimbursement for such services is made on a reasonable cost basis by the Part A intermediary. (See §2148.)

B. Reimbursement for physician services furnished in teaching settings is subject to additional conditions. (See §§2108.8, 2218, 2420.)

C. Reimbursement for the services of interns and residents, as well as physicians who are licensed to practice only in the provider setting, is made on a reasonable cost basis by the Part A intermediary. (See §2120.)

D. Services furnished by physicians to individual patients in providers must meet the criteria in §2182.4 to be reimbursed on a reasonable charge basis.

E. Reimbursement for physician services in all-inclusive rate hospitals may be made by the Part A intermediary on a Part B per diem basis. An all-inclusive rate hospital is a participating hospital in which patients are charged a fixed all-inclusive rate, computed (for inpatients) on a daily or other time basis, or (for outpatients) on a per visit basis applicable uniformly to each patient without regard either to the extent of services required by the patient or the distinction between physicians' and hospital services.

2182.2 Provider Defined.--For the purpose of these instructions, a provider of services is a participating hospital, skilled nursing facility (SNF) or comprehensive outpatient rehabilitation facility (CORF). However, these instructions also can be used to determine customary charges for physicians' services in nonparticipating facilities, e.g., hospitals and other institutional settings in which physicians are compensated for their services and the patients do not pay for the physicians' services they receive on a charge basis. The carrier is responsible for obtaining the data necessary to determine customary charges for the physicians' services furnished in nonparticipating facilities.

2182.3 Allocation of Physician Compensation.--

A. Definition.--For purposes of this instruction, “physician compensation costs” means monetary payments, fringe benefits, deferred compensation and any other items of value (excluding office space, billing and collection services) a provider or other organization furnishes a physician in return for the physician's services to the provider. All costs incurred by the provider, both direct and indirect, related to the physician's private practice must be excluded from physician compensation costs.

Other organizations are entities "related to" the provider, or entities that furnish services for the provider "under arrangements."

B. General Rule on Allocation of Physician Compensation Costs.--Except as provided in paragraph D of this section, each provider that incurs physician compensation costs must allocate those costs, in proportion to the percentage of total time that is spent in furnishing each category of services, among:

- o Physician services to the provider (as described in §2182.6);
- o Physician services to patients (as described in §2182.4); and
- o Activities of the physician, such as funded research, that are not reimbursable under either Part A or Part B of Medicare.

C. Allowable Physician Compensation Costs.--Only compensation allocated to reimbursable physician services to the provider (as described in §2182.6) are includable among provider costs.

Generally, the total compensation received by a physician will be allocated among all services furnished by the physician, unless:

1. a. The provider certifies that the compensation is attributable solely to the physician's services to the provider; and

b. The physician bills all of his or her patients for the physician services he or she furnishes to those patients and personally receives the payment from such billings. If returned directly or indirectly to the provider or an organization related to the provider, these payments are not compensation for physician services to the provider; or

2. The provider and physician agree to accept the assumed allocation of all the physician's services to direct services to individual patients. In this situation a written allocation agreement is not required.

D. Determination and Payment of Allowable Physician Compensation Costs.--

1. The intermediary will reimburse the provider for physician compensation costs only if:

a. The provider submits to the intermediary a copy of the allocation agreement between the provider and the physician that specifies the respective amounts of time (these may be expressed in percentages) the physician spends in furnishing services to the provider, services to patients that meet the criteria of §2182.4; and services that are not reimbursable under either Part A or Part B; and the compensation is reasonable in terms of the time devoted to these services as compared to the applicable Reasonable Compensation Equivalent limit.

2. In the absence of a written allocation agreement, the intermediary will assume, for purposes of determining reasonable costs of the provider, that 100 percent of the physician's compensation cost is allocated to services to patients.

NOTE: If a provider is not seeking reasonable cost reimbursement for costs incurred in compensating provider-based physicians for services to the provider, an allocation agreement is not required.

E. Provider Recordkeeping Requirements.--The intermediary must advise providers that:

1. While they have some discretion as to the types of records they maintain as to the allocation of physicians' time to services, the allocations must be supported by adequate documentation and must normally be comparable to previous allocations or to similar situations in comparable providers. See §2182.13 for an example of a format that providers may use to substantiate allocation agreements.

2. Except for the assumed allocation situations, they must:

o Maintain the data and information used to allocate physician compensation in a form that permits validation by the intermediary and the carrier;

o Report the data or information on which the physician compensation allocation is based to the intermediary and promptly notify the intermediary of any revisions to the compensation allocation; and

o Retain each physician compensation allocation agreement, and the information on which it is based, for at least 4 years after the end of each cost reporting period to which the allocation applies.

3. Allocation agreements are to be submitted annually as part of the cost report filing process. (See §2182.13 for allocation agreement formats.) Revisions from the prior allocation agreement could occur where there is a significant change in the manner or extent to which services are furnished, an increase in the number of physicians in the department, or an increase in a physician's administrative or supervisory duties. While the allocation agreement represents a reasonable depiction of the distribution of physician time among covered physician services to patients and to providers, and to noncovered services in the individual case, it should not be inconsistent with allocations representing the distribution of time for physicians who furnish services in like departments in similar hospitals. If the carrier and the intermediary believe that an allocation agreement is atypical, the physician and provider are given a reasonable opportunity to explain the factors they considered in completing it. Such issues, however, must be resolved before the agreement can serve as a basis for reimbursement. If the carrier and the intermediary cannot agree regarding the acceptability of the allocation agreement, refer the matter to the regional office.

In determining whether these agreements are acceptable, the intermediary, for example, also considers its knowledge of the providers and the experience gained about them in the administration of its private business. If necessary, the carrier and the intermediary may impose an allocation, based on experience in other hospitals, until an acceptable agreement is approved. If the hospital or its physicians disagree with an imposed allocation, the matter is referred to the regional office.

4. While we do not require the maintenance of daily logs or time records to support provider services rendered by physicians, adequate documentation must be maintained to support the total hours for these services to permit application of the RCE limits. This includes work or teaching schedules, workload counts, or other documentation to substantiate these hours.

5. Where providers decide to employ time study techniques to substantiate either the allocation of physicians' time to services or the actual provider services hours figure used in the RCE computation, the provider may choose to employ the methodology described in subsection 2313.2.E, Special Applications, but the provider may not be required by the servicing intermediary to utilize that specific methodology.

F. Effort Reports.--Effort reports generally are not acceptable as a proxy for a time allocation because effort cannot be quantified. However, they may be used if the carrier and the intermediary determine that program payments do not differ significantly by use of effort reports, i.e., that in the individual case, effort can be equated to time. If the intermediary, however, determines that there is a difference between reported effort and actual time that unreasonably increases reimbursement, time must be used. When, for example, there is a question of allocating compensation between covered and noncovered services, such as research, the intermediary must adjust the cost reports based on time.

2182.4 Conditions for Reasonable Charge Payment for "Physicians' Services" to Patients in Providers.--

A. General.--The carrier will pay for physicians' services to patients of providers on a reasonable charge basis only if the following requirements are met:

1. The services are personally furnished for an individual patient by a physician;

2. The services contribute directly to the diagnosis or treatment of an individual patient;

3. The services ordinarily require performance by a physician; and

4. In the case of anesthesiology, radiology, or laboratory services, the additional requirements in either §2182.7, §2182.9 or §2182.11 are met.

B. Services of Physicians to Providers.--If a physician furnishes services in a provider that do not meet the requirements in section A but are related to patient care, the intermediary pays for those services, if otherwise covered, on a reasonable cost basis, or as an element of prospective payment, as appropriate.

C. Effect of Billing Charges for Physician Services to a Provider.--If services furnished by a physician to a provider are paid on a reasonable cost basis by the intermediary, neither the provider nor physician may seek charge payment from the carrier, the beneficiary, or a private insurer. If the physician, the provider, or a private

entity bills the carrier, the beneficiary or another insurer for physician services to the provider, the provider in which and to which the services were furnished is considered to have violated its provider participation agreement, and that agreement may be terminated. The carrier refers any situation in which this happens to the regional office unless it is clearly an isolated case of billing error.

D. Effect of Assumption of Operating Costs.--If a physician or an entity enters into an agreement (such as a lease or concession) with a provider, under which the physician (or entity) assumes some or all of the operating costs of the provider department:

1. The carrier makes reasonable charge payments only for physicians' services to individual patients as defined in Paragraph A.

2. The physician (or other entity) must make its books and records available to the provider and the intermediary, as necessary, to verify the nature and extent of the costs of the services furnished by the physician (or other entity).

3. The intermediary reimburses the provider on a reasonable cost basis, to the extent the provider incurs a cost, or as an element of prospective payment, for the lessee's costs associated with producing these services, including overhead, supplies and equipment costs and the costs of employing nonphysician personnel.

E. Independent Laboratory Services.--Services, such as surgical pathology services, furnished to a provider patient by an independent laboratory, including the laboratory of another hospital, that meet the general conditions in §2182.4.A. and the additional requirements in §2182.11 must be reimbursed as physicians' services on a reasonable charge basis. These services cannot be billed under arrangements. Other services, such as clinical diagnostic laboratory services, furnished to hospital inpatients by an independent laboratory are covered as inpatient hospital services and reimbursable to the hospital on a reasonable cost basis or under the prospective payment system. (However, see §2804 for provisions concerning laboratory tests furnished to inpatients of a hospital with a waiver under 602(k) of the 1983 Amendments to the Social Security Act.) Clinical diagnostic laboratory services furnished by an independent laboratory to other than a hospital inpatient are generally reimbursable under the clinical laboratory fee schedule provision.

F. Other Services and Items Furnished by Outside Suppliers.--Some providers obtain items and services for their patients from outside sources. All items and services, except physicians' services that meet the conditions of §2182.4, must be furnished to hospital inpatients under arrangements. (See §2182.8.C. for a limited exception and §2804 for hospitals with extensive direct billing of nonphysician services under Part B.) For items and services furnished to hospital outpatients and SNF patients, reimbursement may be made either by the carrier on a reasonable charge basis or by the intermediary to the provider of services (as long as the service is otherwise covered as a SNF service or outpatient service at a hospital) on a reasonable cost basis. Physicians' services, however, can be paid only on a reasonable charge basis. Examples:

1. A radiology clinic furnishes CT scan services to hospital inpatients. The technical components of these services must be furnished under arrangements by the hospital. The interpretation component must be reimbursed by the carrier on a reasonable charge basis. The intermediary pays for the technical component. Reimbursement is made in the same manner for the two components of CT scan services furnished to hospital outpatients and SNF patients or, the full service is reimbursed by the carrier on a reasonable charge basis.

2. A surgeon inserts a pacemaker which he furnishes the hospital inpatient. The physician's surgical services are paid by the carrier on a reasonable charge basis. The pacemaker is covered only as an item obtained under arrangements and the physician must, therefore, bill the hospital for the item itself. The hospital is paid for the pacemaker by the intermediary.

3. A supplier furnishes an artificial limb for a hospital inpatient. The artificial limb is covered only as an item obtained under arrangements and must, therefore, be billed to the hospital. The hospital is paid for the artificial limb by the intermediary.

2182.5 Determining Reasonable Charges for "Physicians' Services" in Providers.--

A. General.--The carrier determines reasonable charges for physicians' services to patients in providers in accordance with the general instructions governing reasonable charge payment as well as the additional rules in paragraphs B-F of this section.

B. Customary and Prevailing Charges for Physicians' Services in Provider Settings.-

1. Utilizing compensation data collected by the intermediary, the carrier calculates customary and prevailing charges for physicians' services furnished to individual patients in providers in the same way as for physicians' services furnished outside the hospital, separating, when appropriate, charges for physicians' services furnished in provider-based practices and physicians' services furnished in office-based practices. It applies the appropriate customary and prevailing charge screens in determining reasonable charges for physicians' services considering the setting. For example, in the provider setting, it pays only for EKG interpretations, never the complete service which includes nonphysician and technical inputs. These EKG interpretations are similar to EKG interpretations furnished outside the hospital and are subject to the same prevailing charge screens. They are different, however, from the complete service, which when furnished to a patient outside a provider, includes a technical component. Charges for these different kinds of services are accumulated separately, and customary and prevailing charges are established for each. For this purpose, the carrier must use interpretation-only codes, e.g., EKG, EEG, radiology, ultrasound, and pulmonary function.

In developing customary charges for physicians' services furnished in providers by physicians compensated for those services by the provider or a related organization, the carrier establishes a schedule of charges related to that part of the physician's compensation that is allocated to physicians' services to individual patients. (However, if the hospital and the leasing entity are not under common ownership or control, and are closely related only by virtue of the lease, then this rule does not apply.) Office space and billing and collection costs are excluded from the base on which compensation-related charges are determined. Generally, the carrier uses the compensation paid to the physician during the hospital's most recently ended cost reporting period for this purpose. If the compensation information is unavailable from the hospital, the intermediary makes a reasonable estimate of a fair compensation amount based on what is paid for similar services in another hospital and reports this amount to the carrier.

The carrier develops compensation-related charges on an item-by-item basis, considering the frequency with which the various services are furnished, and the relative values assigned to each service in a relative value study. The intermediary obtains the frequency data from the provider for the same period as the physician compensation was paid.

If the hospital does not maintain frequency data in a form acceptable to the carrier, the hospital must count and code its charge for each service for which a charge is made during a designated month. For this purpose, it must use the carrier's coding system. This frequency data is annualized and used to determine compensation-related customary charges. Customary charges are determined in this way as long as the physician continues to be compensated by the provider for physicians' services to any patients. Compensation-related customary charges are revised as part of the next reasonable charge update. Prevailing charge screens for physicians' services to provider patients

include both compensation-related customary charges as well as the customary charges of physicians who practice in providers but are not compensated for physicians' services by a provider.

If a physician has compensation arrangements with several hospitals, and the compensation-related charges are different in each hospital, a separate identification/billing number is assigned for use in each setting and different customary charges determined in each setting.

2. Example to Illustrate the Development of Compensation-Related Customary Charges.-

a. The radiologist receives $125,000 per year from the hospital for furnishing diagnostic services, reimbursable on a reasonable charge basis under Part B. He/she is not compensated for any provider services.

b. The hospital pays for the radiologist's malpractice expense and for the radiologist's cost of continuing medical education. These amounts are $5,000 and $2,500 respectively.

Compensation-related customary charges are established as follows:

Radiological Procedures	Frequency of Service	Relative Value Units (RVU)	Product	Compensation-Related Charge
Chest x-ray single view	1,200	4.0	4,800	11.80
Chest x-ray, two views	1,000	6.0	6,000	17.80
Spine, Complete	800	10.0	8,000	29.60
Shoulder, Complete	400	6.0	2,400	17.80
Wrist, Complete	400	6.0	2,400	17.80
Hand, Complete	200	6.0	1,200	17.80
Hip, Complete	300	7.0	2,100	20.70
Abdomen, Single	500	4.0	2,000	11.80
Upper G.I.	700	14.0	9,800	41.40
Colon, Barium Enema	500	12.0	6,000	35.50
			44,700	

Compensation	$ 125,000
Malpractice Expense	5,000
Continuing Education	2,500
Total Compensation	$ 132,500

$$\frac{\text{Compensation}}{\text{RVU}} = \frac{\$132{,}500}{44{,}700} = \$2.96/\text{RVU}$$

C. Changes in Compensation Agreements.--If a physician who has been compensated by or through a provider (or other entity) for physicians' services to individual patients ends his or her compensation agreement and, instead, bills all patients

directly for his or her services, i.e., no longer receives any compensation from the hospital or its insurers, determine the physician's customary charges for services based on the 50th percentile of the weighted customary charges used to establish the prevailing charge for the service. These customary charges remain in effect until you have accumulated charge data from at least 3 months of the 12-month period of July 1 through June 30 preceding the January 1 annual reasonable charge update. Customary charges are revised only at the time of the annual reasonable charge update.

If a physician terminates a direct billing arrangement and enters into a compensation agreement with a provider, the carrier determines compensation-related customary charges in accordance with paragraph B, except that during the first year the total payments made on the basis of the compensation-related charges may not exceed what the total payment for a comparable volume of services would have been under the physician's former direct billing practice. The carrier makes this determination on a prospective basis by using reasonable estimates.

D. Additional Criteria for Certain Specialties.--In determining the amount of payment for anesthesiology, radiology or pathology services furnished by a physician to an individual patient, also follow the rules in §2182.8, §2182.10 or §2182.11.

E. Customary Charges for Physicians' Services in Outpatient Settings--Combined Billing Previously Used.--There may be some situations in which combined billing was used in hospital outpatient settings, and the physician was compensated by the hospital for his/her services to patients on the basis of either a schedule of charges or variable percentages of charges. In this case, the carrier uses the schedule of charges or the percentage of the combined charge paid by the hospital to the physician as the physician's customary charges. The intermediary obtains this information from the provider and reports it to the carrier.

F. Customary Charges for Physicians' Services in Outpatient Settings.--Undifferentiated Charges Billed to Patients.--In some cases, charges for physicians' services to patients and the provider's charges associated with these services have been combined and billed to patients on a reasonable charge basis. The provider component of these undifferentiated charges must be identified and billed by the provider to its intermediary. The carrier bases reimbursement only on the portion of the charge that is attributed to physicians' services to patients, i.e., services that meet the criteria in §2182.4.A. The component of the formerly combined charges that represents the physicians' charges for their services must be separately identified. These are the physicians' customary charges. The intermediary obtains the schedule of charges for these physicians' services from the provider and reports it to the carrier.

2182.6 Conditions of Payment for Costs of Physicians' Services to Providers--

A. General.--Costs a provider incurs for services of physicians are allowable only if:

o The services do not meet the conditions in §2182.4.A. for reasonable charge reimbursement for physicians' services to individual patients of a provider;

o The services do not include physician availability services, except for reasonable availability services furnished for emergency rooms; (see §2109);

o The provider has incurred a cost for the salary or other compensation it paid the physician for the services; and

o The costs incurred by the provider for the services meet the requirements regarding costs related to patient care.

These services include, for example, departmental administration, supervision and training of staff, quality control activity, autopsies, clinical laboratory services including analysis (except clinical laboratory consultations and services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient), respiratory therapy, tissue committee work, disposal of radiation waste, non-imaging nuclear medicine services, supervision of anesthetists and routine blood gas studies including analysis of routine blood gas studies. Analysis of clinical laboratory services or routine blood gas studies, although performed by specialists and primary care physicians, are not separately billed under Part B.

B. Payment Determinations.--The intermediary makes payment for these services either as an element of prospective payment or on a reasonable cost basis. When reimbursement is made on a reasonable cost basis, the allowable cost cannot exceed the lower of the actual cost or the reasonable compensation equivalent (RCE).

C. Reasonable Compensation Equivalents (RCEs).--HCFA establishes the methodology for determining RCEs by considering average physician income by specialty and type of location. The best available data are used. If the level of physician compensation exceeds the RCE limit, Medicare payment is based on the RCE. The RCE limit represents reasonable compensation for a full-time physician. Full time is 2,080 hours per year, including a reasonable amount of time devoted to vacation, sick leave and continuing education. The intermediary considers the general practice of the hospitals it serves in determining the reasonableness of a hospital-compensated physician's time devoted to vacation, sick leave and continuing education. It also considers that the need for continuing education in any individual year may vary substantially based on medical specialty and the needs of an individual physician. Consultation with its medical advisors is appropriate.

NOTE: As a result of the clinical lab fee schedule, clinical diagnostic laboratory tests furnished by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules. If the hospital compensates its pathologists for provider services, the portion of the physician's compensation attributable to provider services to hospital outpatients is not reimbursed on a reasonable cost basis and is not subject to the reasonable compensation equivalent if payment for the hospital's diagnostic clinical laboratory services is made pursuant to the clinical laboratory fee schedule. However, the portion of the physician's compensation attributable to provider services to hospital outpatients is reimbursed on a reasonable cost basis and is subject to the reasonable compensation equivalent limit if payment for the hospital's outpatient laboratory services is not made pursuant to the clinical laboratory fee schedule. An example of such services is anatomic pathology services, such as the preparation of a surgical pathology slide for which the hospital has established a separate charge.

The RCE limits are always applied to the hospital's entire cost reporting year based on the calendar year (CY) in which the cost reporting year begins. For example, the CY 1983 limits apply to an entire cost reporting year beginning October 1, 1983. (The RCE limits are applicable for services rendered on or after October 1, 1983.)

The RCE limits are based on a work year of 2,080 hours, i.e., a 40-hour work week. If the physician devotes more or less time to furnishing provider services, the RCE is adjusted accordingly. Thus, a physician who spends 60 hours a week in administration of a department is subject to 150 percent of the applicable limit for a physician who devotes full time to departmental services.

The intermediary uses the RCE levels to compute reimbursement when the physician is compensated by the provider or other related organization for administrative, supervisory and other provider services that are reimbursable under Medicare. In applying the RCE limits, the intermediary assigns each compensated physician to the most appropriate specialty category. Table I - Estimates of Full-Time Equivalency (FTE) Annual Average Net Compensation Levels for 1983 and 1984, §2182.6.F, depicts reasonable compensation levels for nine physician specialties plus a total or general category. If no specialty category is indicated, the intermediary uses the RCE level for the "Total" category, which is based on income data for all physicians. For example, the "Total" category is used in determining the reasonable cost for full-time physician administration of an emergency room. The intermediary determines the appropriate geographic area classification using the tables in paragraph G.

If the physician's contractual compensation covers all duties, activities and services furnished to the provider and to its patients and the physician is employed full time, the lower of the physician's actual compensation or the appropriate specialty compensation limit is used and adjusted by the physician's allocation agreement to arrive at the program's allowable costs for physician compensation. In the absence of an allocation agreement, it is assumed that 100 percent of the compensation was related to services reimbursable on a Part B reasonable charge basis, and that there are no allowable costs for the physician's services to the provider.

If the physician's compensation from the provider represents payment only for administrative, supervisory and other provider services (i.e., the physician bills fees for all physicians' services furnished to individual patients), then the lower of the physician's actual compensation or the appropriate specialty compensation limit is used to arrive at the program's allowable costs for physician compensation.

Generally, it is intended that the RCEs are applied separately for each physician. However, an aggregated application is permitted in larger hospital departments which have similar arrangements with a number of physicians of the same specialty to facilitate administration and reduce paperwork. Under this optional methodology, the provider services hours and compensation of each involved physician is determined individually and then aggregated by specialty to determine total provider services hours and compensation by specialty for all involved physicians. The applicable RCE limit is then applied to the aggregated provider services hours and the result compared to the aggregated provider services compensation to determine allowable provider services compensation costs by specialty.

Example:

Physician	Compensation	Provider Services Hours	Professional Services Hours	Total Hours	Provider Services Percentage	Provider Services Compensation
A	$110,000	230	2070	2300	10%	$ 11,000
B	90,000	480	1920	2400	20%	18,000
C	80,000	1715	735	2450	70%	56,000
D	85,000	2040	360	2400	85%	72,250
Totals	$365,000	4465	5085	9550		$157,250

$$\frac{\text{Total Provider Services Hours}}{\text{Work Year Hours}} \times \text{RCE Amount (1984 Total RCE Nonmetropolitan areas)} = \text{Time Adjusted RCE Limit}$$

$$\frac{4465}{2080} \times \$88,600 = \$190,490$$

The aggregated provider services compensation amount of $157,250 is allowable since it does not exceed the time adjusted RCE limit of $190,490. If the RCE limits were applied to the physicians' provider services compensation individually, not all of the provider services compensation attributable to Physicians A and B is allowable.

In determining the reasonable cost of physician compensation for services to the provider, the intermediary is not limited to merely applying the RCE limit based on existing staffing, but also considers the inherent reasonableness of the arrangement. For example, it generally is not reasonable for a hospital to compensate physicians in a particular department for a number of administrative/managerial hours greatly in excess of the hours utilized in comparable departments in other hospitals.

D. Exceptions to the RCE Limits.--

1. The RCE limits do not apply to inpatient hospital services payable under the prospective payment system (PPS) and are not used to limit such costs in the PPS base year.

2. Some hospitals, particularly but not exclusively small or rural hospitals, may be unable to recruit or maintain an adequate number of physicians at a compensation level within the prescribed limits. If a hospital is able to demonstrate to the intermediary its inability to recruit or maintain physicians at a compensation level allowable under the RCE limits (as documented, e.g., by unsuccessful advertising through national medical or health care publications), then the intermediary may grant an exception to the reasonable compensation limits established under these rules, to the extent reasonable. An exception might be justified in cases where a provider is located in a remote location and needs to pay a premium because of extraordinary travel time.

The provider's request for an exception, together with substantiating documentation, must be submitted to the intermediary each year, no later than 90 days after the close of its cost reporting period. In doing so, it must specify (1) the dollar amount in excess of the limit that it paid its physicians; (2) the name and social security number of the physician; and (3) the specific reasons why an exception is necessary. The hospital must furnish with its request for an exception adequate supporting documentation. The documentation must include, but is not limited to, evidence that it has actively sought to secure the services of physicians by advertising in appropriate journals and similar publications.

E. Adjustments to the RCE Limits.--Intermediaries may adjust the allowance for an individual physician upward to take into consideration the provider's costs of physician membership in professional societies and continuing education. This adjustment is limited to actual costs incurred up to a maximum of 5 percent of the time adjusted RCE limit. The lesser of actual cost or the 5 percent limit is then added to the RCE limit.

An intermediary may also adjust the RCE limit to take into account the cost of malpractice insurance. To the extent malpractice insurance is shown to be related to a physician's (or a group of physicians') services to the provider, the intermediary may recognize as an upward adjustment to the RCE limit the related physician malpractice expense incurred by the provider.

The lesser of actual cost or the RCE limit adjusted appropriately to reflect allowances for the costs of membership in professional associations, continuing medical education and/or malpractice insurance premiums represents the reasonable compensation cost.

Where a written agreement between a provider-based physician and a provider clearly stipulates that a portion of the total compensation paid to the physician by the provider is intended to reimburse the physician for the costs incurred by the physician for membership in professional associations, continuing medical education and/or malpractice insurance relating to the physician's services to the provider, intermediaries may adjust the RCE limit upward to take into consideration the provider's additional costs subject to the limitations as described above.

Example A: A non-Prospective Payment System (PPS) hospital is located in a metropolitan area having a population greater than one million and compensates its radiologist $120,000 for both physician and provider services during its cost reporting period beginning October 1, 1983. The hospital pays the physician's membership fees in professional societies and for the physician's continuing medical education which amounts to $6,000. The hospital also pays the physician's malpractice insurance of $8,000. The physician works a full-time equivalent year of 2,080 hours and the allocation agreement is 50 percent provider services and 50 percent physicians' services.

The applicable RCE amount from the tables in §2182.6.F is $123,400. This amount is factored by the ratio of provider services hours to FTE hours (50% of 2,080 = 1,040 :- 2,080 = .5 X $123,400 = $61,700) to determine the time adjusted RCE limit of $61,700. The time adjusted RCE limit of $61,700 is increased by $3,000 (i.e. 50% of $6,000 = $3,000) to account for the costs of membership in professional societies and continuing medical

education since this amount is lower than five percent of the time adjusted RCE limit (i.e. 5% of $61,700 = $3,085). The time adjusted RCE limit with this adjustment, $64,700, is further adjusted by the provider component percentage of the malpractice premium (i.e. 50% of $8,000 = $4,000). The RCE limit with appropriate adjusters amounts to $68,700.

The physician's actual compensation cost, including the cost of continuing medical education, professional membership fees, and malpractice expense amounts to $134,000 (i.e., $120,000 + $6,000 + $8,000 = $134,000). The provider component compensation amounts to $67,000 (i.e., $134,000 x 50% = $67,000).

The allowable cost is the lower of the actual cost or the adjusted RCE limit (i.e., $67,000 or $68,700). In this case, the allowable cost is $67,000.

Example B: A non-PPS hospital is located in a nonmetropolitan area and compensates its pathologist $75,000 for provider services which benefit both Medicare and non-Medicare patients during its cost reporting period beginning October 1, 1983. The pathologist bills both Medicare and non-Medicare patients directly for Part B physician services. The hospital pays the physician's membership fees in professional societies and for the physician's continuing medical education which amounts to $3,000. The hospital also pays the physician's malpractice insurance of $2,500. During the cost reporting period, the physician spends 1,300 hours or 62.5 percent of a full time equivalent of 2,080 hours furnishing contracted provider services. The allocation agreement is 100 percent provider component.

The time adjusted RCE limit is $71,188 ($\frac{1300}{2080}$ X 113,900 = 71,188). This amount is increased by $3,000, the actual costs incurred for membership in professional societies and continuing medical education (Note: 5% of the time adjusted RCE limit is $3,559.) The time adjusted RCE limit with this adjustment, $74,188, is further increased by the malpractice premium of $2,500 resulting in an RCE limit of $76,688. Because the allocation is 100 percent provider component, the entire malpractice expense is allowable.

The physician's compensation cost including the cost of continuing medical education, professional membership fees and malpractice expense amounts to $80,500 (i.e., $75,000 + $3,000 + $2,500 = $80,500).

The allowable cost is the lower of the actual cost or the adjusted RCE limit (i.e., $80,500 or $76,688). In this case, the allowable cost is $76,688.

F. Table I--Estimates of Full-Time Equivalency (FTE) Annual Average Net Compensation Levels for 1983 and 1984--The following compensation limits apply in the years indicated. All figures are rounded to the nearest $100.

Table I.--ESTIMATES OF FTE ANNUAL AVERAGE NET COMPENSATION LEVELS FOR 1983 AND 1984

Specialty	Non-Metropolitan Areas		Metropolitan area less than one million		Metropolitan area greater than one million	
	1983	1984	1983	1984	1983	1984
Total	87,600	88,600	93,900	95,000	97,100	98,200
GP/FP	78,100	79,000	74,900	75,800	76,000	76,800
Int Med	82,300	83,200	83,200	84,400	90,700	91,800
Surgery	100,200	101,400	111,800	113,100	113,900	115,300
Pediatrics	71,700	72,600	83,300	84,300	77,000	77,900
OB/Gyn	109,700	111,000	106,600	107,800	107,600	108,800
Radiology	119,200	120,600	126,600	128,100	123,400	124,900
Psychiatry	76,000	76,800	78,100	79,000	84,400	85,400
Anesthesiology	91,800	92,800	109,700	111,000	109,700	110,000
Pathology	113,900	115,300	120,300	121,700	118,200	119,500

If a physician, such as a pathologist, bills all patients, except Medicare patients on a fee basis for covered services that are payable under Medicare solely on a reasonable cost or PPS basis, program liability for these services is a Medicare only cost.

G. Geographic Area and Classifications for RCE Limits.--As pointed out in paragraph C, RCE limits are adjusted to account for differences in salary levels by location, as well as by specialty. In the limits set forth in Table I, geographic areas are classified into three types: nonmetropolitan areas with populations of less than one million, and metropolitan areas with populations of more than one million. Table II identifies by type of location, geographic areas (Standard Metropolitan Statistical Areas) grouped into the latter two categories for use with the 1983 RCE limits. Table III is similar except that Metropolitan Statistical Areas are utilized for use with the 1984 RCE limits. All counties not listed and all other affected U.S. possessions and territories not part of a State are considered nonmetropolitan areas.

TABLE II

SMSA	Counties	Type of Location	
		Less than 1 million	Greater than 1 million
Abilene, Texas	Callahan, Jones, Taylor	X	
Akron, Ohio	Portage, Summit	X	
Albany, Georgia	Dougherty, Lee	X	
Albany, New York	Albany, Montgomery, Rensselaer, Saratoga, Schenectady	X	
Albuquerque, New Mexico	Bernalillo, Sandoval	X	
Alexandria, Louisiana	Grant, Rapides	X	
Allentown, Pennsylvania	Pennsylvania--Carbon, Lehigh, Northampton, New Jersey--Warren	X	
Altoona, Pennsylvania	Blair	X	
Amarillo, Texas	Potter, Randall	X	
Anaheim, California	Orange		X
Anchorage, Alaska	3rd Judicial Division	X	
Anderson, Indiana	Madison	X	
Anderson, South Carolina	Anderson	X	
Ann Arbor, Michigan	Washtenaw	X	
Anniston, Alabama	Calhoun	X	
Appleton, Wisconsin	Calumet, Outagamie, Winnebago	X	
Arecibo, Puerto Rico	Arecibo	X	
Asheville, North Carolina	Buncombe, Madison	X	
Athens, Georgia	Clarke, Madison, Oconee, Oglethorp	X	
Atlanta, Georgia	Butts, Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Rockdale, Walton.		X
Atlantic City, New Jersey	Atlantic	X	
Augusta, Georgia	Georgia--Columbia, Richmond, South Carolina--Aiken	X	
Austin, Texas	Hays, Travis, Williamson	X	
Bakersfield, California	Kern	X	
Baltimore, Maryland	Anne Arundel, Baltimore, Baltimore City, Carroll, Harford, Howard		X
Bangor, Maine	Penobscot	X	
Baton Rouge, Louisiana	Ascencion, East Baton Rouge, Livingston, West Baton Rouge	X	
Battle Creek, Michigan	Barry, Calhoun	X	
Bay City, Michigan	Bay	X	
Beaumont, Texas	Hardin, Jefferson, Orange	X	
Bellingham, Washington	Whatcom	X	

SMSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Benton Harbor, Michigan	Barrien, Cass	X	
Billings, Montana	Yellowstone	X	
Biloxi, Mississippi	Hancock, Harrison, Stone	X	
Binghamton, New York	New York--Broome, Tioga, Pennsylvania--Susquehanna	X	
Birmingham, Alabama	Jefferson, Shelby, St. Clair, Walker	X	
Bismarck, North Dakota	Burleigh, Morton	X	
Bloomington, Illinois	McLean	X	
Bloomington, Indiana	Monroe	X	
Boise, Idaho	Ada	X	
Boston, Massachusetts	Massachusetts--Essex, Middlesex, Norfolk, Plymouth, Suffolk, New Hampshire--Rockingham		X
Bradenton, Florida	Manatee	X	
Bremerton, Washington	Kitsap	X	
Bridgeport, Connecticut	Fairfield	X	
Brownsville, Texas	Cameron	X	
Bryan, Texas	Brazos	X	
Buffalo, New York	Erie, Niagara		X
Burlington, North Carolina	Alamance	X	
Burlington, Vermont	Chittenden	X	
Caguas, Puerto Rico	Caguas	X	
Canton, Ohio	Carroll, Stark	X	
Caspar, Wyoming	Natrona	X	
Cedar Rapids, Iowa	Linn	X	
Champaign, Illinois	Champaign	X	
Charleston, South Carolina	Berkeley, Charleston, Dorchester	X	
Charleston, West Virginia	Kanawaha, Putnam	X	
Charlotte, North Carolina	Gaston, Mecklenburg, Union	X	
Charlottesville, Virginia	Albemarle, Charlottesville, Fluranna, Greene	X	
Chattanooga, Tennessee	Tennessee--Hamilton, Marion, Sequatchie, Georgia--Catoosa, Dade, Walker	X	
Cheyenne, Wyoming	Laramie	X	
Chicago, Illinois	Cook, Du Page, Kane, Lake, McHenry, Will		X
Chico, California	Butte	X	
Cincinnati, Ohio	Ohio--Clermont, Hamilton, Warren Indiana--Dearborn, Kentucky--Boone, Campbell, Kanton	X	
Clarksville, Tennessee	Tennessee--Montgomery, Kentucky-Christian	X	

SMSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Colorado Springs, Colorado	El Paso, Teller	X	
Columbia, Missouri	Boone	X	
Columbia, South Carolina	Lexington, Richland	X	
Columbus, Georgia	Georgia--Chattahoochee, Muscogee (or Columbus), Alabama --Russell	X	
Columbus, Ohio	Delaware, Fairfield, Franklin, Madison, Pickaway		X
Corpus Christi, Texas	Nueces, San Patricio	X	
Cumberland, Maryland	Maryland--Allegany, West Virginia--Mineral	X	
Dallas, Texas	Collin, Dallas, Denton, Ellis Hood, Johnson, Kaufman, Parker, Rockwall, Tarrant, Wise		X
Danville, Illinois	Vermillion	X	
Danville, Virginia	Pittsylvania	X	
Davenport, Iowa	Iowa--Scott, Illinois--Henry, Rock Island	X	
Dayton, Ohio	Greene, Miami, Montgomery, Preble	X	
Daytona Beach, Florida	Volusia	X	
Decatur, Illinois	Macon	X	
Denver, Colorado	Adams, Arapahoe, Boulder, Denver Douglas, Gilpin, Jefferson		X
Des Moines, Iowa	Polk, Warren	X	
Detroit, Michigan	Lapeer, Livingston, Macomb, Oakland, St. Clair, Wayne		X
Dubuque, Iowa	Dubuque	X	
Duluth, Minnesota	Minnesota--St. Louis, Wisconsin Douglas	X	
Eau Claire, Wisconsin	Chippewa, Eau Claire	X	
Elkhart, Indiana	Elkhart	X	
Elmira, New York	Chemung	X	
El Paso, Texas	El Paso	X	
Enid, Oklahoma	Garfield	X	
Erie, Pennsylvania	Erie	X	
Eugene, Oregon	Lane	X	
Evansville, Indiana	Indiana--Gibson, Posey, Vanderburgh, Warrick, Kentucky--Henderson	X	
Fargo, North Dakota	North Dakota--Cass	X	
Fayetteville, Arkansas	Benton, Washington	X	
Fayetteville, N. Carolina	Cumberland	X	
Flint, Michigan	Genesee, Shiawassee	X	

SMSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Florence, Alabama	Colbert, Lauderdale	X	
Florence, S. Carolina	Florence	X	
Fort Collins, Colorado	Larimer	X	
Fort Lauderdale, Florida	Broward		X
Fort Meyers, Florida	Lee	X	
Fort Smith, Arkansas	Arkansas--Crawford, Sebastian, Oklahoma--Le Flore, Sequoyah	X	
Fort Walton Beach, Florida	Okaloosa	X	
Fort Wayne, Indiana	Adams, Allen, De Kalb, Wells	X	
Fresno, California	Fresno	X	
Gadsden, Alabama	Etowah	X	
Gainesville, Florida	Alachua	X	
Galveston, Texas	Galveston	X	
Gary, Indiana	Lake, Porter	X	
Glens Falls, New York	Warren, Washington	X	
Grand Forks, North Dakota	North Dakota--Grand Forks, Minnesota--Polk	X	
Grand Rapids, Michigan	Kent, Ottawa	X	
Great Falls, Montana	Cascade	X	
Greeley, Colorado	Weld	X	
Green Bay, Wisconsin	Brown	X	
Greensboro, N. Carolina	Davidson, Forsyth, Guilford, Randolph, Stokes, Yadkin	X	
Greenville, S. Carolina	Greenville, Pickens, Spartanburg	X	
Hagerstown, Maryland	Washington	X	
Hamilton, Ohio	Butler	X	
Harrisburg, Pennsylvania	Cumberland, Dauphin, Perry	X	
Hartford, Connecticut	Hartford, Middlesex, Tolland		X
Hattiesburg, Mississippi	Forrest, Lamar	X	
Hickory, N. Carolina	Alexander, Catawba	X	
Honolulu, Hawaii	Honolulu	X	
Houston, Texas	Brazoria, Fort Bend, Harris, Liberty, Montgomery, Waller	X	
Huntington, West Virginia	West Virginia--Cabell, Wayne, Kentucky--Boyd, Greenup, Ohio--Lawrence	X	
Huntsville, Alabama	Limestone, Madison, Marshall	X	
Indianapolis, Indiana	Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Shelby		X
Iowa City, Iowa	Johnson	X	
Jackson, Michigan	Jackson	X	
Jackson, Mississippi	Hinds, Rankin	X	
Jackson, Tennessee	Madison	X	
Jacksonville, Florida	Baker, Clay, Duval, Nassau, St. Johns	X	

SMSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Jacksonville, N. Carolina	Onslow	X	
Jamestown, New York	Chautauqua	X	
Janesville, Wisconsin	Rock	X	
Jersey City, New Jersey	Hudson	X	
Johnson City, Tennessee	Tennessee--Carter, Hawkins, Sullivan, Unicoi, Washington, Virginia--Bristol, Scott, Washington	X	
Johnstown, Pennsylvania	Cambria, Somerset	X	
Joplin, Missouri	Jasper, Newton	X	
Kalamazoo, Michigan	Kalamazoo, Van Buren	X	
Kankakee, Illinois	Kankakee	X	
Kannapolis, N. Carolina	Cabarrus, Rowan	X	
Kansas City, Missouri	Missouri--Cass, Clay, Jackson, Platte, Ray, Kansas--Johnson, Wyandotte		X
Kenosha, Wisconsin	Kenosha	X	
Killeen, Texas	Bell, Coryell	X	
Knoxville, Tennessee	Anderson, Blunt, Knox, Union	X	
Kokomo, Indiana	Howard, Tipton	X	
LaCrosse, Wisconsin	LaCrosse	X	
Lafayette, Indiana	Tippecanoe	X	
Lafayette, Louisiana	Lafayette	X	
Lake Charles, Louisiana	Calcasieu	X	
Lakeland, Florida	Polk	X	
Lancaster, Pennsylvania	Lancaster	X	
Lansing, Michigan	Clinton, Eaton, Ingham, Ionia	X	
Laredo, Texas	Webb	X	
Las Cruces, New Mexico	Dona Ana	X	
Las Vegas, Nevada	Clark	X	
Lawrence, Kansas	Douglas	X	
Lawton, Oklahoma	Comanche	X	
Lewiston, Maine	Androscoggin	X	
Lexington, Kentucky	Bourbon, Clark, Fayette, Jessamine, Scott, Woodford	X	
Lima, Ohio	Allen, Auglaize, Putnam, Van Wert	X	
Lincoln, Nebraska	Lancaster	X	
Little Rock, Arkansas	Pulaski, Saline	X	
Long Branch, New Jersey	Monmouth	X	
Longview, Texas	Gregg, Harrison	X	
Lorain, Ohio	Lorain	X	
Los Angeles, California	Los Angeles		X
Louisville, Kentucky	Kentucky--Bullitt, Jefferson, Oldham, Indiana--Clark, Floyd	X	
Lubbock, Texas	Lubbock	X	
Lynchburg, Virginia	Amherst, Appomattox, Campbell	X	

SMSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Macon, Georgia	Bibb, Houston, Jones, Twiggs	X	
Madison, Wisconsin	Dane	X	
Manchester, New Hampshire	Hillsborough	X	
Manitowoc, Wisconsin	Manitowoc	X	
Mansfield, Ohio	Richland	X	
Marion, Indiana	Grant	X	
Mayaguez, Puerto Rico	Mayaguez	X	
McAllen, Texas	Hidalgo	X	
Medford, Oregon	Jackson	X	
Melbourne, Florida	Brevard	X	
Memphis, Tennessee	Tennessee--Shelby, Tipton, Arkansas--Crittenden, Mississippi--Desoto	X	
Meridian, Mississippi	Lauderdale	X	
Miami, Florida	Dade		X
Michigan City, Indiana	Laporte	X	
Midland, Texas	Midland	X	
Milwaukee, Wisconsin	Milwaukee, Ozaukee, Washington Waukesha		X
Minneapolis, Minnesota	Minnesota--Anoka, Carver, Chicago, Dakota, Hennepin, Ramsey, Scott, Washington, Wright, Wisconsin--St. Croix		X
Missoula, Montana	Missoula	X	
Mobile, Alabama	Baldwin, Mobile	X	
Modesto, California	Stanislaus	X	
Monroe, Louisiana	Quachita	X	
Montgomery, Alabama	Autagua, Elmore, Montgomery	X	
Muncie, Indiana	Delaware	X	
Muskegon, Michigan	Muskegon, Oceana	X	
Nashville, Tennessee	Cheatham, Davidson, Dickson, Robertson, Rutherford, Sumner, Williamson, Wilson	X	
Nassau, New York	Nassau, Suffolk		X
New Bedford, Massachusetts	Bristol	X	
New Brunswick, New Jersey	Middlesex	X	
New Haven, Connecticut	New Haven	X	
New London, Connecticut	New London	X	
New Orleans, Louisiana	Jefferson, Orleans, St. Bernard St. Tammany		X
New York, New York	Bronx, Kings, New York, Putnam Queens, Richmond, Rockland, Westchester, New Jersey--Bergen		X
Newark, New Jersey	Essex, Morris, Somerset, Union	X	X
Newark, Ohio	Licking	X	

SMSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Newburgh, New York	Orange	X	
Newport News, Virginia	Gloucester, Hampton City, James City, Newport News, York	X	
Norfolk, Virginia	Virginia--Chesapeake,Nansemond, Norfolk, Portsmouth, Virginia Beach City, North Carolina--Currituck	X	
N.E. Pennsylvania, Pa	Lackawanna, Luzerne, Monroe	X	
Ocala, Florida	Marion	X	
Odessa, Texas	Ector	X	
Oklahoma City, Oklahoma	Canadian, Cleveland, McClain, Oklahoma, Pottawatomie	X	
Olympia, Washington	Thurston	X	
Omaha, Nebraska	Nebraska--Douglas, Sarpy, Iowa --Pottawatomie	X	
Orlando, Florida	Orange, Osceola, Seminole	X	
Owensboro, Kentucky	Daviess	X	
Oxnard, California	Ventura	X	
Panama City, Florida	Bay	X	
Parkersburg, W. Virginia	West Virginia--Wirt, Wood, Ohio--Washington	X	
Pascagoula, Mississippi	Jackson	X	
Paterson, New Jersey	Passaic	X	
Pensacola, Florida	Escambia, Santa Rosa	X	
Peoria, Illinois	Peoria, Tazewell, Woodford	X	
Petersburg, Virginia	Dinwiddie, Prince George	X	
Philadelphia, Pennsylvania	Pennsylvania--Bucks, Chester, Delaware, Montgomery, Philadelphia, New Jersey--Burlington, Camden, Gloucester		X
Phoenix, Arizona	Maricopa		X
Pine Bluff, Arkansas	Jefferson	X	
Pittsburgh, Pennsylvania	Allegheny, Beaver, Washington, Westmoreland		X
Pittsfield, Massachusetts	Berkshire	X	
Pocatello, Idaho	Bannock, Power	X	
Ponce, Puerto Rico	Ponce	X	
Portland, Maine	Cumberland, Sagadahoc	X	
Portland, Oregon	Oregon--Clackamas, Multnomah, Washington, Washington--Clark		X
Portsmouth, New Hampshire	New Hampshire--Rockingham, Strafford Maine--York	X	
Poughkeepsie, New York	Dutchess	X	
Providence, Rhode Island	Bristol, Kent, Providence, Washington	X	
Provo, Utah	Utah	X	

SMSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Pueblo, Colorado	Pueblo	X	
Quincy, Illinois	Adams	X	
Racine, Wisconsin	Racine	X	
Raleigh, N. Carolina	Durham, Orange, Wake	X	
Rapid City, South Dakota	Meade, Pennington	X	
Reading, Pennsylvania	Berks	X	
Redding, California	Shasta	X	
Reno, Nevada	Washoe	X	
Richland, Washington	Benton, Franklin	X	
Richmond, Virginia	Charles City, Chesterfield, Goochland, Hanover, Henrico, Powhatan, Richmond	X	
Riverside, California	Riverside, San Bernardino		X
Roanoke, Virginia	Botetourt, Craig, Roanoke	X	
Rochester, Minnesota	Olmsted	X	
Rochester, New York	Livingston, Monroe, Ontario, Orleans, Wayne	X	
Rockford, Illinois	Boone, Winnebago	X	
Sacramento, California	Placer, Sacramento, Yolo		X
Saginaw, Michigan	Saginaw	X	
St. Cloud, Minnesota	Benton, Sherburne, Stearns	X	
St. Joseph, Missouri	Andrew, Buchanan	X	
St. Louis, Missouri	Missouri--Franklin, Jefferson, St. Charles, St. Louis, St. Louis City, Illinois--Clinton, Madison, Monroe, St. Clair		X
Salem, Oregon	Marion, Polk	X	
Salisbury, N. Carolina	Cabarries, Rowan	X	
Salinas, California	Monterey	X	
Salt Lake City, Utah	Davis, Salt Lake, Topele, Weber	X	
San Angelo, Texas	Tom Green	X	
San Antonio, Texas	Bexar, Comal, Guadalupe		X
San Diego, California	San Diego	X	
San Francisco, California	Alameda, Contra Costa, Marin, San Francisco, San Mateo	X	
San Jose, California	Santa Clara	X	
San Juan, Puerto Rico	Bayomen, Carolina, Catano, Guaynalco, San Juan, Tru, Jilo Alto		X
Santa Barbara, California	Santa Barbara	X	
Santa Cruz, California	Santa Cruz	X	
Santa Fe, New Mexico	Santa Fe	X	
Santa Rosa, California	Sonoma	X	
Sarasota, Florida	Sarasota	X	
Savannah, Georgia	Bryan, Chatham, Effingham		X
Seattle, Washington	King, Snohomish		X

SMSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Sharon, Pennsylvania	Merier	X	
Sheboygan, Wisconsin	Sheboygan	X	
Sherman, Texas	Grayson	X	
Shreveport, Louisiana	Bossier, Caddo, Webster	X	
Sioux City, Iowa	Iowa--Woodbury, Nebraska--Dakota	X	
Sioux Falls, S. Dakota	Minnehaha	X	
South Bend, Indiana	Marshall, St. Joseph	X	
Spokane, Washington	Spokane	X	
Springfield, Illinois	Menard, Sangaman	X	
Springfield, Massachusetts	Hampden, Hampshire	X	
Springfield, Missouri	Christian, Greene	X	
Springfield, Ohio	Champaign, Clark	X	
State College, Pa	Centre	X	
Steubenville, Ohio	Ohio--Jefferson, West Virginia--Brooke, Hancock	X	
Stockton, California	San Joaquin	X	
Syracuse, New York	Madison, Onondaga, Oswego	X	
Tacoma, Washington	Pierce	X	
Tallahassee, Florida	Leon, Wakulla	X	
Tampa, Florida	Hillsborough, Pasco, Pineallas		X
Terre Haute, Indiana	Clay, Sullivan, Vermillion, Vigo	X	
Texarkana, Arkansas	Arkansas--Little River, Miller Texas--Bowie	X	
Toledo, Ohio	Ohio--Fulton, Lucas, Ottawa, Wood, Michigan--Monroe	X	
Topeka, Kansas	Jefferson, Osage, Shawnee	X	
Trenton, New Jersey	Mercer	X	
Tuscon, Arizona	Pima	X	
Tulsa, Oklahoma	Creek, Mayes, Osage, Rogers, Tulsa, Wagoner	X	
Tuscaloosa, Alabama	Tuscaloosa	X	
Tyler, Texas	Smith	X	
Utica, New York	Herkimer, Oneida	X	
Vallejo, California	Napa, Solano	X	
Victoria, Texas	Victoria	X	
Vineland, New Jersey	Cumberland	X	
Visalia, California	Tulare	X	
Waco, Texas	McLennan	X	
Washington, D.C.	D.C.--District of Columbia Maryland--Charles, Montgomery, Prince Georges, Virginia--Alexandria, Arlington, Fairfax, Loudoun, Prince William		X
Waterloo, Iowa	Black Hawk	X	

SMSA	Counties	Type of Location	
		Less than 1 million	Greater than 1 million
Wausau, Wisconsin	Marathon	X	
West Palm Beach, Florida	Palm Beach	X	
Wheeling, West Virginia	West Virginia--Marshall, Ohio Ohio--Belmont	X	
Wichita, Kansas	Butler, Sedgwick	X	
Williamsport, Pennsylvania	Lycoming	X	
Wilmington, Delaware	Delaware--New Castle, Maryland, Cecil, New Jersey--Salem	X	
Wilmington, N. Carolina	Brunswick, New Hanover	X	
Worcester, Massachusetts	Worcester	X	
Yakima, Washington	Yakima	X	
York, Pennsylvania	Adams, York	X	
Youngstown, Ohio	Mahoning, Trumbell	X	
Yuba City, California	Sutter, Yuba	X	

TABLE III

MSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Abilene, Texas	Taylor	X	
Aquadilla, Puerto Rico	Aquadilla	X	
Akron, Ohio	Portage, Summit	X	
Albany, Georgia	Dougherty, Lee	X	
Albany-Schnectady-Troy, New York	Albany, Greene, Montgomery, Rensselaer, Saratoga, Schenectady	X	
Albuquerque, New Mexico	Bernalillo	X	
Alexandria, Louisiana	Rapides	X	
Allentown-Bethlehem, Pennsylvania-New Jersey	Pennsylvania--Carbon, Lehigh, Northampton, New Jersey--Warren	X	
Alton-Granite City, Illinois	Jersey, Madison	X	
Altoona, Pennsylvania	Blair	X	
Amarillo, Texas	Potter, Randall	X	
Anaheim-Santa Ana, California	Orange		X
Anchorage, Alaska	Anchorage	X	
Anderson, Indiana	Madison	X	
Anderson, South Carolina	Anderson	X	
Ann Arbor, Michigan	Washtenaw	X	
Anniston, Alabama	Calhoun	X	
Appleton-Oshkosh-Neenah, Wisconsin	Calumet, Outagamie, Winnebago	X	
Arecibo, Puerto Rico	Arecibo	X	
Asheville, North Carolina	Buncombe	X	
Athens, Georgia	Clarke, Jackson, Madison, Oconee	X	
Atlanta, Georgia	Barrow, Butts, Cherokee, Clayton, Cobb, Coweta, Dekalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Rockdale, Spalding, Walton		X
Atlantic City, New Jersey	Atlantic, Cape May	X	
Augusta, Georgia-South Carolina	Georgia--Columbia, McDuffie, Richmond, South Carolina--Aiken	X	
Aurora-Elgin, Illinois	Kane, Kendall	X	
Austin, Texas	Hays, Travis, Williamson	X	

TABLE III

MSA	Counties	Type of Location	
		Less than 1 million	Greater than 1 million
Bakersfield, California	Kern	X	
Baltimore, Maryland	Baltimore City, Anne Arundel, Baltimore, Carroll, Harford, Howard, Queen Annes		X
Bangor, Maine	Penobscot	X	
Baton Rouge, Louisiana	Ascension, East Baton Rouge, Livingston, West Baton Rouge	X	
Battle Creek, Michigan	Calhoun	X	
Beaumont-Port Arthur, Texas	Hardin, Jefferson, Orange	X	
Beaver County, Pennsylvania	Beaver	X	
Bellingham, Washington	Whatcom	X	
Benton Harbor, Michigan	Berrien, Michigan	X	
Bergen-Passaic, New Jersey	Bergen, Passaic		X
Billings, Montana	Yellowstone	X	
Biloxi-Gulfport, Mississippi	Hancock, Harrison	X	
Binghamton, New York	Broome, Tioga	X	
Birmingham, Alabama	Biount, Jefferson, Saint Clair, Shelby, Walker	X	
Bismarck, North Dakota	Burleigh, Morton	X	
Bloomington, Indiana	Monroe	X	
Bloomington-Normal, Illinois	McLean	X	
Boise City, Idaho	Ada	X	
Boston-Lawrence-Salem-Lowell-Brockton, Massachusetts	Essex, Middlesex, Norfolk, Plymouth, Suffolk		X
Boulder-Longmont, Colorado	Boulder	X	
Bradenton, Florida	Manatee	X	
Brazoria, Texas	Brazoria	X	
Bremerton, Washington	Kitsap	X	
Bridgeport-Stamford-Norwalk-Danbury, Connecticut	Fairfield	X	
Brownsville-Harlingen, Texas	Cameron	X	
Bryan-College Station Texas	Brazos	X	

TABLE III

MSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Buffalo, New York	Erie		X
Burlington, North Carolina	Alamance	X	
Burlington, Vermont	Chittenden, Grande Isle	X	
Caguas, Puerto Rico	Caguas	X	
Canton, Ohio	Carroll, Stark	X	
Casper, Wyoming	Natrona	X	
Cedar Rapids, Iowa	Linn	X	
Champaign-Urbana-Rantoul, Illinois	Champaign	X	
Charleston, South Carolina	Berkeley, Charleston, Dorchester	X	
Charleston, West Virginia	Kanawaha, Putnam		X
Charlotte-Gastonia-Rock Hill North Carolina-South Carolina	North Carolina--Cabarrus, Gaston, Lincoln, Mecklenberg, Rowan, Union, South Carolina--York	X	
Charlottesville, Virginia	Albemarle, Charlottesville City, Fluranna, Greene	X	
Chattanooga, Tennessee-Georgia	Georgia--Catoosa, Dade, Walker, Tennessee--Hamilton, Marion Sequatchie	X	
Chicago, Illinois	Cook, DuPage, McHenry		X
Chico, California	Butte	X	
Cincinnati, Ohio-Kentucky-Indiana	Indiana--Dearborn, Kentucky--Boone, Campbell, Kanton, Ohio--Clermont, Hamilton, Warren		X
Clarksville-Hopkinsville, Tennessee-Kentucky	Kentucky--Christian, Tennessee--Montgomery	X	
Cleveland, Ohio	Cuyahoga, Geauga, Lake, Medina		X
Colorado Springs, Colorado	El Paso	X	
Columbia, Missouri	Boone	X	
Columbia, South Carolina	Lexington, Richland	X	
Columbus, Georgia-Alabama	Alabama--Russell, Georgia--Chattahoochee, Muscogee	X	
Columbus, Ohio	Delaware, Fairfield, Franklin, Licking, Madison, Pickaway, Union		X
Corpus Christi, Texas	Nueces, San Patricio	X	
Cumberland, Maryland-West Virginia	Maryland--Allegheny, West Virginia--Mineral	X	

TABLE III

MSA	Counties	Type of Location	
		Less than 1 million	Greater than l million
Dallas, Texas	Collin, Dallas, Denton, Ellis, Kaufman, Rockwall		X
Danville, Virginia	Danville City, Pittsylvania	X	
Davenport-Rock Island-Moline, Iowa-Illinois	Iowa--Scott, Illinois--Henry, Rock Island	X	
Dayton-Springfield, Ohio	Clarke, Greene, Miami, Montgomery	X	
Daytona Beach, Florida	Volusia	X	
Decatur, Illinois	Macon	X	
Denver, Colorado	Adams, Arapahoe, Denver, Douglas, Jefferson		X
Des Moines, Iowa	Dallas, Polk, Warren	X	
Detroit, Michigan	Lapeer, Livingston, Macomb, Monroe, Oakland, Saint Clair, Wayne		X
Dothan, Alabama	Dele, Houston	X	
Dubuque, Iowa	Dubuque	X	
Duluth, Minnesota-Wisconsin	Minnesota--St. Louis, Wisconsin--Douglas	X	
East St. Louis-Belleville, Illinois	Clinton, St. Clair	X	
Eau Claire, Wisconsin	Chippewa, Eau Claire	X	
El Paso, Texas	El Paso	X	
Elkhart-Goshen, Indiana	Elkhart	X	
Elmira, New York	Chemung	X	
Enid, Oklahoma	Garfield	X	
Erie, Pennsylvania	Erie	X	
Eugene-Springfield, Oregon	Lane	X	
Evansville, Indiana-Kentucky	Indiana-Posey, Vanderburgh, Warrick, Kentucky, Henderson	X	
Fargo-Moorhead, North Dakota-Minnesota	Minnesota--Clay, North Dakota--Cass	X	
Fayetteville, North Carolina	Cumberland	X	
Fayetteville-Springdale, Arizona	Washington	X	
Flint, Michigan	Genesee	X	
Florence, Alabama	Colbert, Lauderdale	X	
Florence, South Carolina	Florence	X	
Fort Collins-Loveland, Colorado	Larimer	X	

TABLE III

MSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Fort Lauderdale-Hollywood-Pompano Beach, Florida	Broward		X
Fort Myers, Florida	Lee	X	
Fort Pierce, Florida	Martin, St. Lucie	X	
Fort Smith, Arkansas-Oklahoma	Arkansas--Crawford, Sebastian, Oklahoma--Sequoyah	X	
Fort Walton Beach, Florida	Okaloosa	X	
Fort Wayne, Indiana	Allen, De Kalb, Whitley	X	
Fort Worth-Arlington, Texas	Johnson, Parker, Tarrant	X	
Fresno, California	Fresno	X	
Gadsden, Alabama	Etowah	X	
Gainesville, Florida	Alachua, Bradford	X	
Galveston-Texas City, Texas	Galveston	X	
Gary-Hammond, Indiana	Lake, Porter	X	
Glens Falls, New York	Warren, Washington	X	
Grand Forks, North Dakota	Grand Forks	X	
Grand Rapids, Michigan	Kent, Ottawa	X	
Great Falls, Montana	Cascade	X	
Greeley, Colorado	Weld	X	
Green Bay, Wisconsin	Brown	X	
Greensboro-Winston-Salem-HighPoint, North Carolina	Davidson, Davis, Forsyth, Guilford, Randolph, Stokes, Yadkin	X	
Greenville-Spartanburg, South Carolina	Greenville, Pickens, Spartanburg	X	
Hagerstown, Maryland	Washington	X	
Hamilton-Middletown, Ohio	Butler	X	
Harrisburg-Lebanon-Carlisle, Pennsylvania	Cumberland, Dauphin, Lebanon, Perry	X	
Hartford-Middletown-New Britain-Bristol, Connecticut	Hartford, Lichtfield, Middlesex, Tolland	X	
Hickory, North Carolina	Alexander, Burke, Catawba	X	
Honolulu, Hawaii	Honolulu	X	
Houma-Thibodaux, Louisiana	Lafourche, Terrebonne	X	
Houston, Texas ..... Waller	Fort Bend, Harris, Liberty, Montgomery, .		X
Huntington-Ashland, West Virginia-Kentucky-Ohio	Kentucky--Boyd, Carter, Greenup, Ohio--Lawrence, West Virginia--Cabell, Wayne	X	

TABLE III

MSA	Counties	Type of Location	
		Less than 1 million	Greater than 1 million
Huntsville, Alabama	Madison	X	
Indianapolis, Indiana	Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Shelby		X
Iowa City, Iowa	Johnson	X	
Jackson, Michigan	Jackson	X	
Jackson, Mississippi	Hinds, Madison, Rankin	X	
Jacksonville, Florida	Clay, Duval, Nassau, St. Johns	X	
Jacksonville, North Carolina	Onslow	X	
Janesville-Beloit, Wisconsin	Rock	X	
Jersey City, New Jersey	Hudson	X	
Johnson City-Kingsport-Bristol, Tennessee-Virginia	Tennessee--Carter, Hawkins, Sullivan, Unicoi, Washington, Virginia--Bristol City, Scott, Washington	X	
Johnstown, Pennsylvania	Cambria, Somerset	X	
Joliet, Illinois	Grundy, Will	X	
Joplin, Missouri	Jasper, Newton	X	
Kalamazoo, Michigan	Kalamazoo	X	
Kankakee, Illinois	Kankakee	X	
Kansas City, Kansas	Johnson, Leavenworth, Miami, Wyandotte	X	
Kansas City, Missouri	Cass, Clay, Jackson, Lafayette, Platte, Ray	X	
Kenosha, Wisconsin	Kenosha	X	
Killeen-Temple, Texas	Bell, Coryell	X	
Knoxville, Tennessee	Anderson, Blount, Grainger, Jefferson, Knox, Sevier, Union	X	
Kokomo, Indiana	Howard, Tipton	X	
LaCrosse, Wisconsin	LaCrosse	X	
Lafayette, Louisiana	Lafayette, St. Martin	X	
Lafayette, Indiana	Tippecanoe	X	
Lake Charles, Louisiana	Calcasieu	X	
Lake Country, Illinois	Lake	X	
Lakeland-Winterhaven, Florida	Polk	X	
Lancaster, Pennsylvania	Lancaster	X	
Lansing-East Lansing, Michigan	Clinton. Eaton, Ingham	X	
Laredo, Texas	Webb	X	
Las Cruces, New Mexico	Dona Ana	X	
Las Vegas, Nevada	Clark	X	
Lawrence, Kansas	Douglas	X	
Lawton, Oklahoma	Comanche	X	
Lewiston-Auburn, Maine	Androscogin	X	

TABLE III

MSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Lexington-Fayette, Kentucky	Bourbon, Clark, Fayette, Jessamine Scott, Woodford	X	
Lima, Ohio	Allen, Auglaize	X	
Lincoln, Nebraska	Lancaster	X	
Little Rock-North Little Rock, Arkansas	Faulkner, Lonoke, Pulaski, Saline	X	
Longview-Marshall, Texas	Gregg, Harrison	X	
Lorain-Elyria, Ohio	Lorain	X	
Los Angeles-Long Beach, California	Los Angeles		X
Louisville, Kentucky-Indiana	Indiana--Clark, Floyd, Harrison, Kentucky--Bullitt, Jefferson, Oldham, Shelby	X	
Lubbock, Texas	Lubbock	X	
Lynchburg, Virginia	Amherst, Campbell, Lynchburg City	X	
Macon-Warner Robins, Georgia	Bibb, Houston, Jones, Peach	X	
Madison, Wisconsin	Dane	X	
Manchester-Nashua, New Hampshire	Hillsboro, Merrimack	X	
Mansfield, Ohio	Richland	X	
Mayaguez, Puerto Rico	Mayaguez	X	
McAllen-Edinburg-Mission, Texas	Hidalgo	X	
Medford, Oregon	Jackson	X	
Melbourne-Titusville-Palm Bay, Florida	Brevard	X	
Memphis, Tennessee-Arkansas-Mississippi	Arkansas--Crittenden, Mississippi--De Soto, Tennessee--Shelby, Tipton	X	
Miami-Hialeah, Florida	Dade		X
Middlesex-Somerset-Hunterdon, New Jersey	Hunterdon, Middlesex, Somerset	X	
Midland, Texas	Midland	X	
Milwaukee, Wisconsin	Milwaukee, Ozaukee, Washington, Waukesha		X
Minneapolis-St. Paul, Minnesota-Wisconsin	Minnesota--Anoka, Carver, Chicago, Dakota Hennepin, Isanti, Ramsey, Scott, Washington, Wright, Wisconsin--St. Croix		X
Mobile, Alabama	Baldwin, Mobile	X	
Modesto, California	Stanislaus	X	
Monmouth-Ocean, New Jersey	Monmouth, Ocean	X	
Monroe, Louisiana	Quachita	X	

TABLE III

MSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Montgomery, Alabama	Autauga, Elmore, Montgomery	X	
Muncie, Indiana	Delaware	X	
Muskegon, Michigan	Muskegon	X	
Nashville, Tennessee	Cheatham, Davidson, Dickson, Robertson Rutherford, Sumner, Williamson, Wilson	X	
Nassau-Suffolk, New York	Nassau, Suffolk		X
New Bedford-Fall River-Attlebor, Massachusetts	Bristol	X	
New Haven-Waterbury-Meriden, Connecticut	New Haven	X	
New London-Norwich, Connecticut	New London	X	
New Orleans, Louisiana	Jefferson, Orleans, St. Bernard, St. Charles, St. John the Baptist, St. Tammany		X
New York, New York	Bronx, Kings, New York City, Putnam, Queens, Richmond, Rockland, Westchester		X
Newark, New Jersey	Essex, Morris, Sussex, Union		X
Niagara Falls, New York	Niagara	X	
Norfolk-Virginia Beach-NewPort News, Virginia	Chesapeake City, Gloucester, Hampton City James City Co., Newport News City, Norfolk City, Poquoson, Portsmouth City, Suffolk City, Virginia Beach City, Williamsburg City, York		X
Oakland, California	Alameda, Contra Costa		X
Ocala, Florida	Marion	X	
Odessa, Texas	Ector	X	
Oklahoma City, Oklahoma	Canadian, Cleveland, Logan, McClain, Oklahoma, Pottawatomie	X	
Olympia, Washington	Thurston	X	
Omaha, Nebraska-Iowa	Iowa--Pottawatamie, Nebraska--Douglas, Sarpy, Washington	X	
Orange County, New York	Orange	X	
Orlando, Florida	Orange, Osceola, Seminole	X	
Owensboro, Kentucky	Daviess	X	
Oxnard-Ventura, California	Ventura	X	
Panama City, Florida	Bay	X	
Parkersburg-Marietta, West Virginia-Ohio	Ohio--Washington, West Virginia--Wood	X	
Pascagoula, Mississippi	Jackson	X	
Pensacola, Florida	Escambia, Santa Rosa	X	
Peoria, Illinois	Peoria, Tazewell, Woodford	X	

TABLE III

MSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Philadelphia, Pennsylvania-New Jersey	New Jersey--Burlington, Camden Gloucester, Pennsylvania--Bucks, Chester, Delaware, Montgomery, Philadelphia		X
Phoenix, Arizona	Maricopa		X
Pine Bluff, Arkansas	Jefferson	X	
Pittsburgh, Pennsylvania	Alleghany, Fayette, Washington, Westmoreland		X
Pittsfield, Massachusetts	Berkshire	X	
Ponce, Puerto Rico	Ponce	X	
Portland, Maine	Cumberland, Sagadahoc, York	X	
Portland, Oregon	Clackamas, Multnomah, Washington, Yamhill		X
Portsmouth-Dover-Rochester, New Hampshire	Rockingham, Strafford	X	
Poughkeepsie, New York	Dutchess	X	
Providence-Pawtucket-Woonsocket, Rhode Island	Bristol, Kent, Newport, Providence, Washington	X	
Provo-Orem, Utah	UtahX		
Pueblo, Colorado	Pueblo	X	
Racine, Wisconsin	Racine	X	
Raleigh-Durham, North Carolina	Durham, Franklin, Orange, Wake	X	
Reading, Pennsylvania	Berks	X	
Redding, California	Shasta	X	
Reno, Nevada	Washoe	X	
Richland-Kennewick-Pasco, Washington	Benton, Franklin	X	
Richmond-Petersburg, Virginia	Charles City County, Chesterfield, Colonial Heights City, Dinwiddie, Goochland, Hanover, Henrico, Hopewell City, New Kent, Petersburg City, Powhatan, Prince George, Richmond City	X	
Riverside-San Bernardino, California	Riverside, San Bernardino		X
Roanoke, Virginia	Botetourt, Roanoke, Roanoke City, Salem City	X	
Rochester, Minnesota	Olmsted	X	
Rochester, New York	Livingston, Monroe, Ontario, Orleans, Wayne	X	
Rockford, Illinois	Boone, Winnebago	X	

TABLE III

MSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Sacramento, California	Eldorado, Placer, Sacramento, Yolo		X
Saginaw-Bay City-Midland, Michigan	Bay, Midland, Saginaw	X	
St. Cloud, Minnesota	Benton, Sherburne, Stearns	X	
St. Joseph, Missouri	Buchanan	X	
St. Louis, Missouri-Illinois	Illinois--Monroe, Missouri--Franklin, Jefferson, St. Charles, St. Louis, St. Louis City	X	
Salem, Oregon	Marion, Polk	X	
Salinas-Seaside-Monterey, California	Monterey	X	
Salt Lake City-Ogden, Utah	Davis, Salt Lake, Weber	X	
San Angelo, Texas	Tom Green	X	
San Antonio, Texas	Bexar, Comal, Guadalupe		X
San Diego, California	San Diego		X
San Francisco, California	Marin, San Francisco, San Mateo		X
San Jose, California	Santa Clara		X
San Juan, Puerto Rico	Fajardo, San Juan		X
Santa Barbara-Santa Maria-Lompoc, California	Santa Barbara	X	
Santa Cruz, California	Santa Cruz	X	
Santa Rosa-Petaluma, California	Sonoma	X	
Sarasota, Florida	Sarasota	X	
Savannah, Georgia	Chatham, Effingham	X	
Scranton-Wilkes Barre, Pennsylvania	Columbia, Lackawanna, Luzerne, Monroe, Wyoming	X	
Seattle, Washington	King, Snohomish		X
Sharon, Pennsylvania	Mercer	X	
Sheboygan, Wisconsin	Sheboygan	X	
Sherman-Denison, Texas	Grayson	X	
Shreveport, Louisiana	Bossier, Caddo	X	
Sioux City, Iowa-Nebraska	Iowa--Woodbury, Nebraska--Dakota	X	
Sioux Falls, South Dakota	Minnehaha	X	
South Bend-Mishawaka, Indiana	St. Joseph	X	
Spokane, Washington	Spokane	X	
Springfield, Illinois	Menard, Sangamon	X	
Springfield, Missouri	Christian, Greene	X	
Springfield, Massachusetts	Hampden, Hampshire	X	
State College, Pennsylvania	Centre	X	

TABLE III

MSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Steubenville-Weirton, Ohio-West Virginia	Ohio--Jefferson, West Virginia--Brooke, Hancock	X	
Stockton, California	San Joaquin	X	
Syracuse, New York	Madison, Onondaga, Oswego	X	
Tacoma, Washington	Pierce	X	
Tallahassee, Florida	Gadsden, Leon	X	
Tampa-St. Petersburg-Clearwater, Florida	Hernando, Hillsborough, Pasco, Pinelles		X
Terre Haute, Indiana	Clay, Vigo	X	
Texarkana, Texas-Arkansas	Arkansas--Miller, Texas--Bowie	X	
Toledo, Ohio	Fulton, Lucas, Wood	X	
Topeka, Kansas	Shawnee	X	
Trenton, New Jersey	Mercer	X	
Tucson, Arizona	Pima	X	
Tulsa, Oklahoma	Creek, Osage, Rogers, Tulsa, Wagoner	X	
Tuscaloosa, Alabama	Tuscaloosa	X	
Tyler, Texas	Smith	X	
Utica-Rome, New York	Herkimer, Oneida	X	
Vallejo-Fairfield-Napa, California	Napa, Solano	X	
Vancouver, Washington	Clark	X	
Victoria, Texas	Victoria	X	
Vineland-Millville-Bridgeton, New Jersey	Cumberland	X	
Visalia-Tulare-Porterville, California	Tulare	X	
Waco, Texas	McLennan	X	
Washington, DC-Maryland-Virginia	DC--District of Columbia, Maryland--Calvert, Charles, Frederick, Montgomery, Prince Georges, Virginia--Alexandria, Arlington, Fairfax, Fairfax City, Falls Church City, Loudoun, Manassas City, Manassas Park City, Prince William, Stafford		X
Waterloo-Cedar Falls, Iowa	Black Hawk, Bremer	X	
Wausau, Wisconsin	Marathon	X	
West Palm Beach-Boca Raton-Delray Beach, Florida	Palm Beach	X	
Wheeling, West Virginia-Ohio	Ohio--Belmont, West Virginia--Marshall, Ohio	X	

TABLE III

MSA	Counties	Type of Location: Less than 1 million	Type of Location: Greater than 1 million
Wichita, Kansas	Butler, Sedgwick	X	
Wichita Falls, Texas	Wichita	X	
Williamsport, Pennsylvania	Lycoming	X	
Wilmington, Delaware-New Jersey-Maryland	Delaware--New Castle, Maryland--Cecil, New Jersey--Salem	X	
Wilmington, North Carolina	New Hanover	X	
Worcester-Fitchburg-Leominster, Massachusetts	Worcester	X	
Yakima, Washington	Yakima	X	
York, Pennsylvania	Adams, York	X	
Youngstown-Warren, Ohio	Mahoning, Trumbull	X	
Yuba City, California	Sutter, Yuba	X	

2182.7 Conditions for Payment of Charges--Anesthesiology Services.-

A. General.--Anesthesiology services personally furnished by a physician are reimbursed on a reasonable charge basis. A physician may also be reimbursed on a reasonable charge basis for the personal medical direction he/she furnishes to a qualified anesthetist, e.g., certified registered nurse anesthetist (CRNA), anesthesia assistant (AA) and interns or residents.

B. Concurrent Procedures--Medical Direction.--

1. The direction of not more than four concurrent anesthesia procedures may be a physician service reimbursable on a reasonable charge basis if the physician does not perform any other services (except as provided in paragraph C) during the same period of time. In all cases in which medical direction is furnished, the physician must be physically present in the operating suite.

2. The carrier reimburses a physician for concurrent anesthesiology services furnished to patients in a provider on a reasonable charge basis only if the services meet the conditions for reasonable charge payment in §2182.4.A, and the physician:

a. Performs a pre-anesthetic examination and evaluation;

b. Prescribes the anesthesia plan;

c. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

d. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

e. Monitors the course of anesthesia administration at frequent intervals;

f. Remains physically present and available for immediate diagnosis and treatment of emergencies; and

g. Provides indicated post-anesthesia care.

3. If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation and another fulfill the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who rendered them.

C. Other Services Furnished by the Physician While Directing Concurrent Procedures.--A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients is ordinarily not involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, or administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to the surgical patients and does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, a physician may receive patients entering the operating suite for the next surgery while directing concurrent anesthesia procedures or check or discharge patients in the recovery room and handle scheduling matters without affecting reasonable charge reimbursement.

However, if the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and the carrier does not make reasonable charge payment.

Example: A physician is directing CRNAs during three concurrent procedures. A medical emergency develops in one case that demands the physician's personal continuing involvement. Since the physician is no longer able to personally respond to the immediate needs of the other two surgical patients, medical direction ends in those two cases.

D. Concurrent Procedures--Supervision.--When the physician does not fulfill the criteria in §§2182.7.B.1. and 2182.7.B.2. or is involved in furnishing more than four procedures concurrently, the concurrent anesthesia services are physician services to the provider in which the procedures are performed. In such cases, the physician is not required to meet the criteria of §§2182.7.B.2.c and 2182.7.B.2.g personally, but must ensure that a qualified individual performs any procedure in which he/she does not personally participate. In these cases, the intermediary will pay for the services the physician furnished, i.e., the services are not physicians' services reimbursable on a reasonable charge basis.

2182.8 Determining Reasonable Charges for Anesthesia Services.--

A. General.--The large majority of anesthesiologists use relative value schedules and dollar conversion factors to set their fees. The relative value schedules generally assign procedure-specific base unit values, and provide for additional units to take into account such factors as time, risk and age of the patient. Time units represent the elapsed period of time from when the physician prepares the patient for induction and ends when the physician or anesthetist is no longer in personal attendance with the patients.

Reasonable charges for anesthesia services are, therefore, based on a combination of such unit values, to which dollar conversion factors are applied.

B. Procedure Personally Performed by a Physician.--If the anesthesia procedure is furnished by a physician, the carrier determines reasonable charges by allowing no more than one time unit for each 15-minute interval, or fraction thereof, beginning from the time the physician begins to prepare the patient for induction and ending when the patient may be safely placed under post-operative supervision and the physician is no longer in personal attendance. The same computation is made if an anesthetist assists the physician in the care of a single patient.

C. Medical Direction--Inpatient Hospital Anesthesia.--The carrier determines reasonable charges for the physician's concurrent services, i.e., medical direction, by allowing no more than one time unit for each 30-minute interval, or fraction thereof, beginning from the time the physician or anesthetist begins to prepare the patient for induction and ending when the patient may be safely placed under post-operative supervision and the physician and anesthetist are no longer in personal attendance.

Exception:

Cost Reporting Periods Beginning After September 30, 1983 and Before October 1, 1984 -If it was the physician's practice to employ CRNAs and include charges for their services in his/her bills for anesthesiology services as of the last day of the hospital's most recent cost reporting period (of at least 12 months) ending before September 30, 1983, determine payment under paragraph E.1.

Cost Reporting Periods Beginning on or After October 1, 1984 - If it is the physician's practice to employ CRNAs and other qualified anesthetists and to include charges for their services in his/her bills for anesthesiology services, determine payment under paragraph E.1. This billing practice applies to existing and new employment relationships between physicians and anesthetists effective with hospital cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987.

D. Attending Anesthesiologist Services.--If an anesthesia procedure is furnished in a teaching setting and an attending physician relationship is established, the carrier determines reasonable charges in accordance with paragraph B. In such cases, the attending physician is usually with the resident for the entire procedure, although there may be cases in which 15-minute time units may be paid for two concurrent procedures.

E. Medical Direction--Other Settings.--

1. When the anesthetists are employees of the physician, the carrier determines reasonable charges for the physician's services, i.e., medical direction, by allowing no more than one time unit for each 15-minute interval, or fraction thereof, beginning from the time the physician or anesthetist begins to prepare the patient for induction and ending when the patient may be safely placed under post-operative supervision and the physician and anesthetist are no longer in personal attendance.

2. When the anesthetists are not the employees of the physician, all the aspects in the preceding paragraph are the same except that the carrier will allow no more than one time unit for each 30-minute interval, or fraction thereof.

F. "Standby" Anesthesia Services.--Reasonable charge payment may be made for a physician's "standby" anesthesia services when a physician is physically present in an operating suite monitoring the patient's condition, making medical judgments regarding the patient's anesthesia needs and ready to furnish anesthesia services as necessary to a specific patient who is known to be in potential need of such services. For example, when a patient is given a local anesthetic for performance of a surgical procedure because of the general state of his or her health, it is also recognized that it may become necessary to administer general anesthesia during the operation, and an anesthesiologist may be physically present in the operating suite and standing by to furnish the services as needed. The carrier determines "standby" services the same as any other anesthesia procedure, i.e., it makes reasonable charge reimbursement for up to four concurrent procedures.

G. Supervision of More Than Four Procedures Concurrently.--If the physician is involved in furnishing more than four procedures concurrently, or is performing other services while directing the concurrent procedures, the concurrent anesthesia services are physician services to the provider in which the procedures are performed. In such cases, the physician is not required to meet the criteria of §2182.7.B. personally but must ensure that a qualified individual performs any procedure in which the physician does not personally participate. In these cases, the intermediary will pay for the concurrent services on either a reasonable cost basis or as a component part of prospective payments for physician services to providers. Payment on a reasonable charge basis is appropriate for pre-anesthesia services above when personally furnished by the physician. Payment is based on base value units plus one time unit for induction.

H. Claims for Payment.--To determine the reasonable charge for concurrently furnished anesthesiology services, the bill or claim for payment must indicate whether the anesthetists were employees of the physician, the number of concurrent services and the duration of the procedure. When the physician personally furnished the full service, this should be indicated along with the duration. If this information is not furnished, the carrier will assume that the physician supervised an anesthetist and determine the reasonable charge using the base units only, i.e., for the pre-operative and post-operative physician services.

2182.9 Conditions for Payment of Reasonable Charges--Radiology Services.--

A. Services to Patients.--The carrier reimburses radiology services furnished by a physician to an individual patient on a reasonable charge basis only if the services meet the conditions for reasonable charge payment in §2182.4.A and are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as of x-ray films, angiograms, myelograms, pyelograms, nuclear medicine procedures and ultrasound procedures.

B. Services to Providers.--The carrier does not pay on a reasonable charge basis for physician services to the provider (for example, administrative or supervisory services) or for provider services needed to produce the x-ray films or other items that are interpreted by the radiologist. However, allowable costs for such services will be paid to the provider by the intermediary. (See §2182.4.D for costs borne by a physician, such as under a lease or concession agreement.)

2182.10 Determining Reasonable Charges for Radiology Services.--

A. General Rule.--In determining payment for radiology services that meet the conditions for payment of charges in §2182.4.A, the carrier follows the rules in paragraphs B or C of this section.

B. Services Not Furnished in Providers.--If the services are furnished in a radiologist's office, a freestanding radiology clinic, or any other setting that is not part of a provider, the carrier determines the amount of payment for the services under the general reasonable charge rules. However, if the services are furnished to a hospital inpatient, it follows the rules in paragraph C.

C. Services Furnished in Providers.--If the services are furnished in a hospital radiology department or any setting that is part of a provider, the carrier applies the following rules:

1. Determine the amount of payment under the reasonable charge rules for physician services in providers in §2182.5 and the general reasonable charge rules.

2. The reasonable charge for a radiology service furnished in a provider or furnished by a physician outside the hospital to a hospital inpatient shall not exceed 40 percent of the prevailing charge level for the same service ("sameness" will be determined by the procedure code used) furnished in a nonprovider setting. Apply this limitation to all radiological services (diagnostic and therapeutic) furnished in a provider setting (or furnished by an outside source, e.g., a radiology clinic to a hospital inpatient) if such services are available in a nonprovider setting in the locality (using existing carrier locality designations) in which the hospital is located. As long as there is a prevailing charge for the procedure code based on actual charge data (rather than a "gap filling" technique) in the locality in which the hospital is situated, assume that the service is presently available in nonprovider settings in the area. This assumption can be rebutted by documentation showing that the service is not otherwise available in the locality.

3. Apply the 40 percent limitation to the prevailing charge (after application of the economic index) for the total service furnished in a nonprovider setting, i.e., the complete service comprising both the technical and the physician inputs. There may be instances in which there is no complete service prevailing charge for a service furnished in a nonprovider setting. This could happen where, in the past, the service was furnished exclusively in provider settings with interpretation--only fees billed. In such cases, the 40 percent limitation does not apply. Where the service is actually furnished outside the provider setting, establish a complete service prevailing charge based on actual charge data. Use this new prevailing charge both for purposes of the 40 percent limitation and for the general application of prevailing charge limits.

4. In applying the 40 percent limitation, use specialty prevailing charge screens if you have one and if a specialist furnishes the service. In other cases, use the non-specialty screen.

5. The carrier uses existing locality designations for the purpose of applying the 40 percent limitation.

6. The beneficiary's coinsurance liability is applied in the following manner:

$100.00	=	office prevailing charge after economic index applied
x .40	=	limitation factor
$40.00	=	reasonable charge
x .20	=	coinsurance
$8.00	=	beneficiary coinsurance
$32.00	=	amount payable

D. Leased Departments.--When the radiology department is leased, i.e., the technicians are employees of the physicians who own the equipment and bear the operating costs and the patient is neither an inpatient nor an outpatient of any hospital, e.g., the patient is referred by a physician outside a hospital for an x-ray and is not registered as a hospital outpatient, reimbursement is not subject to the limitation described in paragraph C or in §2182.4.D.

2182.11 Conditions for Payment of Charges--Physician Laboratory Services.--

A. Physician Laboratory Services.--The carrier reimburses laboratory services furnished by a physician to an individual patient on a reasonable charge basis only if the services meet the conditions for reasonable charge payment in §2182.4.A and are:

1. Anatomic pathology services;

2. Consultative pathology services that meet the requirements in paragraph C of this section; or

3. Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient.

B. Anatomic Pathology Services.--The following categories of services are included in anatomic pathology and qualify for Part B reasonable charge reimbursement when they meet the definition of "physician services," particularly the criterion that they require performance by a physician. (§2182.4.A.1-3.)

1. Histopathology (Surgical Pathology), is the gross and microscopic examination of organ tissue and is the most commonly furnished anatomic laboratory service. Surgical pathology always requires performance by a physician and is billable on a reasonable charge basis, except for autopsies which are only reimbursable through the hospital.

2. Cytopathology, is the examination of cells, from fluids, washings, brushings or smears, including cytogenetics but generally excluding hematology. Cervical and vaginal smears are the most common service in cytopathology. Routine cervical and vaginal smears, like all routine examinations, are not Medicare covered services. However, if the patient's history or diagnosis indicate the smear is necessary for

diagnostic or treatment purposes, it may be a covered service. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of the abnormality. This microscopic evaluation does ordinarily require performance by a physician. When medically necessary and when furnished by a physician, it is reimbursed under Part B on a reasonable charge basis.

4. Hematology is, for the purposes of this instruction, an anatomic pathology service only when a physician is required to perform a service. This includes microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist. The carrier's medical advisor should be consulted if appropriate to verify which situations require performance by a physician.

5. Blood Banking Services of hematologists and pathologists are anatomic pathology services billable on a reasonable charge basis when analyses are performed of donor and/or patient blood to determine compatible donor units for transfusion where cross-matching is difficult or where contamination with transmissible disease of donor blood is suspected.

C. Consultative Clinical Pathology Services.--

1. General.--For purposes of this section, consultative pathology services must--

a. be requested by the patient's attending physician;

b. relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient;

c. result in a written narrative report included in the patient's medical record; and

d. require the exercise of medical judgment by the consultant physician.

Routine conversations a laboratory director has with attending physicians about test orders or results are not consultations unless all four requirements are met. Laboratory personnel, including the director, may from time to time contact attending physicians to report test results or to suggest additional testing or be contacted by attending physicians on similar matters. This is an activity that is among the routine responsibilities of nonphysician laboratory directors. These contacts do not constitute consultations. If in the course of such a contact, the attending physician requests a consultation from the pathologist, and if that consultation meets the other criteria and is properly documented, it is reimbursable on a reasonable charge basis.

For purposes of this instruction, clinical pathology consultations generally consist of two types. One type would involve a review of a patient's history and medical records along with the laboratory test results.

Example: A pathologist telephones a surgeon about a patient's suitability for surgery based on the results of clinical laboratory test results. During the course of their

conversation, the surgeon asked the pathologist whether, based on test results, and the patient's history and medical records, the patient should be considered a candidate for surgery. The surgeon's request required the pathologist to render a medical judgment and provide a consultation. The pathologist should follow-up his oral advice with a written report and the surgeon should note in the patient's medical record that he/she requested a consultation.

Another type would be an interpretive consultation which is a consultation of limited duration requiring the exercise of medical judgment in interpreting test findings and furnishing information directly related to the condition of the patient to the attending physician, which ordinarily cannot be furnished by a nonphysician laboratory specialist. This would generally take place when a patient's attending physician consults with a pathologist about the meaning of the results of new or unfamiliar tests or groupings of tests when they are new or unfamiliar to the attending physician or when they reveal an unanticipated test result. At times, interpretive consultations may also be appropriate in emergency situations when a patient has an acute condition that requires immediate attention and the interpretation requires performance by a physician. An interpretive consultation must be requested by the attending physician. This can be requested at the time the testing is ordered or can be noted on the patient's chart after the consultation. In either event, the consultation would be reimbursable under Part B on a reasonable charge basis. In any case, if the information could ordinarily be furnished by a nonphysician laboratory specialist, the service of the physician is not a consultation payable on a reasonable charge basis under Part B.

2. Determining Reasonable Charges for Clinical Pathology Consultations.--The carrier reimburses for laboratory services that meet the conditions for reasonable charge reimbursement by applying the rules in §2182.5.

The carrier should use one code for the interpretive, i.e., the brief consultation, and another for the more comprehensive consultation which usually involves several test results, requires review of the patient's history and generally requires greater physician inputs.

3. Documentation Requirements.--It is not necessary to require that pathologists or hematologists routinely submit a copy of the attending physician's request for a consultation and a copy of the consultation report with every claim. However, carriers may request such documentation on a sample basis and, they should, as they would in other cases, conduct post-payment reviews onsite at hospitals to determine whether the services furnished were medically necessary and meet the applicable criteria. In the course of the reviews, carriers may ask for copies of requests from attending physicians, but if the laboratory physician indicates that the request initially was made orally, the carrier will rely on timely entries made by the attending physician in the patient's medical records to indicate that a request was made.

Consultation reports should be in the form or format that meets the hospital's requirements if it represents good medical practice and should be tailored to the nature of the consultation performed. Because of the unique nature of interpretive pathology consultations, the report can be abbreviated since the patient's history and medical records ordinarily would not be reviewed. It must, however, be made part of the patient's medical record and contain adequate information to demonstrate that the consultant furnished medical judgment rather than the type of information ordinarily furnished by a

technologist. The comprehensive clinical consultation, however, requires a complete narrative report explaining the test results in light of the patient's history and medical records.

2182.12 Blood Gas Studies.--Routine blood gas analyses are ordinarily performed by nonphysician personnel and are not recognized as a service payable on a reasonable charge basis. Even where the blood gas analysis is performed by a physician, the service is not covered as a Part B physicians' service since the criterion in §2182.4.A.3. is not met. The interpretation of routine blood gas studies by a physician specialist or a primary care physician cannot be billed or paid separately under Part B. Such studies and their interpretation are among the many clinical procedures used by an attending physician in arriving at a diagnosis and initiating appropriate treatment. However, payment is made on a reasonable charge basis for blood gas studies performed as a part of more complete pulmonary function testing provided the conditions in §2182.4 are met. In addition, where medically necessary, payment is made for a consultation by a specialist requested by the attending physician because the latter requires assistance in interpreting the results of blood gas studies, e.g., the results fall outside the expected range in light of the patient's history and medical records.

2182.13 Exhibits.--Exhibit I is an interim standard physician-provider allocation agreement that stays in effect until a cost report is filed for a year ending February 28, 1984. Complete this exhibit and submit it to your intermediary. The intermediary indicates whether it is acceptable and sends a copy to the carrier for concurrence. The criteria in §2182.3 must be used. Providers who file cost reports after February 28, 1984, are required to complete Form HCFA-339 Provider Cost Report Reimbursement Questionnaire. The Provider Cost Report Reimbursement Questionnaire includes the Provider-Based Physician Questionnaire which is a series of schedules collecting information on provider-based physician allocation agreements, compensation agreements, and billing agreements. Schedule 3 of the HCFA-339, Allocation of Physician Compensation, is similar to Exhibit I and produces the information on the physician's professional component percentage. Therefore, where Schedule 3 of the HCFA-339 is submitted to the intermediary, the intermediary sends this copy, rather than Exhibit I, to the carrier.

Completion of Exhibit I--Allocation of Physician Compensation.--

Line 1 Indicate the name of the provider, the provider's Medicare identification number and the provider department. Indicate the name of each physician or the name of the physician group if there is an agreement between the head of the physician group and the hospital, and the allocation agreement is a departmental allocation agreement, i.e., it applies to all physicians in the department.

Line 2 Indicate the basis for the allocation agreement, whether it is based on estimate, time studies, or other factors.

Line 3 Indicate the total actual hours the physician or physician group works per week.

Line 4 Indicate the percentages of total time the physician or physician group spends in the various listed activities. Add these individual percentage amounts and list the amount in the Total block.

Line 4A Indicate the percentage of total time the physician or physician group spends in the various listed activities. Add these individual percentage amounts and list the amount in the Total block.

Line 4B Indicate the percentage of total time the physician or physician group spends in furnishing medical or surgical services to individual patients.

Line 4C Indicate the percentage of total time the physician or physician group spends in noncovered Medicare activities, such as research.

At the bottom of the exhibit, the provider's representative and one physician or the head of the physician group signs and dates the agreement.

EXHIBIT I

ALLOCATION OF PHYSICIAN COMPENSATION

1. Provider Name: _____
   Number: _____
   Department: _____
   Name of Physician or Group: _____

2. Basis of Allocation:
   /__/ Estimate
   /__/ Time Study
   /__/ Other (explain):_____

3.	Total hours per week (average)	/___/	
4.	Percentages of Total Time		/100%/
	A. Supervision of technicians, nurses, etc.	/___/	
	Utilization review, other committee work	/___/	
	Administration	/___/	
	Supervision of Interns/Residents	/___/	
	Teaching	/___/	
	Quality Control	/___/	
	Autopsies	/___/	
	Other	/___/	
	Total		/___/
	B. Medical and surgical services to individual Patients		/___/
	C. Noncovered activities, e.g., research		/___/

_____ _____ _____ _____
Signature--Provider Representative Date Signature--Physician(s) Date

2183. LEGAL FEES AND OTHER RELATED COSTS

Legal fees and related costs incurred by a provider are allowable if related to the provider's furnishing of patient care, e.g., legal fees incurred in appeals to the Provider Reimbursement Review Board and, if applicable, further appeals subsequent to a Board decision. However, legal fees and related costs incurred by a provider related to alleged civil fraud or indictment for a criminal act by the provider or its owners, employees, directors, etc., or legal fees for certain anti-union activities (see §2180), are not related to the furnishing of patient care and, therefore, are unallowable provider costs.

Maximum Allowable Cost (MAC) Determinations for Drugs

NOTE: THESE MACs DO NOT APPLY TO UNIT DOSE PACKAGING FOR INSTITUTIONAL USE.

Drug	Strength	MAC	Effective Date
Acetaminophen w/codeine tablets	30 mg.	$0.0780 per tablet	January 25, 1979
Acetaminophen w/codeine tablets	60 mg.	$0.1545 per tablet	January 25, 1979

The most common brand names of these two strengths of Acetaminophen w/codeine are:

Empracet w/codeine
Tylenol w/codeine

Amoxicillin capsules	250 mg.	$0.2108 per capsule	June 28, 1979
Amoxicillin capsules	500 mg.	$0.3942 per capsule	June 28, 1979

The most common brand names of these forms and strengths of Amoxicillin are:

Amoxil Larotid Polymox

Ampicillin capsules	250 mg.	$0.0725 per capsule	June 27, 1977 through January 24, 1979
Ampicillin capsules	250 mg.	$0.0595 per capsule	January 25, 1979
Ampicillin capsules	500 mg.	$0.1390 per capsule	June 27, 1977 through January 24, 1979
Ampicillin capsules	500 mg.	$0.1103 per capsule	January 25, 1979

The most common brand names of these two strengths of Ampicillin capsules are:

Amcill	Omnipen	Pen-A
Penbritin	Pensyn	Polycillin
Principen	QID Amp	SK-Ampicillin
Supen	Totacillin	

Drug	Strength	MAC	Effective Date
Ampicillin oral suspension	125 mg./ 5 ml.	$0.0145 per ml.	October 25, 1977
Ampicillin oral suspension	250 mg./ 5 ml.	$0.0205 per ml.	October 25, 1977

The most common brand names of these two strengths of Ampicillin oral suspension are:

Alpen	Amcill	Omnipen
Pen-A	Penbritin	Pensyn
Polycillin	Principen	SK-Ampicillin
Supen	Totacillin	

Chlordiazepoxide HCL capsules	5 mg.	$0.0270 per capsule	May 12, 1978 through October 14, 1979
Chlordiazepoxide HCL capsules	5mg.	$0.0140 per capsule	October 15, 1979
Chlordiazepoxide HCL capsules	10 mg.	$0.0378 per capsule	May 12, 1978 through October 14, 1979
Chlordiazepoxide HCL capsules	10 mg.	$0.0211 per capsule	October 15, 1979
Chlordiazepoxide HCL capsules	25 mg.	$0.0640 per capsule	May 12, 1978 through October 14, 1979
Chlordiazepoxide capsules	25 mg.	$0.0438 per capsule	October 15, 1979

The most common brand names of these strengths of Chlordiazepoxide are:

Diazachel	Librium	SK-Lygen	A-Poxide

Drug	Strength	MAC	Effective Date
Dicloxacillin Sodium oral capsules	250 mg.	$0.2690 per capsule	December 8, 1980

The most common brand names of this form and strength of Dicloxacillin Sodium are:

Dynapen Pathocil Veracillin

Diphenoxylate hydrochloride/ atropine sulfate tablets	2.5 mg./ 0.025 mg.	$0.0491 per tablet	October 15, 1979

The most common brand names of this strength of Diphenoxylate hydrochloride/ atropine sulfate are:

Lomotil Colonil

Doxepin HCL capsules	10 mg.	$0.0950 per capsule	January 25, 1979
Doxepin HCL capsules	25 mg.	$0.1161 per capsule	January 25, 1979
Doxepin HCL capsules	50 mg.	$0.1765 per capsule	January 25, 1979
Doxepin HCL capsules	100 mg.	$0.2900 per capsule	October 15, 1979

The most common brand names of these strengths of Doxepin are:

Sinequan Adapin

Erythromycin Stearate tablet	250 mg.	$0.0697 per tablet	January 25, 1979
Erythromycin Stearate tablet	500 mg.	$0.1250 per tablet	January 25, 1979

The most common brand names of these strengths of Erythromycin Stearate are:

Erythrocin Stearate Ethril Pfizer-E
Bristamycin SK-Erythromycin Wyamycin-S

Drug	Strength	MAC	Effective Date
Glutethimide oral tablet	500 mg.	$0.0432 per tablet	August 28, 1981

The most common brand names of this form and strength of Glutethimide are:

Doriden Dormtabs

Hydralazine HCL tablet	25 mg.	$0.0279 per tablet	March 31, 1980
Hydralazine HCL tablet	50 mg.	$0.0384 per tablet	March 31, 1980

The most common brand names of these strengths of Hydralazine HCL are:

Apresoline Dralzine Rolazine

Hydrochlorothiazide tablet	25 mg.	$0.0250 per tablet	June 28, 1979 through December 7, 1980
Hydrochlorothiazide tablet	25 mg.	$0.0152 per tablet	December 8, 1980
Hydrochlorothiazide tablet	50 mg.	$0.0306 per tablet	June 28, 1979 through December 7, 1980
Hydrochlorothiazide tablet	50 mg.	$0.0194 per tablet	December 8, 1980

The most common brand names of these strengths of Hydrochlorothiazide are:

Esidrix Hydrodiuril Oretic

Drug	Strength	MAC	Effective Date
Meprobamate tablet	200 mg.	$0.0108 per tablet	January 25, 1979
Meprobamate tablet	400 mg.	$0.0117 per tablet	January 25, 1979

The most common brand names of these two strengths of Meprobamate are:

Miltown Equanil

Methocarbamol tablet	500 mg.	$0.0496 per tablet	October 15, 1979
Methocarbamol tablet	750 mg.	$0.0640 per tablet	October 15, 1979

The most common brand name of these strengths of Methocarbamol is:

Robaxin

Oxyphenbutazone tablet	100 mg.	$0.0847 per tablet	October 15, 1979 through September 30, 1980

The most common brand names of this strength of Oxyphenbutazone are:

Tandearil Oxalid

Drug	Strength	MAC	Effective Date
Penicillin VK oral suspension	125 mg./ 5 ml.	$0.0120 per ml.	October 25, 1977
Penicillin VK oral suspension	250 mg./ 5 ml.	$0.0160 per ml.	October 25, 1977
Penicillin VK tablets	250 mg.	$0.0535 per tablet	October 25, 1977
Penicillin VK tablets	500 mg.	$0.1025 per tablet	October 25, 1977

The most common brand names of these forms and strengths of Penicillin VK are:

Beta-pen VK	Ledercillin VK	QID Pen VK	SK-Penicillin VK
Compocillin VK	Penapar VK	Repen VK	Uticillin VK
Deltapen VK	Pen-Vee K	Robicillin VK	V-Cillin K
Kesso-pen VK	Pfizerpen VK	Ro-Cillin VK	Veetids

Penicillin G Potassium tablet	400 mu.	$0.0237 per tablet	October 15, 1979
Penicillin G Potassium tablet	800 mu.	$0.0640 per tablet	October 15, 1979

The most common brand names of these strengths of Penicillin G Potassium are:

Pentids Pfizerpen G SK-Penicillin-G

Phenylbutazone tablet	100 mg.	$0.0750 per tablet	January 25, 1979 through September 30, 1980

The most common brand names of this form and strength of Phenylbutazone are:

Butazolidin Azolid

Drug	Strength	MAC	Effective Date
Phenylbutazone Alka capsule	100 mg.	$0.0940 per capsule	January 25, 1979 through September 30, 1980

The most common brand names for this form and strength of Phenylbutazone Alka are:

Azolid-A Butzaolidin Alka

Potassium Chloride liquid	10%	$0.0030 per ml.	December 8, 1980

The most common brand names of this strength of Potassium chloride are:

Klorvess Kaochlor Kay Ciel

Probenecid tablet	0.5 gm.	$0.0644 per tablet	January 25, 1979

The most common brand names of this strength of Probenecid are:

Benemid Probalan

Procainamide HCL capsules	250 mg.	$0.0383	August 28, 1981
Procainamide HCL capsules	375 mg.	$0.0505	August 28, 1981
Procainamide HCL capsules	500 mg.	$0.0585	August 28, 1981

The most common brand names of these strengths of Procainamide are:

Pronestyl Procapan Procamide

Drug	Strength	MAC	Effective Date
Propantheline Bromide oral tablet	15 mg.	0.0235	August 28, 1981

The most common brand names of this form and strength of Propantheline Bromide are:

Probanthine Norpanth

Propoxyphene HCL capsules	65 mg.	$0.0317 per capsule	April 24, 1978

The most common brand names of this form and strength of Propoxyphene are:

Darvon Dolene SK-65

Propoxyphene HCL with APC capsules	65 mg.	$0.0330 per capsule	April 24, 1978

The most common brand names of this form and strength of Propoxyphene are:

Darvon Compound-65 SK-65 Compound
Dolene Compound-65 ICN-65 Compound

Quinidine Sulfate oral tablet	200 mg. (3 grain)	$0.0688 per tablet	December 8, 1980

The most common brand names of this strength of Quinidine Sulfate are:

Quinidine Sulfate Cin-Quin Quinora

Drug	Strength	MAC	Effective Date
Sulfisoxazole tablet	500 mg.	$0.0273 per tablet	October 15, 1979

The most common brand names of this strength of Sulfisoxazole are:

Gantrisin S-K - Soxazole

Tetracycline HCL capsules	250 mg.	$0.0250 per capsule	April 10, 1978
Tetracycline HCL capsules	500 mg.	$0.0465 per capsule	April 10, 1978
Tetracycline HCL syrup	125 mg./ 5 ml.	$0.0104 per ml.	October 15, 1979

The most common brand names of these forms and strengths of Tetracycline are:

Achromycin V	Cyclopar	Robitet	Tetracyn
Amtet	Panmycin	SK Tetracycline	Tetram
Bristacycline	Retet	Sumycin	
