CHAPTER 28

PROSPECTIVE PAYMENTS

2801. HOSPITAL PROSPECTIVE PAYMENT SYSTEM BASE PERIOD AND TARGET AMOUNT (Cross refer to §§2406, 2407 and A 2406)

The Social Security Amendments of 1983(PL 98-21) provide that effective with cost reporting periods beginning on or after October 1, 1983, Medicare's payment for Part A hospital inpatient operating costs will be made prospectively on a per discharge basis. Part A inpatient hospital operating costs include those costs (including malpractice insurance costs) for general routine service, ancillary service, and intensive care-type unit services with respect to inpatient hospital services but exclude capital-related and direct medical education costs. Inpatient hospital services are defined as all services provided regardless of source, except for physician services. Payment for other inpatient hospital costs (i.e., capital-related costs, medical education costs,) and for Part B inpatient ancillary and outpatient services, will continue to be paid retrospectively on a reasonable cost basis.

2802. PAYMENT RATES DURING TRANSITION

Under the prospective payment system, each Medicare discharge will be classified into diagnosis related groups (DRGs) and a specific payment rate will be established for each DRG by geographic area. During a 3-year transition period, the prospective payment rate for a given Medicare discharge will be based on a combination of 1) a rate per discharge (subsequently referred to as "target amount per discharge"), based on the hospital's historical cost experience in a base period adjusted by the hospital's case-mix index, and 2) the DRG specific payment rate. After the transition period, the payment will be based only on the DRG-specific payment rate (see F. below). An additional payment will be made to the prospective payment amount for hospitals that have an approved graduate medical education program as defined in 42 CFR 405.421. In order for intermediaries to make the payment, hospitals will need to submit the number of interns and residents it employs along with base period cost adjustment data (see G. below).

Target Rate

The target rate that will comprise one portion of the prospective payment during the transition period is determined on a prospective basis without reference to the hospital's costs in the current year. It is developed by increasing the hospital's base period allowable inpatient operating costs per discharge, as adjusted by the hospital's case-mix index, by an inflation factor during the intervening years. Intermediaries will determine the base period costs and target amount per discharge and notify the hospital of the determination as provided below.

A. Base Period Cost Report--The base period cost is developed from cost data for the next to the last 12 month (or longer) cost reporting period preceding the first cost reporting period subject to the prospective payment system. Thus, the base period under the prospective payment system is generally the same as the base period under §101 of TEFRA and is the 12-month cost reporting period ending on or after 9/30/82 and before 9/30/83.

Example:

1st Fiscal Year Subject to Prospective Reimbursement	Base Period
10/1/83 - 9/30/84	10/1/81 - 9/30/82
1/1/84 - 12/31/84	1/1/82 - 12/31/82
7/1/84 - 6/30/85	7/1/82 - 6/30/83

NOTE: Generally the same base period is used for the prospective payment system and for §101 TEFRA rate of increase ceiling purposes. Also many of the same adjustments will apply for both. Thus collection of data and activities to adjust the base period should be coordinated to the extent possible. Adjustment of the base period for both prospective payments and §101 of TEFRA can then be accomplished in the same format. (See Exhibits A, B and C.) HOWEVER, INTERMEDIARIES WILL PROCEED WITH COMPLETING THE PROSPECTIVE PAYMENT SYSTEM BASE PERIOD AND TARGET AMOUNT CALCULATIONS AS REQUIRED BY THESE INSTRUCTIONS EVEN IF THERE IS ANY DELAY WITH OR DISPUTE BETWEEN THE INTERMEDIARY AND PROVIDER OVER DEVELOPMENT OR COMPUTATION OF TEFRA ADJUSTMENTS OR BASE PERIOD COSTS.

If the hospital's first cost reporting period ending on or after September 30, 1982 was for less than 12-months, the most recent 12-month cost reporting period ending before September 30, 1982 will be used. For example, if the hospital's cost reporting period ending 9/30/82 covered 9 months (1/1/82 - 9/30/82), the preceding cost report for 1/1/81-12/31/81 would be used as the base period and the cost will be trended forward based on the industry-wide inflation factors which will be provided under separate instruction. (Note: In this case, the base period for prospective reimbursement would differ from the base period for the TEFRA rate of increase ceiling.)

If a new hospital (see 42 CFR 405.463) did not have at least one 12-month cost reporting period prior to its first cost reporting period beginning on or after October 1, 1982, the amount of the prospective payments made to such hospitals during the transition period will be determined by using the full Federal payment amount (using the appropriate blend of national and regional standardized amounts) with no hospital-specific amount (see F. below). A change in ownership will not constitute grounds for a hospital to be considered a new provider for purposes of qualifying for this exception. However, if a change of ownership occurs and there has been an actual break (subsequent to what would have been its base period) in providing hospital inpatient services, a hospital will qualify as a new hospital. (Note: any cessation of operations constitutes a termination of the provider agreement; the new hospital will need to request Medicare certification when it resumes operation.)

In the case of a subprovider of a hospital which does not meet the requirements for exclusion from prospective payments under §2803, but did meet the requirements of §2336 for subprovider status, separate hospital-specific amounts must be determined for that unit and the rest of the hospital.

B. Base Period Adjustments to Determine Inpatient Operating Costs .--The purpose of the adjustments is to make the base period costs comparable to inpatient operating costs that will now be paid under the prospective payment system. For purposes of this instruction, Medicare Part A hospital inpatient operating costs include all general routine, ancillary (including kidney acquisition costs for hospitals other than those approved as renal transplant centers), intensive care-type unit, and malpractice insurance costs applicable to the Part A inpatient hospital services; but exclude capital-related and direct medical education costs, physician professional services to individual patients (including adjustments resulting from regulations published March 3, 1983), and physician services furnished in teaching hospitals which have elected to cover those services on the basis of reasonable cost under 42 CFR 405.521. (See §§2148-2148.5.)

The necessary adjustments to the appropriate period's inpatient operating costs are described in the following subsections. These adjustments are to be made using the specific instructions and worksheet provided in Exhibit C of this instruction. The process for developing the prospective payment system base period and target rate are compared and contrasted in Exhibit A to that required under section 101(b) of TEFRA. Hospitals submitting adjustment data pursuant to these instructions should do so by June 15, 1983 for hospitals with fiscal years beginning October 1, 1983 - November 1, 1983. For hospitals with fiscal years beginning on or after November 2, 1983, follow the schedule provided with form HCFA-1008 in Exhibit B. Intermediaries will make base year adjustments using the best data available to them from the base year cost report and any supplemental data furnished voluntarily by hospitals and received by the intermediaries by these dates. Data submitted by hospitals after the applicable due date will be used by

intermediaries to adjust the base year costs only to the extent that it is administratively feasible to do so in the time remaining before the final determination is scheduled to be issued as shown in D. below.

NOTE: In determining the target rate (target amount per discharge) from the base period cost report, intermediaries will use the provider's settled cost report (Notice of Program Reimbursement issued) or, if not settled, the provider's cost report after desk review and, if applicable, field audit. For cost reports that have not been finally settled at the time the target amount determination is made, every effort should be made to resolve disputed amounts based on the Medicare principles of reimbursement in effect for the period involved. Any amounts in dispute between the intermediary and provider must be reviewed and decided upon by the intermediary before a final determination of the base period costs and prospective target amount per discharge is issued. (However, see subsection E. below regarding review and adjustments available to hospitals after the intermediary's determination is issued.) Since this is a prospective payment system, where the intermediary cannot resolve disputed amounts it must make adjustments to the base period costs using the best evidence available that it determines to be in accordance with the principles of reimbursement in effect for that period.

The following adjustments must be made, where appropriate, to the hospital's inpatient routine and ancillary cost items as explained in Exhibit C.

NOTE: The following first four adjustments to total allowable Part A inpatient operating costs in the base period must be made for all hospitals reimbursed under the prospective payment system for fiscal years beginning on or after October 1, 1983.

1. Capital-Related Cost Adjustment - Capital-related costs are not included in the prospective payment system during the transition period (§1886(A)(4) of the Act). Hospitals will be reimbursed for capital related items on a reasonable cost reimbursement basis during the transition. Capital-related costs are considered to be those costs normally classified in depreciation accounts on a hospital's cost report. (For a full definition, see §§2806ff.) During this period, classification of an item as either a capital-related expense or a current operating expense must not be changed in subsequent fiscal years from its classification status in the base period cost report. Further, hospitals will not be permitted to change their policies during the transition period from those used in the base period regarding capitalizing or expensing the items. Intermediaries will assure that any cross-over of items from operating expense categories to capital-related categories will not be allowed in reimbursing hospitals during the transition period. See Exhibit C to make the necessary adjustment.

Hospitals may have been assigning certain capital-related costs directly to departmental cost centers which cannot be readily identified as capital expenditures in the base period cost report. SINCE INTERMEDIARIES MUST MAKE ADJUSTMENTS USING THE BEST EVIDENCE AVAILABLE (I.E., THE BASE PERIOD COST REPORT), ANY ADJUSTMENT TO REFLECT SUCH COSTS AS CAPITAL EXPENDITURES IN THE BASE PERIOD CAN ONLY BE MADE WHEN THE PROVIDER SUBMITS SUCH CHANGES TO THE INTERMEDIARY TIMELY. Without further data from hospitals, intermediaries will assume such adjustments are unnecessary. Subsequent adjustments, however, cannot be made pursuant to the above paragraph. In addition, the provider's capitalization policy

regarding minor asset write-offs that was used in the base period must also consistently be used in the transition period. (See §§106 and 108 of HCFA Pub. 15-I and §306 of HCFA Pub. 15-2.)

2. Direct Medical Education Cost of Approved Educational Activities Adjustment.--Direct medical education costs will also continue to be reimbursed to hospitals on a reasonable cost basis (§1886(a)(4) of the Act). Approved educational activities mean formally organized or planned programs of study actually operated by providers in order to enhance the quality of care in an institution (see 42 CFR 405.421). When direct medical education costs are currently identified in Medicare hospital cost reports, the intermediary will exclude such costs from the total Medicare Part A allowable inpatient costs. However, when determining the direct medical education activities that are to be excluded from base period costs, activities which fall under regulations section 405.421(d) are not within the scope of this principle. The costs of the following activities are recognized as normal operating costs rather than direct medical education costs:

(a) orientation and on-the-job training;

(b) part-time education for bona fide employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate and/or graduate work;

(c) costs, including associated travel expense, of sending employees to educational seminars and workshops which increase the quality of medical care and/or operating efficiency of the provider;

(d) maintenance of a medical library;

(e) training of a patient and/or patient's family in the use of medical appliances;

(f) clinical training of students not enrolled in an approved education program operated by the provider (medical education costs for medical students in programs operated by an organization other than the provider are considered normal operating costs);

(g) costs incurred for education or training activities by supplier organizations whether or not a relationship exists under regulations at 42 CFR 405.427 or 405.550(e) (see Chapter 10, HCFA Pub. 15-1);

(h) other activities or costs which do not involve the actual operation of an approved education program including the cost of interns and residents in anesthesiology who are employed to replace certified registered nurse anesthetists. However, the costs of approved intern and residents programs, whether operated by hospitals or other organizations, are considered direct medical education costs.

NOTE: In cases where intermediaries are aware that expenses for medical education were identified as direct medical education costs based on the interim final regulations of September 1, 1983, and the hospital did not actually operate the program that generated those expenses (as required for classification as direct medical education costs in the final rules published January 3, 1984), such amounts will be removed from cost reimbursement

classification and added to the hospital's PPS base period costs. The resulting upward revision of the hospital-specific rate will be adjusted immediately by intermediaries for payments for all discharges from affected hospitals retroactive to the date they became subject to PPS. Similarly, the removal of such costs from the cost reimbursement classification will be retroactive to the date the hospital first became subject to PPS.

Medical education costs of paraprofessional (e.g., radiological technicians) and other approved programs are often expensed directly in department cost centers and cannot be separately identified based on the hospital's cost report. Since intermediaries must make the base period adjustments using the best evidence available (usually the hospital's cost report), this adjustment can be made only when the provider submits these training costs to the intermediary before calculation of the base period costs and target amount. If information is not submitted timely by a provider, the intermediary will not make such an adjustment for the hospital. However, hospitals will not be allowed to later identify such costs since those costs will have become a part of the base period costs and target amount and reimbursed on that basis (see Exhibit C).

3. Nursing Differential Adjustment.--Since the nursing differential was eliminated effective with services rendered on or after October 1, 1982, the allowable Medicare Part A inpatient costs in the base period will be adjusted to exclude any amount for the inpatient routine nursing salary cost differential (nursing differential) for purposes of making payments under a prospective payment system in fiscal years starting on or after October 1, 1983. Therefore, intermediaries must remove from total allowable Medicare Part A inpatient costs in the base period any amount resulting from the nursing differential that was reimbursable for that period (see Exhibit C).

4. Malpractice Insurance Cost Adjustment.--The cost of Part A inpatient malpractice insurance applicable to Part A inpatient operating costs incurred by the hospital and apportioned to Medicare during the base period must be included in determining the target amount for prospective reimbursement purposes.

NOTE: The following adjustments (see items 5, 6, 7, 8 and 9 below) to total allowable Part A inpatient operating costs in the base period must be made only in the case of those hospitals that: 1) have become subject to the required coverage of hospital employees under Social Security as a result of §1886(b)(6) of the Act, 2) previously had arrangements with an outside supplier to provide non-physician services which would have been reimbursable under Part A if furnished by a hospital (e.g., radiology, laboratory, physical therapy, prostheses, etc.) to hospital inpatients but which were separately billed by a supplier to a carrier or by another provider to its intermediary as an outpatient service under Part B of the Act (§1862(a)(14)), 3) have operating costs previously assumed by physicians which will now be borne by the hospitals pursuant to sections 1862(a)(14), 1866(a)(1)(H), and 1861(w)(1) of the Act, 4) are approved renal transplantation center hospitals for kidney acquisition costs incurred pursuant to §1881(a) and (b)(2)(B) of the Act, or 5) changed their accounting principles or incurred added expenses in the base year, resulting in higher base period costs.

5. Federal Insurance Compensation Act (FICA) Tax Adjustment.--Certain hospitals subject to the prospective payment system are required to enter the Social Security system and begin paying FICA taxes on their employee compensation beginning

January 1, 1984. In recognition of the higher payroll costs those hospitals will incur, PL 98-21 requires adjustment to the base period costs for those hospitals. Therefore, the allowable Medicare Part A inpatient costs in the base period for applicable hospitals must be increased by the amount of such taxes that would have been paid, or accrued, in the base period as if the hospital had elected coverage for its employees under Social Security for that period, or for any part of that period in which the hospital did not provide Social Security coverage for its employees.

In order to include the appropriate amount in the base period costs, providers must submit to the intermediary the total amount of FICA tax that would have been paid only for the base period by the hospital (any amount that would have been paid by employees through payroll withholding are not to be included in the computations) under §3111 of the Internal Revenue Code of 1954 had the hospital's employees wages been subject to such taxes regardless of when the hospital becomes subject to the prospective payment system. If this information is not submitted by the applicable dates given in the second paragraph of B. above, the intermediary will not make any adjustment.

The maximum amount of earnings per individual that was taxable for Social Security purposes and the applicable tax rates for base period years that should include the base period are shown in the following chart. Note that two calendar years will be applicable when the base period is not a calendar year.

FICA Maximum Taxable Amounts	FICA Tax Rate
1980-25,900	6.13 percent
1981-29,700	6.65 percent
1982-32,400	6.7 percent
1983-35,700	6.7 percent

6. Adjustment for Non-Physician Services Billed Under Part B.--Prior to October 1, 1983, payment for certain covered items and non-physician services furnished by an outside source to hospital inpatients could have been made either to the hospital under Part A as inpatient hospital services (i.e., under arrangements) or under Part B to the beneficiary, or if assignment was taken, to the entity that furnished the services or items. Examples of these services are:

a. diagnostic and therapeutic service received as an outpatient of another hospital;

b. independent laboratory services (except for anatomical pathology services);

c. diagnostic radiology and certain pathology services; and other diagnostic services such as testing by an independent psychologist or audiologist;

d. prosthetic devices including pacemakers, implant lenses and artificial limbs;

e. physical therapy and speech-language pathology services furnished by an outpatient physical therapy provider;

f. certified registered nurse anesthetists (CRNA) and other medical and health services previously billed by physicians (e.g., "incident to" services), however, see the Note and Exception in item 7. below;

g. transportation to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available in the inpatient's hospital.

Effective October 1, 1983, all hospitals (including hospitals and hospital units exempt from the prospective payment system, except those noted below) must agree to furnish either directly or under arrangements as defined in §1861(w)(1) of the Act, all items and nonphysician services received by Medicare inpatients. No Medicare payment may be made for any items or nonphysician services received by Medicare hospital inpatients unless furnished by the hospital (§1862(a)(14) of the Act). Since hospitals will be assuming the costs for such services previously billed directly by outside suppliers or by physicians (except, for example, anatomical pathology services), the base period costs must be adjusted for those hospitals that had regularly arranged for an outside source to bill directly for services it furnished to the hospital's inpatients during the base period. The adjustment will increase base period costs by the estimated direct cost that would have been incurred if the services had been furnished directly or under arrangements (i.e., if the outside source had billed the hospital instead of billing under Part B); that is, the direct cost without any hospital overhead applied. However, see the Note and Exception in item 7. below.

SINCE THIS ADJUSTMENT IS APPLICABLE TO ALL HOSPITALS WHETHER THEY ARE SUBJECT TO THE PROSPECTIVE PAYMENT SYSTEM OR TEFRA LIMITS, THE INFORMATION NECESSARY TO ADJUST BASE PERIODS FOR ALL HOSPITALS THAT WILL ASSUME SUCH COSTS AFTER SEPTEMBER 30, 1983 MUST BE SUBMITTED USING FORM HCFA-1008 ACCORDING TO THE SCHEDULE GIVEN IN THE SECOND PARAGRAPH UNDER B. ABOVE.

Adjustments are to be made on amounts determined prior to application of Medicare coinsurance and deductibles.

EXCEPTION: Certain hospitals may continue to have outside sources bill directly for their services during the 3-year transition period (§602(k) of PL 98-21). Exceptions for continued separate direct billing under Part B by suppliers or other providers for services to hospital inpatients will be granted only in special circumstances. Those instances will be restricted to situations where this practice was in effect prior to October 1, 1982 and was so extensively used that immediate compliance would threaten the stability of patient care. Excepted hospitals will have their reimbursement adjusted downward for those amounts that are billed under Part B during the fiscal year. Those few hospitals that believe they would qualify and wish to request an exception should apply to the regional office through their intermediary by September 10, 1983.

The intermediary will not make any adjustment to the base period costs unless the hospital submits its estimate of such costs and sufficient information on which to make the adjustment (see Exhibit B).

The information for each outside source that billed directly for its services to hospital inpatients that must be submitted is:

a. Name and address of suppliers, physicians or other providers;

b. Servicing carrier or intermediary;

c. Amounts that would have been incurred by the hospital during the base period for services rendered to Medicare inpatients that represent the cost of non-physician services billed by the supplier, physician or other provider;

d. A listing of beneficiaries by name and Health Insurance Number who were discharged from the hospital during September 1982 and who received services from the supplier, physician or other provider during that inpatient stay even though the admission occurred prior to September 1982.

The amounts to be included in the hospital's estimate should include all amounts that would have been incurred for such nonphysician services but not more than the reasonable charges or other limitations, such as the therapy guidelines, which would have been allowed under the principles of reimbursement applicable in the base period. The intermediary will validate, with the carrier involved, the provider's estimate as to the reasonable costs that would have been incurred had the services been furnished under arrangements. The representative month listing of beneficiaries will be used as part of the verification process in which intermediaries and carriers will exchange data on provider and beneficiary claims for services on discharges occurring during September 1982. The adjusted amounts will be included in the hospital's base period cost before calculating the target amount as explained in Exhibit C.

7. Adjustments for Hospital-Based Physician Provider Inpatient Services.--Final regulations were published in the Federal Register on March 2, 1983 governing payment for physician services furnished in providers. These regulations establish more specific criteria for distinguishing physician services reimbursable on a reasonable charge basis from physician services reimbursable only on a reasonable cost basis. In some cases, for example, a portion of the services of hospital pathologists to hospital inpatients that was reimbursed by the carrier on a reasonable charge basis during the hospital's base period now will be reimbursed only under Part A as hospital services. Since hospitals will assume the cost of the pathologist's compensation for these services, the base period costs should be adjusted by the estimated cost that would have been incurred if the hospital had compensated the pathologist for these services during the base period.

NOTE: When anesthesiologists utilize the services of CRNAs that they employ in furnishing anesthesia services to hospital inpatients, the physicians have traditionally included the CRNAs' services in their bills. Medicare has paid for these services on a reasonable charge basis, i.e., the CRNAs' services were "incident to" the physicians' services. Effective October 1, 1983, all "incident to" services furnished to hospital inpatients, including CRNAs' services, except as noted below, must be claimed through the hospital. Therefore, if payment for such "incident to" services was made by the carrier during the hospital's base period, the estimated reasonable cost of such services should be reported to the intermediary by the hospital on form HCFA-1008 (see Exhibit B)

so that base period costs may be adjusted. The claimed cost is not the anesthesiologist's total charge. It is the intermediary's estimate of the cost that would have been incurred by the hospital if the CRNA services had been furnished directly by the hospital or under arrangements. It may be based only on the portion of the reasonable charge attributed to the CRNA's services. This portion of the physician's charge would generally be one half of the part of the physician's reasonable charge that is attributed to the duration of the procedure, i.e., time units multiplied by the dollar conversion factor divided by 2.

EXCEPTION: If the physician's practice was to employ CRNAs and bill their services under Part B on a reasonable charge basis as of the last day of the affected hospital's base year cost reporting period, the physician may continue such practice for cost reporting periods beginning before October 1, 1986. In such cases, the cost of the CRNA services are not to be added to the hospital's base period costs and the physician may continue to bill for the CRNA services through the cost reporting period cited above. (Note: Since this exception may be applicable to all hospitals whether they are subject to the prospective payment system or TEFRA limits, the base period to be used in determining the basis of this exception will be that cost reporting period as defined in subsection A. above.)

The hospital is responsible for submitting the cost estimate and sufficient information to the intermediary on which to base an adjustment (see Exhibit B). The information that should be submitted for each hospital physician or physician group that billed the Medicare carrier or the hospitalized beneficiary include:

a. Name and address of physician or physician group;

b. Servicing carrier;

c. Amounts that would have been incurred by the hospital but were previously billed under Part B by, or on behalf of, the physician or physician group during the base period for services now reimbursed only on a reasonable cost basis;

d. A listing of beneficiaries by name and Health Insurance Number who were discharged from the hospital during September 1982 and who received services from the physician or physician group during that inpatient stay even though the admission occurred prior to September 1982.

The amounts to be included in the hospital's estimate should include all amounts that would have been incurred for such services that were previously considered physician services, but not more than the reasonable charges that would be allowed under the principles of reimbursement applicable in the base period. The intermediary will verify the information submitted by providers and adjust the billed amounts to reflect estimated reasonable costs that would have been incurred had the hospital compensated the physician. The adjusted amounts (i.e., direct cost without any hospital overhead applied) would be included in the hospital's base period cost before calculating the target amount as explained in Exhibit C.

8. Kidney Acquisition Costs for Hospitals Approved as Renal Transplantation Centers.--Kidney acquisition costs incurred by kidney transplant hospitals are not included in the prospective payment system and will be reimbursed on a reasonable cost basis. Kidney acquisition costs for those hospitals will be paid for as a "pass-through" item for Medicare hospital inpatients similar to capital-related and direct medical education costs. However, hospitals that only excise kidneys and are not approved Renal Transplantation Centers are not affected by this adjustment.

Adjustment of base period costs for kidney transplant hospitals to remove kidney acquisition costs from the hospital specific portion of the prospective payment amount will be accomplished by intermediaries using statistical data provided by HCFA. Therefore, hospitals affected by this "pass-through" requirement for kidney acquisition cost do not need to submit base year information on those costs as is necessary for the other adjustment factors cited in this section.

9. Provider Changes in Cost Accounting Principles and Other Changes Initiated in the Base Year.--Intermediaries will adjust for any base period cost items when a hospital changes its accounting principles in the base year and the change inflates the provider's cost experience for that item above the cost that would have been reported under the previously applied accounting principle. In such cases, the intermediary will remove the resulting higher costs, but only with respect to the hospital-specific amount computation and not the settlement of the base year cost report. Examples of accounting principle changes for which an adjustment is required when costs are increased due to this change include a change from cash to accrual basis of accounting or a change in method for pricing inventory.

In addition, for purposes of this section, the intermediary will exclude any higher costs that were incurred for the purpose of increasing base year costs which would have the effect of inflating the hospital-specific rate or that have the effect of distorting base year costs upward and makes them inappropriate for computing the hospital-specific rate.

Similarly, the intermediary will exclude one-time nonrecurring receipts that would reduce significant hospital costs in determining allowable base period costs and would have the effect of making them inappropriate for computing the hospital-specific rate. One time nonrecurring receipts would include special one-time insurance rebates or court awarded damages but would not include imputed costs to substitute for costs not actually incurred such as for employee strikes or reduced supply costs, etc. Effective October 1, 1983, restricted grants are no longer to be offset against costs. That change in the regulations is not a basis for retroactively or prospectively increasing base period costs and the hospital-specific payment rates, therefore, the loss of grant income will not be considered an appropriate circumstance for making this adjustment.

Hospitals that experienced one-time nonrecurring receipts that were not excluded as described above in setting their hospital-specific payment rate because that rate was set at a date, under D. below, prior to publication of the January 3, 1984, PPS regulations, may submit supporting data and request an adjustment by their intermediaries no later than April 30, 1985. If the intermediary agrees to the change, it will adjust the hospital payments for all discharges retroactive to the date the hospital became subject to PPS.

C. Computing Target Amounts Per Discharge.--After making all appropriate adjustments to the base period costs as called for in B. above, the adjusted base period costs resulting from the procedures provided in Exhibit C are to be divided by the actual number of Medicare discharges in the base period when computing the hospital-specific amount per discharge for all hospitals. The figure on line 6(c), page 3, Part 3 of form HCFA 2552-81 will be used to make this computation if the intermediary is assured that the number of discharges shown is accurate.

The intermediary will then adjust the hospital-specific amount per discharge by the hospital's case-mix index for 1981. This will be accomplished by dividing the updated hospital-specific amount per discharge by the hospital's case-mix index. See the Example in F. below. This adjustment is made in order to neutralize the effect of the base year case-mix on the hospital-specific amount per discharge so that the actual mix of patients served by the hospital in the transition period can be reflected at the time prospective payment is made for each case by multiplying the hospital-specific amount by the DRG-specific weighting factor.

This will result in a case-specific target rate which conforms to changes the hospital may experience in the types of patients serviced during the transition period. If the hospital's case-mix in a transition year under the prospective payment system is identical to its 1981 case-mix experience, the hospital would be reimbursed the same amount as if the case-mix adjustment had not been made. If, however, the hospital experiences an increase in its case-mix index, the hospital's reimbursement will increase proportionately. Thus, the case-mix adjustment permits the entire payment for hospital inpatient operating costs to be responsive to changes in the mix of patients served. (Note: Since a case-mix index was not established for any subproviders, no adjustment for case-mix is necessary in those cases.)

NOTE: Under interim final rules published in the Federal Register on September 1, 1983, the hospital-specific amount was to be reduced for outlier case payments by 5.7 percent (i.e., multiplying .943 times the per discharge rate). This reduction was eliminated by final rules published January 3, 1984. Any such reduction made under the interim final rule will be adjusted by intermediaries for discharges from affected hospitals retroactive to the date they became subject to the prospective payment system.

The resulting cost per case, updated by the appropriate inflation factor provided by HCFA for intervening years, will represent the hospital-specific amount per discharge that will be used during the prospective payment transition period to establish that portion of a non-exempt hospital's Medicare reimbursement related to its historical cost experience. The calculation of the hospital-specific amount per discharge must be prepared and the hospital notified according to the time requirement chart given in D below. The intermediary will advise the hospital by certified mail of the base period cost and hospital-specific portion of the prospective payment amount that will be the basis for reimbursing the hospital during the 3-year transition period.

D. Schedule for Determination of Base Period Costs/Hospital-Specific Amount.--The provider will be informed of the target amount established according to the following schedule:

Hospital FY Begins	Hospital Notified	Rate Becomes Effective
Between 10/1/83-10/31/83	No later than 8/15/83	The first day of the fiscal year the hospital is subject to the prospective payment system (See E. below)
On/After 11/1/83	8 weeks prior to beginning of hospital's fiscal year	The first day of the fiscal year the hospital is subject to the prospective payment system (See E. below)

E. Finality of Base Period/Hospital-Specific Amount Determination.--Once the intermediary has made a determination and notified the hospital of the base period costs and prospective hospital-specific amount per case in accordance with the schedule required in D. above, the hospital may submit additional adjustment data and request an informal reconsideration of the determination within 3 weeks of receipt of the intermediary's notice. (Exception: Hospitals which become subject to the prospective payment system on or after October 1, 1983 and before November 16, 1983 may request their intermediary, up to November 15, 1983, to recompute their base period costs to take into account inadvertent omissions in their previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of determining the base period costs. Specifically, such corrections after the initial 3-week period would pertain to those data submissions and adjustments under §2802B. 1, 2, 5, 6, 7 and 9.). Hospitals are urged to use certified mail in these circumstances. The intermediary may also initiate changes to the determination: (1) for any reason prior to the date the hospital becomes subject to prospective payment, and (2) before November 16, 1983, for corrections pursuant to the above exception. The intermediary then must notify the provider of any change to the hospital-specific amount as a result of the provider's request within 30 days of receipt of the additional data. Any change to base period costs made pursuant to the above exception will be made effective retroactively, beginning with the first day of the affected hospital fiscal year.

In addition, a hospital may request, or the intermediary may initiate changes to correct mathematical or computational errors made in the determination for 90 days after the determination has been sent to the hospital. Intermediaries have 30 days to make any appropriate adjustment and notify the hospital of its action. Any resulting change to the hospital-specific portion will be made effective with the first day of the affected hospital fiscal year.

Subsequent to the date the hospital becomes subject to PPS, the intermediary's estimate of base year costs and any modifications of the base year cost estimate pursuant to B.1,2,5,6,7 and 9 are final except: (1) to recompute costs for inadvertent omissions allowed by the above exception for hospitals which become subject to PPS before November 16, 1983; (2) to correct mathematical or computational errors within 90 days

after the determination is sent to the hospital; (3) to recognize additional allowable base year costs as a result of reopening and revision, prehearing order or decision, or final administrative or judicial review decision of a matter at issue in the hospital's base year notice of program reimbursement (NPR); or (4) to account for a successful administrative or judicial appeal of modifications to base year costs based on an NPR for the applicable fiscal year payments under PPS. Adjustments to recognize additional allowable base year costs may be based on evidence submitted before or after the hospital became subject to PPS, and will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order/finding or review decision. However, changes to the hospital-specific rate due to revision of modifications specified in Medicare regulations 42 CFR 405.474(b)(2) to the base year costs, resulting from a successful appeal decision as noted in 4. above, may only be based on data available to the intermediary at the time the rate was set and will be effective retroactive to the date the hospital became subject to PPS.

F. Prospective Payment Computation.--During the transition period, the prospective payment system will be comprised of a composite prospective payment amount consisting of a hospital-specific portion (computed under these instructions) and a Federal portion (DRG amount), except for certain hospitals that will be paid the full Federal portion as discussed in A. above. The DRG rate is based on a diagnosis classification system which classifies patients into groups that are clinically related and homogenous with respect to resource use. The amount for each DRG is a relative price compared to the average cost of a Medicare case based on the most recent cost report data available. These average standardized amounts are separately determined for urban and rural areas and are adjusted for area wage differences. During the transition period, the Federal portion of the prospective payment amount will be determined by using a blend of regional standardized amounts for urban and rural areas and the national standardized amounts.

At the end of the transition period, the Federal portion will be based only on national urban or rural DRG payment rates. These DRG payment rates will be updated annually.

The relative proportions of the hospital-specific amount and the Federal amount of the prospective payment during the transition period are as follows:

Hospital Fiscal Years Beginning on or after	Hospital-Specific Portion	Federal Portion (Federal Fiscal Year Basis)	
		Region[1]	National[1]
October 1, 1983	75	25 (100)	(0)
October 1, 1984	50	50 (75)	(25)
October 1, 1985	25	75 (50)	(50)
October 1, 1986	--	100 (0)	(100)

[1] Regional/National blend of the Federal portion changes according to Federal fiscal years.

EXAMPLE: Computation of Prospective Payment Amounts

Data:	Base year cost per discharge [1]:	$2,000
	DRG average standardized amount (labor component [2]):	$2,300 ($1840)
	Hospital's 1981 case-mix index [3]:	.9
	Case DRG specific weighting factor [3]:	1.1965
	Base year cost inflation factor [2] (computed for the 2-year period involved):	1.16
	Area wage index [2]:	1.10

Hospital-Specific Amount

Computation:	Base year cost per discharge:	$2,000
	Divide by case-mix index:	.9
	Case mix adjusted base year costs:	$2,222
	Multiply by inflation factor:	1.16
Hospital-specific amount per discharge:		$2,578

Federal Amount

DRG average standardized amount:	$2,300
Wage index adjusted standardized DRG (1840 x 1.10 + 460 (nonlabor component)):	2,484

Prospective Payment Amount

Federal portion of payment ($2,484 + .25):	$ 621
Hospital-specific portion of payment ($2,578 x .75):	1,933
Blended standardized amount:	$ 2,554
Case DRG specific weighting factor:	1.1965
Blended prospective payment amount:	$ 3,056

1 - TAC Worksheet, Part VII, line 14, see Exhibit C.
2 - Published in the Federal Register for the applicable year.
3 - From the Federal Register published September 1, 1983.

G. Indirect Medical Education Cost Adjustment to DRG Payment Amount.--Under the provisions of PL 98-21, if a hospital has an approved graduate medical education

program as defined in § 402.1, an additional payment based on a specified adjustment factor will be made based on the Federal portion of the prospective payments and outlier payments related to those portions, for each .1 increase (above zero) in the hospital's ratio of full-time equivalent (FTE) interns and residents in approved programs to its number of beds. In order to make this payment, the hospital must report to its intermediary the number of interns and residents it expects to have in its employ at the beginning of the fiscal year in which the hospital becomes subject to prospective reimbursement. The number of beds is also determined at the beginning of the reporting period. The information must be submitted under the time requirements given in B. above, using form HCFA-1008 (see Exhibit B).

For purposes of this adjustment, hospitals are to report only FTE interns and residents in approved teaching programs who are assigned to and working at that hospital. The number of FTE interns and residents is the sum of:

1. Interns and residents working 35 hours or more per week, and

2. One-half the total number of interns and residents working less than 35 hours per week (regardless of the number of hours worked).

Interns and residents in unapproved programs and those on the hospital's payroll who only furnish services at another site must not be included in the count. In addition, interns and residents employed to replace certified registered nurse anesthetists will also be excluded from the count.

H. Fraudulent Claims. -- If a hospital's base year costs, as estimated for purposes of determining the hospital-specific portion, are determined by criminal conviction or imposition of a civil money penalty or assessment, to include costs that were unlawfully claimed, the hospital's base period costs will be adjusted to remove the effect of the excess costs, and HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates.

I. Additional Payment Amounts for Hospitals That Have a High Percentage of End Stage Renal Disease (ESRD) Beneficiary Discharges.--Under Medicare regulations, 42 CFR 412.90 (g), an additional payment will be paid on the Federal portion of the PPS rate if 10 percent or more of a hospital's Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining the number of discharges, all Medicare discharges classified in DRG No. 302 (Kidney Transplant), DRG No. 316 (Renal Failure) and DRG No. 317 (Admit for Renal Dialysis) are excluded. In these DRGs, dialysis is not ordinarily limited to ESRD beneficiaries and the relative weights adequately reflect dialysis. The percentage of ESRD beneficiary discharges is determined by dividing the remaining ESRD beneficiary discharges by the remaining Medicare discharges, rounded to the fourth decimal place.

onsistent with the objectives of the PPS, the additional payment is not intended to recognize the actual cost an individual hospital might incur in delivering inpatient dialysis services or to provide full reimbursement of all costs in every case. Rather, it is intended to ameliorate those circumstances in which the concentration of beneficiaries receiving dialysis may be such that the hospital would not be able to absorb the entire cost with revenue from other less costly cases. The estimated weekly cost of dialysis is determined by HCFA and will be revised as appropriate. Data obtained from hospital-based facilities in connection with establishing the composite rate reimbursement for outpatient maintenance dialysis are used in determining the average cost above the DRG rate. Only those costs representing the direct cost (salaries, employee health and welfare, drugs, supplies, and laboratory costs) of furnishing dialysis services were selected. The overhead cost of the inpatient service is already reflected in the DRG rate. The average number of dialysis sessions per week is obtained from the same data source.

The additional payment is based on the average length of stay for ESRD beneficiaries in the hospital times a factor based on the average cost of furnishing dialysis during a usual beneficiary stay. The average length of stay will be expressed in terms of weeks. The following example represents a determination of the additional payment amount:

1. Cost reporting period--10/1/84 - 9/30/85

2. Total Medicare discharges excluding discharges for DRGs 302, 316, and 317 --

   1,028 discharges.

3. Total ESRD beneficiary discharges excluding discharges for DRGs 302, 316, and 317 --

   110 discharges.

4. Percent of ESRD beneficiary discharges to total Medicare discharges --

   110 discharges divided by 1,028 discharges = .1070 = 10.70%

   Hospital qualifies for additional payment.

5. Total ESRD beneficiary inpatient days excluding inpatient days reflected in discharges for DRGs 302, 316, and 317 -- 957 inpatient days.

6. Average length of stay for ESRD beneficiaries expressed as inpatient days --

   957 inpatient days divided by 110 discharges = 8.7 inpatient days per stay

7. Average length of stay expressed in weeks --

   8.7 inpatient days divided by 7 days = 1.24 weeks

8. Payment calculation --

   1.24 weeks x $335 (average weekly cost) x 110 ESRD beneficiary discharges =$45,694

9. Payment amount based on Federal portion of the rate --

   Cost reporting period beginning 10/1/84, Federal portion represents 50% of the PPS rate

   .5 x $45,694 = $22,847

The additional payment amount will be determined when the hospital files its Medicare cost report and the report has been reviewed by the fiscal intermediary. No interim payments will be made. The hospital will include on the cost report information concerning the number of ESRD beneficiary discharges and the average length of stay of ESRD beneficiaries.

The following Table represents the average weekly cost of furnishing inpatient dialysis and the effective date for such:

Cost Reporting Periods Beginning On or After	Average Weekly Cost
10/1/84	$335.00

2802.1 Exhibits

Prospective Payment System Target Amount Adjustments

Exhibit A - Comparison of Base Period and Target Amounts under the Rate of Increase Ceiling (Section 1886(b)) and Prospective Reimbursement (Section 1886(d))

Exhibit B - Transmittal of Supplementary Information for Determination of the Target Amount under the Medicare Prospective Payment System for Inpatient Hospital Services

Exhibit C - Worksheet TAC - Target Amount Computation

Exhibit D - Inflation Factors, Adjusted for Budget Neutrality

EXHIBIT A

COMPARISON OF THE BASE PERIOD RULES UNDER RATE OF INCREASE CEILING (SECTION 1886(b)) AND PROSPECTIVE REIMBURSEMENT (SECTION 1886(d))

		Rate of Increase Ceiling	Prospective Reimbursement
I.	Base Period Cost Report A. 12-Month Cost Report before September 30, 1983.	A. 12-Month cost reporting periods ending on or after September 30, 1982, and	A. Same.
	B. Short-Period Reports	B. First 12-month cost reporting period ending after September 30, 1982.	B. Most recent full 12-month cost reporting period ending before September 30, 1982.
II.	Cost Report Status	Settled.	Best estimate of costs in accordance with Medicare principles of reimbursement prior to fiscal year beginning on or after October 30, 1983.
III.	Adjustments to Base Period Costs for Routine and Ancillary Part A Inpatient Costs	1. Remove capital-related cost.	1. Same.
		* 2. Remove direct medical education costs for approved intern and resident and nursing school programs.	2. All approved medical education costs 42 CFR 405.421.
		3. Remove the nursing differential.	3. Same.
		* 4. Exclude malpractice costs.	4. Include malpractice costs.
		5. Special adjustments may be made, either prospectively or retroactively in special circumstances to prevent distortion in cost comparisons between the base year and subsequent period(s).	5. Special prospective adjustments. a. Hospitals brought under Social Security effective January 1, 1984; ** b. Hospitals in which suppliers billed the program directly under Part B prior to October 1, 1983; ** c. Hospital-based physician services.
		* 6. Exclude kidney acquisition cost center amounts with no adjustment for revenues.	6. Include kidney acquisition cost center adjusted for revenues for hospitals which excise kidneys only.
		7. -	7. Adjustment for hospital base year case mix.
		* 8. SAME	8. Exclude kidney acquisition costs for kidney transplant hospitals.

*For cost reporting periods beginning on or after October 1, 1983, these items will be adjusted the same as under prospective reimbursement.
**For services rendered after September 30, 1983, these items are equally applicable to all hospitals including those exempt from prospective reimbursement.

EXHIBIT B

INSTRUCTIONS FOR COMPLETION OF FORM HCFA-1008, PART I TRANSMITTAL OF SUPPLEMENTARY INFORMATION FOR DETERMINATION OF THE TARGET AMOUNT UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

Submission of this form is voluntary. Medicare fiscal intermediaries will use this information in the determination of individual hospital target amounts for payment under the Medicare prospective payment system for inpatient hospital services. If a hospital does not submit this form and related information, the determination of the target amount under the prospective payment system will be made based upon all relevant information known to the fiscal intermediary[1].

So that this information may be taken into consideration in determining the target amount, form HCFA-1008 and necessary supporting information will be submitted to the hospital's fiscal intermediary in accordance with the following schedule:

Base Period Ends	Form HCFA-1008 Due
9/30/82	6/15/83
10/31/82	6/15/83
11/30/82	7/15/83
12/31/82	7/31/83
1/31/83	7/31/83
2/28/83	7/31/83
3/31/83	7/31/83
4/30/83	8/31/83
5/31/83 or later	By cost report due date

INSTRUCTIONS FOR FORM HCFA-1008, PART I

Item 1 Enter the hospital's name.

Item 2 Enter the hospital's provider number.

1 - Where pertinent, chain home offices should also complete a form HCFA-1008 with a schedule showing the distribution of costs applicable to base year adjustments for each of its member hospitals. Generally, this could relate to items 6 and 7.

Item 3 Enter the hospital's address.

Item 4 Enter the name and telephone number of a person who can be contacted by the fiscal intermediary for additional information or clarification of information.

Item 5 Enter the beginning and ending dates of the base period to which the information applies.

Item 6 This information is to be furnished only for hospitals that were not subject to FICA tax during the base period indicated in item 5, but will be subject to FICA tax during all or part of the first cost reporting period under the prospective payment system. These hospitals should enter the amount of the employer's share of the FICA tax that the hospital would have paid if it had been subject to FICA tax during the base period. (If the hospital was exempt for only a part of the base period, it should reflect the total amount that it would have paid for the entire base period less any actual FICA amounts paid or accrued.)

Item 7 Hospitals would have had an entry on their base period cost report, form HCFA-2552-81, Worksheet D-1, Part I, column O, line 25AA, only if they had directly assigned capital-related costs to cost centers not listed on Worksheet D-1. In this case, fiscal intermediaries will need to know the amount of directly assigned capital-related cost for each of these cost centers in order to properly determine the hospital's adjusted base period inpatient operating costs.

Item 8 Hospitals that included the net cost of approved paramedical education programs in the direct cost of other cost centers should prepare a schedule showing for each such paramedical education program operated during the base period:

a. The type of approved paramedical education program

b. The net cost of the program

c. The cost center in which the net cost was included.

Item 9 Hospitals for which inpatient hospital operating costs will be affected by regulations pertaining to hospital-based physicians published in the Federal Register, pages 48 FR 8902 to 8951 on March 2, 1983, should submit the information required in section 2802 B.7. and, for each cost center in which provider-based physician remuneration is indicated, the following information to their fiscal intermediary, to the extent that the information has not already been submitted for other purposes so the intermediary can determine the affect of the regulations on the hospitals target amount:

1. The total amount of remuneration paid to each provider-based physician
2. The provider component of the remuneration
3. The professional component of the remuneration
4. The amount of provider-based physician remuneration included in each cost center on form HCFA-2552-81, Worksheet A, column 3, for the base period.

Item 10 In order to furnish information to adjust base period costs, hospitals should attach a schedule showing the computation of the amount billed for certain nonphysician items or services furnished to Medicare inpatients with Part A coverage during the base period. As explained elsewhere in section 2802 B.6., these are items and services furnished by outside suppliers, other providers or

physicians as services incident to a physician's service. The hospital did not bill for these items or services. They would have been covered as Part A inpatient hospital services if the hospital had billed. However, the party furnishing the services billed directly rather than to or through the hospital. See section 2802 B.6. for detailed information regarding the data which should be submitted to make this adjustment.

Item 11 In order to make an additional payment, where appropriate, to the hospital's DRG payment for indirect costs resulting from an approved graduate medical education program, any hospital which employs interns and residents in an approved program (as defined in 42 CFR 405.421) should enter the number of full-time equivalent (FTE) interns and residents it expects to have on its payroll at the beginning of its fiscal year starting between September 30, 1983 and October 1, 1984. Interns and residents in unapproved programs must not be included in the number submitted. The hospital's best estimate should be given at the time the form is submitted. Reconciliation will be made after the actual number of FTE interns and residents is determined at the end of that fiscal year.

CERTIFICATION: This must be signed by an officer or administrator of the hospital with authority to act on behalf of the hospital.

EXHIBIT B (Continued)

Form Approved
OMB No. 0938-0288
Expires June 1984

The Office of Management and Budget requires us to tell you that HCFA reserves the right not to use the data reported on this form if the data reported are incomplete or inconsistent with other cost data. HCFA may estimate dollar amounts equal to zero for data elements which are incomplete or inconsistent.

1. Hospital	2. Provider Number
3. Address	
4. Name and Telephone Number of Person to Contact for Additional Information	
5. Base Period — Beginning Date	Ending Date

6. Hospitals not subject to FICA tax during the base period, enter the amount of FICA tax that would have been paid if becoming subject as a result of PL 98-21.

7. Hospitals that had an entry on base period cost report, form HCFA-2552-81, Worksheet D-1, Part I, column 0, line 25AA, submit a schedule showing the amount of directly assigned capital-related costs to be applied to each cost center.

8. Hospitals that have approved paramedical education programs and have directly assigned costs, submit a schedule showing the type of each program, the net cost of each program, and the cost center in which the net cost was included.

9. Hospitals that have provider-based physicians which are affected by the regulation published in the Federal Register, pages 48 FR 8902 to 8951 on March 2, 1983, submit a schedule showing, by cost center, the name and medical specialty of each provider-based physician, the amount of remuneration for each provider-based physician and the computation showing the provider component and professional component of the remuneration for each provider-based physician. Also show the total amount of provider-based physician remuneration included on form HCFA-2552-81, Worksheet A, column 3 for each cost center for the base period. (See Instructions for complete listing requirements).

10. Attach a schedule showing the computation of the amount billed for certain nonphysician items and services furnished by outside sources to inpatients covered under Part A of Medicare where billing was done directly by an outside supplier or another hospital rather than by or through the hospital. (See instructions for complete listing requirements).

11. The number of full-time equivalent interns and residents' the hospital expects to have employed in an approved educational program pursuant to 42 CFR 405.421 on the first day of the fiscal year it will be subject to the prospective payment system:

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS TRANSMITTAL MAY BE PUNISHABLE BY FINE OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I hereby certify that I have read the above statement, and that I have examined the above transmittal and all accompanying schedules and/or information, and that to the best of my knowledge, all information transmitted herewith is true, complete and correct and was prepared in accordance with applicable instructions, except as noted.

Signature	Title	Date

EXHIBIT B (Continued)

INSTRUCTIONS FOR COMPLETION OF FORM HCFA-1008, PART II HOSPITAL UTILIZATION REVIEW COST SUMMARY FOR BASE PERIOD

Data on utilization review costs have been requested by the Executive Office of Management and Budget for fiscal planning purposes. They will not be used for any base period adjustment; however, the data should be reported for the base period as defined in section 2802A. Note to intermediaries: Instructions on the submittal of this information to HCFA will be forthcoming.

Item 1 Enter the hospital's name.

Item 2 Enter the hospital's provider number.

Item 3 Enter the number of admissions (including kidney donors) which occurred according to Federal program and according to level of care. Also enter non-Federal admission in the appropriate space. Provide totals in the appropriate blanks.

Item 4 Enter the hospital utilization review costs relating strictly to the conduct of admission certification and continued stay review should be entered in this column regardless of whether it is performed on a 100 percent basis for all admissions or on a modified or focused basis.

Item 5 Enter the utilization review costs incurred by the hospital in the design, conduct and analysis of Medical Care Evaluation (MCE) Studies. This includes costs for collecting and analyzing MCE study data, and coordination with medical education, where necessary.

CERTIFICATION: This must be signed by an officer or administrator of the hospital with authority to act on behalf of the hospital.

EXHIBIT B (Continued)

Form Approved
OMB No. 0938-0288
Expires June 1984

HOSPITAL UTILIZATION REVIEW COST SUMMARY FOR BASE PERIOD

1. HOSPITAL NAME _____

2. PROVIDER NUMBER

_____

3. ADMISSIONS

Category	Acute	Hospital-based SNF	Hospital-based ICF	Totals
Title XVIII			////////////////////	
Title XIX			////////////////////	
Title V				
Nonfederal		////////////////////	////////////////////	
Totals				

4. TOTAL COST OF ADMISSION CERTIFICATION AND CONTINUED STAY CONCURRENT REVIEW

_____

5. TOTAL COST OF MEDICAL CARE EDUCATION STUDIES

_____

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS TRANSMITTAL MAY BE PUNISHABLE BY FINE OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I hereby certify that I have read the above statement, and that I have examined the above transmittal and all accompanying schedules and/or information, and that to the best of my knowledge, all information transmitted herewith is true, complete and correct and was prepared in accordance with applicable instructions, except as noted.

_____

Signature **Title** **Date**

FORM HCFA-1008, PART I

EXHIBIT C

INSTRUCTIONS FOR COMPLETION OF FORM HCFA-1007
WORKSHEET TAC - TARGET AMOUNT COMPUTATION

The TAC worksheets are for intermediary use only. They are designed to serve two basic purposes. First, the worksheets provide for the computation of the "target amount" used to establish the hospital-specific portion of the prospective payment rate under section 1886(d) of the Social Security Act. This provision (enacted on March 1983 by Title VI of PL 98-21) is effective for cost reporting periods beginning on or after October 1, 1983. The provision provides that Medicare's payment for inpatient operating costs will be made prospectively on a per discharge basis. During a 3-year transition period, a portion of the prospective payment rate will be based on a target amount derived from historical cost experience in the hospital's base period (see section 2802A). Secondly, these worksheets provide for the computation of the "target amount" in accordance with the limitation on allowable rates of increase in hospital operating costs under section 1886(b) of the Social Security Act. This provision (enacted on September 3, 1982 by section 101(b) of PL 97-248) is effective for cost reporting periods beginning on or after October 1, 1982. The rate of increase ceiling limits the amount by which a hospital's inpatient operating costs per discharge may increase over its costs per discharge in the 12-month cost reporting period immediately preceding the effective date of the provision (the 12-month cost reporting period ending on or after September 30, 1982 and before September 30, 1983).

When the same base period is used for 12-month cost reporting periods, the adjustments to base period costs for purposes of determining the "target amounts" under the rate of increase ceiling and under prospective reimbursement may be coordinated. In doing so, however, the intermediary must be aware of three basic differences in the determinations of the respective target amounts. Exhibit A illustrates the similarities and differences between the respective target amount computations.

However, when the base period for the prospective payment system (PPS) is different than the base period for TEFRA, the computation of the respective target amounts cannot be coordinated in the same manner. Instead, the intermediary will complete Parts I through VII only for the PPS target amount computation, and separately complete Parts I through XI for the TEFRA target amount computation based on costs applicable to the appropriate base period. In addition, the intermediary should make appropriate changes

to existing line references on all parts of Worksheet TAC if the base period costs are reported on any cost report form other than form HCFA-2552-81.

Parts I through VII of these worksheets are for the computation of the target amount per discharge under prospective payment, and Parts VIII through XI are for the computation of the target amount per discharge under TEFRA.

Throughout form HCFA-1007 required computations result in the use of fractions. The decimal equivalents of such fractions are to be carried two, four or eight places to the right of the decimal point as specified below:

Two Decimal Places
a. Target amount per discharge
b. Per diem cost for comparison to cost limit

Four Decimal Places
Case mix index

Eight Decimal Places
a. Unit cost multipliers
b. Ratios of cost to charges
c. Applicable factor for the FICA, provider-based physician and unbundling adjustments

In completing form HCFA-1007, all negative amounts must be entered in parenthesis ( ).

NOTE: Intermediaries can elect to utilize automated desk review systems to expedite the computations required on form HCFA-1007, providing the same target amounts result that would have if the form HCFA-1007 had been completed manually.

Part I - Allocation of Capital-Related Cost--This part is provided to compute the amount of allocated capital-related costs that are part of the ancillary and inpatient routine service cost. This part will be used in conjunction with form HCFA-2552-81, Worksheets

B and B-1 submitted by the hospital for cost reporting periods beginning before October 1, 1982. The format and allocation process to be employed is identical to that used on form HCFA-2552-81, Worksheets B and B-1.

Column 0--Where providers have directly assigned capital-related costs, additional information may be needed to properly complete this part. Where an amount has been reported in column O of the form HCFA-2552-81, Worksheet D-1, Part I, line 25AA of the submitted cost report, the detail amounts applicable to the various cost centers must be obtained from the hospital (see Exhibit B).

Columns 1 and 2--The amounts to be entered in column 1 are obtained from form HCFA-2552-81, Worksheet B, column 2. The amounts to be entered in column 2 are obtained from form HCFA-2552-81, Worksheet B, column 3. The total of columns 0 through 2 must be entered in column 3.

The statistics for allocating capital-related costs will be those reported on form HCFA-2552-81, Worksheet B-1 of the submitted cost report. Enter on line 82, the total statistics over which the costs are to be allocated (e.g., column 4 - Employee Health and Welfare, enter on line 82, the statistics from form HCFA-2552-81, Worksheet B-1, column 4, line 4). Enter on line 81, the total cost to be allocated. This amount will be used to compute the unit cost multiplier on line 83. The unit cost multiplier must be rounded to eight decimal places, for example, .062244386 rounded to .06224439. The allocation process is identical to that used on form HCFA-2552-81, Worksheets B and B-1. In doing the allocation process, form HCFA-1007, Worksheet TAC, Part I, and the statistics on form HCFA-2552-81, Worksheet B-1 will be used. Line 79AA is to be used to accumulate the costs which are not included in lines 4 through 79. The costs which would have been entered in columns 18 and 19 (shaded lines) should be totaled and entered on line 79AA. The shaded lines are preprinted because adjustment for the cost of nursing school and Interns and Residents (in approved teaching program) including capital-related cost, are made elsewhere, and any applicable cost entered on line 79AA.

On form HCFA-1007, Worksheet TAC, Part V, data for intensive care, coronary care, and two columns designated "other" intensive type care cost centers is requested. The assumption is made that lines 49 and 50 on form HCFA 2552-81, Worksheets A, B and B-1 are used for "other" intensive type care cost centers. Where the provider has used lines 49 and/or 50 as "subprovider" cost centers, the amount(s) in column 21 are transferred to Part IV, column 2 and/or 3, line 2.

Exception: When a general service cost center is not allocated on Worksheet B because it has a credit balance at the point it would normally be allocated, the capital-related cost for the same general service cost center on form HCFA-1007, Worksheet TAC, Part I, is not to be allocated. For crossfooting purposes, enter the total capital-related cost on line 79AB.

Also, when a general service cost center has a negative direct cost balance on form HCFA-2552-81, Worksheet B, column 1, and the negative balance becomes a positive balance through the cost allocation process, the amount of capital-related cost determined on form HCFA-1007, Worksheet TAC, Part I, for that general service cost center must be adjusted to reflect the amount that was allocated on form HCFA-2552-81, Worksheet B. The adjusted amount of capital-related cost to be allocated on form HCFA-1007, Worksheet TAC, Part I, is computed by dividing the capital-related cost by the total indirect cost allocated to the cost center on form HCFA-2552-81, Worksheet B (do not include the negative direct cost) and multiplying the ratio times the net amount allocated on form HCFA-2552-81, Worksheet B, for that general service cost center. Enter the adjusted amount of capital-related amounts to be allocated on the diagonal line (i.e., column 8, line 8; column 11, line 11, etc.). For crossfooting purposes, the difference between the amount of capital-related cost to be allocated and the adjusted amount of capital-related cost actually allocated must be reported on line 79AB and labeled "Negative Cost Centers."

The amount entered on line 81 must equal the amount entered on the diagonal line (i.e., column 8, line 8; column 11, line 11; etc.).

Part II - Computation of FICA Tax Adjustment Factor--This part is for the computation of the FICA tax adjustment factors for an individual hospital that was not subject to the

FICA tax during its base period, but will be subject to the tax during all or part of its first cost reporting period under the prospective payment system and under TEFRA system. The adjustment factors computed in this part will be used in the computation of the FICA tax adjustment that will be made subsequently in Parts IV, V, VI, VIII, IX and X of the form HCFA-1007. For further information, refer to section 2802.B.5.

Line 1 - Enter the amount of FICA tax that is reported by the provider on form HCFA-1008.

Lines 2-5 - Enter the amount resulting from the specific line instructions provided on this form. Carry the adjustment factor to 8 decimal places.

Line 6 - The applicable factor referred to on this line represents the decimal equivalent (carried to 8 places) of the number of months that are subject to the FICA tax in the hospital's first cost reporting period under TEFRA. The applicable factor is applied to the amount entered on line 5 and the resulting amount is entered in the column on line 6. The following schedule presents the applicable factor:

Base Year Ended	First TEFRA Year Ended	Applicable Factor
9-30-82	9-30-83	-0-
10-31-82	10-31-83	-0-
11-30-82	11-30-83	-0-
12-31-82	12-31-83	-0-
1-31-83	1-31-84	.08333333
2-28-83	2-28-84	.16666667
3-31-83	3-31-84	.25000000
4-30-83	4-30-84	.33333333
5-31-83	5-31-84	.41666667
6-30-83	6-30-84	.50000000
7-31-83	7-31-84	.58333333
8-31-83	8-31-84	.66666667

If the first TEFRA year does not correspond to one of those listed in the above chart, compute the adjustment factor as follows:

$$\text{Adjustment Factor} = \frac{\text{Number of days after 12/31/83 in first TEFRA year}}{\text{Number of days in first TEFRA year}}$$

Part III - Provider-Based Physician Adjustment--In order to establish the target amount per discharge, an adjustment may be needed for the hospital-based physician provider inpatient costs due to changes required by sections 1861(w)(1) and 1862(a)(14) of the Act. Included in this regulation is a provision that requires that the costs of nonphysician inputs in providers must be paid through the provider on a reasonable cost basis and when a physician assumes some or all of the costs of furnishing services in a provider to the provider's patients, only "physicians' services" to individual patients may be paid for on a reasonable charge basis.

Line Descriptions

The cost centers in this Part are listed in the exact order that the cost centers are listed on form HCFA-2552-81, Worksheet A, and the lines are numbered in accordance with the line numbers on Worksheet A. Because of space limitations, unused lines (e.g., title lines) are not reprinted.

Column Descriptions

Column 1 - Adjusted Provider Component - Enter the provider component remuneration as it is submitted with the form HCFA-1008 from the provider's data or from information contained in the intermediary's records.

Column 2 - Provider Component Per Cost Report - Enter the provider component of the remuneration which was included in the provider's base period cost reports

Column 3 - Enter the provider-based physician adjustment (increase or decrease) by subtracting the amount in column 2 from the amounts in column 1 for each line item.

Column 4 - Transfer the amount in column 3, line 46 to Worksheet TAC, Part IV line 7, column 1. If lines 49 and 50 are used for Subprovider I and II costs, the amounts in column 3 should be transferred to Part IV, columns 2 and 3, as appropriate, line 7. Transfer the amounts in column 3, lines 22 through 44, to Worksheet TAC, Part VI, line 8, columns 2 through 23, as indicated in this column. Transfer the amounts in column 3, lines 55,

56 and 57 to Part VI, columns 25, 26, and 27, respectively. Transfer the amounts in column 3, lines 47 and 48 to Part V, line 9, columns 1 and 2, respectively. If lines 49 and 50 are used for "other" intensive type care cost centers, then the amounts on these lines (column 3) will be transferred to Part V, line 9, columns 3 and 4, respectively.

Part IV - Computation of Target Amount for General Inpatient Routine Service Costs--This part of Worksheet TAC is to be used to compute the general inpatient routine service cost for inclusion into the target amount for hospitals, Subprovider I and Subprovider II.

Line Descriptions
Line 1 - Enter on line 1 the inpatient routine service cost from form HCFA 2552-81, Worksheet D-1, Part I, line 11, columns 1, 2 or 3, respectively.

Line 2 - Enter on line 2 the capital-related costs, the nursing school costs, and the intern and resident in approved teaching program costs which are included on line 1, for column 1 from Part I, line 46, column 21 plus the amount from Worksheet B, sum of columns 18 and 19, line 46. For columns 2 and 3, from Part I, lines 49 or 50, as appropriate, plus Worksheet B, sum of columns 18 and 19, lines 49 or 50, as appropriate.

Line 3 - Enter on line 3 the cost of an approved paramedical education program which was included on line 1. This information should have been provided on form HCFA-1008 submitted from the provider. However, if on the base period cost report, the provider established one or more general service cost centers for approved paramedical education programs, enter the amount allocated on Worksheet B to the applicable cost center.

Line 4 - Enter on line 4 the Net Cost for computing the FICA adjustment. Subtract the sum of the amounts on lines 2 and 3 from the amount on line 1 for each column. Multiply this amount by the FICA tax adjustment factor from Part II, line 5, for each column, and enter the results on line 5.

Line 6 - Enter the sum of lines 4 plus 5 for each column.

Line 7 - Enter the provider-based physician adjustment from Part III, column 3, lines 46, 49 or 50, as appropriate, in columns 1, 2 or 3, respectively.

Line 8 - Enter the net of lines 6 and 7.

Line 9 - Enter the patient days from form HCFA-2552-81, Worksheet D-1, Part I, columns 1, 2 or 3, line 3.

Line 11 - Enter the Medicare inpatient days from form HCFA-2552-81, Worksheet D-1, Part I, column 1, 2 or 3, line 8.

Line 12 - Multiply the days on line 11 (in each column) by the amount on line 10 (each column) to obtain the adjusted general inpatient routine service cost.

Line 13 - Enter the general inpatient routine service cost limitation adjusted for aggregate charges for excess cost applicable to kidney acquisition from form HCFA-2552-81, Worksheet D-1, Part I, columns 1, 2 or 3, line 37.

Line 14 - Enter the sum of line 5, plus or minus line 7, minus line 3. This sum represents the adjustments to base period costs that are applicable to cost limitation. Enter any negative amounts in parenthesis.

Line 15 - Enter the per diem cost of adjustments resulting from dividing line 14 by line 9. Enter any negative amounts in parenthesis.

Line 16 - Enter the Medicare cost of adjustments applicable to general inpatient routine service cost limitation. Enter any negative amounts in parenthesis.

Line 17 - Enter the sum of line 13, plus or minus line 16. This sum represents the adjusted cost limitation.

Line 18 - Enter lesser of line 12 or line 17. Transfer the amounts in columns 1, 2 or 3 to the corresponding column in Part VII, line 1.

Part V - Computation of Target Amount for Intensive Care Type Inpatient Hospital Units--
This part of Worksheet TAC is to be used to compute the adjusted cost of intensive care type inpatient hospital units for target amount computation.

Line Descriptions
Line 1 - Enter the total inpatient cost for intensive care type units from form HCFA-2552-81, Worksheet D-1, Part I, column 1, lines 39 through 42, in columns 1 through 4, as applicable.

Line 2 - Enter the capital-related cost which has been included on line 1. This is obtained from Part I, column 21, lines 47 through 50, and entered here in columns 1 through 4, respectively.

Line 3 - Enter the nursing school cost included on line 1. This is obtained from form HCFA-2552-81, Worksheet B, column 18, lines 47 through 50, and entered here in columns 1 through 4, as applicable.

Line 4 - Enter the intern and resident in an approved teaching program cost which was included on line 1, from form HCFA-2552-81, Worksheet B, column 19, lines 47-50, in columns 1 through 4, respectively.

Line 5 - Enter the cost of the approved paramedical education program which was included on line 1, from form HCFA-1008. However, if on the base period cost report, the provider established one or more general service cost centers for approved paramedical education programs, enter the amount allocated on Worksheet B to the applicable cost center.

Line 6 - Subtract the sum of lines 2 through 5 from line 1 and enter the balances in the appropriate columns.

Line 7 - Multiply the amount in each column on line 6 by the FICA tax adjustment factor in Part II, line 5, and enter the results in the appropriate columns.

Line 8 - Enter the sum of line 6 and line 7 in the appropriate columns.

Line 9 - Enter in the appropriate column the provider-based physician adjustment from Part III, column 3, lines 47 through 50, as appropriate.

Line 10 - Enter the sum of line 8, plus or minus line 9, in the appropriate columns.

Line 11 - Enter the total patient days reported on form HCFA-2552-81, Worksheet D-1, Part I, column 2, lines 39-42, as appropriate.

Line 12 - Divide the cost in each column on line 10 by the patient days in each column on line 11, and enter the result in the appropriate column.

Line 13 - Enter the Medicare patient days in the appropriate columns from form HCFA-2552-81, Worksheet D-1, Part I, column 4, lines 39-42, as appropriate.

Line 14 - Enter in the appropriate column the result of multiplying line 12 by line 13. Transfer the sum of the amounts in all columns to Part VII, column 1, line 2.

PART VI - COMPUTATION OF TARGET AMOUNT FOR INPATIENT HOSPITAL ANCILLARY SERVICES--The purpose of this worksheet is to determine the Medicare cost for inpatient hospital ancillary services. To accomplish this the capital-related cost, nursing school cost, interns and residents costs, and the approved paramedical education program costs must be extracted from the inpatient hospital ancillary services. The amount of FICA tax that would have been paid by the provider who was not withholding and paying Social Security tax is added to the cost of each inpatient hospital ancillary service. In addition, an adjustment is made for the provider based physician cost in accordance with regulations published in the Federal Register on March 2, 1983.

Line Descriptions

Line 1 - Enter the total cost from form HCFA-2552-81, Worksheet B, column 21 as adjusted, if appropriate. Note that lines 22 through 41, 43 and 44 correspond to columns 2 through 23. Column 24 on Part VI has been deleted to correspond to Worksheet B, line 42. Lines 55, 56 and 57 in Part III correspond to columns 25, 26 and 27 in Part VI.

Line 2 - Enter on line 2 the capital-related cost from Part I, column 21. Lines 22 through 41, 43 and 44 correspond to columns 2 through 23. Lines 55, 56 and 57 on Part I correspond to columns 25, 26 and 27 on Part VI. Column 24 has been deleted because it is not used in this computation.

Line 3 - Enter on line 3 the nursing school cost from form HCFA-2552-81, Worksheet B, column 18. The amounts are obtained from the lines on Worksheet B that correspond to the columns in Part VI.

Line 4 - Enter on line 4 the intern and residents in an approved teaching program cost from form HCFA-2552-81, Worksheet B, column 19. The amounts are obtained from the lines on Worksheet B that correspond to the columns in Part VI.

Line 5 - Enter on line 5 the amount of paramedical education program cost from the form HCFA-1008. However, if on the base period cost report, the provider established one or more general service cost centers for approved paramedical education programs, enter the amount allocated on Worksheet B to the applicable cost center.

Line 6 - Add the amounts on lines 2, 3, 4 and 5, and subtract this sum from the amount on line 1, and enter the net amount on line 6. This computation must be completed for each column.

Line 7 - Multiply the amount on line 6 by the FICA tax adjustment factor from Part II, line 5, and enter the results on Part VI, line 7. If line 6 is zero or negative, enter zero on line 7.

Line 8 - Enter the provider-based physician adjustment from Part III, column 3.

Line 9 - Enter the net of lines 6, 7 and 8. If the amount in any column on line 9 results in zero or a negative amount, do not complete the remainder of that column.

Line 10 - Enter the charges from form HCFA-2552-81, Worksheet C, column 1, line b. The lines on Worksheet C correspond to the columns in Part VI.

Line 11 - Compute the ratio of adjusted cost to charges (line 9 divided by line 10), and enter the results in each column.

Lines 12 and 13 - Enter on line 12, columns 2 through 27, the Hospital Medicare charges from form HCFA-2552-81, Worksheet D, column 3. Multiply the amount on line 12 by the ratio on line 11 for each column, and enter the Medicare cost for inpatient hospital ancillary services on line 13. Enter the sum, of columns 2 through 27, in column 1. Transfer the amount in column 1, line 13 to Part VII, column 1, line 3.

Lines 14 and 15 - Enter on line 14, columns 2 through 27, the Subprovider I Medicare charges from form HCFA-2552-81, Subprovider I, Worksheet D, column 3. Multiply the amount on line 14 by the ratio on line 11 for each column, and enter the Medicare cost for Subprovider I ancillary services on line 15. Enter the sum, of columns 2 through 27, in column 1. Transfer the amount in column 1, line 15 to Part VII, column 2, line 3.

Lines 16 and 17 - Enter on line 16, columns 2 through 27, the Subprovider II Medicare charges from form HCFA-2552-81, Subprovider II, Worksheet D, column 3. Multiply the amount on line 16 by the ratio on line 11 for each column, and enter the Medicare cost for inpatient Subprovider II ancillary services on line 17. Enter the sum, of columns 2 through 27, in column 1. Transfer the amount in column 1, line 15 to Part VII, column 3, line 3.

Part VII - Computation of Target Amount Per Discharge for Prospective Payment System--This part provides for the computation of the target amount per discharge for the individual hospital and up to two Subproviders, when applicable, for reimbursement under the prospective payment system. For further details, refer to section 2802.C.

Line Descriptions
Line 1--Enter in the appropriate column the amount of the general inpatient routine service cost from Part IV, line 18, columns 1, 2 and 3, as appropriate.

Line 2--Enter in the hospital column the amount of the intensive care type inpatient hospital unit cost from Part V, line 14, sum of all columns.

Line 3--Enter the amount of ancillary service costs from Part VI, column 1, lines 13, 15 and 17, as appropriate.

Line 4--Enter in the appropriate columns the kidney acquisition costs reported on form HCFA-2552-81, Worksheet E, Part I, columns 1, 4 and 6, line 8.

Line 5--Enter in the appropriate columns the cost of services furnished "under arrangements" reported on form HCFA-2552-81, Worksheet E, Part I, columns 1, 4 and 6, line 9.

Line 6--Enter malpractice insurance costs reported on form HCFA-2552-81, Worksheet E, Part I, line 10, columns 1, 4 and 6, as appropriate.

Line 7--Enter in the appropriate column the amount reported by provider on form HCFA-1008, Part I.

Line 8--Enter the sum of lines 1 through 7 in the appropriate column.

Lines 9 and 10--Enter the amounts requested in the appropriate columns from form HCFA-2552-81, Worksheet E, Part I, columns 1, 4 and 6, lines 14 and 17, respectively.

Line 11--Enter the sum of lines 9 and 10.

Line 12--Subtract line 11 from line 8 and enter the balance in the appropriate columns.

Line 13--Enter the Medicare discharges from form HCFA-2552-81, page 3, Part III, line 6c for hospitals; page 4, Part V, line 7c for Subproviders I and II.

Line 14--Enter the base period cost per discharge. Divide the amount on line 12 by the amount on line 13.

Line 15--Enter the case-mix index as will be provided by HCFA. This index will be provided by HCFA for the hospital, Subprovider I and Subprovider II.

Line 16--Enter the case-mix adjusted base year cost. Divide the amount on line 14 by the amount on line 15.

Line 17--Enter the applicable percentage of increase plus 100 percent. This appropriate inflation factor will be provided by HCFA. Enter the same percentage in each column.

Line 18--Enter the average target amount per discharge for prospective payment. Multiply the amount on line 16 by the amount on line 17 for each column.

Part VIII - TEFRA Computation of Target Amount for General Inpatient Routine Service Costs--This part provides for the TEFRA computation of the target amount for the general inpatient routine service costs of an individual hospital and its subproviders.

Line Descriptions
Line 1--Enter in columns 1-3, the sum of lines 3 and 4, Part IV.

Line 2--Enter the result of multiplying line 1 by line 6, Part II.

Line 3--Enter sum of lines 1 and 2.

Line 4--The applicable factor referred to on this line represents the decimal equivalent (carried to eight places) of the number of months that are subject to the provider-based physician adjustment in the hospital's first cost reporting period under TEFRA. The applicable factor is applied to the amount entered in Part IV, line 7, and the resulting amount is entered in the columns on line 4. The following schedule presents the applicable factor for provider-based physician services furnished on or after October 1, 1983, pursuant to the final rule published in the Federal Register on May 31, 1983, which implements a delay in the effective date of the final rule that appeared in the Federal Register on March 2, 1983.

Base Year Ended	First TEFRA Year Ended	Applicable Factor
9-30-82	9-30-83	-0-
10-31-82	10-31-83	.08333333
11-30-82	11-30-83	.16666667
12-31-82	12-31-83	.25000000
1-31-83	1-31-84	.33333333
2-28-83	2-28-84	.41666667
3-31-83	3-31-84	.50000000
4-30-83	4-30-84	.58333333
5-31-83	5-31-84	.66666667
6-30-83	6-30-84	.75000000
7-31-83	7-31-84	.83333333
8-31-83	8-31-84	.91666667

If the first TEFRA year does not correspond to one of those listed in the above chart, compute the applicable factor as follows:

$$\text{Applicable Factor} = \frac{\text{Number of days after 9/30/83 in first TEFRA year}}{\text{Number of days in first TEFRA year}}$$

For further details, refer to section 2802.B.7.

Line 5--Enter sum of line 3, plus or minus, line 4, in the appropriate column.

Line 6--Enter the total patient days reported in Part IV, line 9.

Line 7--Enter the per diem cost resulting from dividing line 5 by line 6.

Line 8--Enter the Medicare inpatient days reported in Part IV, line 11.

Line 9--Enter the amount resulting from multiplying line 7 by line 8.

Line 10--Enter the amount reported in Part IV, line 13.

Line 11--Enter the sum of line 2, plus or minus line 4. Enter any negative amounts in parenthesis.

Line 12--Enter the per diem cost resulting from dividing line 11 by line 6. Enter any negative amounts in parenthesis.

Line 13--Enter amount resulting from multiplying line 8 by line 12. Enter any negative amounts in parenthesis.

Line 14--Enter sum of line 10, plus or minus line 13.

Line 15--Enter the lesser of line 9 or line 14. Transfer the amounts in columns 1, 2 or 3 to the corresponding columns on Part XI, line 1.

Part IX - TEFRA Computation of Target Amount for Intensive Care Type Inpatient Hospital Units--The purpose of this worksheet is to determine the adjusted cost for TEFRA target amount for intensive care units, coronary care units and other intensive care type units of the hospital. Amounts to be entered on this Part are derived from other Parts within this worksheet. The amounts for lines 1, 4, 6 and 8 are obtained from Part V of this worksheet. The amount for line 2 is obtained from Part II. The applicable factor to be used in the computation on line 4 is the same factor as used on Part VIII, line 4. The line descriptions are to be completed for each column. Add the amounts on line 9, all columns and transfer this total to Part XI, line 2, column 1.

Part X - TEFRA Computation of Target Amount for Inpatient Hospital Ancillary Services- The purpose of this worksheet is to determine the TEFRA Medicare cost for inpatient hospital ancillary services. To accomplish this, Part VI must be completed through line 6. The FICA tax adjustment must be completed through line 6. The FICA tax adjustment and provider-based physician adjustment are computed to determine the adjusted cost.

Line Descriptions
Line 1--Enter on line l the net cost of ancillary services for TEFRA for Part VI, sum of lines 5 and 6, each column. Enter any negative amounts in parenthesis.

Line 2--Multiply the amount on line 1 by the FICA tax adjustment factor for Part II, line 6. If line 1 is zero or negative, enter zero on line 2.

EXHIBIT C (Continued)

Line 3--Enter the sum of lines 1 and 2 for each column.

Line 4--Enter the provider-based physician adjustment factor in the space provided on line 4. This adjustment factor is obtained from the instructions for Part VIII above. Multiply this adjustment factor by the amount on Part VI, line 8 for each column. Enter the results on this part in the corresponding columns.

Line 5--Determine the adjusted cost by entering the net of line 3, plus or minus line 4, on line 5 for columns 2 through 27. Enter any negative amounts in parenthesis. Do not complete the remaining lines for any column in which the amount on line 5 is zero or negative.

Line 6--Enter the charges from Part VI, line 10.

Line 7--Compute the ratio of adjusted cost to charges (line 5 divided by line 6), and enter the results in each column.

Lines 8 and 9--Enter on line 8, columns 2 through 27, the Hospital Medicare charges from Part VI, line 12. Multiply the amount on line 8 by the ratio on line 7 for each column, and enter the Medicare cost for inpatient hospital ancillary services on line 9. Enter the sum of columns 2 through 27 in column 1. Transfer the amount in column 1, line 9 to Part XI, column 1, line 3.

Lines 10 and 11--Enter on line 10, columns 2 through 27, the Subprovider I Medicare charges from Part VI, line 14. Multiply the amount on line 10 by the ratio on line 7 for each column, and enter the Medicare cost for Subprovider I ancillary services on line 11. Enter the sum of columns 2 through 27 in column 1. Transfer the amount in column 1, line 11 to Part XI, column 2, line 3.

Lines 12 and 13--Enter on line 12, columns 2 through 27, the Subprovider II Medicare charges from Part VI, line 16. Multiply the amount on line 12 by the ratio on line 7 for each column, and enter the Medicare cost for inpatient Subprovider II ancillary services on line 13. Enter the sum of columns 2 through 27 in column 1. Transfer the amount in column 1, line 13 to Part XI, column 3, line 3.

Part XI - Computation of Target Amount Per Discharge for TEFRA--The purpose of this worksheet is to determine the average target amount per discharge for TEFRA. The amounts to be entered on lines 1 through 4 are obtained from previous parts within this worksheet, according to the individual line descriptions. The applicable factor reference on line 5 represents the decimal equivalent (carried to eight places) of the number of months that are subject to the "unbundling" provision in the hospital's first cost reporting period under TEFRA. The applicable factor is applied to the amount entered on Part VII, column 1, 2 or 3, respectively, line 7, and the resulting amount is entered in the applicable column on line 5. The following schedule presents the applicable factor:

Base Year Ended	First TEFRA Year Ended	Applicable Factor
9-30-82	9-30-83	-0-
10-31-82	10-31-83	.08333333
11-30-82	11-30-83	.16666667
12-31-82	12-31-83	.25000000
1-31-83	1-31-84	.33333333
2-28-83	2-28-84	.41666667
3-31-83	3-31-84	.50000000
4-30-83	4-30-84	.58333333
5-31-83	5-31-84	.66666667
6-30-83	6-30-84	.75000000
7-31-83	7-31-84	.83333333
8-31-83	8-31-84	.91666667

If the first TEFRA year does not correspond to one of those listed in the above chart, compute the adjustment factor as follows:

$$\text{Adjustment factor} = \frac{\text{Number of days after l0-1-83 in first TEFRA year}}{\text{Number of days in first TEFRA year}}$$

Line 7--Enter the Medicare discharges from Part VII corresponding column line 13.

Line 8--Enter the base year cost per discharge resulting from dividing line 6 by the Medicare discharges on line 7.

Line 9--Enter the applicable percentage increase plus 100 percent. This appropriate inflation factor will be provided by HCFA. Enter the same percentage in each column.

Line 10--Compute the average target amount per discharge for TEFRA by multiplying line 8 by line 9 for each column.

Part XII - Allocation of General Services Operating Cost--This part is provided to compute the amount of general service operating cost allocated to cost centers in which costs are included for the nonphysician anesthetist cost centers. This part will be used in conjunction with form HCFA 2552-81 Worksheet B and B-1 submitted by the hospital for cost reporting periods beginning before October 1, 1983. The format and allocation process to be employed is compatible with that used on Form HCFA 2552-81, Worksheets B and B-1.

Line 1--Enter the cost to be allocated from Form HCFA 2552-81, Worksheet B-1, line 79.

Line 2--Enter capital - related cost from Form HCFA 1007, Part I.

Line 3--Enter operating cost to be allocated determined by subtracting line 2 from line 1.

Line 4--Enter total allocation basis from Form HCFA 1007, Part I line 82.

Line 5--Enter the unit cost multiplier resulting from dividing line 3 by line 4.

Line 6--Enter the statistics from Form HCFA 2552-81 Worksheet B-1 for the appropriate cost centers shown on line 6 of this form; 22 through 25 and 43.

Line 7--Enter the cost allocation determined by multiplying lines 7-22 through 7-25 and 7-43 by the unit cost multiplier shown on line 5.

Part XIII - Computation of Medicare Nonphysician Anesthetist Adjustment--The purpose of this worksheet is to determine the Medicare cost for inpatient hospital ancillary services after adjustment for the Medicare nonphysician anesthetist cost.

Line Descriptions

Line 1--Enter the nonphysician anesthetist cost as provided by the hospital.

Line 2--Enter direct costs for the cost centers shown on line 1 HCFA-2552-81, Worksheet B, column 1.

Line 3--Enter the ratio determined by dividing the amount on line 1 by the amount on line 2.

Line 4--Enter the allocated general operating cost from Worksheet TAC, Part XII column 7, lines 7-2 through 7-43, as applicable.

Line 5--Enter the nonphysician anesthetist overhead determined by multiplying the ratio on line 3 by the amount on line 4.

Line 6--Enter the nonphysician anesthetist cost by adding the amounts on line 1 and line 5.

Line 7--Enter on line 7 the FICA tax adjustment computed by multiplying line 6 by the FICA tax adjustment factor from Worksheet TAC, Part II, line 5.

Line 8--Enter on line 8 the adjusted cost determined by adding line 6 and line 7.

Line 9--Enter the charges from Worksheet TAC, Part VI, line 10, columns as appropriate.

Line 10--Compute the ratio of adjusted cost to charges (line 8 divided by line 9) and enter the results in each column.

Lines 11 and 12--Enter on line 11, columns 2 through 6, the hospital Medicare charges from Worksheet TAC, Part VI, line 12, columns as appropriate. Multiply the amount on line 11 by the ratio on line 10 for each column, and enter the Medicare cost for inpatient hospital ancillary services on line 12. Enter the sum of the amounts in columns 2 through 6 in column 1. Transfer the amount in column 1, line 12 to Part XIV, column 1, line 2.

Lines 13 and 14--Enter on line 13, columns 2 through 6, the subprovider I Medicare charges from Worksheet TAC, Part VI, line 14. Multiply the amount on line 13 by the ratio on line 10 for each column, and enter the Medicare cost for subprovider I ancillary services on line 14. Transfer the amount in column 1, line 14 to Part XIV, column 2, line 2.

Lines 15 and 16--Enter on line 15, columns 2 through 6, the subprovider II Medicare charges from Worksheet TAC, Part VI, line 16. Multiply the amount on line 15 by the ratio on line 10 for each column, and enter the Medicare cost for inpatient subprovider II ancillary services on line 16. Enter the sum, of the amounts in columns 2 through 6, in column 1. Transfer the amount in column 1, line 16 to Part XIV, column 3, line 2.

Part XIV - Computation of Target Amount Per Discharge for Prospective Payment System-This part provides for the computation of the target amount per discharge for the individual hospital and up to two subproviders, when applicable for reimbursement under the prospective payment system. For further details, refer to section 2802-C.

Line 1--Enter Medicare inpatient hospital operating costs for target amount computation from Worksheet TAC, Part VII, columns 1, 2 and 3, line 12.

Line 2--Enter Medicare nonphysician anesthetist adjustment from Part XIII, column 1, lines 12, 14 or 16 as appropriate.

Line 3--Subtract the amount on line 2 from the amount on line 1 and enter the result on this line for each column.

Line 4--Enter Medicare discharges from Worksheet TAC, Part VII, columns 1, 2 and 3, line 13.

Line 5--Enter base period cost per discharge (line 3 divided by line 4).

Line 6--Enter the case-mix index from Worksheet TAC, Part VII, columns 1, 2 and 3, as appropriate, line 15.

Line 7--Enter the case-mix adjusted base year cost. Divide the amount on line 5 by the index on line 6.

Line 8--Enter the applicable percentage of increase plus 100 percent. This appropriate inflation factor will be provided by HCFA. Enter the same percentage in each column.

Line 9--Enter the average target amount per discharge for prospective payment. Multiply the amount on line 7 by the percentage on line 8.

EXHIBIT C (Continued)

Part XV - Computation of Target Amount Per Discharge for TEFRA (SECOND YEAR)--The purpose of this worksheet is to determine the average amount per discharge for TEFRA for cost reporting periods beginning on or after October 1, 1983. The regulations governing TEFRA were changed so that the differences in determining the average cost per discharge for TEFRA and PPS are (1) nonphysician anesthetist costs are not a pass through for TEFRA and are included in the average cost per discharge, (2) base period nonrecurring costs are not adjusted out of the TEFRA average cost per discharge, and (3) adjustments for base period nonrecurring revenue are not reversed in determining the TEFRA average cost per discharge.

Line 1--Enter the base year cost per discharge for PPS from Part VII, column 1, 2 or 3, as appropriate, line 14. (The base period average cost per discharge is determined without adjustments for nonrecurring expenses or nonrecurring revenue.)

Line 2--Enter the applicable percentage increase plus 100%.

Line 3--Compute the average target amount per discharge by multiplying line 1 by line 2 for each column.

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL RELATED COSTS

	COST CENTER (OMIT CENTS)	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	DEPRE-CIATION BLDGS & FIXTURES	DEPRE-CIATION MOVABLE EQUIPMENT	SUBTOTAL (SUM OF COLS 0-2)	
		1	2	3	4	
1	**GENERAL SERVICE COST CENTERS**					1
4	Employee Health and Welfare					4
5	Administrative and General					5
6	Maintenance and Repairs					6
7	Operation of Plant					7
8	Laundry and Linen Service					8
9	Housekeeping					9
10	Dietary					10
11	Cafeteria					11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services and Supply					14
15	Pharmacy					15
16	Medical Records and Library					16
17	Social Service					17
18	Nursing School					18
19	Intern-Resident Service (In approved teaching program)					19
20						20
21	**ANCILLARY SERVICE COST CENTERS**	////////////////////	////////////////////	////////////////////	////////////////////	21
22	Operating Room					22
23	Recovery Room					23
24	Delivery Room and Labor Room					24
25	Anesthesiology					25
26	Radiology-Diagnostic					26
27	Radiology-Therapeutic					27
28	Radioisotope					28
29	Laboratory					29
30	Whole Blood and Packed Red Cells					30

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL RELATED COSTS

	COST CENTER (OMIT CENTS)	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	DEPRE-CIATION BLDGS & FIXTURES	DEPRE-CIATION MOVABLE EQUIPMENT	SUBTOTAL (SUM OF COLS 0-2)	
		1	2	3	4	
31	Blood Storing, Processing and Transfusion					31
32	Intravenous Therapy					32
33	Oxygen (Inhalation) Therapy					33
34	Physical Therapy					34
35	Occupational Therapy					35
36	Speech Pathology					36
37	Electrocardiology					37
38	Electroencephalography					38
39	Medical Supplies Charged to Patients					39
40	Drugs Charged to Patients					40
41	Renal Dialysis					41
42	Kidney Acquisition					42
43						43
44						44
45	**INPATIENT ROUTINE SERVICE COST CENTERS**	////////////////////	////////////////	////////////////////	////////////////	45
46	Adults and Pediatrics (General Routine Care)					46
47	Intensive Care Unit					47
48	Coronary Care Unit					48
49						49
50						50
51	Nursery					51
52	Skilled Nursing Facility--Certified					52
53	Skilled Nursing Facility--Noncert					53
54	**OUTPATIENT SERVICE COST CEN**	////////////////////	////////////////	////////////////////	////////////////	54
55	**Clinic**					55
56	**Emergency**					56
57						57
58	**OTHER REIMBURSABLE COST CENTERS**	////////////////////	////////////////	////////////////////	////////////////	58
59	Home Program Dialysis--Other					59
60	Administrative and General--HHA					60

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL RELATED COSTS

	COST CENTER (OMIT CENTS)	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	DEPRE-CIATION BLDGS & FIXTURES	DEPRE-CIATION MOVABLE EQUIPMENT	SUBTOTAL (SUM OF COLS 0-2)	
		1	2	3	4	
61	Skilled Nursing Care--HHA					61
62	Medical Social Services--HHA					62
63	Home Health Aide--HHA					63
64	Medical Appliances--HHA/DME-Rented					64
65	Durable Medical Equipment S					65
66	Home Delivered Meals--HHA					66
67	Other Home Health Services--HHA					67
68	Home Program Dialysis Equipment--100% Medicare					68
69	Ambulance Services					69
70	Intern-Resident Service (Not in approved teaching program)					70
71						71
72	SUBTOTAL (Sum of lines 4-71)	$	$	$	$	72
73	**NONREIMBURSABLE COST CENTERS**	////////////////////	////////////////////	////////////////////	////////////////////	73
74	Gift, Flower, Coffee Shops and Can					74
75	Research					75
76	Physicians' Private Offices					76
77	Nonpaid Workers					77
78						78
79						79
79AA	Cross Foot Adjustment					79AA
79AB						79AB
80	TOTAL (Sum of lines 72-79AB)	$	$	$	$	80
81	Cost to be Allocated	////////////////////	////////////////////	////////////////////	////////////////////	81
82	Total Statistics from Form HCFA-2552-81, Wkst. B-1	////////////////////	////////////////////	////////////////////	////////////////////	82
83	Unit Cost Multiplier	////////////////////	////////////////////	////////////////////	////////////////////	83

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL RELATED COSTS

	COST CENTER (OMIT CENTS)	EMPLOYEE HEALTH & WELFARE STS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
		4	5	6	7	
1	**GENERAL SERVICE COST CENTERS**					1
4	Employee Health and Welfare					4
5	Administrative and General					5
6	Maintenance and Repairs					6
7	Operation of Plant					7
8	Laundry and Linen Service					8
9	Housekeeping					9
10	Dietary					10
11	Cafeteria					11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services and Supply					14
15	Pharmacy					15
16	Medical Records and Library					16
17	Social Service					17
18	Nursing School					18
19	Intern-Resident Service (In approved teaching program)					19
20						20
21	**ANCILLARY SERVICE COST CENTERS**	////////////////////	////////////////////	////////////////////	////////////////////	21
22	Operating Room					22
23	Recovery Room					23
24	Delivery Room and Labor Room					24
25	Anesthesiology					25
26	Radiology-Diagnostic					26
27	Radiology-Therapeutic					27
28	Radioisotope					28
29	Laboratory					29
30	Whole Blood and Packed Red Cells					30

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL RELATED COSTS

	COST CENTER (OMIT CENTS)	EMPLOYEE HEALTH & WELFARE STS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
		4	5	6	7	
31	Blood Storing, Processing and Transfusion					31
32	Intravenous Therapy					32
33	Oxygen (Inhalation) Therapy					33
34	Physical Therapy					34
35	Occupational Therapy					35
36	Speech Pathology					36
37	Electrocardiology					37
38	Electroencephalography					38
39	Medical Supplies Charged to Patients					39
40	Drugs Charged to Patients					40
41	Renal Dialysis					41
42	Kidney Acquisition					42
43						43
44						44
45	**INPATIENT ROUTINE SERVICE COST CENTERS**	////////////////////	////////////////////	////////////////////	////////////////////	45
46	Adults and Pediatrics (General Routine Care)					46
47	Intensive Care Unit					47
48	Coronary Care Unit					48
49						49
50						50
51	Nursery					51
52	Skilled Nursing Facility--Certified					52
53	Skilled Nursing Facility—Noncert.					53
54	**OUTPATIENT SERVICE COST CEN**	////////////////////	////////////////////	////////////////////	////////////////////	54
55	**Clinic**					55
56	**Emergency**					56
57						57
58	**OTHER REIMBURSABLE COST CENTERS**	////////////////////	////////////////////	////////////////////	////////////////////	58
59	Home Program Dialysis--Other					59
60	Administrative and General--HHA					60

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL RELATED COSTS

	COST CENTER (OMIT CENTS)	EMPLOYEE HEALTH & WELFARE STS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
		4	5	6	7	
61	Skilled Nursing Care--HHA					61
62	Medical Social Services--HHA					62
63	Home Health Aide--HHA					63
64	Medical Appliances--HHA/DME-Rented					64
65	Durable Medical Equipment S					65
66	Home Delivered Meals--HHA					66
67	Other Home Health Services--HHA					67
68	Home Program Dialysis Equipment--100% Medicare					68
69	Ambulance Services					69
70	Intern-Resident Service (Not in approved teaching program)					70
71						71
72	SUBTOTAL (Sum of lines 4-71)	$	$	$	$	72
73	**NONREIMBURSABLE COST CENTERS**					73
74	Gift, Flower, Coffee Shops and Can					74
75	Research					75
76	Physicians' Private Offices					76
77	Nonpaid Workers					77
78						78
79						79
79AA	Cross Foot Adjustment					79 AA
79AB						79 AB
80	TOTAL (Sum of lines 72-79AB)	$	$	$	$	80
81	Cost to be Allocated					81
82	Total Statistics from Form HCFA-2552-81, Wkst. B-1					82
83	Unit Cost Multiplier					83

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER No.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTEr (OMIT CENTS)	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING_ _	DIETARY	CAFETERIA	
		8	9	10	11	
1	**GENERAL SERVICE COST CENTERS**	//////////	//////////	//////////	//////////	1
4	Employee Health and Welfare					4
5	Administrative and General					5
6	Maintenance and Repairs					6
7	Operation of Plant					7
8	Laundry and Linen Service	$				8
9	Housekeeping		$			9
10	Dietary			$		10
11	Cafeteria				$	11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services and Supply					14
15	Pharmacy					15
16	Medical Records and Library					16
17	Social Service					17
18	Nursing School					18
19	Intern-Resident Service (In approved teaching program)					19
20						20
21	**ANCILLARY SERVICE COST CENTERS**	//////////	//////////	//////////	//////////	21
22	Operating Room					22
23	Recovery Room					23
24	Delivery Room and Labor Room					24
25	Anesthesiology					25
26	Radiology--Diagnostic					26
27	Radiology--Therapeutic					27
28	Radioisotope					28
29	Laboratory					29
30	Whole Blood and Packed Red Blood Cells					30

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC
	_____	_____		

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		8	9	10	11	
31	Blood Storing, Processing and Transfusion					31
32	Intravenous Therapy					32
33	Oxygen (Inhalation) Therapy					33
34	Physical Therapy					34
35	Occupational Therapy					35
36	Speech Pathology					36
37	Electrocardiology					37
38	Electroencephalography					38
39	Medical Supplies Charged to Patients					39
40	Drugs Charged to Patients					40
41	Renal Dialysis					41
42	Kidney Acquisition					42
43						43
44						44
45	**INPATIENT ROUTINE SERVICE COST CENTERS**	//////////	//////////	/////////	/////////	45
46	Adults and Pediatrics (General Routine Care)					46
47	Intensive Care Unit					47
48	Coronary Care Unit					48
49						49
50						50
51	Nursery					51
52	Skilled Nursing Facility--Certified					52
53	Skilled Nursing Facility--Noncertified					53
54	**OUTPATIENT SERVICE COST CENTERS**	//////////	//////////	/////////	/////////	54
55	Clinic					55
56	Emergency					56
57						57
58	**OTHER REIMBURSABLE COST CENTERS**	//////////	//////////	/////////	/////////	58
59	Home Program Dialysis--Other					59
60	Administrative and General--HHA					60

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC
	_____	_____		

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	LAUNDRY AND LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		8	9	10	11	
61	Skilled Nursing Care--HHA					61
62	Medical Social Services--HHA					62
63	Home Health Aide--HHA					63
64	Medical Appliances--HHA/DME-Rented					64
65	Durable Medical Equipment Sold					65
66	Home Delivered Meals--HHA					66
67	Other Home Health Services--HHA					67
68	Home Program Dialysis Equipment--100% Medicare					68
69	Ambulance Services					69
70	Intern-Resident Service (Not in approved teaching program)					70
71						71
72	SUBTOTALS (Sum of lines 9-71)	$	$	$	$	72
73	**NONREIMBURSABLE COST CENTERS**	//////////	//////////	//////////	//////////	73
74	Gift, Flower, Coffee Shops and Canteen					74
75	Research					75
76	Physicians' Private Offices					76
77	Nonpaid Workers					77
78						78
79						79
79AA	Cross Foot Adjustment					79 AA
79AB	Negative Balances					79 AB
80	TOTAL (Sum of lines 72-79AB)	$	$	$	$	80
81	Cost to be Allocated					81
82	Total Statistics from Form HCFA-2552-81, Wkst. B-1					82
83	Unit Cost Multiplier					83

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD	WORKSHEET
	_____	_____	FROM _____ TO _____	TAC

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	MAINTENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES AND SUPPLY	
		12	13	14	
1	**GENERAL SERVICE COST CENTERS**	//////////	//////////	//////////	1
4	Employee Health and Welfare				4
5	Administrative and General				5
6	Maintenance and Repairs				6
7	Operation of Plant				7
8	Laundry and Linen Service				8
9	Housekeeping				9
10	Dietary				10
11	Cafeteria				11
12	Maintenance of Personnel	$			12
13	Nursing Administration		$		13
14	Central Services and Supply			$	14
15	Pharmacy				15
16	Medical Records and Library				16
17	Social Service				17
18	Nursing School				18
19	Intern-Resident Service (In approved teaching program)				19
20					20
21	**ANCILLARY SERVICE COST CENTERS**	//////////	//////////	//////////	21
22	Operating Room				22
23	Recovery Room				23
24	Delivery Room and Labor Room				24
25	Anesthesiology				25
26	Radiology--Diagnostic				26
27	Radiology--Therapeutic				27
28	Radioisotope				28
29	Laboratory				29
30	Whole Blood and Packed Red Blood Cells				30

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM TO	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	MAINTENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES AND SUPPLY	
		12	13	14	
31	Blood Storing, Processing and Transfusion				31
32	Intravenous Therapy				32
33	Oxygen (Inhalation) Therapy				33
34	Physical Therapy				34
35	Occupational Therapy				35
36	Speech Pathology				36
37	Electrocardiology				37
38	Electroencephalography				38
39	Medical Supplies Charged to Patients				39
40	Drugs Charged to Patients				40
41	Renal Dialysis				41
42	Kidney Acquisition				42
43					43
44					44
45	**INPATIENT ROUTINE SERVICE COST CENTERS**	//////////	//////////	//////////	45
46	Adults and Pediatrics (General Routine Care)				46
47	Intensive Care Unit				47
48	Coronary Care Unit				48
49					49
50					50
51	Nursery				51
52	Skilled Nursing Facility--Certified				52
53	Skilled Nursing Facility--Noncertified				53
54	**OUTPATIENT SERVICE COST CENTERS**	//////////	//////////	//////////	54
55	Clinic				55
56	Emergency				56
57					57
58	**OTHER REIMBURSABLE COST CENTERS**	//////////	//////////	//////////	58
59	Home Program Dialysis--Other				59
60	Administrative and General--HHA				60

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO. _____	PROVIDER NO. _____	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	MAINTENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES AND SUPPLY	
		12	13	14	
61	Skilled Nursing Care--HHA				61
62	Medical Social Services--HHA				62
63	Home Health Aide--HHA				63
64	Medical Appliances--HHA/DME-Rented				64
65	Durable Medical Equipment Sold				65
66	Home Delivered Meals--HHA				66
67	Other Home Health Services--HHA				67
68	Home Program Dialysis Equipment--100% Medicare				68
69	Ambulance Services				69
70	Intern-Resident Service (Not in approved teaching program)				70
71					71
72	SUBTOTALS (Sum of lines 13-71)	$	$	$	72
73	**NONREIMBURSABLE COST CENTERS**	//////////	//////////	//////////	73
74	Gift, Flower, Coffee Shops and Canteen				74
75	Research				75
76	Physicians' Private Offices				76
77	Nonpaid Workers				77
78					78
79					79
79AA	Cross Foot Adjustment				79 AA
79AB	Negative Balances				79 AB
80	TOTAL (Sum of lines 72-79AB)	$	$	$	80
81	Cost to be Allocated				81
82	Total Statistics from Form HCFA-2552-81, Wkst. B-1				82
83	Unit Cost Multiplier				83

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC
	_____	_____		

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	PHARMACY	MEDICAL RECORDS AND LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	
		15	16	17	18	
1	**GENERAL SERVICE COST CENTERS**	//////////	//////////	//////////	//////////	1
4	Employee Health and Welfare					4
5	Administrative and General					5
6	Maintenance and Repairs					6
7	Operation of Plant					7
8	Laundry and Linen Service					8
9	Housekeeping					9
10	Dietary					10
11	Cafeteria					11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services and Supply					14
15	Pharmacy	$				15
16	Medical Records and Library		$			16
17	Social Service			$		17
18	Nursing School				$	18
19	Intern-Resident Service (In approved teaching program)				//////////	19
20					//////////	20
21	**ANCILLARY SERVICE COST CENTERS**	//////////	//////////	//////////	//////////	21
22	Operating Room				//////////	22
23	Recovery Room				//////////	23
24	Delivery Room and Labor Room				//////////	24
25	Anesthesiology				//////////	25
26	Radiology--Diagnostic				//////////	26
27	Radiology--Therapeutic				//////////	27
28	Radioisotope				//////////	28
29	Laboratory				//////////	29
30	Whole Blood and Packed Red Blood Cells				//////////	30

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC
	_____	_____		

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	PHARMACY	MEDICAL RECORDS AND LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	
		15	16	17	18	
31	Blood Storing, Processing and Transfusion				////////////////	31
32	Intravenous Therapy				////////////////	32
33	Oxygen (Inhalation) Therapy				////////////////	33
34	Physical Therapy				////////////////	34
35	Occupational Therapy				////////////////	35
36	Speech Pathology				////////////////	36
37	Electrocardiology				////////////////	37
38	Electroencephalography				////////////////	38
39	Medical Supplies Charged to Patients				////////////////	39
40	Drugs Charged to Patients				////////////////	40
41	Renal Dialysis				////////////////	41
42	Kidney Acquisition				////////////////	42
43					////////////////	43
44					////////////////	44
45	**INPATIENT ROUTINE SERVICE COST CENTERS**	////////////////	////////////////	////////////////	////////////////	45
46	Adults and Pediatrics (General Routine Care)				////////////////	46
47	Intensive Care Unit				////////////////	47
48	Coronary Care Unit				////////////////	48
49					////////////////	49
50					////////////////	50
51	Nursery				////////////////	51
52	Skilled Nursing Facility--Certified				////////////////	52
53	Skilled Nursing Facility--Noncertified				////////////////	53
54	**OUTPATIENT SERVICE COST CENTERS**	////////////////	////////////////	////////////////	////////////////	54
55	Clinic				////////////////	55
56	Emergency				////////////////	56
57					////////////////	57
58	**OTHER REIMBURSABLE COST CENTERS**	////////////////	////////////////	////////////////	////////////////	58
59	Home Program Dialysis--Other				////////////////	59
60	Administrative and General--HHA				////////////////	60

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD	WORKSHEET
	_____	_____	FROM _____ TO _____	TAC

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	WELFARE	MEDICAL RECORDS AND LIBARY	SOCIAL SERVICE	NURSING SCHOOL	
		15	16	17	18	
61	Skilled Nursing Care--HHA				////////////////	61
62	Medical Social Services--HHA				////////////////	62
63	Home Health Aide--HHA				////////////////	63
64	Medical Appliances--HHA/DME-Rented				////////////////	64
65	Durable Medical Equipment Sold				////////////////	65
66	Home Delivered Meals--HHA				////////////////	66
67	Other Home Health Services--HHA				////////////////	67
68	Home Program Dialysis Equipment--100% Medicare				////////////////	68
69	Ambulance Services				////////////////	69
70	Intern-Resident Service (Not in approved teaching program)				////////////////	70
71					////////////////	71
72	SUBTOTALS (Sum of lines 16-71)	$	$	$	$	72
73	**NONREIMBURSABLE COST CENTERS**	////////////////	////////////////	////////////////	////////////////	73
74	Gift, Flower, Coffee Shops and Canteen				////////////////	74
75	Research				////////////////	75
76	Physicians' Private Offices				////////////////	76
77	Nonpaid Workers				////////////////	77
78					////////////////	78
79					////////////////	79
79AA	Cross Foot Adjustment					79AA
79AB	Negative Balances					79AB

80	TOTAL (Sum of lines 72-79AB)	$	$	$	$	80
81	Cost to be Allocated					81
82	Total Statistics from Form HCFA-2552-81, Wkst. B-1					82
83	Unit Cost Multiplier					83

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM TO	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	INTERN-RESIDENT SERVICE IN APPROVED TEACHING PROGRAM		TOTAL (COS 3-20)	
		19	20	21	
1	**GENERAL SERVICE COST CENTERS**	//////////	//////////	//////////	1
4	Employee Health and Welfare				4
5	Administrative and General				5
6	Maintenance and Repairs				6
7	Operation of Plant				7
8	Laundry and Linen Service				8
9	Housekeeping				9
10	Dietary				10
11	Cafeteria				11
12	Maintenance of Personnel				12
13	Nursing Administration				13
14	Central Services and Supply				14
15	Pharmacy				15
16	Medical Records and Library				16
17	Social Service				17
18	Nursing School				18
19	Intern-Resident Service (In approved teaching program)	$			19
20		//////////			20
21	**ANCILLARY SERVICE COST CENTERS**	//////////	//////////	//////////	21
22	Operating Room	//////////			22
23	Recovery Room	//////////			23
24	Delivery Room and Labor Room	//////////			24
25	Anesthesiology	//////////			25
26	Radiology--Diagnostic	//////////			26
27	Radiology--Therapeutic	//////////			27
28	Radioisotope	//////////			28
29	Laboratory	//////////			29
30	Whole Blood and Packed Red Blood Cells	//////////			30

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM TO	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	INTERN-RESIDENT SERVICE IN APPROVED TEACHING PROGRAM		TOTAL (COLS 3-20)	
		19	20	21	
31	Blood Storing, Processing and Transfusion	////////////////////			31
32	Intravenous Therapy	////////////////////			32
33	Oxygen (Inhalation) Therapy	////////////////////			33
34	Physical Therapy	////////////////////			34
35	Occupational Therapy	////////////////////			35
36	Speech Pathology	////////////////////			36
37	Electrocardiology	////////////////////			37
38	Electroencephalography	////////////////////			38
39	Medical Supplies Charged to Patients	////////////////////			39
40	Drugs Charged to Patients	////////////////////			40
41	Renal Dialysis	////////////////////			41
42	Kidney Acquisition	////////////////////			42
43		////////////////////			43
44		////////////////////			44
45	**INPATIENT ROUTINE SERVICE COST CENTERS**	////////////////////	///////////////	/////////////////	45
46	Adults and Pediatrics (General Routine Care)	////////////////////			46
47	Intensive Care Unit	////////////////////			47
48	Coronary Care Unit	////////////////////			48
49		////////////////////			49
50		////////////////////			50
51	Nursery	////////////////////			51
52	Skilled Nursing Facility--Certified	////////////////////			52
53	Skilled Nursing Facility--Noncertified	////////////////////			53
54	**OUTPATIENT SERVICE COST CENTERS**	////////////////////	///////////////	/////////////////	54
55	Clinic	////////////////////			55
56	Emergency	////////////////////			56
57		////////////////////			57
58	**OTHER REIMBURSABLE COST CENTERS**	////////////////////	///////////////	/////////////////	58
59	Home Program Dialysis--Other	////////////////////			59
60	Administrative and General--HHA	////////////////////			60

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART I - ALLOCATION OF CAPITAL-RELATED COST

	COST CENTER (OMIT CENTS)	INTERN-RESIDENT SERVICE IN APPROVED TEACHING PROGRAM		TOTAL (COLS 3-20)	
		19	20	21	
61	Skilled Nursing Care--HHA	//////////			61
62	Medical Social Services--HHA	//////////			62
63	Home Health Aide--HHA	//////////			63
64	Medical Appliances--HHA/DME-Rented	//////////			64
65	Durable Medical Equipment Sold	//////////			65
66	Home Delivered Meals--HHA	//////////			66
67	Other Home Health Services--HHA	//////////			67
68	Home Program Dialysis Equipment--100% Medicare	//////////			68
69	Ambulance Services	//////////			69
70	Intern-Resident Service (Not in approved teaching program)	//////////			70
71		//////////			71
72	SUBTOTALS (Sum of lines 20-71)	$	$	$	72
73	**NONREIMBURSABLE COST CENTERS**	//////////	//////////	//////////	73
74	Gift, Flower, Coffee Shops and Canteen	//////////			74
75	Research	//////////			75
76	Physicians' Private Offices	//////////			76
77	Nonpaid Workers	//////////			77
78		//////////			78
79		//////////			79
79AA	Cross Foot Adjustment				79 AA
79AB	Negative Balances				79 AB
80	TOTAL (Sum of lines 72-79AB)	$	$	$	80
81	Cost to be Allocated			//////////	81
82	Total Statistics from Form HCFA-2552-81, Wkst. B-1			//////////	82
83	Unit Cost Multiplier			//////////	83

FORM HCFA-1007

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO. _____	PROVIDER NO. _____	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART II - COMPUTATION OF FICA TAX ADJUSTMENT FACTOR

1	Amount of FICA tax that would have been paid during base period by provider not subject to FICA tax (From provider information)	
2	Total provider cost for base period (From Wkst. A, column 7, line 84)	
3	Total capital-related cost for base period (From Wkst. TAC, column 21, line 80)	
4	Net cost for allocation of FICA tax (Line 2 minus line 3)	
5	FICA tax adjustment factor for prospective payment system (Line 1 divided by line 4)	
6	FICA tax adjustment factor for TEFRA (Line 5 multiplied by applicable factor _____)	

FORM HCFA-1007

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO. _____	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART III - PROVIDER-BASED PHYSICIAN ADJUSTMENT

	COST CENTER	ADJUSTED PROVIDER COMPONENT	PROVIDER COMPONENT PER COST	PBP ADJUSTMENTS INCREASE OR (DECREASE)	TRANSFER AMOUNTS IN COLUMN 3 TO PART	COLUMN	LINE	
		1	2	3	4			
22	Operating Room				VI	2	8	22
23	Recovery Room				VI	3	8	23
24	Delivery Room and Labor Room				VI	4	8	24
25	Anesthesiology				VI	5	8	25
26	Radiology - Diagnostic				VI	6	8	26
27	Radiology - Therapeutic				VI	7	8	27
28	Radioisotope				VI	8	8	28
29	Laboratory				VI	9	8	29
30	Whole Blood and Packed Red Cells				VI	10	8	30
31	Blood Storing, Processing and Transfusion				VI	11	8	31
32	Intravenous Therapy				VI	12	8	32
33	Oxygen (Inhalation) Therapy				VI	13	8	33
34	Physical Therapy				VI	14	8	34
35	Occupational Therapy				VI	15	8	35
36	Speech Pathology				VI	16	8	36
37	Electrocardiology				VI	17	8	37
38	Electroencephalography				VI	18	8	38
39	Medical Supplies Charged to Patients				VI	19	8	39
40	Drugs Charged to Patients				VI	20	8	40
41	Renal Dialysis				VI	21	8	41
43					VI	22	8	43
44					VI	23	8	44
46	Adjults and Pediatrics (General Routine Care)				V	1	7	46
47	Intensive Care Unit				V	1	9	47
48	Coronary Care Unit				V	2	9	48
49					See footnote below.			49
50					See footnote below.			50
55	Clinic				VI	25	8	55
56	Emergency				VI	26	8	56
57					VI	27	8	57

*If lines 49 and 50 are used for Intensive Care Type cost centers, the amounts in column 3 should be transferred to Part V, columns 3 and 4, line 9. If lines 49 and 50 are used for Subprovider costs, the amounts in column 3 should be transferred to part IV, columns 2 and 3, as appropriate, line 7.

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART IV - COMPUTATION OF TARGET AMOUNT FOR GENERAL INPATIENT ROUTINE SERVICE COSTS

		HOSPITAL	SUBPROVIDER I	SUBPROVIDER II
1	Total Inpatient Routine Service Cost (From Wkst. D-1, Part I, col. 1, 2 or 3, line 11)			
2	Col. 1, from Part I, line 46, col. 21, plus Wkst. B, sum of cols. 18 and 19, line 46; cols. 2 and 3, from Part I, lines 49 or 50, as appropriate, plus Wkst. B, sum of cols. 18 and 19, line 49 or 50, as appropriate			
3	Approved paramedical education program costs included on line 1 (From provider information)			
4	Net cost for computation of FICA tax adjustment (Line 1 minus sum of lines 2 and 3)			
5	FICA tax adjustment (Line 4 multiplied by FICA tax adjustment factor From Part II, line 5))			
6	Total (Line 4 plus line 5)			
7	Provider-based physician adjustment (From Part III, col. 3, line 46, 49 or 50, as appropriate) (Show decreases in parenthesis ( ))			
8	Net cost for comparison to cost limit (Line 6 plus or minus line 7)			
9	Total patient days (From Wkst. D-1, Part I, col. 1, 2 or 3, line 3)			
10	Per diem cost for comparison to the cost limit (Line 8 divided by line 9)			
11	Medicare inpatient days (From Wkst. D-1, Part I, col. 1, 2 or 3, line 8)			
12	Adjusted general inpatient routine service cost for comparison to the adjusted cost limitation (Line 10 multiplied by line 11)			
13	General inpatient routine service cost limitation adjusted for aggregate charges for excess cost applicable to kidney acquisition (From Wkst. D-1, Part I, col. 1, 2 or 3, line 37)			
14	Total cost of the adjustments applicable to cost limitation (line 5, plus or minus line 7 minus line 3) (Enter negative amounts in parenthesis)			
15	Per diem cost of adjustments applicable to cost limitation (line 14 divided by line 9) (Enter negative amounts in parenthesis)			
16	Medicare cost of adjustments applicable to general inpatient routine service cost limitation (line 11 multiplied by line 15) (Enter negative amounts in parenthesis)			
17	Adjusted general inpatient routine service cost limitation (line 13 plus or minus line 16)			
18	General inpatient routine service cost for inclusion in target amount (Lesser of line 12 or line 17) (Transfer cols 1, 2 or 3 to corresponding columns in Part VII, line 1)			

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART V - COMPUTATION OF TARGET AMOUNT FOR INTENSIVE CARE TYPE INPATIENT ROUTINE SERVICE COSTS

		(1) Intensive Care Unit	(2) Coronary Care Unit	(3) Other (Specify)	(4) Other (Specify)
1	Total inpatient cost for unit (From Wkst. D-1, Part I, col. 1, lines 39-42, as appropriate)				
2	Capital-related cost included on line 1 (From Part I, col. 21, lines 47-50, as appropriate)				
3	Nursing school cost included on line 1 (From Wkst. B, col. 18, lines 47-50, as appropriate)				
4	Intern and Resident (in approved teaching program) cost included on line 1 (From Wkst. B, col. 19, lines 47-50, as appropriate)				
5	Approved paramedical education program cost included on line 1 (From provider information)				
6	Net cost for computation of FICA tax adjustment (Line 1 minus sum of lines 2 through 5)				
7	FICA tax adjustment (Line 6 multiplied by FICA tax adjustment factor (From Part II, line 5)				
8	Total (Line 6 plus line 7)				
9	Provider-based physician adjustment (From Part III, col. 3, lines 47 through 50, as appropriate) (Show decreases in parenthesis)				
10	Provider-based physician adjustment (From Part III, col. 3, lines 47 through 50, as appropriate) (Show decreases in parenthesis)				
11	Total patient days (From Wkst. D-1, Part I, col. 2, lines 39-42, as appropriate				
12	Adjusted per diem cost (Line 10 divided by line 11)				
13	Medicare patient days (From Wkst. D-1, Part I, col. 4, lines 39-42, as appropriate)				
14	Adjusted cost for target amount computation (Line 12 multiplied by line 13) (Transfer the sum of the amounts in all columns to Part VII, column 1, line 2)				

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART VI - COMPUTATION OF TARGET AMOUNT FOR INPATIENT HOSPITAL ANCILLARY SERVICES

		TOTAL (SUM OF COLS 2-27	OPERATING ROOM	RECOVERY ROOM	DELIVERY ROOM AND LABOR ROOM
		1	2	3	4
1	Total inpatient cost for unit (From Wkst. D-1, Part I, col. 1, lines 39-42, as appropriate)	////////////			
2	Capital-related cost included on line 1 (From Part I, col. 21)	////////////			
3	Nursing school cost included on line 1 (From Wkst. B, col. 18)	////////////			
4	Interns and residents (in approved teaching program) cost included on line 1 (From Wkst. B, col. 19)	////////////			
5	Approved paramedical education program cost included on line 1 (From provider information)	////////////			
6	Net cost for computation of FICA tax adjustment (line 1 minus sum of lines 2 through 5)	////////////			
7	FICA tax adjustment (line 6 multiplied by FICA tax adjustment factor (From Part II, line 5))	////////////			
8	Provider-based physician adjustment (From Part III, col. 3) (Show decreases in parenthesis ( ))	////////////			
9	Adjusted cost (line 6 plus line 7 plus or minus line 8) (If line 9 is zero, do not compute further)	////////////			
10	Total charges (From Wkst. C, col. 1, line b)	////////////			
11	Ratio of cost to charges (line 9 divided by line 10)	////////////			
12	**HOSPITAL** Medicare charges for inpatient HOSPITAL ancillary services (From Wkst. D, col. 3)				
13	Medicare cost for inpatient HOSPITAL ancillary services (line 11 multiplied by line 12) (Enter sum of amounts in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 1, line 3)				
14	**SUBPROVIDER I** Medicare charges for inpatient SUBPROVIDER I ancillary services (From Wkst. D, col. 3)				
15	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 11 multiplied by line 14)(Enter sum of amts. in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 2, line 3)				
16	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (From Wkst. D, col. 3)				
17	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 11 multiplied by line 16)(Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 3, line 3)				

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART VI - COMPUTATION OF TARGET AMOUNT FOR INTENSIVE CARE TYPE INPATIENT ROUTINE SERVICE COSTS

		ANESTHES-IOLOGY	RADIOLOGY DIAGNOSTIC	RADIOLOGY THERAPEUTIC	RADIO-ISOTOPE
		5	6	7	8
1	Total inpatient cost for unit (From Wkst. D-1, Part I, col. 1, lines 39-42, as appropriate)				
2	Capital-related cost included on line 1 (From Part I, col. 21)				
3	Nursing school cost included on line 1 (From Wkst. B, col. 18)				
4	Interns and residents (in approved teaching program) cost included on line 1 (From Wkst. B, col. 19)				
5	Approved paramedical education program cost included on line 1 (From provider information)				
6	Net cost for computation of FICA tax adjustment (line 1 minus sum of lines 2 through 5)				
7	FICA tax adjustment (line 6 multiplied by FICA tax adjustment factor (From Part II, line 5))				
8	Provider-based physician adjustment (From Part III, col. 3) (Show decreases in parenthesis ( ))				
9	Adjusted cost (line 6 plus line 7 plus or minus line 8) (If line 9 is zero, do not compute further)				
10	Total charges (From Wkst. C, col. 1, line b)				
11	Ratio of cost to charges (line 9 divided by line 10)				
12	**HOSPITAL** Medicare charges for inpatient HOSPITAL ancillary services (From Wkst. D, col. 3)				
13	Medicare cost for inpatient HOSPITAL ancillary services (line 11 multiplied by line 12) (Enter sum of amounts in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 1, line 3)				
14	**SUBPROVIDER I** Medicare charges for inpatient SUBPROVIDER I ancillary services (From Wkst. D, col. 3)				
15	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 11 multiplied by line 14)(Enter sum of amts. in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 2, line 3)				
16	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (From Wkst. D, col. 3)				
17	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 11 multiplied by line 16)(Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 3, line 3)				

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART VI - COMPUTATION OF TARGET AMOUNT FOR INTENSIVE CARE TYPE INPATIENT ROUTINE SERVICE COSTS

		LABORATORY	WHOLE BLOOD & PACKED RED BLOOD CELLS	BLOOD STORING PROCESSING & TRANSFUSION	INTRAVENOUS THERAPY
		9	10	11	12
1	Total inpatient cost for unit (From Wkst. D-1, Part I, col. 1, lines 39-42, as appropriate)				
2	Capital-related cost included on line 1 (From Part I, col. 21)				
3	Nursing school cost included on line 1 (From Wkst. B, col. 18)				
4	Interns and residents (in approved teaching program) cost included on line 1 (From Wkst. B, col. 19)				
5	Approved paramedical education program cost included on line 1 (From provider information)				
6	Net cost for computation of FICA tax adjustment (line 1 minus sum of lines 2 through 5)				
7	FICA tax adjustment (line 6 multiplied by FICA tax adjustment factor (From Part II, line 5))				
8	Provider-based physician adjustment (From Part III, col. 3) (Show decreases in parenthesis ( ))				
9	Adjusted cost (line 6 plus line 7 plus or minus line 8) (If line 9 is zero, do not compute further)				
10	Total charges (From Wkst. C, col. 1, line b)				
11	Ratio of cost to charges (line 9 divided by line 10)				
12	**HOSPITAL** Medicare charges for inpatient HOSPITAL ancillary services (From Wkst. D, col. 3)				
13	Medicare cost for inpatient HOSPITAL ancillary services (line 11 multiplied by line 12) (Enter sum of amounts in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 1, line 3)				
14	**SUBPROVIDER I** Medicare charges for inpatient SUBPROVIDER I ancillary services (From Wkst. D, col. 3)				
15	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 11 multiplied by line 14)(Enter sum of amts. in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 2, line 3)				
16	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (From Wkst. D, col. 3)				
17	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 11 multiplied by line 16)(Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 3, line 3)				

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART VI - COMPUTATION OF TARGET AMOUNT FOR INTENSIVE CARE TYPE INPATIENT ROUTINE SERVICE COSTS

		OXYGEN (INHALATIOON) THERAPY	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH PATHOLOGY
		13	14	15	16
1	Total inpatient cost for unit (From Wkst. D-1, Part I, col. 1, lines 39-42, as appropriate)				
2	Capital-related cost included on line 1 (From Part I, col. 21)				
3	Nursing school cost included on line 1 (From Wkst. B, col. 18)				
4	Interns and residents (in approved teaching program) cost included on line 1 (From Wkst. B, col. 19)				
5	Approved paramedical education program cost included on line 1 (From provider information)				
6	Net cost for computation of FICA tax adjustment (line 1 minus sum of lines 2 through 5)				
7	FICA tax adjustment (line 6 multiplied by FICA tax adjustment factor (From Part II, line 5))				
8	Provider-based physician adjustment (From Part III, col. 3) (Show decreases in parenthesis ( ))				
9	Adjusted cost (line 6 plus line 7 plus or minus line 8) (If line 9 is zero, do not compute further)				
10	Total charges (From Wkst. C, col. 1, line b)				
11	Ratio of cost to charges (line 9 divided by line 10)				
12	**HOSPITAL** Medicare charges for inpatient HOSPITAL ancillary services (From Wkst. D, col. 3)				
13	Medicare cost for inpatient HOSPITAL ancillary services (line 11 multiplied by line 12) (Enter sum of amounts in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 1, line 3)				
14	**SUBPROVIDER I** Medicare charges for inpatient SUBPROVIDER I ancillary services (From Wkst. D, col. 3)				
15	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 11 multiplied by line 14)(Enter sum of amts. in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 2, line 3)				
16	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (From Wkst. D, col. 3)				
17	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 11 multiplied by line 16)(Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 3, line 3)				

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART VI - COMPUTATION OF TARGET AMOUNT FOR INTENSIVE CARE TYPE INPATIENT ROUTINE SERVICE COSTS

		ELECTRO-CARDIOLOGY	ELECTROEN-CEPHALOGRAPHY	MED SUPPLIES CHARGED TO PATIENTS	DRUGS CHARGED TO PATIENTS
		17	18	19	20
1	Total inpatient cost for unit (From Wkst. D-1, Part I, col. 1, lines 39-42, as appropriate)				
2	Capital-related cost included on line 1 (From Part I, col. 21)				
3	Nursing school cost included on line 1 (From Wkst. B, col. 18)				
4	Interns and residents (in approved teaching program) cost included on line 1 (From Wkst. B, col. 19)				
5	Approved paramedical education program cost included on line 1 (From provider information)				
6	Net cost for computation of FICA tax adjustment (line 1 minus sum of lines 2 through 5)				
7	FICA tax adjustment (line 6 multiplied by FICA tax adjustment factor (From Part II, line 5))				
8	Provider-based physician adjustment (From Part III, col. 3) (Show decreases in parenthesis ( ))				
9	Adjusted cost (line 6 plus line 7 plus or minus line 8) (If line 9 is zero, do not compute further)				
10	Total charges (From Wkst. C, col. 1, line b)				
11	Ratio of cost to charges (line 9 divided by line 10)				
12	**HOSPITAL** Medicare charges for inpatient HOSPITAL ancillary services (From Wkst. D, col. 3)				
13	Medicare cost for inpatient HOSPITAL ancillary services (line 11 multiplied by line 12) (Enter sum of amounts in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 1, line 3)				
14	**SUBPROVIDER I** Medicare charges for inpatient SUBPROVIDER I ancillary services (From Wkst. D, col. 3)				
15	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 11 multiplied by line 14)(Enter sum of amts. in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 2, line 3)				
16	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (From Wkst. D, col. 3)				
17	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 11 multiplied by line 16)(Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 3, line 3)				

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART VI - COMPUTATION OF TARGET AMOUNT FOR INTENSIVE CARE TYPE INPATIENT ROUTINE SERVICE COSTS

		RENAL DIALYSIS			CLINIC
		21	22	23	25
1	Total inpatient cost for unit (From Wkst. D-1, Part I, col. 1, lines 39-42, as appropriate)				
2	Capital-related cost included on line 1 (From Part I, col. 21)				
3	Nursing school cost included on line 1 (From Wkst. B, col. 18)				
4	Interns and residents (in approved teaching program) cost included on line 1 (From Wkst. B, col. 19)				
5	Approved paramedical education program cost included on line 1 (From provider information)				
6	Net cost for computation of FICA tax adjustment (line 1 minus sum of lines 2 through 5)				
7	FICA tax adjustment (line 6 multiplied by FICA tax adjustment factor (From Part II, line 5))				
8	Provider-based physician adjustment (From Part III, col. 3) (Show decreases in parenthesis ( ))				
9	Adjusted cost (line 6 plus line 7 plus or minus line 8) (If line 9 is zero, do not compute further)				
10	Total charges (From Wkst. C, col. 1, line b)				
11	Ratio of cost to charges (line 9 divided by line 10)				
12	**HOSPITAL** Medicare charges for inpatient HOSPITAL ancillary services (From Wkst. D, col. 3)				
13	Medicare cost for inpatient HOSPITAL ancillary services (line 11 multiplied by line 12) (Enter sum of amounts in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 1, line 3)				
14	**SUBPROVIDER I** Medicare charges for inpatient SUBPROVIDER I ancillary services (From Wkst. D, col. 3)				
15	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 11 multiplied by line 14)(Enter sum of amts. in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 2, line 3)				
16	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (From Wkst. D, col. 3)				
17	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 11 multiplied by line 16)(Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 3, line 3)				

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART VI - COMPUTATION OF TARGET AMOUNT FOR INTENSIVE CARE TYPE INPATIENT ROUTINE SERVICE COSTS

		EMERGENCY	
		26	27
1	Total inpatient cost for unit (From Wkst. D-1, Part I, col. 1, lines 39-42, as appropriate)		
2	Capital-related cost included on line 1 (From Part I, col. 21)		
3	Nursing school cost included on line 1 (From Wkst. B, col. 18)		
4	Interns and residents (in approved teaching program) cost included on line 1 (From Wkst. B, col. 19)		
5	Approved paramedical education program cost included on line 1 (From provider information)		
6	Net cost for computation of FICA tax adjustment (line 1 minus sum of lines 2 through 5)		
7	FICA tax adjustment (line 6 multiplied by FICA tax adjustment factor (From Part II, line 5))		
8	Provider-based physician adjustment (From Part III, col. 3) (Show decreases in parenthesis ( ))		
9	Adjusted cost (line 6 plus line 7 plus or minus line 8) (If line 9 is zero, do not compute further)		
10	Total charges (From Wkst. C, col. 1, line b)		
11	Ratio of cost to charges (line 9 divided by line 10)		
12	**HOSPITAL** Medicare charges for inpatient HOSPITAL ancillary services (From Wkst. D, col. 3)		
13	Medicare cost for inpatient HOSPITAL ancillary services (line 11 multiplied by line 12) (Enter sum of amounts in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 1, line 3)		
14	**SUBPROVIDER I** Medicare charges for inpatient SUBPROVIDER I ancillary services (From Wkst. D, col. 3)		
15	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 11 multiplied by line 14)(Enter sum of amts. in cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 2, line 3)		
16	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (From Wkst. D, col. 3)		
17	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 11 multiplied by line 16)(Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part VII, col. 3, line 3)		

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART VII - COMPUTATION OF TARGET AMOUNT PER DISCHARGE FOR PROSPECTIVE PAYMENT SYSTEM

		HOSPITAL	SUBPROVIDER I	SUBPROVIDER II
		1	2	3
1	Total inpatient cost for unit (From Wkst. D-1, Part I, col. 1, lines 39-42, as appropriate)			
2	Intensive Care Type Inpatient Hospital Unit Cost (From Part V, Sum of all columns, line 14)		//////////////////////// ////////	//////////////////////// ////////
3	Ancillary Service Costs (From Part VI, col. 1, line 13, 15 or 17)			
4	Kidney Acquisition Costs (From Wkst. E, Part I, col. 1, 4 or 6, line 8)			
5	Cost of services furnished "under arrangements" to Medicare beneficiaries only (From Wkst. E, Part I, col. 1, 4 or 6, line 9)			
6	Malpractice Insurance Costs (From Wkst. E, Part I, col. 1, 4 or 6, line 10)			
7	Cost of services furnished to Medicare beneficiaries billed as services incident to a physicians service and cost of arranged for services furnished to inpatient Medicare beneficiaries and billed for by the outside supplier where these services would have been covered as an inpatient hospital service if billed for by a hospital (From provider information)			
8	Total (Sum of lines 1 through 7)			
9	Enter as a positive amount, the total kidney acquisition charges billed to Medicare under Part B (From Wkst. E, Part I, col. 1, 4 or 6, line 14)			
10	Enter as a positive amount, the total revenues received for kidneys furnished to other providers, organ procurement agencies and others and for kidneys transplanted in non-Medicare patients (From Wkst. E, Part I, col. 1, 4 or 6, line 17)			
11	Total (Line 9 plus line 10)			
12	Medicare inpatient hospital operating costs for target amount computation (Line 8 minus line 11)			
13	Medicare discharges (From Statistical Data, page 3, Part III, line 6c for hospitals; page 4, Part V, line 7c for Subproviders I and II			
14	Base period cost per discharge (line 12 divided by line 13)			
15	Case-mix index			
16	Case-mix adjusted base year cost (line 14 divided by line 15)			
17	Applicable percentage increase plus 100% (Enter same amount in each column)			
18	Average target amount per discharge for prospective payment (Line 16 multiplied by line 17)			

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO. _____	PROVIDER NO. _____	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART VIII - TEFRA COMPUTATION OF TARGET AMOUNT FOR GENERAL INPATIENT ROUTINE SERVICE COSTS

		HOSPITAL	SUBPROVIDER I	SUBPROVIDER II
		1	2	3
1	Net cost of inpatient routine services (From Part IV, Sum of lines 3 and 4)			
2	FICA tax adjustment (Line 1 multiplied by applicable factor from Part II, line 6)			
3	Total (Line 1 plus line 2)			
4	Provider-based physician adjustment (Part IV, line 7 multiplied by applicable factor) (Show decreases in parenthesis ( ))			
5	Net cost for comparison to cost limit (Line 3 plus or minus line 4)			
6	Total patient days (From Part IV, line 9)			
7	Per diem cost for comparison to the cost limit (Line 5 divided by line 6)			
8	Medicare inpatient days (From Part IV, line 11)			
9	Adjusted general inpatient routine service cost for comparison to the adjusted cost limitation (Line 7 multiplied by line 8)			
10	Comparison amount (From Part IV, line 13)			
11	Total cost of the adjustments applicable to cost limitation (line 2 plus or minus line 4) (Enter negative amounts in parenthesis)			
12	Per diem cost of adjustments applicable to cost limitation (line 11 divided by line 6) (Enter negative amounts in parenthesis)			
13	Medicare cost of adjustments applicable to general inpatient routine service cost limitation (line 8 multiplied by line 12) (Enter negative amounts in parenthesis)			
14	Adjusted general inpatient routine service cost limitation (line 10 plus or minus line 13))			
15	General inpatient routine service cost for inclusion in TEFRA target amount (lesser of line 9 or line 14) (Transfer columns 1, 2 or 3 to corresponding columns in Part XI, line 1)			

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART VIII - TEFRA COMPUTATION OF TARGET AMOUNT FOR GENERAL INPATIENT ROUTINE SERVICE COSTS

		(1) Intensive Care Unit	(2) Coronary Care Unit	(3) Other (Specify)	(4) Other (Specify)
1	Net cost of intensive care type inpatient hospital units (From Part V, sum of lines 5 and 6)				
2	FICA tax adjustment (Line 1 multiplied by factor from Part II, line 6)				
3	Total (Line 1 plus line 2)				
4	Provider-based physician adjustment (From Part V, line 9 multiplied by applicable factor) (Show decreases in parenthesis ( ))				
5	Net cost for target amount computation (Line 3 plus or minus line 4)				
6	Total patient days (From Part V, line 11)				
7	Adjusted per diem cost (Line 5 divided by line 6)				
8	Medicare patient days (From Part V, line 13)				
9	Adjusted cost for TEFRA target amount computation (Line 7 multiplied by line 8) (Transfer the sum of the amounts in all columns to Part XI, column 1, line 2)				

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART X - TEFRA COMPUTATION OF TARGET AMOUNT FOR INPATIENT HOSPITAL ANCILLARY SERVICES

		TOTAL (SUM OF COLS 2-27)	OPERATING ROOM	RECOVERY ROOM	DELIVERY ROOM AND LABOR ROOM	ANESTHES -IOLOGY	RADIOLOGY DIAGNOSTIC
		1	2	3	4	5	6
1	Net cost of ancillary services (From Part VI, sum of lines 5 and 6) (Enter negative amounts in parenthesis)	//////////////////////// //////////////////////// //					
2	FICA tax adjustment (Line 1 multiplied by factor from Part II, line 6)	//////////////////////// //////////////////////// //					
3	Total (Line 1 plus line 2)	//////////////////////// /					
4	Provider-based physician adjustment (Part VI, line 8 multiplied by applicable factor)(Show decreases in parentheses ( ))	//////////////////////// //////////////////////// //////////////////////// ///					
5	Adjusted cost (line 3 plus or minus line 4) (Enter negative amounts in parenthesis)	//////////////////////// //////////////////////// //					
6	Total charges (From Part VI, line 10)	//////////////////////// /					
7	Ratio of cost to charges (line 5 divided by line 6)	//////////////////////// /					
8	HOSPITAL--Medicare charges for inpatient HOSPITAL ancillary svcs (Fr Part VI, line 12)						
9	Medicare cost for inpatient HOSPITAL ancillary services (line 7 multiplied by line 8) (Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part XI, col 1, line 3)						
10	**SUBPROV. I**--Medicare chrgs for I/P SUBPROV. I ancillary svcs (Fr Part VI, line 14)						
11	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 7 multiplied by line 10)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 2, line 3)						
12	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (Fr Part VI, line 16)						
13	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 7 multiplied by line 12)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 3, line 3)						

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART X - TEFRA COMPUTATION OF TARGET AMOUNT FOR INPATIENT HOSPITAL ANCILLARY SERVICES

		RADIOLOGY THERAPEUTIC	RADIO-ISOTOPE	LABORATORY	WHOLE BLOOD & PACKED RED BLOOD CELLS	BLOOD STORING PROCESSING & TRANSFUSION	INTRAVENOUS THERAPY
		7	8	9	10	11	12
1	Net cost of ancillary services (From Part VI, sum of lines 5 and 6) (Enter negative amounts in parenthesis)						
2	FICA tax adjustment (Line 1 multiplied by factor from Part II, line 6)						
3	Total (Line 1 plus line 2)						
4	Provider-based physician adjustment (Part VI, line 8 multiplied by applicable factor)(Show decreases in parentheses ( ))						
5	Adjusted cost (line 3 plus or minus line 4) (Enter negative amounts in parenthesis)						
6	Total charges (From Part VI, line 10)						
7	Ratio of cost to charges (line 5 divided by line 6)						
8	HOSPITAL--Medicare charges for inpatient HOSPITAL ancillary svcs (Fr Part VI, line 12)						
9	Medicare cost for inpatient HOSPITAL ancillary services (line 7 multiplied by line 8) (Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part XI, col 1, line 3)						
10	**SUBPROV. I**--Medicare chrgs for I/P SUBPROV. I ancillary svcs (Fr Part VI, line 14)						
11	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 7 multiplied by line 10)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 2, line 3)						
12	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (Fr Part VI, line 16)						
13	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 7 multiplied by line 12)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 3, line 3)						

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART X - TEFRA COMPUTATION OF TARGET AMOUNT FOR INPATIENT HOSPITAL ANCILLARY SERVICES

		OXYGEN (INHALATION) THERAPY	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH PATHOLOGY	ELECTRO-CARDIOLOGY	ELECTRO-ENCEPHALOGRAPHY
		13	14	15	16	17	18
1	Net cost of ancillary services (From Part VI, sum of lines 5 and 6) (Enter negative amounts in parenthesis)						
2	FICA tax adjustment (Line 1 multiplied by factor from Part II, line 6)						
3	Total (Line 1 plus line 2)						
4	Provider-based physician adjustment (Part VI, line 8 multiplied by applicable factor)(Show decreases in parentheses ( ))						
5	Adjusted cost (line 3 plus or minus line 4) (Enter negative amounts in parenthesis)						
6	Total charges (From Part VI, line 10)						
7	Ratio of cost to charges (line 5 divided by line 6)						
8	HOSPITAL--Medicare charges for inpatient HOSPITAL ancillary svcs (Fr Part VI, line 12)						
9	Medicare cost for inpatient HOSPITAL ancillary services (line 7 multiplied by line 8) (Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part XI, col 1, line 3)						
10	**SUBPROV. I**--Medicare chrgs for I/P SUBPROV. I ancillary svcs (Fr Part VI, line 14)						
11	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 7 multiplied by line 10)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 2, line 3)						
12	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (Fr Part VI, line 16)						
13	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 7 multiplied by line 12)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 3, line 3)						

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART X - TEFRA COMPUTATION OF TARGET AMOUNT FOR INPATIENT HOSPITAL ANCILLARY SERVICES

		MED SUPPLIES CHARGED TO PATIENTS	DRUGS CHARGED TO PATIENTS	RENAL DIALYSIS		
		19	20	21	22	23
1	Net cost of ancillary services (From Part VI, sum of lines 5 and 6) (Enter negative amounts in parenthesis)					
2	FICA tax adjustment (Line 1 multiplied by factor from Part II, line 6)					
3	Total (Line 1 plus line 2)					
4	Provider-based physician adjustment (Part VI, line 8 multiplied by applicable factor)(Show decreases in parentheses ( ))					
5	Adjusted cost (line 3 plus or minus line 4) (Enter negative amounts in parenthesis)					
6	Total charges (From Part VI, line 10)					
7	Ratio of cost to charges (line 5 divided by line 6)					
8	HOSPITAL--Medicare charges for inpatient HOSPITAL ancillary svcs (Fr Part VI, line 12)					
9	Medicare cost for inpatient HOSPITAL ancillary services (line 7 multiplied by line 8) (Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part XI, col 1, line 3)					
10	**SUBPROV. I**--Medicare chrgs for I/P SUBPROV. I ancillary svcs (Fr Part VI, line 14)					
11	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 7 multiplied by line 10)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 2, line 3)					
12	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (Fr Part VI, line 16)					
13	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 7 multiplied by line 12)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 3, line 3)					

EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART X - TEFRA COMPUTATION OF TARGET AMOUNT FOR INPATIENT HOSPITAL ANCILLARY SERVICES

		CLINIC	EMERGENCY	
		25	26	27
1	Net cost of ancillary services (From Part VI, sum of lines 5 and 6) (Enter negative amounts in parenthesis)			
2	FICA tax adjustment (Line 1 multiplied by factor from Part II, line 6)			
3	Total (Line 1 plus line 2)			
4	Provider-based physician adjustment (Part VI, line 8 multiplied by applicable factor)(Show decreases in parentheses ( ))			
5	Adjusted cost (line 3 plus or minus line 4) (Enter negative amounts in parenthesis)			
6	Total charges (From Part VI, line 10)			
7	Ratio of cost to charges (line 5 divided by line 6)			
8	HOSPITAL--Medicare charges for inpatient HOSPITAL ancillary svcs (Fr Part VI, line 12)			
9	Medicare cost for inpatient HOSPITAL ancillary services (line 7 multiplied by line 8) (Enter sum of cols. 2 through 27 in col. 1) (Transfer amount in col. 1 to Part XI, col 1, line 3)			
10	**SUBPROV. I**--Medicare chrgs for I/P SUBPROV. I ancillary svcs (Fr Part VI, line 14)			
11	Medicare cost for inpatient SUBPROVIDER I ancillary services (line 7 multiplied by line 10)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 2, line 3)			
12	**SUBPROVIDER II** Medicare charges for inpatient SUBPROVIDER II ancillary services (Fr Part VI, line 16)			
13	Medicare cost for inpatient SUBPROVIDER II ancillary services (line 7 multiplied by line 12)(Enter sum of cols. 2 through 27 in col. 1)(Transfer amount in col. 1 to Part XI, col. 3, line 3)			

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO	WORKSHEET TAC

PART XI - COMPUTATION OF TARGET AMOUNT PER DISCHARGE FOR TEFRA

		HOSPITAL	SUBPROVIDER I	SUBPROVIDER 2
		25	26	27
1	General inpatient routine service costs (From Part VIII, col. 1, 2 or 3, line 15)			
2	Intensive care type inpatient hospital unit cost (From Part IX, sum of all columns,line 9)			
3	Ancillary service costs (From Part X, col. 1, line 9, 11 or 13, as appropriate)		// //	// //
4	Cost of services furnished "under arrangements" to Medicare beneficiaries only (From Part VII, col. 1, 2 or 3, line 5)			
5	Cost of services furnished to Medicare beneficiaries billed as services incident to a physician's service and cost of arranged for services furnished to inpatient Medicare beneficiaries and billed for by the outside supplier, where those services would have been covered as an inpatient hospital service if billed for by a hospital (Part VII, col. 1, 2 or 3, line 7 multiplied by applicable factor)			
6	Medicare inpatient hospital operating costs for TEFRA target amount computation (Sum of lines 1 through 5)			
7	Medicare discharges (From Part VII, corresponding column, line 13)			
8	Base year cost per discharge (Line 6 divided by line 7)			
9	Applicable percentage increase plus 100%			
10	Average target amount per discharge for TEFRA (Line 8 multiplied by line 9)			

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM TO	WORKSHEET TAC

PART XII - ALLOCATION OF GENERAL SERVICE OPERATING COST

	COST CENTER (OMIT CENTS)	EMPLOYEE HEALTH & WELFARE	ADMINIS-TRATIVE & GENERAL	LAUNDRY & LINEN	CAFETERIA	MAINTEN-ANCE OF PERSONNEL	NURSING ADMINIS-TRATION	TOTALS COLS 1-6	
		1	2	3	4	5	6	7	
1	Cost to be allocated (From Form HCFA-2552-81,Wkst B-1, line 79)								1
2	Capital - Related Cost (From Form HCFA-1007, Part I)								2
3	Operating Cost to be allocated (Line 1 minus line 2)								3
4	Total allocation Basis (From Form HCFA-1007, Part I, line 82)								4
5	Unit Cost Multiplier (Line 3 divided by line 4)								5
6	Allocation Statistics								6
6-22	Operating Room								6-22
6-23	Recovery Room								6-23
6-24	Anesthesiology								6-24
7	Case Allocation								7
7-22	Operating Room (Line 5 X Line 6-22)								7-22
7-23	Recovery Room (Line 5 X Line 6-23)								7-23
7-24	Delivery Room and Labor Room (Line 5 X Line 6-24)								7-24
7-25	Anesthesiology								7-25
7-43	Other (Line 5 X line 6-43)								7-43

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD	WORKSHEET
			FROM TO	TAC

PART XIII - COMPUTATION OF MEDICARE NONPHYSICIAN ANESTHETIST ADJUSTMENT

		TOTAL SUM OF COLS 2-6	OPERATING ROOM	RECOVERY ROOM	DELIVERY ROOM AND LABOR ROOM	ANESTHES-IOLOGY	OTHER	
		1	2	3	4	5	6	
1	Nonphysician Anesthetist Cost	////////////////////////						1
2	Direct Cost (From Form HCFA-2552-81, Wkst B, col 1)	////////////////////////						2
3	Ratio (Line 1 divided by line 2)	////////////////////////						3
4	Allocated General Operating Cost (From Wkst TAC, Part XII, col 7, as applicable)	//////////////////////// ////////////////////						4
5	Nonphysician Anesthetist Overhead (Line 3 x line 4)	////////////////////////						5
6	Nonphysician Anesthetist Cost (Line 1 + line 5)	////////////////////////						6
7	FICA Tax Adjustment (Line 1 multiplied by FICA Tax Adjustment Factor (From Part II, line 5)	//////////////////////// ////////////////////						7
8	Adjusted Cost (Line 6 + line 7)	////////////////////////						8
9	Total Charges (From Wkst TAC, Part VI, line 10)	////////////////////////						9
10	Ratio of Cost to Charges (Line 8 divided by line 9)	////////////////////////						10
11	Medicare Charges for Inpatient Hospital Ancillary Services (From Wkst TAC, Part VI, line 12)							11
12	**HOSPITAL** Medicare Cost for Inpatient Hospital Ancillary Services (line 10 x line 11) (Enter sum of amounts in cols 2-6 in col 1) (Transfer amount in col 1 to Part XIV, col 1, line 2)							12
13	Medicare Charges for Inpatient Subprovider I **Ancillary Services (From Wkst TAC, Part VI, line 14)**							13
14	**SUBPROVIDER I** Medicare Cost for Inpatient Subprovider I Ancillary Services (Line 10 x line 13) (Enter sum of amounts in cols 2-6 in col 1) (Transfer amount in col 1 to Part XIV, col 2, line 2)							14
15	Medicare Charges for Inpatient Subprovider II **Ancillary Services (From Wkst TAC, Part VI, line 16)**							15
16	**SUBPROVIDER II** Medicare Cost for Inpatient Subprovider II Ancillary Services (Line 10 x line 15) (Enter sum of amounts in cols 2-6 in col 1) (Transfer amount in col 1 to Part XIV, col 3, line 2)							16

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO.	PROVIDER NO.	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART XIV - COMPUTATION OF TARGET AMOUNT PER DISCHARGE FOR PROSPECTIVE PAYMENT SYSTEM

		HOSPITAL	SUBPROVIDER I	SUBPROVIDER II	
		1	2	3	
1	Medicare inpatient hospital operating costs for target amount computation (From Worksheet TAC, Part VII, columns 1, 2 and 3, line 12)				1
2	Less Medicare Nonphysician Anesthetist adjustment (From Worksheet TAC, Part XIII, column 1, lines 12, 14, or 16)				2
3	Subtotal (Line 1 minus line 2)				3
4	Medicare discharges (From Worksheet TAC, Part VII, columns 1, 2 and 3, line 13)				4
5	Base period cost per discharge (Line 3 divided by line 4)				5
6	Case-mix index (From Worksheet TAC, Part VII, columns 1, 2 and 3, line 15)				6
7	Case-mix adjusted base year cost (Line 5 divided by line 6)				7
8	Applicable percentage increase plus 100% (Enter same amount in each column)				8
9	Average target amount per discharge for prospective payment (Line 7 multiplied by line 8)				9

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EXHIBIT C (Continued)

TARGET AMOUNT COMPUTATION	INTERMEDIARY NO. _____	PROVIDER NO. _____	PERIOD FROM _____ TO _____	WORKSHEET TAC

PART XV - COMPUTATION OF TARGET AMOUNT PER DISCHARGE FOR TEFRA – SECOND YEAR

		HOSPITAL	SUBPROVIDER I	SUBPROVIDER II	
		1	2	3	
1	Base year cost per discharge for PPS (From Part VII, line 14, col. 1, 2 or 3, as appropriate)				1
2	Applicable percentage increase plus 100%				2
3	Average target amount per discharge for TEFRA - second year (Line 1 multiplied by line 2)				3

FORM HCFA-1007

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2805. COST APPORTIONMENT FOR HOSPITALS UNDER PROSPECTIVE PAYMENT SYSTEM (PPS)

Prior to PPS, all providers were required to use cost apportionment data (e.g., charges and days) for the actual services rendered during the cost reporting period. For Medicare inpatients, cut-off bills at the end of the cost reporting period were required to arrive at the Medicare days and charges for actual services rendered. That is, days and charges for patients remaining in the provider at the end of the cost reporting period were accrued through the last day of the period.

In hospitals subject to PPS, payment for Medicare inpatients is based on discharges. Therefore, beginning with the end of each hospital's first cost reporting year under PPS, cut-off bills are no longer required. Since only bills for discharged patients are required, the cost apportionment data available based on individual bills for Medicare inpatients includes only services rendered to patients discharged during the cost reporting period. Therefore, hospitals under PPS use utilization statistics for services (i.e., days and charges) related to discharges occurring during the cost reporting period as the Medicare apportionment statistics. During the initial year that discharge statistics are used, apportionment data includes all data for discharges occurring during the year, including those for any portions of stays occurring during the prior year, even though those data also were used to apportion costs during the prior year. Cost apportionment data for all other services rendered to Medicare patients (i.e., other than Medicare inpatient services subject to PPS) continue to include the actual volume of services rendered during the cost reporting period.

In order to provide for an orderly transition in data accumulation methods, for cost reporting periods which ended prior to January l, 1985, hospitals under PPS may still use accrued charges and patient days applicable to actual services rendered during the period for the apportionment process. Since the use of such accrued data is not related to cut-off bills, hospitals using this method must maintain auditable data.

The change described above does not affect Medicare policy for the accumulation of costs subject to apportionment in any provider, including PPS hospitals.

2806. CAPITAL-RELATED COSTS - GENERAL

Effective for cost reporting periods beginning on or after October 1, 1991, capital-related costs for inpatient hospital services are paid on a prospective basis. Effective for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1991, capital-related costs are excluded from the prospective payment system for operating costs and are paid on a retrospective reasonable cost basis. (See §§2801, 2802, and §2807.) This section defines capital-related costs for purposes of the pre-October 1991 exclusion.

NOTE: For cost reporting periods beginning on or after October 1, 1983, and before October 1, 1986, the capital-related costs for each hospital must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's prospective payment rate. (See §2802B1.)

2806.1 Costs Included In Capital-Related Costs.--This section sets forth the costs that may be included in capital-related costs.

A. Net depreciation expense as determined under §§100-104.22, 108-122 and 134-134.12, adjusted by gains and losses realized from the disposition or involuntary conversion of assets as determined under §§130-133.5 and by recovery of accelerated depreciation as determined under §136ff, are included in capital-related costs. If the adjustments for gains and losses and recovery of accelerated depreciation result in a negative amount (i.e., a net negative adjustment exceeds the allowable depreciation expense in the cost reporting year), the negative amount must be used to reduce all other allowable cost reimbursement due the provider. If a negative amount remains after reducing all allowable cost reimbursement to zero, the negative amount must be applied against any amounts otherwise due in determining the final year-end settlement. Finally, if after absorbing all cost reimbursement due the provider and all unpaid prospective payments due the provider, an un-recovered balance remains, that balance is declared an overpayment and is treated in accordance with the provisions of §2409ff. This subsection sets forth the ordering of adjustments for gains and losses realized from the disposition or involuntary conversion of assets and recovery of accelerated depreciation and is not intended to change the manner in which these adjustments are reported in the provider's cost report.

EXAMPLE 1: Provider A incurs the following capital-related costs during the fiscal year ended September 30, 1984: Depreciation - $600,000, Interest Expense - $470,000, Insurance Expense - $40,000, Return on Equity Capital - $10,000 (Medicare's portion) and Property Tax Expense - $1,250. During the fiscal year, the provider sold assets and the sales resulted in a net gain of $370,000 (Medicare's share as calculated in accordance with §132.4). Assuming 50% Medicare utilization, Provider A's capital-related costs would be calculated as follows:

Depreciation	$300,000
Interest expense	235,000
Insurance expense	20,000
Return on equity capital	10,000
Property tax expense	625
Total capital-related costs	$565,625
Less gain on sale	-370,000
Net capital-related costs	$195,625

EXAMPLE 2: Assume the same facts as in example 1 except that the provider terminated from the Medicare program effective September 30, 1984, and, as a result of the sale, experienced a gain of $730,000 (Medicare's share as calculated in accordance with §132.4). Provider A's capital-related costs would be calculated as follows:

Depreciation	$300,000
Interest expense	235,000
Insurance expense	20,000
Return on equity capital	10,000
Property tax expense	625
Total capital-related costs	$565,625
Less recovery of gain	730,000
Net capital-related costs	($164,375)

The amount of $164,375 is considered an overpayment subject to recovery by the program in accordance with §2409ff.

B. Taxes on land or depreciable assets used for patient care are includable in capital-related costs.

C. Lease and rental payments, including license and royalty fees, for the use of assets that would be depreciable if you owned them outright or for the use of land, are includable in capital-related costs. The distinction between an operating lease and a capital lease as those terms are defined for purposes of generally accepted accounting principles is not relevant to the inclusion of lease costs in capital-related costs. The fact that the lease or rental is for a depreciable asset is sufficient for consideration as a capital-related item. However, the lease or rental must convey to you the use, possession, and enjoyment of the asset.

A distinction must be made between the lease of equipment and the purchase of services. A lease of equipment is considered a capital-related cost while a purchase of service is considered an operating cost. Generally, for the agreement to be considered a lease or rental (and therefore a capital-related cost), the agreement must convey to the provider the possession, use, and enjoyment of the asset. There is a wide variety in such agreements and each such agreement must be examined on its own merits. Factors that would weigh in favor of treating a particular agreement as a lease of equipment include the following:

- The equipment is operated by personnel employed by the provider or an organization related to the provider under the meaning of Chapter 10;

- The physicians who perform the services with or interpret the tests from the equipment are associated with the provider;

- The agreement is memorialized in one document rather than in two or more documents (for example, one titled a "Lease Agreement" and one titled a "Service Agreement");

- The document memorializing the agreement is titled a "Lease Agreement". If one or more of the documents memorializing the agreement are titled "Service Agreements", this would indicate a purchase of services;

- The provider holds the certificate of need (CON) for the services being furnished with the equipment;

- The basis for determining the lease payment is units of time and is not volume sensitive (for example, number of scans);

- The provider attends to such matters as utilization review, quality assurance, and risk management with respect to the services involving the equipment;

- The provider schedules the patients for services involving the equipment;

- The provider furnishes any supplies required to be used with the equipment; and

- The provider's access to the equipment is not subject to interruption without notice or on very short notice.

The foregoing list represents guidelines, rather than an absolute checklist of factors evidencing a lease agreement. The fiscal intermediary may consider other factors beyond those in the list. Because no single factor is necessarily determinative of the nature of a given agreement (capital-related or operating cost), the intermediary will examine all aspects of an agreement in determining whether the arrangement constitutes a lease of equipment or a purchase of service and thus be classified as a capital-related cost or an operating cost.

1. Transactions considered sale and leaseback agreements are includable in capital-related costs. However, the amount to be included must be determined following the instructions set forth in §110A.

2. Transactions considered lease purchase agreements based on the criteria set forth in §110B are includable in capital-related costs. However, the amount to be included must be determined following the instructions in that same section.

3. Costs incurred for the repair or maintenance of equipment or facilities are specifically excluded (See 42 CFR 413.130(b)(7)) from the definition of capital-related costs. Amounts included in rentals or lease payments for repair or maintenance are therefore excluded from capital-related cost. Intermediaries must review agreements carefully to determine if such costs are included in any rental and lease agreement. If no amount is identified in the lease or rental agreement for maintenance, you are not required to carve out a portion of the lease payment to represent the maintenance portion. Where no amount is identified, the entire lease payment may be considered a capital-related cost subject to the provisions above.

D. The costs of betterments and improvements as those terms are defined in §108.2 are includable in capital-related costs. However, the amount to be included must be determined following the instructions in that same section.

E. The costs of minor equipment are includable in capital-related costs so long as the costs of the minor equipment are treated by the provider in a manner consistent with §§106(b) or (c).

F. The costs of insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business interruption are includable in capital-related costs. If an insurance policy also provides protection for other than the replacement of depreciable assets or to pay capital-related costs in the case of business interruption, only that portion of the premium(s) related to the replacement of depreciable assets or to pay capital-related costs in the case of business interruption is includable in capital-related costs.

G. Net interest expense as determined under Chapter 2 is includable in capital-related costs, if such expense is incurred in acquiring land and/or depreciable assets (either through purchase or lease) used for patient care or refinancing existing debt, if the original purpose of the refinanced debt was to acquire land and/or depreciable assets used for patient care. Since only the capital-related part of interest expense will be recognized as a capital-related cost, only a proportionate share of investment income should be offset

(if investment income offset is required under §202.2 and/or §226.4B). This proportionate share is obtained by applying a ratio of capital-related interest expense to total interest expense to the total investment income. However, investment income generated from an advance refunding, as described in §233.3D, is not subject to apportionment between capital-related interest expense and operating interest expense.

EXAMPLE 1: During the fiscal year ending September 30, 1984, Provider B incurs interest expense of $40,000 on a loan to purchase patient-care-related equipment and $10,000 on a loan to generate additional working capital. During the same fiscal year, the provider held investments purchased with income from prior operations which generated interest income of $4,500. Based on §202.2, the investment income must be used to reduce the interest expense. However, because only part of the interest expense is capital-related ($40,000), a proration must be made to ascertain that portion of the investment income to be used to reduce capital-related interest expense as follows:

$$\frac{\text{Capital-related interest expense}}{\text{Total interest expense}} = \frac{\$40{,}000}{\$50{,}000} = \frac{4}{5} \times \$4{,}500 = \$3{,}600$$

Total capital-related interest expense of $40,000 is reduced by a proportionate share of investment income of $3,600 to determine the net interest expense to be included in capital-related costs ($36,400).

EXAMPLE 2: During the fiscal year, the hospital had interest expense as follows:

Allowable capital-related interest expense	$150,000
Allowable noncapital-related interest expense	50,000
Non-allowable interest expense (related to a borrowing for non-patient care activities)	100,000
	$300,000

The hospital also had investment income as follows:

Interest income on funded depreciation account	$1,000,000
Interest income on hospital operating funds	250,000
	$1,250,000

To determine the offset:

Investment income from the funded depreciation account is not offset against interest expense (See §202.1.) The total investment income available for offset is $250,000.

The interest expense subject to offset by the investment income is $200,000 ($150,000 in allowable capital related interest and $50,000 in non-capital related interest).

The total capital-related interest expense of $150,000 is reduced by a proportionate share of the investment income determined as follows:

Capital-related interest $150,000 = 3 x $250,000 = $187,500
Total allowable interest $200,000 4

The balance of the investment income ($62,500) is offset against the non-capital interest expense of $50,000.

The investment income in excess of the interest expense ($37,500 in capital related and $12,500 in non-capital related) is not used to offset other expenses.

H. For proprietary providers, a return on equity capital as determined under Chapter 12 is includable in capital-related costs.

I. Capital-Related Costs of Related Organizations.--The capital-related costs of related organizations (as described in Chapter 10) may be included in the provider's capital-related costs. (See §1005 and §2806.3A.)

J. Debt Issuance Costs, Debt Discounts, and Debt Redemption Costs.--If the associated debt was incurred to acquire land or depreciable assets used for patient care or to refinance existing debt for which the original purpose was to acquire land or depreciable assets used for patient care, debt issuance costs, debt discounts, and debt redemption costs are includable in capital-related costs.

2806.2 Costs Excluded From Capital-Related Costs.--This section sets forth some of the costs that are excluded from capital-related costs. To the extent that these costs are allowable, they may be included in determining each provider's operating costs. Exclusions from capital-related costs include:

a. Costs incurred for the repair or maintenance of equipment or facilities;

b. Amounts included in rentals or lease payments for repair or maintenance agreements;

c. Interest expense incurred to borrow working capital (for operating expenses);

d. General liability insurance or any other form of insurance to provide protection other than for the replacement of depreciable assets or to pay capital-related costs in the case of business interruption;

e. Taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care (taxes not related to patient care, such as income taxes, are not allowable and are, therefore, not included among either capital-related or operating costs);

f. The costs of minor equipment that are charged off to expense as in §106(a);

g. Cleaning services, guard services, and utilities;

h. Abandoned planning costs. (See §2154.1.) Allowable abandoned planning costs are administrative and general costs and are included in allowable costs either in the year of abandonment or amortized over a 3-year period; and

i. Maintenance agreements. Costs incurred for maintenance and repair insurance agreements (commonly referred to as maintenance agreements) are excluded from capital-related costs even where those agreements provide for the replacement of assets in certain circumstances.

2806.3 Costs of Supplying Organizations.--

A. Supplying Organization Related to the Provider.--If the supplying organization is related to the provider within the meaning of Chapter 10, except as provided in the following paragraph, the provider's capital-related costs may include the capital-related costs of the supplier. Where organizations other than the provider are also serviced by the supplier, a reasonable allocation of the supplier's capital-related costs must be made among all organizations serviced.

EXAMPLE 1: Hospital C sends its laundry and linens out to be cleaned by a related laundry service, XYZ Laundry, Inc. The laundry service also cleans laundry for two other hospitals, a nursing home and three motels. Assume that the cost of the laundry service is less than the open market price and the exception in §1010 does not apply. The laundry and linens are processed in an identical fashion for all customers of XYZ Laundry, Inc. Hospital C may include in its capital-related costs an appropriate share of the capital-related costs of XYZ Laundry, Inc. Included in the laundry service's capital-related costs would be only costs that would be capital-related costs if Hospital C incurred the costs directly. Excluded from Hospital C's capital-related costs would be that portion of the laundry service's capital-related costs attributable to the other six customers (e.g., such apportionment could be made on the basis of relative pounds of laundry processed).

If the costs of the services, facilities or supplies being furnished exceed the open market price, or if the exception in §1010 applies, the costs will be treated as provided in subsection B. The exception in §1010 is not an option. If all the criteria in §1010 are met, the exception must be applied.

EXAMPLE 2: Assume the same facts as in the example in the preceding paragraph, except that the exception in §1010 applies to the transactions between Hospital C and XYZ Laundry, Inc. (or, alternatively, the costs of providing the laundry services exceed the open market price for such services). In that case, no part of XYZ Laundry's capital-related costs would be included in Hospital C's capital-related costs.

B. Supplying Organization Not Related to the Provider.--If the supplying organization is not related to the provider within the meaning of Chapter 10, no part of the charge to the provider may be considered a capital-related cost, unless the services, facilities or supplies are capital-related in nature (e.g., a provider purchases depreciable equipment from an unrelated supplier). However, where a provider leases or rents facilities or equipment that would be depreciable if the provider owned them outright, in conjunction with obtaining a service (see Example 1 below) from an unrelated supplier, the capital-related portion of the supplier's charge may be included in the provider's capital-related costs only if (1) the capital-related facilities or equipment are leased or rented by the provider (that is, the provider has the possession, use and enjoyment of the facilities or equipment), (2) the capital-related equipment is located on the provider's premises, and (3) the capital-related portion of the charge is separately specified in the charge to the provider. All three of the foregoing criteria must be met for a provider to include the capital-related portion of the supplier's charge in the provider's capital-related costs.

EXAMPLE 1: In conjunction with furnishing telephone service to Hospital D, MNO Bell leases the telephones and switchboard equipment to the hospital. The telephones and switchboard equipment are all located on the hospital's premises. The monthly bill that MNO Bell sends to the hospital includes two line items, one line specifying an amount for telephone service and the other line specifying a reasonable amount for rental of the equipment. Because all three criteria above are met, Hospital D may include in its capital-related costs the amount specified for rental of the telephone equipment, even though Hospital D and MNO Bell are unrelated organizations.

EXAMPLE 2: Acme Cleaning Company, an unrelated supplier, provides housekeeping services for Hospital E. In conjunction with the provision of these services, Acme keeps certain depreciable equipment (vacuum cleaners, electric buffers, etc.) permanently located on the hospital's premises for the use of the contract housekeeping staff. The bill sent by Acme Cleaning specifies two reasonable amounts to be paid by the hospital, one for housekeeping services and the other for equipment rental. Hospital E may not include in its capital-related costs the billing amount designated as equipment rental because the first criterion above is not met. This situation does not describe a true lease or rental because the hospital does not have the possession, use and enjoyment of the assets. The equipment is placed on the hospital's premises for the use of the contract housekeeping staff in fulfilling its responsibilities under the contract.

2806.4 Costs of Certain Provider-Based Physicians.--If the provider has a relationship with a physician or other entity (e.g., professional corporation, partnership) and the relationship exists as contemplated by 42 CFR 405.550(e), the capital-related portion of the costs reimbursable to the provider on a reasonable cost basis as described in 42 CFR 405.550(e)(2), which includes the costs assumed by the physician or other entity, may be included in the provider's capital-related costs. This provision applies only in situations

where the physician or other 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 in which the physician furnishes physician services in the provider. (See §2182.4D.)

2806.5 Jointly Owned Equipment.--If the equipment is jointly owned, all of the provider-owners that use the equipment may share in the capital-related costs associated with that equipment. The apportionment of the capital-related costs of jointly owned assets among the owners must be on a basis that reflects the relative use by each owner, rather than the ownership share or the amount of time the asset is located at each owner's site.

2807. PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL CAPITAL-RELATED COSTS

Effective with hospital cost reporting periods beginning on or after October 1, 1991, payment for hospital inpatient capital-related costs is made under a prospective payment system for all hospitals paid under the prospective payment system for operating costs. The final rule establishing the capital prospective payment system (capital-PPS) was published in the Federal Register on August 30, 1991 (see 56 FR 43358-43524). The rule provides for a 10-year transition from reasonable cost based reimbursement to payment based solely on a Federal rate.

This section describes the Federal rate and capital-PPS transition policies and provides further clarification of the applicable rules contained in 42 CFR 412.300ff. Changes to the capital-PPS Federal rate and other payment factors will be published annually in the Federal Register around September 1.

Hospitals and hospital units that are excluded from the prospective payment system and rural primary care hospitals (see §1820(i)(2) of the Act) continue to be paid on a reasonable cost basis for capital-related inpatient costs.

2807.1 Capital Prospective Payment System Transition Period.--The capital-PPS transition period starts with a hospital's cost reporting period beginning in Federal fiscal year (FY) 1992 (October 1, 1991, through September 30, 1992). The transition extends for a 10-year period ending with a hospital's last cost reporting period beginning before October 1, 2001, except for new hospitals that enter the program after the transition starts. (See §2807.7.)

If a hospital has a cost reporting period ending after September 30, 1991, capital-related costs for the period from October 1, 1991, to the beginning of its FY 1992 cost reporting period are paid for on a reasonable cost basis as described in §2806, subject to a 10 percent reduction for the period from October 1, 1991, to the beginning of its FY 1992 cost reporting period.

To provide an orderly 10-year transition, a hospital with a 52-53 week cost reporting period is deemed to have the same cost reporting period beginning date for capital-PPS purposes throughout the transition period. Thus, if a hospital's FY 1992 cost reporting period begins September 28, 1992, the hospital is deemed to have a September 28 cost reporting period beginning date throughout the 10-year transition. This policy applies only for purposes of the capital-PPS transition. For all other purposes, the hospital's actual fiscal year is used.

During the capital-PPS transition period, a hospital is paid for the capital-related costs of inpatient hospital services based on an increasing proportion of the capital-PPS Federal rate and a decreasing proportion of its historical costs for capital-related items and services. Payment is made under one of two alternative methods:

- The fully prospective methodology (see §2807.5A), or
- The hold harmless methodology. (See §2807.5B.)

When a hospital comes under the capital-PPS, the payment methodology applicable to the particular hospital is determined by comparing its hospital-specific rate, which is derived from the hospital's inpatient capital-related costs per discharge in a specified base year, to the applicable Federal rate (after adjustment for appropriate payment variables). If the hospital-specific rate is above the adjusted Federal rate, as described in §2807.4D, the hospital is paid under the hold harmless methodology. If the hospital-specific rate is below the adjusted Federal rate, as described in §2807.4D, the hospital is paid under the fully prospective methodology. Except in limited situations involving hospitals paid under the fully prospective payment methodology, the same payment methodology is applicable throughout the transition. (See §2807.4E.)

In addition to the basic payments a hospital receives under the hold harmless or fully prospective payment methodology, additional payments may be made for outlier cases that are extraordinarily costly or involve an atypically long stay. (See §2807.2C.) Also, a hospital may qualify for an exceptions payment if its total capital-PPS payments are below a specified level of the total Medicare inpatient capital-related costs, or if unexpected extraordinary circumstances occur. (See §2807.5C.)

2807.2 Federal Rate.--

A. Standard Federal Rate.--The Federal rate is payable on a per discharge basis. During the transition period, the percentage of the Federal rate that is payable for a discharge is dependent on the hospital's payment methodology. Effective with the hospital's cost reporting period beginning in FY 2002, payment is based on 100 percent of the Federal rate.

A single national standard Federal rate is applicable to hospitals located in the 50 States and the District of Columbia. Hospitals located in Puerto Rico are paid a blended rate based on 25 percent of the national Federal rate and 75 percent of a Puerto Rico Federal rate. For discharges occurring in FY 1992, the national standard Federal rate is $415.59, and the Puerto Rico standard Federal rate (before blending) is $319.68.

For discharges occurring in FY 1993, the national standard Federal rate is $417.29, and the Puerto Rico standard Federal rate (before blending) is $320.99.

Updated Federal rates are effective each October 1 and are published in the Federal Register as part of the final rule implementing PPS payment rates and policies that is published around September 1 of each year.

B. Payment Adjustments.--The standard Federal rate is adjusted for the diagnosis-related group (DRG) to which the discharge is assigned and the hospital's geographic location. For qualifying hospitals, additional adjustments are made for indirect teaching costs and for serving a low income patient population. The result is termed the adjusted Federal rate.

1. DRG Weight.--The standard Federal rate is multiplied by the relative weight applicable to the DRG to which the discharge is assigned. The same DRG classification system and relative weights are used under the PPS for operating costs and the capital-PPS. (See §2405.) Classification changes and revised relative weights are published in the Federal Register around September 1 of each year.

2. Geographic Adjustment Factor.--The standard Federal rate is multiplied by a geographic adjustment factor that is based on the wage index applicable to the hospital under the PPS for operating costs. If a hospital has been reclassified by the Medicare Geographic Classification Review Board for hospital wage index purposes, the geographic adjustment factor is based on the wage index that is applicable to the hospital after reclassification. If a multi-campus hospital has campuses in two wage areas, the hospital wage index that is applicable to each campus determines the geographic adjustment factor that is applicable to Federal rate payments to that campus. However, the geographic adjustment factor is applied separately by the fiscal intermediary in such cases rather than automatically through the PRICER program.

The geographic adjustment factor increases the hospital's payments based on the Federal rate by approximately 6.8 percent for every 10 percent increase in the hospital's wage index. The geographic adjustment factor is calculated by raising the hospital's wage index to the .6848 power and changes each time the hospital's wage index changes. Annual revisions in the geographic adjustment factors are published in the Federal Register around September 1 of each year.

3. Large Urban Add-on.--If a hospital is located in a large urban area, the standard Federal rate is increased by three percent; i.e., the standard Federal rate is multiplied by 1.03. Consistent with the PPS for operating costs, a large urban area is defined as a metropolitan statistical area (MSA) with a population of more than one million (or New England County metropolitan area (NECMA) with a population of more than 970,000). If a hospital is classified as a large urban hospital for purposes of the standardized amount under the PPS for operating costs, the hospital is eligible for the large urban add-on. This includes a hospital that is reclassified to a large urban area for purposes of the standardized amount by the Medicare Geographic Classification Review Board. It does not include a hospital that is reclassified to a large urban area for wage index purposes only.

4. Cost of Living Adjustment (COLA) for Hospitals Located in Alaska and Hawaii.--For a hospital located in Alaska or Hawaii, the standard Federal rate is increased by a COLA factor derived from the COLA adjustment applicable to the hospital under the PPS for operating costs. The COLA adjustment under the capital-PPS is calculated as (.3152 x (1- the applicable operating COLA) + 1) and is applied to the standard Federal rate. The effect is to increase approximately 31.5 percent of the Federal rate by the COLA applicable under the PPS for operating costs.

The COLA factor under the capital-PPS changes each time the COLA under the PPS for operating costs changes. Changes in the COLA under PPS for operating costs are published in the Federal Register around September 1 of each year.

5. Disproportionate Share of Low Income Patients.--An urban hospital with at least 100 beds that serves low income patients, as determined under 42 CFR 412.106(b), or demonstrates that 30 percent or more of its inpatient care revenues are derived from State and local government payments for indigent patient care, under 42 CFR 412.106(c)(2), receives an adjustment in its Federal rate payments. The adjustment increases its Federal rate payments by approximately 2.025 percentage points for each 10 percent increase in the hospital's disproportionate share patient ratio.

Rural hospitals and urban hospitals with fewer than 100 beds do not qualify for the disproportionate share adjustment under capital-PPS.

For purposes of this provision, a hospital is considered an urban hospital if it is classified as an urban hospital under the PPS for operating costs for purposes of the standardized amount regardless of its classification for wage index purposes. This includes a rural hospital that is reclassified to a large or other urban area for purposes of the standardized amount by the Medicare Geographic Classification Review Board. It does not include a hospital that is reclassified to an urban area for wage index purposes only.

Bed size is based on the number of bed days in the portion of the hospital covered by the prospective payment system that are available during the cost reporting period (not including beds assigned to newborns, custodial care and excluded distinct part units), divided by the number of hospital days in the cost reporting period. This determination is consistent with the bed size determination for the disproportionate share adjustment under the PPS for operating costs.

The disproportionate share patient percentage is the same as the disproportionate share patient percentage under the PPS for operating costs. It is based on the percentage of the hospital's total inpatient days that are attributable to Medicare patients receiving Supplemental Security Income (SSI) and to covered Medicaid days.

There is no minimum disproportionate share patient percentage that must be met before an urban hospital with at least 100 beds qualifies for a disproportionate share adjustment. The formula for calculating the adjustment is:

$$(e^{(.2025 \times DSH\%)}) - 1$$

where e equals the natural antilog of 1, or 2.7183, and DSH% equals the hospital's disproportionate share patient percentage.

An urban hospital with at least 100 beds that derives at least 30 percent of its total inpatient revenues from State or local government sources for the care of indigent patients who are not covered by Medicare or Medicaid receives a disproportionate share adjustment under capital-PPS equal to 14.16 percent.

The disproportionate share adjustment increases the hospital's DRG payments based on the Federal rate (basic and outlier payments but not payments for indirect medical education). The intermediary makes an interim adjustment on a per discharge basis based on its best estimate of the hospital's bed size and disproportionate share patient percentage for the cost reporting period. At final settlement of the cost report, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period.

6. Indirect Medical Education Adjustment.--A teaching hospital receives an adjustment in its Federal rate payments based on the ratio of its average number of residents to its average daily census (resident-to-day ratio). (The resident-to-day ratio is applicable to capital PPS but not to operating PPS indirect medical education adjustments.) The adjustment increases the hospital's payments based on the Federal rate by 2.822 percentage points for each 10 percent increase in the hospital's resident-to-day ratio.

In determining the hospital's resident-to-day ratio, the number of residents is determined consistent with the PPS for operating costs based on the average number of full time equivalent residents working in the portion of the hospital subject to the prospective payment system during the cost reporting period. Average daily census equals total acute inpatient days divided by the number of days in the cost reporting period.

The formula for calculating the indirect teaching adjustment is:

$$(e^{(.2822 \times \text{resident-to-day ratio})})-1$$

where e equals the natural antilog of 1, or 2.7183.

The indirect teaching adjustment increases the hospital's DRG payments based on the Federal rate (basic and outlier payments but not disproportionate share payments). The intermediary makes an interim adjustment on a per discharge basis based on its best estimate of the hospital's resident-to-day ratio. At final settlement of the cost report, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period.

C. Outlier Payments.--If a discharge is extraordinarily costly (a cost outlier) or has an atypically long stay (a day outlier), the hospital receives an additional payment for the discharge. During the transition period, the additional payment is calculated as if the hospital were receiving payment based on 100 percent of the adjusted Federal rate, and is then multiplied by the actual percentage of the adjusted Federal rate received by the hospital during the cost reporting period based on its transition payment methodology.

A single set of thresholds is used to identify outlier cases under both the operating and capital prospective payment systems. An outlier payment is made for a cost outlier only if the hospital's combined capital-related and operating costs for the discharge exceed the cost outlier threshold. The marginal cost factors used to determine the outlier payment are the same as those used in the PPS for operating costs. (See §2405.5.)

The outlier thresholds are updated effective each October 1 and are published in the Federal Register as part of the annual final rule implementing PPS payment rates and policies that is published around September 1 of each year.

2807.3 Distinguishing Between Old And New Capital Costs During Transition Period.--Under the capital-PPS, assets that were put in use to provide patient care on or before December 31, 1990, are defined as old capital and the capital-related costs associated with these assets are generally treated separately from the capital-related costs associated with assets put in use for patient care after December 31, 1990 (i.e., new capital costs). Certain capital-related costs that were obligated as of December 31, 1990, for assets that are put in use for patient care after December 31, 1990, may be recognized as old capital costs. It is necessary to distinguish between old and new capital in order to determine the applicable payment methodology (see §2807.4) and the hold harmless payment (see §2807.5B) and to redetermine the hospital-specific rate. (See §2807.4E.)

A. New Capital Costs.--New capital costs are:

- Allowable capital-related costs associated with assets first put in use for patient care after December 31, 1990, unless the costs were obligated as of December 31, 1990, and meet the conditions for recognition as old capital costs as described in subsection C;

- Allowable capital-related costs associated with assets in use for patient care as of December 31, 1990, that exceed the limitations for recognition as old capital costs described in subsection B; and

- Allowable capital-related costs obligated after December 31, 1990, for the betterment or improvement of an existing asset regardless of when the asset was initially put in use for patient care.

EXAMPLE: In FY 1994, Hospital A replaces the roof on its 20-year old building. The allowable costs for replacing the roof are recognized as new capital costs even though the building was in use as of December 31, 1990.

B. Old Capital Costs.--Old capital costs are allowable capital-related costs for land and depreciable assets put in use for patient care on or before December 31, 1990. Old capital costs are subject to the limitations described below.

1. Depreciation.--Allowable depreciation costs incurred during the cost reporting period for old capital assets, based on the applicable useful life guidelines, are recognized as old capital costs.

a. Asset Disposal.--A gain or loss to correct depreciation expense claimed upon disposal of an old capital asset (including an asset recognized as an old capital asset under the provisions in subsection C for obligated capital) qualifies as old capital costs. As described in §2807.8, the portion of the gain or loss that may be recognized as old capital costs in the year of disposal is based on the portion of the gain or loss that applies to that cost reporting period. If the allowable net loss (See §132) on an old capital asset is amortized over future cost reporting periods, the amortized costs are recognized as old capital costs in the cost reporting periods in which they are an allowable cost. (See §2807.8B).

b. Change of Ownership, Merger, Consolidation or Lease of Hospital.--If there is a change of ownership, allowable capital-related costs incurred by the new owner that would have been recognized as old capital costs in the absence of a change of ownership continue to be recognized as old capital costs under the new ownership. (See §§2807.8C and 2807.9.) In cases of merger, consolidation or leasing of the entire hospital operation, old capital retains its status within certain limits established by the original determination of old capital in the base period. (See §2807.9.)

2. Interest Costs.--The allowable capital-related interest expense the hospital was legally obligated to pay as of December 31, 1990, is recognized as old capital costs, subject to the provisions described below.

a. Variable Rate Debt.--Increased interest expense is recognized as old capital cost if the increase is due to fluctuating interest rates under a variable interest rate loan.

b. Loan Conversion.--Increased interest expense is recognized as old capital cost if the increase occurs at the time of conversion from a variable to a fixed rate loan, provided no other loan terms are changed. If there are changes in the loan terms, the interest expense that is recognized each year as old capital may not exceed the interest expense that may be recognized under the guidelines for other types of refinancing as provided in subsections 2c, 2d and 2e.

EXAMPLE: Hospital B converts from a variable rate loan to an 8 percent fixed rate loan and, at the same time, extends the remaining repayment period from 11 years to 25 years. The amount of allowable annual interest expense that is recognized as old capital cannot exceed the amount that would be recognized by applying the rules in subsection 2d.

c. Rolled-Over Debt.--A portion of allowable interest on a short term debt instrument that is used to finance assets of longer depreciable life and is rolled over may be recognized as old capital cost provided the asset remains in use. For this purpose, a loan qualifies as a short term debt instrument if the loan repayment schedule is for no more than 5 years or half the remaining useful life of the assets at the time of the financing, whichever is less. The portion of allowable interest expense that is recognized as old capital is equal to the ratio of the net book value at the beginning of the applicable cost reporting period for depreciable assets that were in patient care use in the base year, to the net book value as of the beginning of base year for those assets. In determining the ratio, the net book value equals the historical cost of the depreciable assets that were financed with the short term debt instrument less accumulated depreciation as determined for Medicare purposes. If the specific assets that were financed with the rolled-over debt cannot be identified, all depreciable assets, exclusive of those that were financed by other identifiable debt instruments, are included in the ratio. The base year net book value remains constant throughout the transition and is not adjusted for assets that have been fully depreciated, retired or otherwise disposed of subsequent to the base year. In contrast, the current year net book value reflects the net book value of only those assets which remain in use as of the beginning of the applicable cost reporting period.

To determine whether the financing qualifies as short term debt when more than one asset is involved, the average useful life of the assets financed by the debt is computed by weighting the useful life of each asset by its net book value at the time of financing. If the debt obligated as of December 31, 1990 (before roll-over) cannot be associated with specific assets, the average useful life is computed as of the base year by weighting the remaining useful life of each asset by its net book value. The remaining useful life is recomputed each time the debt is rolled over.

EXAMPLE: Hospital Q, a new hospital in 1970, financed its original buildings and equipment with a $50 million mortgage but subsequently financed asset acquisitions amounting to $20 million through short term financing that has been rolled over several times so that, except for the original mortgage, specific debt cannot be associated with specific assets. The net book value of the subsequent acquisitions at the beginning of the hospital's base year is $15 million with an average useful life of 12 years. In 1994, the hospital rolls over a 5-year note that had been issued in 1989. The actual interest expense on the 1989 note is recognized as old capital cost since the interest payments were obligated as of December 31, 1990. Since the payment term for the 1989 note is for less than half the average useful life of the subsequent acquisitions as of the base period, a portion of the interest expense on the rolled-over debt issued in 1994 is recognized as old capital cost. The value of the assets financed by the original mortgage is not included in determining the proportion of interest expense on the 1994 debt that is old capital costs. To determine the portion that is recognized as old capital cost in FY 1994, the ratio of the net asset value of the subsequent acquisitions (that were in use during the base year) at the beginning of the hospital's FY 1994 cost reporting period to $15 million is applied to Hospital Q's FY 1994 interest expense on the 1994 note. In FY 1995, the ratio of the net asset value of the subsequent acquisitions at the beginning of the hospital's FY 1995 cost reporting period to $15 million is applied to Hospital Q's FY 1995 interest on the 1994 note.

d. Refinancing Debt.--If old capital indebtedness is refinanced or the terms of the debt instrument are otherwise revised (except as provided in subsections 2b, 2c, or 2e), the annual interest expense on the refinanced debt that is recognized as old capital cost cannot exceed the amount of interest expense for which the hospital was obligated to pay each year as of December 31, 1990. If the refinancing results in a lower annual interest payment but a longer repayment term, the limitation is applied on an aggregate basis based on the amount that would have been incurred during the transition.

If old capital and new capital indebtedness is commingled, the ratio of the amount of the loan principal related to old capital debt to the total loan principal amount is applied to the allowable interest expense to determine the portion that is recognized as old capital cost, subject to the general limitation on the amount recognized as old capital cost.

EXAMPLE: In FY 1993, Hospital X refinances old capital moveable equipment to remove restrictive covenants at the same time it finances a purchase of new operating room equipment. The breakdown of loan principal for each category is:

Old capital outstanding loan principal	$240,000
New capital loan principal	$ 60,000
Total loan principal	$ 300,000

The annual interest on the loan is at 10 percent with a resulting annual cost of $30,000.

Thus, the interest expense recognized as old capital cost is:

$$\frac{\$240,000}{\$300,000} \times \$30,000 = \$24,000$$

However, the terms of the old loan on the old capital stipulated a 9 percent interest rate over a 10-year period, for which 5 years have elapsed, with repayment of the loan principal at the end of the 10-year term. Under those terms for the old capital debt, only $21,600 ($240,000 x .09) in interest expense in each of the remaining 5 years would have been recognized under the terms of the old loan. Therefore, only that amount can be recognized over the term of the new loan as old capital cost, and the remainder is recognized as new capital cost.

e. Advance Refunding.--Medicare recognizes all reasonable costs associated with an advance refunding under cost reimbursement rules, including debt cancellation costs on the refunded debt and the debt issuance costs on the related debt issuance, if the refunding is found to be necessary, proper and prudent. (See §233ff.) If such an advance refunding is executed for capital-related debt that was in effect or obligated on or before December 31, 1990, the allowable costs associated with the advance refunding are recognized as old capital costs.

During the capital-PPS transition period, hospitals may use advance refunding to refinance old capital assets either separately or in combination with new capital assets. If the interest expense on the refunded debt is solely old capital cost, the reasonable costs associated with the advance refunding, as defined in §233.4, are considered old capital costs subject to the limitation that the old capital costs cannot exceed the costs that would have been recognized during the transition period if the refunding had not occurred. Thus, the total advance refunding costs to be amortized during the remaining transition years must be compared with the total costs of the original financing over that same period to determine the old capital cost. Any reasonable capital-related costs (e.g., not unnecessary borrowing or excess working capital) for the advance refunding that are in excess of this limitation can be recognized only as new capital costs. If the advance refunding involves only new capital costs, all reasonable capital-related costs are recognized as new capital ascribable to the applicable periods. If the advance refunding is attributable to both old capital and new capital, the reasonable costs are allocated between old and new capital costs according to the outstanding principal that is associated with each category.

EXAMPLE: Hospital X decides to call in a 1986 construction bond issuance using a new issuance in 1992 to take advantage of lower interest rates through advance refunding. No new acquisitions are being financed through this action. Due to the life of the advance refunding, which exceeds the capital transition period by several years, the costs for the debt refunding exceed that for the refunded debt by $90,000 over the transition period. The excess is amortized over the remaining 9 year transition period at $10,000 per year and is treated as new capital.

EXAMPLE: Use the same information for Hospital X as in the above example except that in addition to the 1986 $2 million loan, the refunding of debt includes a $200,000 loan for equipment added in 1991. Prior to the adjustment to limit recognition of old capital for the $90,000 excess interest expense determined above, the allowable and reasonable costs of the advance refunding are divided between old capital and new capital in accordance with subsection 2d on a ratio of 91 percent old capital to 9 percent new capital (i.e., $2,000,000/$2,200,000 and $200,000/$2,200,000, respectively.)

f. Investment Income Offset.--Old capital interest expense is reduced by investment income (excluding investment income earned from sources listed in §202.2, such as funded depreciation accounts) based on the ratio of total old capital interest expense to total allowable interest expense in each cost reporting period.

g. Curing of Unnecessary Borrowing.--If available funded depreciation was not used at the time borrowing occurred, the interest expense may be unallowable. If the unnecessary borrowing occurred on or before December 31, 1990, and is cured through spend-down of funded depreciation accounts as provided in 42 CFR 413.134(e)(3)(i)(C), the interest expense is an allowable capital-related cost and is considered an old capital cost effective with the cost reporting period during which the curing occurs.

3. Lease and Rental Costs.--Allowable lease and rental costs for land and depreciable assets that were in patient care use or obligated as of December 31, 1990, are recognized as old capital costs. Under certain conditions, costs may be recognized as old capital costs even if the lease in effect as of December 31, 1990, expires or there are other changes in the arrangements.

a. Renewals.--If an asset has been continuously leased on and after December 31, 1990, and the lease is renewed when it expires, the lease payments under the renewal are recognized as old capital costs up to the amount of annual lease payment obligated as of December 31, 1990, provided the following conditions are met:

- The identical asset remains in use;
- The asset has a useful life of three or more years; and
- Before renewal, the annual lease payment for the asset is at least $1000.

The annual lease payment must be determined for each asset. If assets of different value are covered by the same lease agreement and the agreement does not specify the payments attributable to each asset, the lease payment is apportioned among the assets based on an estimate of what the lease payment would be if each asset were leased separately. If more than one asset is covered by the lease agreement, only that portion of the lease payment attributable to assets that meet the specified conditions is recognized as old capital cost.

EXAMPLE: Hospital X leases space for its accounting and billing departments. The lease agreement covers 1989-1993 and provides for automatic annual renewal thereafter unless either party takes appropriate action to terminate the lease. When the lease was entered into in 1989, the agreement specified that the lease payment for 1989 is $20,000 and that it increases by $1,000 annually. Thus, the hospital was obligated as of December 31, 1990, for a $24,000 lease payment in 1993. In 1994 when the lease is automatically renewed, $23,000 of the lease payment is recognized as old capital cost and the remaining $1,000 of the lease payment is recognized as new capital cost. As long as the hospital continues to lease the space, up to $24,000 in annual lease payments is recognized as old capital.

EXAMPLE: Hospital Y has an agreement with a medical equipment supplier to rent bedside monitoring devices on an as needed basis. The agreement is that the supplier furnishes the equipment as required on four hour notice at a daily charge of $250. A separate rental agreement is executed each time the equipment is delivered. Only the rental payments for monitoring devices that have been continually leased since December 31, 1990, are recognized as old capital costs. The rental payments for any monitoring devices that are rented after December 31, 1990, are recognized as new capital costs on several grounds. The rental agreement is not a renewal of a rental agreement that was in effect as of December 31, 1990, the hospital was not obligated to rent the equipment as of December 31, 1990, and the same asset has not remained in use.

EXAMPLE: In 1990, Hospital Z enters into an agreement to lease 10 bedside monitoring devices for 4 years at an annual payment of $20,000. The useful life of the devices is 10 years. When the lease expires in 1994, Hospital Z renews the lease for 2 additional years. The payments under the lease renewal are recognized as old capital costs because the annual lease payment attributable to each device is $2000 and the useful life for each asset is more than 3 years.

EXAMPLE: In 1990, Hospital Z enters into an agreement to lease a photocopy machine for 5 years. The machine breaks down in 1993, and the supplier replaces it free of charge. The lease payments through the initial lease period are recognized as old capital costs because the hospital was obligated to pay these amounts as of December 31, 1990. When the lease is renewed in 1995, the payments under the lease renewal are recognized as new capital costs because the same asset has not remained in use.

b. Lease Back Arrangements.--If an old capital asset owned by a hospital is sold or transferred to another party after December 31, 1990, and is then immediately leased back by the hospital, the asset continues to qualify as old capital. The amount that is recognized as old capital cost is limited to the amount allowed for that asset in the last cost reporting period during which the asset was owned by the hospital.

c. Lease Purchase of Assets.--A leased asset that qualifies as old capital and has been in continuous use for patient care on and after December 31, 1990, may be purchased by the hospital during or at the end of the lease/rental agreement. The allowable costs for the asset are recognized as old capital provided the identical asset remains in use and has a useful life of at least 3 years, and the annual lease payment for the asset was at least $1,000 per year. The amount that is recognized as old capital cost after the purchase is the actual allowable capital-related costs of acquisition.

d. Treatment of Old Capital for Hospitals Leased After December 31, 1990.--Hospitals may be leased and operated in their entirety after December 31, 1990, resulting in situations in which the hospital is leased without assumption of its asset costs. In such cases, the amount of allowable capital-related costs that could be recognized as old capital cost is limited to the amount that could be recognized for the same assets in the last cost reporting period before the current lease became effective. Any leased cost above that amount is treated as a new capital cost.

4. Other Capital-Related Costs.--A portion of the hospital's allowable costs for other capital-related expenses (e.g., taxes, insurance and royalty fees) is recognized as old capital cost. The amount that is recognized as old capital cost is based on the ratio of the hospital's gross old asset value to gross total asset value in each cost reporting period. For this purpose, gross asset value is the historical cost of the hospital's land and depreciable assets that are used in patient care activities.

5. Related Organization Costs.--Old capital costs include the allowable capital-related costs of related organizations, as described in Chapter 10, and §2150ff. and referenced instructions, that would be recognized as old capital costs if those costs had been directly incurred by the hospital.

EXAMPLE: Hospital W's home office reports segregate the capital-related costs attributable to assets owned as of December 31, 1990, and those acquired afterward and by type of capital-related cost (e.g., depreciation, interest, lease). The intermediary servicing the home office audits the home office cost statement and assures the limitations on old capital costs are applied properly and old, new and other capital costs incurred by the home office are appropriately allocated to Hospital W. Those costs are then included in Hospital W's capital-related costs. A portion of the hospital's total other capital costs (including other capital-related costs directly assumed by the home office) is allocated to old capital costs based on Hospital W's total old capital costs to total capital-related costs.

6. Assets Returned to Patient Care Use.--A hospital may have a nonreimbursable cost center or otherwise incur nonallowable hospital costs for a depreciable asset as of December 31, 1990. Examples of these nonallowable

costs include costs attributable to idle space or equipment, or space that is leased to another party or used to provide nonhospital services in part of a building that is also used to provide hospital services. To the extent the costs of such space or equipment becomes an allowable hospital cost after December 31, 1990, the allowable costs for the asset that are attributable to inpatient hospital services are recognized as old capital costs as long as a portion of the asset was in use for hospital patient care on December 31, 1990, and it meets all other requirements for recognition as old capital costs cited in this section. (See §2807.3B.) The allowable costs that are recognized as old capital costs are subject to the limitations in subsection B on old capital costs. If no portion of the asset was used to provide hospital patient care services prior to December 31, 1990, the allowable costs are recognized as new capital costs when the asset is put in use for hospital patient care.

EXAMPLE: Hospital A has operated an excluded rehabilitation unit in a wing of its building since 1985. Effective with its cost reporting period beginning in FY 1994, the hospital closes the unit and converts the beds to acute inpatient hospital beds. The increased capital-related costs attributable to the inpatient hospital services provided in the wing are recognized as old capital costs effective with the FY 1994 cost reporting period.

EXAMPLE: Hospital B leases its radiology department, including radiology equipment, to an outside contractor. Effective with its cost reporting period beginning in FY 1994, the hospital does not renew the contract and assumes the operations of the department. All assets within the radiology department have historical costs that date back before December 31, 1990. The increased capital costs attributable to the space are recognized as old capital costs effective with the FY 1994 cost reporting period since a portion of the asset (building) was used to provide hospital patient care service prior to December 31, 1990. The equipment costs are considered new capital because the assets were not used to provide hospital patient care services by the hospital prior to December 31, 1990.

EXAMPLE: Hospital C had gutted two floors of its building in 1989 after a physician group vacated its lease of the space as a separate clinic. In l992, the hospital reconstructs the "shelled-in space" and institutes inpatient routine acute care services in the renovated area. The costs for the existing "shelled in space" as of December 31, 1990, that otherwise meet the criteria for recognition of old capital qualify as old capital costs when it is put into patient care use. However, the additional renovation costs that were incurred after December 31, 1990, to bring the asset into patient care use are classified as new capital because the hospital was not obligated to incur those costs as of December 31, 1990. If the "shelled-in space" had not been part of an asset that was in hospital inpatient acute care use as of December 31, 1990 (e.g., in another building housing a PPS-excluded rehabilitation facility), its capital-related costs do not qualify as old capital costs, but only as new capital costs.

7. Obligated Capital Costs.--Obligated capital costs meeting the requirements for such commitments provided in subsection C qualify as old capital costs.

C. Obligated Capital Costs.--If the conditions in subparagraphs 1, 2, or 3 are met, certain capital-related costs for assets that are put into patient care use after December 31, 1990, may be recognized as old capital costs. The amount of capital-related costs associated with the asset that is recognized as old capital costs is generally limited to the lesser of the actual allowable costs of the asset when it is put in use or the estimated costs of the asset when it was obligated. The intermediary establishes the limitation on the amount of obligated capital that is recognized as old capital costs based on the best documentation available on or before December 31, 1990.

NOTE: Allowable capital-related costs for assets that do not meet these requirements are new capital costs.

If the obligated expenditures involve a multiphase capital project, the requirements of this section apply independently to each phase.

1. General Rule.--Capital-related costs that were put into patient care use after December 31, 1990, are recognized as old capital costs if the following conditions are met.

a. Binding Enforceable Agreement.--A binding enforceable agreement was entered into on or before December 31, 1990, by a hospital or related party with an outside unrelated party for the construction, reconstruction, purchase, lease, rental or financing of an asset for which allowable capital-related costs are recognized by Medicare. The agreement must be in writing and signed by authorized representatives of both parties. It must have been executed on or before December 31, 1990, and obligate the hospital on or before that date to proceed with the capital expenditure. To be considered binding, the agreement must contain specific provisions setting forth the obligations of each party and the penalties that are applicable if those obligations are not met. An agreement may be considered enforceable even if it is subject to conditions, but agreements that have conditions that are under the control of either party or a predecessor must be questioned and submitted to the CMS Regional Office for review under State contract law. Agreements that do not contain penalty or forfeiture provisions, or that limit damages to a specified amount (e.g., by use of a liquidated damages provision), also are subject to legal review. The intermediary forwards such agreements to the Regional Office servicing the State in which the hospital is located.

Only agreements that constitute a legal obligation to proceed with the actual acquisition of the asset or capital project are considered for purposes of recognizing old capital costs. Planning, design or feasibility study agreements do not constitute binding contracts for this purpose since these agreements do not commit the hospital to acquiring the asset or undertaking the project. However, the costs for such studies and plans are recognized as old capital costs for projects that do meet the conditions established for obligated capital.

b. Special Requirement for Moveable Equipment.--Moveable equipment qualifies as old capital if a binding contract for the lease or purchase of the moveable equipment was entered into on or before December 31, 1990. Otherwise, moveable equipment that is put in use after December 31, 1990, qualifies as old capital only if the following conditions are met:

(1) A binding contract for financing the acquisition was entered into on or before December 31, 1990;

(2) The equipment is an item that costs at least $100,000;

(3) The item was specifically listed in an equipment purchase plan approved by the hospital's Board of Directors on or before December 31, 1990; and

(4) If a group of assets are involved, each piece of equipment must meet the specified conditions.

EXCEPTION: In cases where the equipment at issue is a computer system, the requirement in subsection b(2) that each item's cost must be $100,000 or more is applied to the basic set of equipment needed for computer functioning; i.e., the central processing unit, one monitor and one terminal. If that configuration costs at least $100,000, the criterion in subsection b(2) is met and all additional equipment included in the total system approved under the requirement in subsection b(3) is considered part of the item involved in the determination.

EXAMPLE: A hospital entered into a binding contract for financing the acquisition of a computer system and received specific approval from the Board of Directors prior to December 31, 1990. The system was purchased in April 1991. The cost of the computer system in the aggregate was more than $100,000. However, the cost of each component of the system was less than $100,000, even after consideration of the basic configuration necessary to functioning of a computer system (i.e., the central processing unit, a monitor and a terminal together do not meet the $100,000 threshold). Therefore, the acquisition cannot meet the obligated capital criteria because no item meets the individual item cost requirement. If the basic computer configuration had met the cost criteria, the system description approved by the Board of Directors is considered old capital costs.

EXAMPLE: A hospital purchases 100 hospital beds in 1991 after securing financing and Board approval in November l990. Each bed costs $2,000. The criteria for recognition of these costs as obligated capital costs are not met since each item does not meet the threshold.

NOTE: A purchase order executed by a hospital for equipment acquisitions does not, by itself, necessarily constitute a contract binding on both parties. Most States have adopted the Uniform Commercial Code with little or no change. The code provides that an order may represent an invitation to contract for goods and is not an absolute obligation to perform on the parties involved. If the supplier of goods or services does demonstrate acceptance of the offer by December 31, 1990 (e.g., by delivery of order, return invoice or acceptance of a down payment by the deadline) or is required to perform by the deadline under State law even in the absence of such evidence of acceptance, the requirements for the existence of a binding contract may be met. When there is a question of acceptance or required performance under State law without other evidence of acceptance of the order, send the document to the Regional Office servicing the provider's State for resolution of the issue. In any other instance, the requirements of subsections b(1)-(3) must be met in such instances for equipment to be considered old capital.

c. Deadline for Notifying Intermediary.--The hospital must notify the intermediary of any obligated capital, including full documentation of contracts, agreements, approvals and expenditures by the later of October 1, 1992, or 90 calendar days after the hospital becomes subject to the capital prospective payment system. The documentation must include a project description (including details of any phased construction or financing) and an estimate of costs that was made no later than December 31, 1990.

d. In Use by September 30, 1994.--The asset is put in use for patient care on or before September 30, 1994. In the case of extraordinary circumstances that are beyond the hospital's control, CMS may extend the deadline to a later date not to exceed September 30, 1996. (See subsection C4.)

e. Limitation on Amount of Obligated Capital Recognized as Old Capital Costs.--When an asset that is put in use for patient care after December 31, 1990, qualifies as old capital, the actual reasonable costs for the asset that are recognized as old capital are generally limited to the lesser of the actual allowable costs when the asset is put in use or the estimated costs of the asset when the binding agreement was entered into. Except in the limited situations described in subparagraph (2), any allowable costs in excess of the estimated costs of the asset are recognized as new capital costs. Any increased costs arising from changes in the nature of the binding contract which occur after December 31, 1990, but which relate back to the initial date of the agreement, are recognized as new capital costs.

(1) Assets Acquired by Lease or Purchase.--Generally, the old capital cost limitation for an asset acquired by lease or purchase equals the cost specified in the lease or purchase agreement. If the asset is an item of moveable equipment for which only a financing agreement had been entered into by December 31, 1990 (and the item qualifies under subsections 1b, 1c and 1d as old capital), the amount that can be recognized as old capital costs is limited to the lower of the actual cost or the estimated costs approved by the hospital's Board of Directors on or before December 31, 1990.

(2) Construction Contracts--The amount of the limitation on obligated capital costs for a construction project applies only to the amount of the project's construction costs. Moveable equipment that is acquired as part of a construction project is included in the limitation and recognized as old capital costs only if the conditions in subsections 1b, 1c and 1d are met. Otherwise, the allowable costs for moveable equipment acquired as part of a construction project are recognized as new capital costs. The limitation on obligated capital costs does not apply to other costs that are related to the project and are capitalized as part of the asset's historical costs, such as legal and architect fees and planning costs. These costs qualify as old capital when the project is completed and the asset is put in use for patient care.

The amount of obligated capital costs recognized as old capital cannot exceed the estimated construction costs for the project established as of December 31, 1990. Primary sources for the estimated cost of the project are the project description and the estimated cost identified in contractual documents related to the financing and construction of the project. Additional costs that are documented as a revised estimate of the project costs are recognized only if that estimate was prepared on or before December 31, 1990. In addition, increases that are documented as being directly attributable to changes in life safety codes or other building requirements established by government ordinance that occurred after the project was obligated are recognized as old capital costs. Other increases in allowable project costs, such as those resulting from changes in project specifications or from construction delays, are not recognized as old capital but are allowable as new capital costs.

(3) Financing Costs.--The limitation on financing costs is based on the interest expense for which the hospital was legally obligated as of December 31, 1990. Interest expense not legally obligated as of that date is treated as old capital only to the extent the expenses are specified in a detailed financing plan approved by the hospital's Board of Directors on or before December 31, 1990, for a capital acquisition or project that was legally obligated on or before that date. Increases in interest expense are recognized only on variable rate debt instruments.

2. Special Provision for Significant Delay in Certificate of Need (CON) Approval.--If a hospital is subject to a lengthy certificate of need approval process, a capital expenditure that does not meet the criteria under the general rule for recognizing obligated capital may nevertheless qualify for recognition as old capital costs if the following criteria are met.

a. General Criteria.--A capital expenditure must meet the following criteria to be recognized as old capital under this special provision.

(1) CON Approval Required.--The hospital is required under State law to obtain approval of the capital project or acquisition by a designated State or local planning agency in its State. If CON approval is not required for the asset (e.g., the cost of the item of equipment is less than the dollar threshold requiring pre-approval), the capital-related costs associated with the asset cannot qualify for recognition as old capital under this special provision. In such cases, the costs associated with a project or acquisition can only be recognized as old capital if it meets the general criteria in subsections 1a-1e.

(2) Application Filed by December 31, 1989.--The hospital filed an initial application for approval of the capital project or acquisition on or before December 31, 1989. At a minimum, the application must have included a detailed description of the capital expenditure project and its estimated costs. Although modifications in the scope of the project may be made between the initial application and the final project as part of the approval process, the project must be an identifiable component of the initial application.

(3) Approval Received After September 30, 1990.--The hospital had not received approval for the capital project or acquisition on or before September 30, 1990.

(a) Conditional Approval.--If the hospital received conditional approval for the project, the intermediary assesses the nature of the conditions to determine whether the hospital received sufficient approval for the scope of the project to enter into a binding contract. For example, if a hospital received approval before September 30, 1990, for a construction project that was contingent on the hospital securing adequate financing or making minor design modifications, the hospital may be considered to have received approval before September 30, 1990, since the scope of the project has been approved. On the other hand, if the hospital received approval before September 30, 1990, that was contingent on a reduction in the size of an addition from 50 beds to 20 beds, the hospital is not considered to have received approval by September 30, 1990, because the approval was conditional on a substantial change in the scope of the project that requires additional planning before the hospital could enter into a contract for the actual construction project.

A hospital is considered to have received approval for the project as of September 30, 1990, if the intermediary determines that the hospital received sufficient approval for the project to proceed without significant delay.

(b) Partial Approval.--A hospital's application for CON approval may have covered several projects that could be undertaken independently or in separate phases. If the hospital received approval on or before September 30, 1990, for a phase or segment of the project that could be undertaken independently of the rest of the project, the costs of those phases or segments of a project that received CON approval prior to September 30, 1990, may be recognized as old capital only if they were legally obligated by December 31, 1990, and meet all the other criteria for recognition of obligated capital under the general rule in subsection C1. Those phases or segments that did not receive approval on or before September 30, 1990, can be recognized as old capital only if they meet all the criteria of the special provision for significant delay in CON approval in this subsection.

EXAMPLE: A hospital's CON application included proposals to expand its inpatient acute care capacity and to renovate its radiology department in conjunction with the addition of MRI equipment. The hospital received partial approval for the inpatient expansion as of September 30, 1990, but had not yet received approval for the MRI project. Unless the hospital had entered into a binding contract for the inpatient expansion project on or before December 31, 1990, the costs for the inpatient expansion are not recognized as old capital. The MRI project can be recognized as old capital only if it meets the significant cost requirement and the deadline for putting assets in use.

(4) Significant Cost Incurred By December 31, 1990.--The hospital incurred the lesser of $750,000 or 10 percent of the project's estimated cost on or before December 31, 1990. To determine whether the cost threshold has been met, the reasonable costs incurred by the hospital that are directly related to the planned capital expenditure and are capitalized as part of the depreciable asset's historical costs are considered. This includes legal, architect and accounting fees, and costs incurred by the hospital for studies, surveys, designs, plans, working drawings, specifications and other activities related to the capital expenditure. It does not include marketing or general feasibility studies that relate to overall institutional strategic planning activities. Further, it does not include nondepreciable costs of land but does include depreciable land improvements.

(5) Put in Use Within 4 Years or By September 30, 1996.--The asset is put in use for patient care services on or before the earlier of September 30, 1996, or 4 years from the date the certificate of need is approved. In the case of extraordinary circumstances that are beyond the hospitals control, CMS may extend the deadline to no later than September 30, 1996. (See subsection C4.)

b. Additional Requirement for Moveable Equipment.--The costs of moveable equipment may qualify as old capital under the special rule for delays in the CON approval process, but only if the State or local authority requires separate CON approval for the equipment. The initial application for approval must have been filed on or before December 31, 1989, and the equipment must cost at least $100,000 for each item. If these requirements are not met, the equipment is considered new capital when it is put in use for patient care.

c. Limitation on Amount of Cost Recognized as Old Capital Costs.--Only those portions of a project that require CON approval are recognized as old capital under this paragraph. In most cases, this includes fixed capital projects and major moveable equipment that cost a specified dollar threshold. Any other portions of the project (e.g. equipment that costs less than the specified threshold for CON approval) is subject to the provisions in subsection C1. The amount of capital-related costs that is recognized as old capital costs under this paragraph is based on the most recent estimate of the costs for the old capital portion that was documented on or before December 31, 1990.

Generally, the intermediary relies on the most recent cost estimate that was developed on or before December 31, 1990, as part of the CON approval process to establish the limitation on the amount of costs that is recognized as old capital costs. An expansion in the scope of the project or a change in its nature is not recognized unless specifically required by the planning agency as a condition of approval. If the approval involves a reduction in the scope of the project, the estimated costs of the project that are recognized as old capital are reduced accordingly.

(1) Assets Acquired by Purchase or Lease.--The capital-related costs that are recognized as old capital cost for assets that are purchased or leased is based on the purchase price or annual leasing costs that were estimated on or before December 31, 1990. If the estimate covers only the first few years of a lease arrangement, the estimated annual payment for the last year included in the estimate serves as the limitation on the amount that is recognized as old capital costs in succeeding years.

(2) Construction Project.--The limitation on the amount of capital-related costs for a construction project that is recognized as old capital costs applies only to the construction costs. Planning, legal and architectural costs that are part of the project are not subject to the limitation but are capitalized with the construction costs as old capital at the time the asset is put into patient care use. Separate limitations apply to moveable equipment and financing costs that are part of the construction project.

(3) Financing Costs.--Financing costs are recognized as old capital only to the extent such expenses are specified in a detailed financing plan for the project that provides a description of and identifies the cost estimates for each project, phase, or component of construction or renovation and that was formally approved by the hospital's Board of Directors on or before December 31, 1990.

3. Special Criteria for Construction in Progress.--Construction in progress as of March 31, 1991 that does not meet the criteria in subsection C1 or C2 may nevertheless qualify for recognition as old capital costs if all of the following criteria are met:

a. CON Approval Received by December 31, 1990.--The hospital received any necessary certificate of need approval on or before December 31, 1990.

b. Board of Directors Approval by December 31, 1990.--The hospital's Board of Directors formally authorized the capital project with a detailed description of its scope and costs on or before December 31, 1990.

c. Major Project.--The estimated cost of the project exceeds 5 percent of the hospital's total patient revenues during its base year. To determine whether this requirement is met, the estimated amount for the project that was approved by the hospital's Board of Directors on or before December 31, 1990, is divided by the hospital's total inpatient and outpatient revenues in its 12-month or longer cost reporting period ending on or before December 31, 1990. Thus, for purposes of this calculation the base year consists of at least a 12-month period. Hospitals that must use more than 12 months, use the average monthly revenues (inpatient plus outpatient) for the period to develop a 12-month total of patient revenues. Determine whether the 5 percent minimum level is met by dividing the estimated amount of the project that was approved by the Board of Directors on or before December 31, 1990, by total patient revenues for 12 months.

d. Significant Cost Incurred by December 31, 1990.--The capitalized cost that had been incurred for the project as of December 31, 1990, exceeded the lesser of $750,000 or 10 percent of the estimated project cost. For purposes of determining whether the cost threshold has been met, include the reasonable costs incurred by the hospital that are directly related to the planned capital expenditure and that would be capitalized as part of the depreciable asset's historical costs once the asset was put into use for patient care. This includes legal, architect and accounting fees and costs incurred by the hospital for studies, surveys, designs, plans, working drawings, specifications and other activities related to the capital expenditure. It does not include marketing or general feasibility studies that relate to overall institutional strategic planning activities. Further, it does not include nondepreciable costs of land but does include depreciable land improvements.

e. Construction in Progress by March 31, 1991.--The hospital began actual construction or renovation (groundbreaking) on or before March 31, 1991.

f. Put In Use By September 30, 1994.--The project is completed and the asset is put in use on or before September 30, 1994. If there are extraordinary circumstances beyond the hospital's control, CMS may extend the deadline to no later than September 30, 1996. (See subsection C4.)

g. Limitation on Amount of Costs Recognized as Old Capital Costs.--Only buildings and other fixed assets are recognized as old capital under this provision. Any moveable equipment associated with the construction in progress is considered new capital unless it meets the general requirements for recognition as obligated capital under subsection C1. The amount of construction costs that are recognized as old capital is limited to the estimated construction costs approved by the hospital's Board of Directors on or before December 31, 1990. Financing costs associated with the construction costs are recognized as old capital only if the financing was described in a detailed financing plan adopted by the Board of Directors on or before December 31, 1990. Allowable planning, legal and architectural costs associated with the construction project are not subject to the limitation but are capitalized with the construction costs as old capital at the time the asset is put into patient care use.

4. Extension of Deadline for Putting Asset in Use.--CMS may extend the applicable deadline for putting an asset in use for patient care to no later than September 30, 1996, for extraordinary circumstances beyond the control of the hospital. Extraordinary circumstances may include a construction strike or atypically severe weather conditions that significantly delay construction. Normal construction delays do not constitute extraordinary circumstances.

a. Developing Extension Requests.--A hospital must submit its request for an extension to its fiscal intermediary by the later of January 1, 1993, or within 180 days after the occurrence that the hospital believes is extraordinary and beyond its control and is expected to delay placing the asset in patient care use by the deadline. The request must be in writing, and, at a minimum, contain a description of the circumstances, an explanation of why it is extraordinary and beyond the hospital's control, why the delay attributable to the circumstances cannot be overcome, and a new estimated completion date established by the contractor, supplier or other servicing party. The request must be accompanied by documentation of the circumstances (e.g., media releases, insurance or underwriter documents, public agency reports).

b. Processing Extension Requests.--The intermediary reviews and verifies the documentation submitted by the hospital and forwards the request along with its recommendation and the results of its review to CMS within 60 days of receipt for a determination. The extension request is sent to:

Health Care Financing Administration
Office of Payment Policy, BPD
Room 181, East High Rise
6325 Security Boulevard
Baltimore, MD 21207

CMS makes a determination within 90 days of receipt of the request and appropriate documentation.

5. Determination Process for Obligated Capital.--Any hospital that expects to put assets into patient care use after December 31, 1990, that would qualify as old capital must submit documentary evidence of binding agreements, contracts, cost estimates, estimated completion dates, Board of Director minutes, certificate of need documents, groundbreaking evidence and other documentation needed to verify and determine a hospital's obligated capital costs during the transition period. The hospital must submit its documentation to its intermediary by the later of October 1, 1992, or 90 days after the start of its first cost reporting period that begins on or after October 1, 1991. If the hospital cannot document the project description and the estimated cost for the project as of December 31, 1990, the expenditure does not qualify as old capital.

The intermediary determines if the capital cost qualifies as obligated old capital cost and the applicable limitation on the amount of obligated capital costs that are recognized as old capital costs. If necessary, the intermediary consults with the CMS Regional Office in making its determination. The intermediary notifies the hospital in writing of its determination by the later of the close of the hospital's first cost reporting period under the capital-PPS, or 9 months from the date the hospital submits its completed documentation. The intermediary's determination is contingent upon the asset being put into patient care use by the applicable deadline.

The intermediary's determination is subject to appeal during the hospital's first cost reporting period in which the intermediary's obligated capital determination affects the amount of payment under capital-PPS. Appeals are processed under the provisions of 42 CFR Part 405, Subpart R, with respect to recognition of the capital-related cost as obligated capital or the amount so recognized, or both.

D. Consistent Cost Finding During Transition Period.--During the transition period, a hospital must follow consistent cost finding methods for classifying and allocating capital-related costs for all cost reporting actions involving step down or direct assignment of capital-related costs.

1. Old Capital.--Except as indicated below, the hospital must continue the same cost finding methods for old capital costs, including its practices for the direct assignment of capital-related costs and its cost allocation bases, that were in effect in the hospital's last cost reporting period ending on or before October 1, 1991.

a. If the intermediary approved on or before August 30, 1991, a hospital's request to change one or more of its cost finding practices for capital-related costs effective for a cost reporting period beginning before October 1, 1991, the cost finding methods in effect for that cost reporting period must be used for old capital during the transition.

b. If there is a change of ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. The request for a change and the intermediary's approval is subject to the provisions in §§2300ff.

2. New Capital.--A hospital may change its capitalization policy or cost finding methods for new capital only if the intermediary determines that there is reasonable justification for the change. Any request for change must be made in writing to the intermediary prior to the beginning of the cost reporting period for which the change is to apply. The request must justify why the change will result in more appropriate and accurate cost finding. The request must also show that the change will meet the applicable provisions in §§2300ff.

2807.4 Capital-PPS Transition Payment Methodologies.--The payment methodology applicable to a particular hospital during the capital-PPS transition period is determined by comparing the hospital's hospital-specific rate, which is derived from the hospital's inpatient capital-related costs in a specified base year, to the applicable Federal rate. (See §2807.4D.) If the hospital-specific rate is above the Federal rate, the hospital is paid under the hold harmless methodology. A hospital with a hospital-specific rate below the Federal rate is paid under the fully prospective methodology. Except as provided in §2807.4E, the same payment methodology is applicable throughout the transition period.

A. Capital-PPS Base Year.--The initial base year used to determine the hospital-specific rate for all hospitals, other than new hospitals, is the latest 12 month or longer cost reporting period (or combination of periods totaling at least 12 months in the case of short cost reporting periods) ending on or before December 31, 1990. In the case of a new hospital (see §2807.7), the initial base period is the 12 month or longer (or combination of periods totaling at least 12 months) cost reporting period that begins at least one year after the hospital accepts its first patient. (See §2807.7 for further discussion of treatment of new hospital base year and old capital costs.)

If a hospital, other than a new hospital as defined in §2807.7, does not have a 12-month or longer cost reporting period or does not have adequate Medicare utilization to file a cost report in a period ending on or before December 31, 1990, the hospital's old capital costs per discharge as described in subsection B for its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) ending after December 31, 1990, is used to establish the hospital-specific rate. However, the criteria for determining old and new capital costs remain the same as for all other hospitals subject to capital-PPS.

As discussed in §2807.4E, a hospital paid under the fully prospective payment methodology may request that its hospital-specific rate be redetermined through the later of its cost reporting period beginning in FY 1994 or after obligated capital that qualifies as old capital has been put in use based on its old capital costs in the later cost reporting period. The redetermination year serves as the new base year.

B. Capital-PPS Hospital-Specific Rate.--The intermediary determines the hospital-specific rate according to the following steps:

Step 1.--To establish an initial hospital-specific rate, determine the total allowable Medicare inpatient capital-related cost for the hospital in the capital-PPS base year. Include only the capital-related costs attributable to inpatient hospital stays covered under the prospective payment system.

To redetermine a hospital-specific rate using a later base period in accordance with §2807.4E, determine the total allowable Medicare inpatient old capital costs in the new base year.

Exclude the costs attributable to skilled nursing facility level days in swing bed hospitals and to inpatient stays in units that are excluded from the prospective payment system.

If a depreciable asset is disposed of in the base year, include only that portion of the gain or loss that is allocated to the base year cost reporting period. Any gain or loss on assets owned in the base year and subsequently disposed of is not reflected in the hospital-specific rate.

Step 2.--Determine the transfer case adjusted discharge count for the base year.

a. CMS determines a transfer adjustment factor for each hospital using the base year MEDPAR data on file as of June 30, 1991, for hospitals subject to the capital-PPS in FY 1992. For later base years beginning before FY 1992 (involving a new hospital or a redetermination of the hospital-specific rate), CMS determines a transfer adjustment factor for the hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least six months after the close of the base period. CMS calculates a transfer adjusted discharge value for each transfer case by dividing the length-of-stay for the case by the geometric mean length of stay for DRG to which the case is classified and assigning the result, not to exceed 1.0, to the transfer case. CMS assigns each nontransfer case a value of 1.0. To determine the transfer adjustment factor, CMS adds together the transfer adjusted discharge values and divides the result by total discharges, including transfer cases.

b. The intermediary determines the transfer adjustment factor for a base year beginning in FY 1992 or later based on the most recent billing data available from the Provider Statistical and Reimbursement System as of the date of the final determination of the hospital-specific rate.

c. The intermediary determines the transfer adjusted discharge count by multiplying the Medicare discharges, determined by the intermediary for the applicable cost report, by the transfer adjustment factor.

Step 3.--Determine the transfer adjusted case mix index for the base year.

a. CMS determines a transfer-adjusted case mix index for each hospital using the base year MEDPAR data on file as of June 30, 1991, for hospitals subject to capital-PPS in FY 1992. For later base years beginning before FY 1992, CMS determines a transfer-adjusted case mix index for the hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least six months after the close of the base period. CMS calculates a transfer-adjusted DRG weight for each transfer case by multiplying the transfer-adjusted discharge value for the case determined in step 2 by the relative weight assigned to the DRG to which the case is classified. CMS assigns to each nontransfer case the relative weight for the DRG to which the case is classified. To determine the transfer-adjusted case mix index, CMS adds together the transfer adjusted DRG weights and divides by the transfer-adjusted discharge count.

b. The intermediary determines the transfer adjusted case mix index for a base year beginning in FY 1992 or later based on the most recent billing data available as of the date of the final determination of the hospital-specific rate.

Step 4.--Calculate the base year average cost per discharge by dividing the total allowable Medicare inpatient capital-related costs (or the total allowable Medicare inpatient old capital costs in the case of a redetermination) (see step 1) by the transfer-adjusted discharge count (see step 2c).

Step 5.--Calculate the case mix adjusted base year average cost per discharge by dividing the base year average cost per discharge (see step 4) by the transfer-adjusted case mix index. (See step 3.)

Step 6.--Update the case mix adjusted base year average cost per discharge (see step 5) to Federal fiscal year 1992 based on the national average increase in Medicare inpatient capital cost per discharge (adjusted for changes in case mix) published by CMS, as follows:

12-Month Cost Reporting Period Ending	Update Factor
Jan. 31, 1990	1.22185
Feb. 28, 1990	1.21453
Mar. 31, 1990	1.20725
Apr. 30, 1990	1.20002
May 31, 1990	1.19283
June 30, 1990	1.18568
July 31, 1990	1.17858

Aug. 31, 1990	1.17151
Sept. 30, 1990	1.16449
Oct. 31, 1990	1.15719
Nov. 30, 1990	1.14993
Dec. 31, 1990	1.14272
Jan. 31, 1991	1.13555
Feb. 28, 1991	1.12843
Mar. 31, 1991	1.12135
Apr. 30, 1991	1.11432
May 31, 1991	1.10733
June 30, 1991	1.10038
July 31, 1991	1.09348
Aug. 31, 1991	1.08662
Sept. 30, 1991	1.07980

NOTE: If the base period covers more than 12 months, the intermediary must request the appropriate update factor from CMS, Bureau of Policy Development, Office of Payment Policy, Division of Hospital Payment Policy.

Step 7.--Multiply the updated amount calculated in step 6 by the applicable budget neutrality adjustment factor and exceptions adjustment factor for estimated capital-PPS exceptions payments for the fiscal year. The FY 1992 adjustment factors are as follows:

Exceptions Adjustment Factor: .9813
Budget Neutrality Adjustment Factor: .9602

The resulting amount is the hospital's hospital-specific rate. The hospital-specific rate is updated annually at the beginning of each Federal fiscal year. Future update factors, exceptions adjustment factors, and budget neutrality adjustment factors for the hospital-specific rate will be published annually in the Federal Register.

EXAMPLE: Hospital A has a base year ending September 30, 1990. The hospital's FY 1992 hospital-specific rate is calculated as follows:

Base year total allowable Medicare inpatient capital-related costs	$2,457,024
Total Medicare discharges for FY 1990	1,563
Transfer-adjusted discharges (1563 base year discharges x .9921 transfer adjustment)	1550.7
Transfer-adjusted case mix index (see 56 FR 43465.)	1.4331
Base year cost per discharge ($2,457,024/1,550.7)	$1,584.46
Case mix index adjustment ($1,584.46/1.4331)	$1,105.62
Update to FY 1992 ($1,105.62 x 1.16449)	$1,287.48
Exceptions payments adjustments ($1,287.48 x .9813)	$1,263.41
Budget neutrality adjustment ($1,263.41 x .9602)	$1,213.12
Hospital A's FY 1992 hospital-specific rate	$1,213.12

NOTE: The budget neutrality and exceptions reductions factors are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the hospital-specific rate. Therefore, when updating the hospital specific rate for FY 1993 and beyond, the exceptions reduction and budget neutrality factors for the preceding year are first removed before the factors for the current year are applied. For example, to determine Hospital A's hospital specific rate for FY 1993, the following recalculation is necessary.

Budget neutrality adjustment for FY 1993	.9162
Exceptions reduction adjustment for FY 1993	.9756
Net budget neutrality adjustment for FY 1993 (.9162/.9602)	.9542
Net exceptions reduction adjustment for FY 1993 (.9756/.9813)	.9942
FY 1993 update factor (See 57 FR 39837)	1.0607
Cumulative FY 1993 adjustment (.9542 x .9942 x 1.0607)	1.0062
FY 1993 hospital-specific rate (1.0062 x $1,213.12)	$1,220.64

C. Limitations on Changes to the Hospital-Specific Rate.--The intermediary updates the hospital-specific rate each Federal fiscal year for inflation and changes in the exceptions payment adjustment factor and the budget neutrality adjustment factor. Otherwise, the hospital-specific rate cannot be changed throughout the transition period except in the following situations.

- The initial base year hospital-specific rate determination may be revised as a result of a reopening of the base year cost report that affects the determination of base year costs per discharge. (See §2807.6A.)

- The hospital requests a redetermination of its hospital-specific rate based on its old capital costs in a subsequent base period in accordance with §2807.4E.

- The hospital merges with another hospital, or different campuses of a multi-campus hospital become separate providers (see §2807.9).

D. Payment Methodology Determination.--The intermediary compares the hospital's hospital-specific rate to its Federal rate (after taking into account the effect of estimated outlier payments and the payment adjustments other than case mix) to determine if the hospital is paid during the transition period under the hold harmless methodology or the fully prospective methodology.

The initial payment methodology determination is based on the hospital-specific rate and Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. For cost reporting period beginning dates other than October 1, an average hospital-specific rate and Federal rate for the cost reporting period is determined based on the number of months of each Federal fiscal year in the cost reporting period.

If the hospital-specific rate is redetermined in accordance with §2807.4E using a base year beginning on or after October 1, 1992, the payment methodology is also redetermined by comparing the hospital-specific rate and Federal rate applicable to the redetermination base year.

In making the comparison, the Federal rate for the cost reporting period is determined by adjusting:

- For outliers by dividing the standard Federal rate by the outlier reduction factor applied to the rate for that fiscal year; and

- For the payment adjustment factors (other than case mix) applicable to the hospital (i.e., adjustments for geographic location, disproportionate share of low income patients and indirect teaching costs). The result is referred to as the adjusted Federal rate for a hospital.

EXAMPLE: Hospital A is located in San Jose, California, a large urban area, and has a disproportionate patient percentage of 25 percent and a resident-to-day ratio of 0.1456 in FY 1992. Its hospital-specific rate is $1,205.52. The hospital's cost reporting period begins October 1.

The adjusted Federal rate for Hospital A is:

$415.59 (FY 1992 standard Federal rate) divided by .9497 (FY 1992 outlier reduction) equals $437.60 multiplied by 1.2995 (geographic adjustment) multiplied by 1.03 (large urban adjustment) multiplied by (1+.0519+.0419) (disproportionate share and indirect medical education adjustments) equals $640.66.

Since Hospital A's hospital-specific rate is higher than its adjusted Federal rate, Hospital A is paid under the hold harmless methodology throughout the transition period. If the hospital-specific rate was equal to or lower than the adjusted Federal rate, the hospital would have been paid under the fully prospective methodology throughout the capital-PPS transition period unless a hospital-specific rate redetermination results in a subsequent change to the hold harmless methodology.

E. Redetermination of Hospital-Specific Rate.--If requested by the hospital, the intermediary redetermines the hospital-specific rate for a hospital paid under the fully prospective methodology using the process described below.

1. A hospital may request redetermination of its hospital-specific rate for any 12-month or longer cost reporting period or combination of cost reporting periods beginning subsequent to its original base year but no later than its cost reporting period beginning in FY 1994 or its first cost reporting period beginning after obligated capital that is recognized as old capital is put in use in accordance with §2807.3C. The hospital may request that its hospital-specific rate be redetermined more than once.

2. A hospital may request a redetermination only when there is an increase in the hospital's total old capital costs from its base period. Requests for redetermination cannot be recognized for any other conditions that could affect the hospital-specific rate, such as a decline in utilization that produced an increase in a hospital's old capital cost per case. However, if a hospital's total old capital costs increase over the base period determination and, in addition, the hospital experienced a decline in discharges in the same cost reporting period, the hospital's request for redetermination is appropriate.

3. The hospital's request for redetermination must be made in writing no later than the date the cost report must be filed with the hospital's intermediary for the cost reporting period that will serve as the new base year or its first cost reporting period beginning on or after October 1990, whichever is later. If the hospital receives an extension in filing its cost report for the new base year from the intermediary, the deadline for requesting the determination is automatically extended.

4. The hospital's request for redetermination must be accompanied by the hospital's cost report for the new base period, an estimate of its old capital costs for the new base year and its calculation of the redetermined hospital-specific rate. The estimate must demonstrate that the redetermined hospital-specific rate is higher than the hospital's current hospital-specific rate. If the intermediary determines, after audit of the final cost report data, that the redetermined hospital-specific rate is lower than the hospital's current hospital-specific rate, it advises the hospital that its request is denied and provides the hospital with an explanation of the intermediary's decision.

5. The intermediary redetermines the hospital-specific rate based on the hospital's actual old capital costs in the new base period following the steps in §2807.4B. The intermediary accounts for the changes in allowable old capital costs that have occurred subsequent to the base year. The intermediary includes in old capital costs the capital-related costs for obligated capital that is recognized as old capital under §2807.3C and for assets acquired before January 1, 1991, that were not fully represented in the base year capital-related cost determination. The intermediary excludes from the hospital-specific rate determination all new capital costs and the costs of old capital assets that were retired or disposed of subsequent to the original base year.

6. The intermediary compares the redetermined hospital-specific rate to the Federal rate applicable to the new base year (after taking into account the estimated effect of the payment adjustments and outlier payments pursuant to §2807.4D). Based on the results of that comparison, the intermediary determines whether the hospital is paid under the fully prospective or hold harmless methodology. The revised hospital-specific rate and payment methodology determination are effective retroactively to the beginning of the new base year (or the hospital's first cost reporting period under the capital-PPS if later). If the hospital's redetermined hospital-specific rate is higher than its previously established hospital specific rate, but is still lower than the adjusted Federal rate, the hospital continues to be paid under the fully prospective payment methodology. However, the new (increased) hospital-specific rate is used in determining payments effective with the start of the cost reporting period used as the new base period and onward.

EXAMPLE: Hospital E, whose cost reporting period begins January 1, is paid under the fully prospective payment methodology. The hospital opens a new inpatient wing on June 1, 1992, that the intermediary determined qualifies as old capital costs pursuant to §2807.3C. In January 1993, the hospital requests a redetermination of its hospital-specific rate due to the substantial obligated capital costs incurred during the 6 months the new wing has been in use for patient care ($1,000,000) and provides an estimate showing the redetermined hospital-specific rate is higher than the current hospital-specific rate for its FY 1992 cost reporting period. The

hospital revises its old capital costs to reflect actual FY 1992 old capital costs. Changes since the original base year include the 6 months capital-related costs for the new wing, the elimination of capital-related costs for retired equipment and expired leases, and lower interest payments on the hospital's original mortgage. In addition, the insurance costs apportioned to old capital costs are affected by a revised ratio of old capital asset value to total asset value. The intermediary makes final settlement on the FY 1992 cost report and redetermines the hospital-specific rate using the revised old capital costs and the new base year's transfer adjusted discharges and case mix index and the exceptions payment and budget neutrality adjustment factors provided by CMS.

The intermediary determines that the redetermined hospital-specific rate is higher than the hospital's new base year Federal rate. As a result, the hospital is paid under the hold harmless methodology effective January l, 1992, and the FY 1992 cost report is revised on that basis. Since the hospital is now paid under the hold harmless methodology, the annual capital-related costs for the new wing are automatically recognized as old capital in subsequent transition years. If the hospital remained on the fully prospective methodology (i.e., its redetermined hospital-specific rate was lower than its new base year Federal rate), it could request another redetermination in FY 1993 so that the annual costs of the new wing are reflected in its hospital-specific rate.

2807.5 Transition Payments.--Based on the capital-PPS transition payment methodology applicable to a hospital, the intermediary makes an interim payment for each discharge during a cost reporting period pursuant to procedures in §§2406ff. The final payment determination is made during final settlement of the cost report. Any adjustments based on the actual payment parameters or capital-related costs for the cost reporting period are effective retroactively to the beginning of the cost reporting period.

NOTE: The Federal rate used in the following calculations is the payment rate specific to each hospital after adjustment for its case mix, geographic location, and, as applicable, the disproportionate share and indirect teaching factors and any outlier amounts payable for the discharge. The rate is referred to as the adjusted Federal rate.

A. Fully Prospective Payment Methodology.--The payment for each inpatient discharge is determined by multiplying the hospital's hospital-specific rate by the DRG relative weight assigned to the discharge and multiplying that product by the applicable hospital-specific rate blend percentage for the cost reporting period. The applicable percentage of the adjusted Federal rate for the period is added to the hospital-specific amount. The blend percentages are as follows:

Cost Reporting Period Beginning On or After	Federal Rate Percentage	Hospital-Specific Rate Percentage
10/1/91	10	90
10/1/92	20	80
10/1/93	30	70
10/1/94	40	60
10/1/95	50	50
10/1/96	60	40
10/1/97	70	30
10/1/98	80	20
10/1/99	90	10
10/1/2000	100	0

B. Hold Harmless Payment Methodology.--The payment amount for each inpatient discharge is the higher of:

- An old capital payment equal to 85 percent of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period, plus a new capital payment based on a percentage of the adjusted Federal rate. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare inpatient new capital costs to its total Medicare inpatient capital costs in the cost reporting period. For sole community hospitals, the old capital payment equals 100 percent of the hospital's allowable Medicare inpatient old capital costs per discharge; or

- 100 percent of the adjusted Federal rate.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost reporting period beginning on or after October 1, 1993 (or the first cost reporting period after obligated capital that qualifies as old capital is put in use for patient care, if later), the hospital continues to receive capital-PPS payments on that basis throughout the remainder of the transition. The hospital may not switch to a payment based on its old and new capital costs in a subsequent cost reporting period.

If the status of a sole community hospital changes during the cost reporting period, an average percentage payment for old capital is determined based on the number of days the cost reporting period during which the hospital was classified as a sole community hospital. For example, if the hospital was classified as a sole community hospital for three months of the cost reporting period, the hospital receives 88.75 percent [(85 x .75) + (100 x .25)] of its allowable old capital costs for the cost reporting period.

Any hospital that is eligible to receive capital-PPS payments under the hold harmless methodology may elect to receive 100 percent of the adjusted Federal rate even if the separate old and new capital payments are higher. A hospital that does not maintain records adequate to identify its old capital costs is deemed to have selected payment based on 100 percent of the adjusted Federal rate.

C. Exceptions Payments.--During the capital-PPS transition period, a hospital may receive additional payments under an exceptions process when its capital-PPS payments are less than its Medicare allowable inpatient capital-related costs.

1. Minimum Payment Level by Class of Hospital.--The amount of the exceptions payment is determined as the difference between a percentage, or minimum payment level, of the hospital's reasonable inpatient capital-related costs and the payments that the hospital would receive under the capital-PPS in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital is subject to the capital-PPS transition payment method. The minimum payment levels are determined by class of hospital and are subject to revision, if necessary, to keep total payments under the exceptions process at no more than 10 percent of capital prospective payments. The minimum payment levels for portions of cost reporting periods occurring during FY 1992 are:

- For sole community hospitals, 90 percent;

- For urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or that received more than 30 percent of net revenues from State or local funds for indigent care, 80 percent; and

- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

Any revisions in the minimum payment levels are published in the Federal Register as part of the annual final rule implementing of PPS rates and policies.

For purposes of determining the hospital's minimum payment level for a given cost reporting period, a hospital's eligibility to receive the 80 percent minimum payment level as a disproportionate share hospital is determined consistent with §2807.2B5. An urban hospital with at least 100 beds that derives at least 30 percent of its inpatient revenues from State or local government sources for the care of indigent patients who are not covered by Medicare or Medicaid qualifies for the 80 percent payment threshold. If a hospital's status as a sole community hospital changes during a cost reporting period, the minimum payment level is determined based on the number of days in the cost reporting period during which the hospital was classified as a sole community hospital.

The exceptions payment is made during the cost report settlement process based on the hospital's class and minimum payment level for that cost reporting period. If the hospital's payments under the capital-PPS are less than its minimum payment level for the cost reporting period, a cumulative comparison is made between the hospital's capital-PPS payments in each cost reporting period and the minimum payment level applicable to the respective cost reporting periods. Any amounts by which, on a cumulative basis, the hospital's capital-PPS payments exceeded its minimum payment levels for those cost reporting periods are subtracted from the difference between the hospital's costs and minimum payment level in the current cost reporting period. If the result is positive, the hospital's exceptions payment equals this amount. If the result is negative, no exceptions payment is payable for the cost reporting period. Any additional payments made under this provision are further reduced by any payments received pursuant to the extraordinary circumstance exceptions provision. (See subsection C2.)

NOTE: CMS does not recover prior exceptions payments if a hospital receives payments in excess of the minimum payment level in any year subsequent to a year in which exceptions payments were made. However, any prior exceptions payments are included in the cumulative cost comparison to determine eligibility for an exceptions payment in a subsequent year.

EXAMPLE: Hospital Z is an urban hospital with more than 100 beds and a disproportionate share patient percentage of 16 percent. It has not received any exceptions payments for extraordinary circumstances. During its cost reporting period beginning in FY 1992, it has allowable capital-related inpatient costs amounting to $1 million and receives capital-PPS payments totaling $710,000 for that period. Hospital Z does not qualify for an exceptions payment because its capital-PPS payments exceed 70 percent of its allowable inpatient capital-related costs by $10,000.

For FY 1993, CMS announces continuance of the prior year minimum payment levels. Hospital Z again has $1 million in inpatient capital-related costs but receives only $670,000 in total capital-PPS payments, or $30,000 less than its minimum payment level. To determine its exceptions payment, the $10,000 excess over the FY 1992 minimum payment level is subtracted from the $30,000 shortfall in FY 1993. The exceptions payment is made for $20,000 and, consistent with the minimum payment levels, the hospital receives payment equal to 70 percent of its allowable inpatient capital-related costs on a cumulative basis.

EXAMPLE: Same as above except that in FY 1993, Hospital Z's disproportionate share patient percentage increases to 23 percent and the hospital qualifies for an 80 percent minimum payment level. Thus, Hospital Z receives $130,000 less than its minimum payment level in the absence of the exceptions process. To determine its FY 1993 exceptions payment, the $10,000 excess over the FY 1992 minimum payment level is subtracted from the $130,000, resulting in a $120,000 exceptions payment.

2. Exceptions Payments for Extraordinary Circumstances.--If a hospital experiences extraordinary circumstances beyond its control such as flood, fire or earthquake damage which result in unanticipated capital expenditures in excess of $5 million (after applying insurance proceeds), it may request and be eligible for an additional payment for such costs during the capital-PPS transition period. The minimum payment level applicable under this exceptions provision is:

- For sole community hospitals, 100 percent of Medicare's share of the allowable inpatient capital-related costs attributable to the extraordinary circumstances. (If a hospital loses its SCH status during a cost reporting period, to apportion its payments properly multiply the 100 percent by the ratio of patient days it did qualify for exceptions payments to the total of patient days in the cost reporting period.); or

- For all other hospitals, 85 percent of such costs.

A hospital must apply to its CMS Regional Office by the later of October 1, 1992, or within 180 days after the extraordinary circumstances causing the unanticipated expenditures for a determination by the CMS Administrator of whether the hospital is eligible for an additional payment based on the nature of the circumstances, any recovery proceeds from other parties and the amount of financial loss documented by the hospital. The request must be made in writing and provide an explanation with supporting documentation of the circumstances that led to the unanticipated capital expenditure and the estimated amount of the expenditure, along with the sources and amounts of any anticipated reimbursement from insurance and other sources directly related to the capital expenditure. The Regional Office evaluates the request and forward its recommendation to the Administrator for a decision.

EXAMPLE: Hospital X, a 75-bed rural hospital, receives capital prospective payments effective with its cost reporting period beginning January 1, 1992. On July 3, it sustains severe structural damage to an inpatient wing as a result of a tornado. Prior to January 3, 1993, the hospital files a request with the servicing CMS Regional Office for an additional payment under the extraordinary circumstances provision along with the following supporting documentation:

- Evidence of the extraordinary circumstance from public media releases, insurance company and public agency damage reports;
- Independent capital replacement and repair cost estimates from architects and construction firms, and current equivalent equipment replacement cost statements from manufacturers and suppliers; and
- An explanation with appropriate documentation of the extent to which the loss will be covered by insurance proceeds and other sources such as government relief funds.

Upon completion of the CMS review process, CMS grants conditional approval for the exception request pending reopening of the wing and verification, by the intermediary, of the net cost to the hospital.

During Hospital X's 1996 fiscal year, the rebuilt wing is reopened. The hospital submits documentation with its cost report that the increase in the hospital's cost base for depreciable assets that is attributable to the hospital's allowable loss on the damaged wing as calculated in accordance with Medicare reasonable cost principles (see §133) and the building repairs equal $6 million. The Regional Office notifies the intermediary and the hospital of final approval of the extraordinary circumstances exception request. Since the increased cost basis is amortized over the remaining life of the wing, Medicare's share of the increased costs is determined in each remaining transition year based on the depreciation and interest expenses in that year attributable to the building damage repairs.

In its cost reporting period beginning January 1, 1998, the hospital reports $400,000 in depreciation and interest expenses attributable to the extraordinary circumstances and $1.2 million in other inpatient capital-related costs. Assuming the hospital is subject to the 70 percent minimum payment level, the minimum payment level for the cost reporting period is $1,180,000 ($400,000 x .85 plus $1,200,000 x .70). If the hospital's capital prospective payments for the cost reporting period are less than this amount, the hospital receives an additional payment equal to the difference between the payments and the adjusted minimum floor, less any cumulative excess payments over the minimum payment levels in prior cost reporting periods.

2807.6 Determination Process.--During the capital-PPS transition period, the intermediary makes interim determinations of the hospital's hospital-specific rate, its old, new and obligated capital costs, the appropriate payment methodology, and the payment amounts for the cost reporting period. Final determinations are not made until after the close of the applicable cost reporting period when final data for that period is available.

Interim determinations are not subject to administrative or judicial review. All final determinations are subject to administrative and judicial review as provided in 42 CFR Part 405, Subpart R.

A. Hospital-Specific Rate Determinations.--If the initial base year cost report has not been settled, the intermediary makes an interim determination of the hospital-specific rate based on the hospital's submitted cost report and notifies the hospital of its determination at least 30 days before the start of the hospital's first cost reporting period beginning on or after October 1, 1991. The final determination of the hospital specific rate normally is made when the base year cost report is settled. The final determination is effective retroactively to the beginning of the hospital's first cost reporting period under the capital-PPS. In cases where the base period cost report remains open only for reasons unrelated to the determination of the hospital-specific rate (when the remaining issues do not affect hospital specific rate calculation), the intermediary issues a final determination as soon as possible instead of delaying until final settlement. Appeal of the final hospital specific rate determination is subject to the rules in 42 CFR Part 405, Subpart R, and therefore, coincides with the settlement of the first capital-PPS cost report the hospital files.

If the hospital requests a redetermination of its hospital-specific rate in accordance with §2807.4E, the intermediary makes an interim determination based on the submitted cost report and notifies the hospital within 90 days of receipt of the hospital's fully documented request. The final determination of the redetermined hospital-specific rate is normally made when the new base year cost report is settled. The final determination of the redetermined hospital-specific rate is effective retroactively to the beginning of the later of the hospital's first cost reporting period under the capital-PPS or the new base year.

The intermediary adjusts the hospital-specific rate to reflect any changes in base year capital-related costs per discharge that result from administrative or judicial review of the initial determination. The adjustments are effective retroactively to the date of the intermediary's initial determination.

B. Payment Methodology Determination.--Any time the intermediary makes a hospital-specific rate determination, the intermediary also determines which payment methodology is applicable based on a comparison of the hospital-specific rate and the Federal rate for the cost reporting period and notifies the hospital of its determination. The intermediary makes an interim payment methodology determination until it makes a final determination of the hospital-specific rate. If the hospital is receiving Federal rate payment adjustments for indirect teaching costs or for serving low income patients, the intermediary continues to make an interim determination until the cost report for the applicable cost reporting period under the capital-PPS is settled. Until the cost report is settled, the intermediary makes the comparison using the best available estimate of the payment adjustments for indirect teaching costs and disproportionate share applicable during the cost reporting period.

The intermediary makes a final payment methodology determination when a final determination of the hospital-specific rate has been made and the cost report under the capital-PPS (the first year or a redetermination base year, as applicable) has been settled. The final determination is effective retroactively to the beginning of the later of the hospital's first cost reporting period under the capital-PPS or the new base year. If the hospital-specific rate is adjusted as a result of administrative or judicial review, the intermediary makes a new payment methodology determination on the basis of the new hospital-specific rate. The new determination is effective with the beginning of the cost reporting period in which the new hospital-specific rate is applicable.

C. Determination of Payment Amounts.--The payment rates under the capital-PPS are determined prospectively; however, since the amount of payment during the transition may depend in part on adjustments made to rates and costs, adjustments to the actual payment amounts may be made when the cost report is settled.

1. Fully Prospective Payment Methodology.-- If a hospital is paid under the fully prospective payment methodology, the intermediary makes a final determination of any Federal rate payment adjustments for indirect teaching costs and for serving low income patients based on the final cost report data. In addition, the intermediary makes a determination of any additional amounts payable under the exceptions process.

2. Hold Harmless Payment Methodology.--If a hospital is paid under the hold harmless payment methodology, the intermediary makes interim payments based on the best available data concerning the hospital's old and new capital costs for the cost reporting period. For the hospital's first cost reporting period under the capital-PPS, this data usually includes supplemental information submitted by the hospital estimating its discharges and old capital-related costs for the first period that the hospital is subject to the capital-PPS. The supplemental information must be submitted by the hospital in sufficient time for the intermediary to take it into account in its interim determination. If the necessary data and cost report(s) are not available to the intermediary, the intermediary bases its determination on the available information.

The intermediary makes the final determination of the hospital's payments under the hold harmless payment methodology, including any additional amounts payable under the exceptions process, when the cost report is settled based on the hospital's actual old and new capital costs and Federal rate payments for the cost reporting period.

In addition to the intermediary's final determination of the hold harmless payment amounts for the cost reporting period, the intermediary's final determination of assets that qualify for recognition as old capital and any limitation on the amount of capital-related costs that are recognized as old capital costs is subject to administrative and judicial review for the first cost reporting period for which the determination affects the amount of program reimbursement. If administrative or judicial review results in an adjustment to old capital costs, the adjustment is effective with the intermediary's initial determination.

2807.7 Payments to New Hospitals.--A new hospital is a hospital that has operated (under current or previous ownership) for less than two years and does not have a 12-month cost reporting period (or a combination of cost reporting periods covering at least 12 months) ending on or before December 31, 1990. A new hospital is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost reporting period ending at least two years after the hospital accepts its first patient. The new hospital exemption is only available to those hospitals that have not received reasonable cost payments in the past and need special protection during their initial period of operation. The exemption does not apply to a facility that opens as an acute care hospital if that hospital operated in the past, under current or previous ownership, and has an historic asset base. Also, a hospital that replaces its entire facility (regardless of change of ownership) does not qualify for a new hospital exemption even if it experiences a significant change in its asset base. Thus, the new hospital exemption does not apply in the following situations:

- A hospital that changes status from an excluded hospital paid under §1886(b) of the Act (i.e., TEFRA limitation on reasonable cost reimbursement) to an acute care hospital subject to PPS;

- A hospital that has been in operation for more than 2 years but has been participating in the Medicare program for less than 2 year;

- A hospital that closes and then reopens under the same or different ownership; or

- A hospital that builds a new or replacement facility at the same or a new location, even if a change in ownership or new leasing arrangements are involved.

For its first cost reporting period beginning at least 2 years after a new hospital accepts its first patient, the hospital is paid under the applicable capital-PPS payment methodology based on a comparison of its hospital-specific rate and its adjusted Federal rate in accordance with §2807.4D. The base year used to establish the hospital-specific rate is the new hospital's 12-month or longer cost reporting period (or combination of periods totaling at least 12 months) that begins at least one year after the hospital accepts its first patient. The hospital's allowable capital-related costs for land and depreciable assets that were put in use on or before the last day of its base year cost reporting period qualify as old capital costs. The limitations in §2807.3B on the amount of capital-related costs that are recognized as old capital costs apply except that the limitations are based on the amount that the hospital is obligated to pay as of the last day of its base year cost reporting period instead of December 31, 1990.

If the new hospital is paid under the fully prospective payment methodology, the hospital is paid based on the appropriate Federal/hospital-specific blend. If the hospital is paid based on the hold harmless payment methodology, it is eligible to receive a hold harmless payment for up to 8 years, beginning with the cost reporting period that it first begins to receive prospective payments. The hold harmless payment may continue beyond the FY 2001 cut-off for hold harmless payments to other hospitals. However, eligibility to receive an exceptions payment ceases with the hospital's cost reporting period beginning in FY 2001.

The rules for obligated capital are applicable to new hospitals without modification. (See §2807.3C.) As is the case with other hospitals, a new hospital may request that its hospital-specific rate be redetermined through the later of its cost reporting period beginning in FY 1994 or the cost reporting period beginning after obligated capital that is recognized as old capital is put in use. (See §2807.4E.)

If a hospital has been in operation for more than two years as of December 31, 1990, but does not have a 12-month cost reporting period ending before December 31, 1990, because it is newly participating in the Medicare program, the hospital does not qualify as a new hospital. The hospital's base year is its first 12-month cost reporting period (or combination of cost reporting periods totaling 12 months) under the Medicare program. However, the hospital's old capital costs are based on its capital-related costs attributable to assets that were put in use for patient care as of December 31, 1990, and the hospital is subject to all other capital-PPS transition payment rules. (See §2807.4A for implementing capital-PPS transition rules in such cases.)

2807.8 Gain or Loss on Disposal of Old Capital.--Under Medicare's reasonable cost principles (see §§132 ff.), a gain or loss to correct depreciation expense claimed upon disposal of an asset is recognized in the year that the asset disposal takes place, even though some portion of the gain or loss applies to the years prior to the asset disposal. However, in determining Medicare's share of the gain or loss, the gain or loss is spread over the cost reporting periods for which Medicare shared in the cost of the asset. Medicare's share of the gain or loss applicable to prior cost reporting periods is determined based on Medicare utilization in each of the prior cost reporting periods and is recognized as a prior period adjustment on the settlement worksheet (Worksheet E) of the Medicare cost report (Form CMS-2552). The portion of the gain or loss applicable to the cost reporting period during which the disposal occurs is reflected in that period's costs.

A. Disposal Occurring in the Base Year.--If there is a gain or loss in the capital-PPS base year, only that portion of the gain or loss applicable to the base year is reflected in the hospital-specific rate. The remaining gain and loss amounts are ascribed to prior years on the Worksheet E.

B. Disposal Occurring After the Base Year.--After a hospital becomes subject to the capital-PPS, the treatment of the gain or loss adjustments for current and prior cost reporting periods is dependent upon the capital-PPS payment methodology applicable to the hospital. In all cases, any adjustment to prior periods reflects the appropriate capital discount applicable to that period. In the few cases where gains or losses on disposals are carried forward to future periods, any adjustment depends on the capital-PPS methodology under which the hospital is paid in each cost reporting period for old capital costs and, as appropriate, the provisions of 42 CFR 413.134(f).

1. Fully Prospective Payment Methodology.--For hospitals paid under the fully prospective methodology, prior period adjustments in these cases are made as Medicare Part A settlement adjustments only for those years prior to the capital-PPS since reasonable cost reimbursement was only applicable in those periods. This does not affect the hospital-specific rate determination if the base year is a prior adjustment period. (See §2807.4B.) Medicare Part B adjustments are made for all cost reporting periods. For new assets purchased and disposed of after the hospital's capital-PPS effective date, only the gain or loss applicable to Medicare Part B payments may be reflected as a cost reporting adjustment.

2. Hold Harmless Payment Methodology.--Under the hold harmless methodology, gains or losses on disposals after the effective date of the capital-PPS for hospitals paid based on 100 percent of the Federal rate are handled in the same fashion as fully prospective methodology hospitals. For hospitals receiving a hold harmless payment for old capital, the gain or loss on old capital assets is handled through the cost report for appropriate period adjustments, pursuant to the appropriate capitalization policies in 42 CFR 413.134(f), for both Medicare Part A and Part B, and for both the pertinent capital-PPS and prior periods. In the case of disposal of new capital assets by a hospital paid under the hold harmless method, only gains or losses on disposal of such assets that are applicable to Medicare Part B payments are adjusted on Worksheet E of the cost report.

C. Change of Ownership.--Gains or losses associated with a change of ownership situation must be treated in accordance with special rules due to the provisions of §1861(v)(1)(o) of the Act. If the sale price of the asset is greater than or less than the net book value of the asset and cost reimbursement rules are applicable to Medicare capital payments in the prior period, Medicare adjusts for the resultant gain or loss, respectively. This adjustment, which represents a correction of Medicare's share of the depreciation recognized during the years that the asset was in use, is made to the seller's share of Medicare payments in the year that the asset is sold. For treatment of the purchaser's costs and any effect on the hospital's capital-PPS payment methodology or amount, see §2807.9 regarding change of ownership situations.

2807.9 Change Of Ownership.--

A. Single Hospital Involved.--If there is a change of ownership involving a single hospital during its base period under the capital-PPS, the base period capital-related costs used to determine the hospital-specific rate include any portion of the old owner's gain or loss that is attributable to the base year only. The base year capital-related costs do not include any prior period adjustments for the gain or loss. The base period capital-related costs are used to determine the new owner's hospital-specific rate and to identify its old capital costs that qualify for any hold harmless payment.

If there is a change of ownership subsequent to the base period, the new owner receives capital-PPS payments under the same payment methodology and rates as the previous owner if the change of ownership results in a single surviving hospital. If the hospital is paid under the fully prospective methodology, the new owner may request that its hospital-specific rate be recalculated based on its old capital costs in a cost reporting period beginning subsequent to the initial base year, if appropriate under §2807.4E. If the hospital is paid under the hold harmless methodology, the depreciation costs associated with the old capital assets in patient care use as of December 31, 1990, may decline if the purchase price of the new owner affects the valuation under the original depreciation schedule used to establish the old capital costs for those assets. However, the depreciation costs cannot increase since the same depreciation guidelines used in the hospital's base period must be maintained in determining any change in the old capital asset valuation in accordance with 42 CFR 412.302(b)(1).

B. Formation of Separate Hospitals.--If a change of ownership, or other action, involving a multi-campus hospital results in the formation of two separate PPS hospitals from facilities that are subject to capital-PPS payments, the intermediary determines a new hospital specific rate for each separate hospital effective with the date of dissolution. The intermediary determines if the base year capital-related costs for each hospital can be reconstructed. If the base year capital-related costs can be reconstructed, the hospital-specific rate for each hospital is recomputed based on the original base period costs. If the base year capital-related costs for each hospital cannot be reconstructed based on the original base year records, each hospital's hospital-specific rate is recalculated, pursuant to the guidelines in §2807.4, by establishing the respective hospital's base year as its first 12-month or longer cost reporting period (or combination of cost reporting periods covering at least 12 months) subsequent to the dissolution. In determining each hospital's old capital-related costs, the amount that is recognized as old capital is limited to the capital-related costs attributable to assets in patient care use as of December 31, 1990. The hospitals also are subject to all other transition period rules. Payments are made subject to the requirements in §2807.5. However, during the period before the hospital specific rate is recalculated for each hospital, interim payments for such hospitals are determined by the intermediary on the basis of the best data available prior to receipt of the new base period cost reports. The final hospital-specific rates are applied retroactively to the later of the hospitals' first cost reporting period under capital-PPS or the effective date of the dissolution that required the recalculation.

C. Hospital Merger or Consolidation.--If two or more hospitals merge or consolidate into one hospital during the base period, the hospitals' latest cost reporting period(s) of at least 12 months duration ending on or before December 31, 1990, is the base period, and an average discharge-weighted, hospital-specific rate is calculated.

NOTE: This provision for recalculation of the hospital-specific rate, and any applicable effect on the capital-PPS payments due the resulting hospital, is applicable only to those cases that meet the previously existing capital-related reasonable cost rules regarding the criteria for recognizing a merger or consolidation in 42 CFR 413.134(k). In cases in which the merger or consolidation rules are not met, the transaction is treated simply as a normal asset acquisition for Medicare program purposes. Thus, even if a hospital purchases the entire stock of assets of another hospital without meeting the merger or consolidation criteria (e.g., when a hospital has filed for bankruptcy and all the assets are purchased by another hospital at auction or through the court), those assets of the acquired hospital are considered new capital for the purchasing hospital.

EXAMPLE: Hospital A merged with Hospital B (pursuant to 42 CFR 413.134(k)(2)(ii)) on September 1, 1990, and Hospital B is the surviving hospital. Hospital A had a fiscal year ending June 30, 1990, and Hospital B had a fiscal year ending December 31, 1990, which it retains after the merger. The following data is obtained for each hospital:

	Medicare Discharges	Medicare Inpatient Capital Cost	Case Mix Index	Case Mix Adjusted Cost Per Case
Hospital A:				
FY End 6/30/90	1,200	$1,200,000	1.12	$892.86
Short Period 7/01/90 - 8/31/90	410	400,000	1.14	$855.80
Hospital B:				
Short Period 1/01/90 - 8/31/90	1,100	2,400,000	1.18	$1,849.00
Short Period 9/01/90 - 12/31/90	700	980,000	1.15	$1,217.39

Hospital A's combined adjusted base year cost is determined as:

$$\frac{(\$892.86 \times 1200) + (\$855.80 \times 410)}{1200 + 410} = \$883.42$$

Hospital B's combined adjusted base year cost is determined as:

$$\frac{(\$1849.00 \times 1100) + (\$1217.39 \times 700)}{1100 + 700} = \$1,603.37$$

The combined adjusted base year cost per case for each hospital is multiplied by the applicable update factor:

Hospital A: $883.27 x 1.17858 = $1,041.00
Hospital B: $1,603.37 x 1.14272 = $1,832.20

The combined average cost per case is then determined by weighting for the applicable number of discharges.

$$\frac{(\$1,041.00 \times 1610) + (\$1,832.20 \times 1800)}{1610 + 1800} = \$1,458.64$$

The combined cost per case is then multiplied by the FY 1992 exceptions reduction factor and the budget neutrality adjustment factor to yield the hospital-specific rate:

.9813 x $1,458.64 = $1,431.37
.9602 x $1,431.37 = $1,374.40

The hospital-specific rate of $1,374.40 is then used to determine the payment methodology that is applicable during the transition period. The assets and other capital-related costs on the books of the merged facilities as of December 31, 1990, are recognized as old capital for hold harmless determination purposes as well as any obligated costs of either hospital that meet the requirements in §2807.3C.

If the merger or consolidation occurs after the base period, an average hospital-specific rate, weighted as in the above example by the number of base year discharges, is determined based on each hospital's base year data and compared to the Federal rate applicable to the resulting hospital to determine which payment methodology the hospital is paid during the remainder of the transition period. If the weighted hospital-specific rate is below the Federal rate, the hospital is paid under the fully prospective methodology during the remainder of the transition even if one of the hospitals had been paid under the hold harmless methodology prior to the merger. The weighted hospital- specific rate is applied effective with the date of the merger. The capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990, are recognized as old capital costs during the remaining transition period. If the hospital is paid under the hold harmless methodology after the merger, only the capital-related costs for the remaining old capital are eligible for hold harmless payments.

2810 SPECIAL TREATMENT OF SOLE COMMUNITY HOSPITALS UNDER THE INPATIENT PROSPECTIVE PAYMENT SYSTEM

Effective with cost reporting periods beginning on or after October 1, 1983, Medicare pays most hospitals for inpatient operating costs on the basis of prospectively determined rates per discharge, as described in §2801. (See §2803 for excluded hospitals.) However, the law requires special payment provisions for sole community hospitals (SCHs) that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of inpatient hospital services reasonably available in a geographic area to individuals who are entitled to Part A benefits under the program. For guidance on the special treatment of SCHs for cost reporting periods beginning prior to January 1, 2009, see 42 CFR 412.92(d). For cost reporting periods beginning on or after January 1, 2009, approved SCHs are paid based upon whichever of the following yields the greatest aggregate payment for the cost-reporting period:

- The IPPS Federal rate;
- The greatest of the updated hospital-specific rate based on fiscal years (FY) costs per discharge for FY 1982, FY 1987, FY 1996, or FY 2006.

A. Criteria for SCH Classification.--

1. Automatic Classification.--A hospital that has been granted an exemption from the hospital cost limits as an SCH before October 1, 1983, or whose request for the exemption was received by the appropriate Medicare Administrative Contractor (contractor) before October 1, 1983, and was subsequently approved, is classified as an SCH under the inpatient prospective payment system (IPPS) unless there is a change in the circumstances under which the classification was approved. An example of a situation in which an existing SCH's continued classification is questioned is the opening of another hospital in the area. In evaluating whether SCH classification continues, CMS considers whether the hospital meets the criteria with respect to isolation and serving as the sole source of care reasonably available to Medicare beneficiaries.

2. All Other Hospitals.--A hospital that requested SCH designation on or after October 1, 1983, may be classified as a SCH and receive payment adjustments under the IPPS if it is located in a rural area and meets the criteria in (a), (b), (c), or (d) below. A hospital that requested SCH designation on or after June 4, 1991, may be classified as a SCH and receive payment adjustments under the IPPS if it meets (a) below, or is located in a rural area and meets (b), (c), or (d) below.

a. The hospital is located more than 35 miles from other like hospitals.

b. The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

(1) No more that 25 percent of the residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted for care to other like hospitals within a 35 mile radius of the hospital or, if larger, within its service area; or

(2) The hospital has fewer than 50 beds and the contractor certifies that the hospital would have met the criteria in item (1) were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital.

(3) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each year for 2 out of 3 years.

c. The hospital is located between 15 and 25 miles from other like hospitals, but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years.

d. Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

In evaluating the distance between hospitals, CMS measures the most direct (i.e., shortest) route between the facilities using improved road miles. An improved road is a road that is maintained for regular use by a governmental entity (i.e., local, State, or Federal) and that is available for use by the general public.

The term "like hospitals," for purposes of making a determination on SCH designations, applies to those hospitals furnishing short-term acute care services. For cost reporting periods beginning on or after October 1, 2002, a hospital is defined as a "like hospital" if the total inpatient days attributable to units of the hospital that provides a level of care characteristic of the level of care payable under the acute care hospital IPPS are greater than 8 percent of the similarly calculated total inpatient days of the hospital seeking SCH classification. For example, a hospital that has an intensive care unit would not be classified as an SCH on the basis that another neighboring acute care hospital does not furnish this specialty service. The neighboring acute care hospital can be considered a like hospital even if it does not furnish a particular specialty service.

A hospital's service area is the area from which the hospital draws at least 75 percent of its inpatients during the most recently completed cost reporting period ending before it files for SCH status. A hospital may define its service area as the lowest number of ZIP codes from which the hospital draws at least 75 percent of its inpatients, or it may use boundaries established by the statewide health planning agency. Additionally, documented data from any independent source that can be used to identify the hospital's service area, such as a State hospital association, will be considered and reviewed, provided that CMS is able to verify that a hospital drew at least 75 percent of its inpatients from the defined service area.

B. Requesting SCH Classification.--A hospital that believes it qualifies as a SCH under the criteria listed above may submit a written request to be designated as an SCH to its contractor at any time during its cost reporting period. The hospital's request must include the following documentation to substantiate its request:

1. Information on Requesting Hospital.--A hospital's request must show the requesting hospital's name, address, county, urban/rural classification, type, bed size, and provider number.

2. Location of Neighboring Hospitals.--The hospital must submit the name and address of all hospitals within a 35-mile radius of the requesting hospital. In addition, the requesting hospital must submit a detailed road map showing the most direct route to each neighboring hospital using "improved roads" as defined above and actual road mileage to each hospital.

3. Utilization Data.--If a hospital is requesting SCH classification on the basis that it is located between 25 and 35 miles of another hospital and no more than 25 percent of the service area residents utilize services at another hospital (see subsection A.2.b.), the requesting hospital must submit the following information on utilization and service areas.

a. A map depicting the hospital's service area and a description of how the service area was determined must be submitted.

b. If a statewide planning agency has not established the boundaries of the hospital's service area, admissions data showing the address of every patient admitted during the most recently completed cost reporting period must be submitted. Admissions data must be displayed so that the reviewer may easily verify the construction of the service area from this documentation. For example, if the service area was established by using postal ZIP codes, the admissions data must be grouped by area ZIP codes.

c. In order to document that no more than 25 percent of the residents or, if applicable, Medicare beneficiaries from the hospital's service area were admitted to other like hospitals for care, admissions data from all hospitals located within 35 miles of the requesting hospital or, if larger, the requesting hospital's service area, must be analyzed. In many areas, the State hospital association periodically analyzes hospital market areas and can produce the utilization data necessary for making this determination.

In the event that existing data are not available on utilization, the requesting hospital gathers the information necessary to permit an evaluation of utilization of other like hospitals. These utilization data are gathered on general resident usage or Medicare beneficiary utilization. Such data gathering may involve the cooperation of the neighboring hospitals in order to assure that information is valid and reliable.

If a hospital is unable to collect the data necessary to document the percentage of patients it admits, it may request CMS assistance. Using central office records, CMS can furnish data on Medicare admissions to identified hospitals for specific periods of time. The hospital's request is submitted through its contractor and must include its full name, provider number, and a statement that it is requesting admissions information for SCH qualification. The hospital's request must furnish a listing of ZIP codes within the hospital's service area and it must provide the full name and address and, if available, the Medicare provider number of every other hospital located within the larger of the hospital's service area or a 35-mile radius. The request must also include the beginning and ending dates of the hospital's most recently completed cost reporting period.

If a hospital fails to achieve SCH status based on CMS-generated data, it may not substitute other patient-origin data for the same time period. That is, once a hospital elects to have CMS furnish the patient origin data, only CMS data are considered in the determination.

If general resident utilization is used, the documentation may be gathered from a sample period. However, the sample period must be of sufficient duration to produce reliable results. A minimum of 6 months of admission data, or such other sample as the CMS Regional Office finds acceptable, is essential for this evaluation.

Since the universe of Medicare beneficiary utilization is significantly smaller than general resident usage, a sample period is not appropriate for documenting utilization of other like hospitals for only the Medicare beneficiary population. Therefore, in requesting SCH status under this criterion, a hospital must provide utilization data for 12 months using its most recently completed cost reporting period.

Regardless of the population used to document patient origin utilization, the data must be displayed by the requesting hospital so that reviewers may easily verify those patients that reside in the requesting hospital's service area.

EXAMPLE: Hospital A (the requesting hospital) is located 27 miles from Hospital B and 30 miles from Hospital C. Hospital A defines its service area as postal ZIP codes 21345, 21347, and 21350. The following is a summary of the admissions data submitted.

	Number of Admissions			Total
Area	Hospital A	Hospital B	Hospital C	Admissions
21345	300	50	25	375
21347	250	25	50	325
21350	500	50	50	600
Total	1,050	125	125	1,300
Other Areas	275	1,000	525	1,800
Grand Total	1,325	1,125	650	3,100

Thus, of the 1,300 patients in Hospital A's service area who have been hospitalized during the year, only 19 percent (250) received services from other hospitals.

d. The criterion in A.2.b.(2) provides that hospitals with fewer than 50 beds that do not meet the criterion in B.3.c. may provide additional data to justify the reasons residents or beneficiaries sought care outside the service area. This alternative is available only to these small rural hospitals that are located between 25 and 35 miles of other like hospitals. Qualifying hospitals requesting SCH status under this provision gather the necessary data using the patient origin data obtained under B.3.c. The hospital obtains information as to the diagnoses and services necessary for those residents or Medicare beneficiaries who obtained care outside the requesting hospital's service area during the survey period. If the hospital is unable to obtain the data from any other source, the contractor provides assistance by making available Medicare discharge data by patient origin for neighboring hospitals.

The hospital must group the cases by type of service to simplify and expedite the contractor's certification process. For example, assume the utilization data showed that, of the 1,300 patients in Hospital A's service area who were hospitalized during the survey period, 500 patients (38.5 percent) were admitted to alternative hospitals. However, Hospital A obtained certifications

that 200 patients required intensive care unit services and 50 were obstetrical patients. Hospital A does not provide either of these services. Therefore, these cases are removed from both the out-of-area services and the total services, leaving utilization data for Hospital A's service area of 800 of 1,050 total cases (76.2 percent) treated at Hospital A. Consequently, the hospital meets the criteria for SCH designation.

4. Accessibility Data.--If a hospital is requesting SCH classification on the basis that it is at least 15 miles from another hospital but, because of local topography or severe weather conditions, the other hospital is inaccessible for more than 30 days in each year for 2 out of 3 years, the requesting hospital must submit data to document a history of such inaccessibility. The fact that alternative hospital services were not available for a total of 30 days in a single 12-month period is not sufficient evidence to substantiate the prolonged and predictable inaccessibility intended in this criterion. Thus, we are requiring official documentation demonstrating inaccessibility for 30 days in each year for 2 out of 3 years. Documentation, such as reports of a State highway department or local public safety officials, must specify the location of the road closure and the periods of time the road was inaccessible. In addition, the requesting hospital must detail the alternate route to the neighboring hospital and the mileage using the alternate route.

C. Approval of SCH Classification.--The contractor reviews the documentation submitted by the requesting hospital. If the request is incomplete, the contractor contacts the hospital to obtain additional information. Once all the necessary data have been obtained, the contractor forwards the completed package to the appropriate CMS Regional Office with its recommendation for further action.

The CMS Regional Office makes the final determination on the hospital's request and responds in writing to the contractor. The hospital receives notification of the decision from its contractor. For applications received on or before September 30, 2018, SCH status becomes effective for discharges occurring 30 days after the date of CMS approval except as provided in 42 CFR 412.92(b)(2)(v). For applications received on or after October 1, 2018, SCH status is effective as of the date the MAC receives the complete application, except as provided in 42 CFR 412.92(b)(2)(v). There are no retroactive effective dates on SCH designations other than requests granted by a court order or PRRB decision.

Once a hospital has been designated as an SCH, it retains that classification indefinitely unless there is a change in the circumstances under which the classification was approved suggesting a need for reevaluation or the hospital requests its SCH classification be cancelled.

D. Cancellation of SCH Classification.--It might be to a hospital's advantage in certain instances to give up its SCH classification and elect to be paid as other hospitals in the region. Therefore, a hospital may voluntarily cancel its SCH classification at any time by notifying the Regional Office in writing of its request. The Regional Office notifies the contractor of the decision.

Hospitals are expected to notify the Regional Office in advance of their decision to give up their SCH designations. No SCH cancellations are made effective retroactively. The change to fully national rates becomes effective no later than 30 days after the hospital submits its request. The "no later than 30-day" time frame allows the hospital, the Regional Office, and the contractor to select a mutually agreeable date, e.g., at the end of a month.

Once a hospital gives up its SCH designation, it may reapply for SCH status only after one full year has passed since the cancellation was effective. SCH status is granted to the hospital only if it meets the qualifying criteria in effect at the time it reapplies.

2810.1 Additional Payments to SCHs that Experience a Decrease in Discharges.--If, due to circumstances beyond its control, a hospital that is classified as a SCH experiences a decrease of more than five percent in its total number of discharges compared to the immediately preceding cost reporting period, the hospital may receive a payment adjustment. This additional payment provision applies to cost reporting periods beginning on or after October 1, 1983. For additional payments to a Medicare dependent hospital (MDH) that experiences a decrease in discharges, see 2810.1.H.

A. Criteria for Determining Eligibility for Additional Payments.--A provider that qualifies as a SCH, for at least a part of the cost reporting period, may qualify for a volume decrease adjustment (VDA) payment when the hospital meets the following criteria:

1. Circumstances Beyond the Hospital's Control.--The decrease in discharges must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects. CMS will take into consideration how frequently a SCH requests this adjustment and/or uses a particular set of circumstances to request this adjustment, and whether or not the SCH took reasonable steps to mitigate the cause of the decrease in discharges (for example, recruiting efforts to replace a physician, efforts to cut costs where possible etc.).

2. Decrease in Discharges.--A SCH must experience a more than five percent decrease in its total discharges of inpatients as is compared to its immediately preceding cost reporting period. If a hospital experiences an occurrence toward the end of a cost reporting period that does not result in more than a five percent decrease in total discharges for the cost reporting period, additional payments are not made to the hospital (see Example A). Similarly, if a hospital experiences an occurrence that results in a sustained decrease in total discharges, each cost reporting period must be compared to each immediately preceding cost reporting period, and an adjustment is made only for a cost reporting period where the change resulted in a decrease more than five percent of the total discharges (see Example B).

EXAMPLE A: The nursing staff of Hospital X, a SCH, went on strike 6 weeks before the end of the cost reporting period ending December 31, 2004, resulting in a sharp decrease in discharges during the end of that period and the beginning of the next period.

- Discharges for the cost reporting period ending December 31, 2003, equal 2,500.
- Discharges for the period January 1, 2004, through November 15, 2004, equal 2,400.
- Discharges for the period November 16, 2004, through December 31, 2004, equal 10.
- Discharges for the period ending December 31, 2005, equal 2,410.

In this case, Hospital X is not eligible for additional payment because there was not a more than five percent decrease in total discharges from the previous cost reporting period (2,500 vs. 2,410 = 3.6 percent decrease).

EXAMPLE B: Hospital Y's community physician retires in January of its cost reporting period ending September 30, 2004. This results in a sustained lower case load until June 2005, when the physician is replaced.

- Discharges for cost reporting period ended September 30, 2003, equal 5,000.
- Discharges for cost reporting period ended September 30, 2004, equal 3,000.
- Discharges for cost reporting period ended September 30, 2005, equal 3,500.

Additional payment is available only for the cost reporting period ending September 30, 2004. Even though discharges for the period ending September 30, 2005, were more than five percent less than the cost reporting period ending September 30, 2003, an adjustment for this period is not available because the comparison must be made to the immediately preceding cost reporting period.

B. Amount of Payment Adjustment.--Additional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total payment for inpatient operating costs.

Fixed costs are operating costs that remain constant and do not vary with short-term changes in hospital operations and business practices. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food, laundry costs, billable medical supplies, and billable drug costs.

In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with utilization. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.

In evaluating semi-fixed costs, the contractor considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semi-fixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses to align them with revised expectations for volume projections. Therefore, if a hospital did not take such action, some of the semi-fixed costs may not be included in determining the amount of the payment adjustment.

The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The contractor reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

C. Requesting Additional Payments.--A SCH must submit a VDA request, by mail or electronically, to its contractor. The SCH may submit the VDA request by mail or electronically with its submission of the cost report for the period for which the VDA payment is requested, or any time following the submission, but no later than 180 days after the date of the Notice of Program Reimbursement for that cost report. The request must include the following documentation or the information must be readily available to the contractor.

1. General Information.--The VDA request must be signed by an official of the hospital and include the requesting hospital's name, address, provider CCN, and date of classification as a SCH.

2. Discharge Data.--The SCH must submit data on the number of discharges in the cost reporting period for which the payment adjustment is being requested and the number of discharges in the cost reporting period immediately preceding the period in question. If either the preceding cost reporting period or the period in which the decrease occurred is not 12 months in duration, the hospital must annualize discharges in the short cost reporting period.

EXAMPLE: A hospital requests a VDA payment for a less-than-12-month cost reporting period and a 12-month cost reporting period. For the less-than-12-month cost reporting period, the total discharges must be annualized.

Cost Reporting Period	Discharges
January 1, 2004 through December 31, 2004	1,500
January 1, 2005 through May 31, 2005	600
June 1, 2005 through May 31, 2006	1,225

Discharges for cost reporting period ending May 31, 2005, are annualized to 1,440 discharges (600 ÷ 5 = 120 x 12 = 1,440).

The provider is not eligible for an adjustment for cost reporting period ending May 31, 2005, as discharges only decreased 4 percent (1500 - 1440 = 60 ÷ 1500 = 4 percent).

The provider is eligible for an adjustment for cost reporting period ending May 31, 2006, as discharges decreased 14.9 percent (1440 - 1225 = 215 ÷ 1440 = 14.9 percent).

3. Circumstances.--The hospital's request must include documentation outlining the circumstances that resulted in the decrease in discharges. This must include a narrative description of the occurrence, date of its onset, date of its conclusion as applicable, and how it affected the number of discharges.

4. Cost Data.--The hospital's request must identify the cost reporting period for which the VDA is requested and the immediately preceding cost reporting period. The hospital must demonstrate that the total Program inpatient operating cost, excluding pass-through costs, exceeds total payment for inpatient operating costs (the higher of the federal payment amount or the hospital-specific payment amount) plus the operating portion of a provider's low volume hospital payment adjustment (42 CFR 412.101). For example, total Program inpatient operating cost excluding pass-through costs, reported on Form CMS-2552-10, Worksheet D-1, Part II, line 53, must exceed the total payment for inpatient operating costs reported Form CMS-2552-10, Worksheet E, Part A, line 49, plus the operating portion of a provider's low volume hospital payment adjustment.

5. Costs.--The request must include a narrative description of those actions taken by the hospital to reduce costs and/or align them with revised volume expectations.

6. Core Staff and Services.--

a. For cost reporting periods beginning on or after October 1, 2007, and prior to October 1, 2017, a comparison, by cost center, of full-time equivalent (FTE) employees and salaries in both cost reporting periods must be submitted. The requesting hospital must identify core staff and services in each center and the cost of these staff and services. The request must

include justification of the selection of core staff and services including minimum staffing requirements imposed by an external source. The contractor's analysis of core staff is limited to those cost centers (general service, inpatient, ancillary, etc.) where costs are components of Medicare inpatient operating cost.

Core nursing staff is determined by comparing FTE staffing in the Adults and Pediatrics and Intensive Care Unit cost centers to FTE staffing in the prior year and FTE staffing in peer hospitals. Peer hospital information is obtained from data on nursing hours per patient day using the results of the occupational mix survey or the AHA Annual Survey for hospitals of the same size, geographic area (Census Division), and period of time. Acceptable core nursing staff for a year in which a hospital had a volume decline is the lesser of actual staffing in the prior fiscal year or core staff for the prior fiscal year as determined from the occupational mix survey or the AHA Annual Survey data from peer hospitals. When determining core staff hours for other than a full year, the standard hours worked must be multiplied by the actual number of weeks in the cost reporting period. For example, a hospital with a standard work week of 37.5 hours requesting a VDA for a a cost reporting period of January 1, 2008, through June 30, 2008, has a paid hours per year of 975 (26 weeks x 37.5 hours per week).

EXAMPLE A: Hospital A is a 100-bed SCH located in Nebraska (Census Division 6). Its discharges for its cost reporting period ending June 30, 2008, were 1,160; its discharges for cost reporting period ending June 30, 2007, were 1,450. The hospital is eligible for a payment adjustment on the basis of a 20 percent volume decrease (1,450 – 1,160 = 290 ÷ 1,450 = 20 percent). For cost reporting period ending June 30, 2007, Hospital A had 115.50 routine service (Adults and Pediatrics) nursing FTEs and 21,783 routine inpatient days. Hospital A had 12 intensive care unit (ICU) FTEs and 767 ICU inpatient days. For cost reporting period ending June 30, 2008, Hospital A had 82.14 total nursing FTEs (routine and ICU). Compute the patient care core staff determination for Hospital A as follows:

Hospital A Core Staff Determination Cost Reporting Period Ending June 30, 2008	
Paid average nursing hours per patient day (from FY 2006 Occupational Mix Survey)	19.77
Hospital A total routine days and ICU days (21,783 + 767)	22,550
Core staff hours (19.77 x 22,550)	445,813.50
Paid hours per year (based on standard 40-hour work week)	2,080
Core staff FTEs (445,813.50 ÷ 2,080)	214.33
Hospital A cost reporting period ending June 30, 2007, actual routine service and ICU FTEs (115.50 + 12)	127.50
Hospital A cost reporting period ending June 30, 2008, total actual nursing FTEs	82.14

Hospital A's actual nursing FTEs of 82.14 for cost reporting period ending June 30, 2008, are less than the lower of the actual nursing FTEs of 127.50 from the prior year, or the core staff FTEs of 214.33 calculated from the FY 2006 Occupational Mix Survey data. Hospital A is eligible for a payment adjustment for cost reporting period ending June 30, 2008, up to the difference between its Program inpatient operating cost (excluding cost of excess staffing) and its total payment for inpatient operating costs (including the operating portion of the LVA payment amount) for the fiscal year.

EXAMPLE B: Hospital B is a 75-bed SCH located in Colorado (Census Division 8). Its discharges for its cost reporting period ending September 30, 2012, were 946; its discharges for cost reporting period ending September 30, 2011, were 1,075. The hospital is eligible for a payment adjustment on the basis of a 12 percent volume decrease (1,075 – 946 = 129 ÷ 1,075 = 12 percent). For cost reporting period ending September 30, 2011, Hospital B had 72.35 routine service (Adults and Pediatrics) nursing FTEs and 5,215 routine inpatient days. For cost reporting period ending September 30, 2012, Hospital B had 70.54 nursing FTEs. Compute the patient care core staff determination for Hospital B as follows:

Hospital B Core Staff Determination Cost Reporting Period Ending September 30, 2012	
Paid average nursing hours per patient day (from FY 2009 AHA annual survey)	25.14
Hospital B total routine days	5,215
Core staff hours (25.14 x 5,215)	131,105.10
Paid hours per year (based on standard 40-hour work week)	2,080
Core staff FTEs (131,105.10 ÷ 2,080)	63.03
Hospital B cost reporting period ending September 30, 2011, actual nursing FTEs	72.35
Hospital B cost reporting period ending September 30, 2012, actual nursing FTEs	70.54

Hospital B's actual nursing FTEs of 70.54 for cost reporting period ending September 30, 2012, exceeds the core staff FTEs by 7.51. Hospital B is eligible for a payment adjustment, but its cost in the Adults and Pediatrics cost center must be reduced by the salary costs of the 7.51 FTEs in excess of core staff and the revised the Program inpatient operating cost must be used for the basis of the payment adjustment.

b. For cost reporting periods beginning on or after October 1, 2017, hospitals are no longer required to demonstrate that they adjusted the number of staff in hospital inpatient areas based on the decrease in the number of inpatient days. Contractors are no longer required to adjust the VDA payment amount for excess staffing, and the VDA payment is not subject to the payment ceiling (or cap), which is the lesser of the prior year inpatient operating costs updated to current year dollars or the current year Program inpatient operating costs.

D. Determination on Requests.--The contractor reviews a hospital's request for additional payment for completeness and accuracy; requests missing, incomplete, or inaccurate, documentation; and, makes a determination on the request and notifies the hospital of the decision within 180 days of the date the contractor receives all required information.

1. Types of Determinations.--The contractor may make an interim VDA determination and/or a final VDA determination.

a. Interim VDA Determinations.--The regulations do not preclude a hospital from submitting a request for a VDA prior to issuance of the NPR. The contractor may issue an interim VDA determination prior to issuing the NPR. The interim VDA determination is not appealable and must be followed by a final VDA determination once the contractor issues the NPR. For an interim VDA determination, the contractor:

- notifies the provider of the interim VDA determination;
- specifies on the notification that the decision is an interim VDA determination and not appealable; and,
- includes in the notification that information regarding appeal rights will be included with the final VDA determination.

b. Final VDA Determination.--The contractor issues a final VDA determination either with the NPR or after the NPR has been issued. Only the final VDA determination is appealable. For a final VDA determination, the contractor:

- notifies the provider of the final VDA determination;
- specifies on the notification that the decision is a final VDA determination and informs the provider of their appeal rights;
- issues a Notice of Reopening, if the final VDA determination is not included in the NPR, follows the normal reopening process, and issues a revised NPR; and,
- includes the amount of the interim VDA determination, if applicable, as a tentative payment on Form CMS-2552, Worksheet E-1.
- includes the amount of the final VDA determination on Worksheet E, Part A (line 24, or subscript thereof, on Form CMS-2552-96; or line 70.88 on Form CMS-2552-10).

2. Calculating the VDA Payment Amount.--

If a contractor determines that the procedures in this section, when applied to a specific adjustment request, generate an anomalous result, the contractor may request a review by CMS. This may occur, for example, when the decrease in Medicare discharges is significantly less than the decrease in total discharges.

a. Cost Reporting Periods Beginning Prior to October 1, 2017.--The VDA payment amount is calculated under the same assumption used to evaluate core staff, i.e., the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost. Therefore, the adjustment allows an increase in cost up to the prior year's total Program inpatient operating cost (excluding pass-through costs), increased by the IPPS update factor. The contractor determines a provider's VDA payment amount as the lesser of the pre-ceiling VDA payment or the payment ceiling. The contractor calculates the VDA payment amount as follows:

Step 1--Determine the maximum allowable cost as the lesser of the prior cost reporting period Program inpatient operating cost updated by the IPPS update factor for the cost reporting period for which the provider requests the VDA compared to the actual Program inpatient operating cost of the cost reporting period for which the provider requests the VDA.

Step 2--Determine the payment ceiling as the maximum allowable cost from Step 1 minus the total payment for inpatient operating costs (including the operating portion of the LVA payment amount) for the cost reporting period for which the provider requests the VDA.

Step 3--Determine the pre-ceiling VDA payment as the Program inpatient fixed costs (as identified by the provider and verified by the contractor) for the cost reporting period for which the provider requests the VDA (excluding the cost of excess staffing), minus the total payment for inpatient operating costs (including the operating portion of the LVA payment amount) for the cost reporting period for which the provider requests the VDA.

Step 4--Determine the VDA payment amount as the lesser of the payment ceiling determined in Step 2 or the pre-ceiling VDA payment determined in Step 3.

EXAMPLE A: Hospital C is eligible for a VDA for cost reporting period ending September 30, 2005. Hospital C's Program inpatient operating costs for cost reporting period ending September 30, 2004, were $2,900,000 (Worksheet D-1, Part II, line 53). For cost reporting period ending September 30, 2005, the Program inpatient operating costs were $2,800,000. Hospital C received a LVA payment amount of $200,000 ($180,500 operating and $19,500 capital). The total payment for inpatient operating costs (Form CMS-2552-96, Worksheet E, Part A, line 8) was $2,319,500. The VDA payment amount is calculated as follows:

Step 1: Determine maximum allowable cost.	
Cost reporting period ending September 30, 2004, Program inpatient operating costs	$2,900,000
FFY 2005 IPPS update factor	1.033
Cost reporting period ending September 30, 2004, updated Program inpatient operating costs ($2,900,000 x 1.0330)	$2,995,700
Cost reporting period ending September 30, 2005, Program inpatient operating costs	$2,800,000
Maximum allowable cost (lesser of $2,995,700 or $2,800,000)	$2,800,000
Step 2: Determine the payment ceiling.	
Cost reporting period ending September 30, 2005, total payment for inpatient operating costs (Form CMS-2552-96, Worksheet E, Part A, line 8) plus the operating portion of the LVA payment amount ($2,319,500 + $180,500)	$2,500,000
Payment ceiling ($2,800,000 - $2,500,000)	$ 300,000
Step 3: Determine the pre-ceiling VDA payment.	
Hospital C cost reporting period ending September 30, 2005, Program inpatient operating fixed costs (as identified by provider and verified by contractor)	$2,683,000
Cost of excess staffing	$ 70,000
Cost reporting period ending September 30, 2005, Program inpatient operating fixed costs excluding the cost of excess staffing ($2,683,000 - $70,000)	$2,613,000
Cost reporting period ending September 30, 2005, pre-ceiling volume decrease adjustment payment ($2,613,000 - $2,500,000)	$ 113,000
Step 4: Determine the VDA payment amount.	
VDA payment amount (lesser of $300,000 or $113,000)	$ 113,000

Application of the Payment Ceiling to VDA:

Hospital C's cost reporting period ending September 30, 2005, Program inpatient operating cost was less than that of cost reporting period ending September 30, 2004, increased by the IPPS update factor. Therefore, the payment ceiling is the difference between the cost reporting period ending September 30, 2005, Program inpatient operating costs minus the total payment for inpatient operating costs (including the operating portion of the LVA payment amount).

Hospital C's cost reporting period ending September 30, 2005, pre-ceiling VDA payment is less than the payment ceiling. Therefore, its VDA payment amount is equal to the entire difference between the cost reporting period ending September 30, 2005, Program inpatient operating fixed costs (excluding the cost of excess staffing), and the total payment for inpatient operating costs (including the operating portion of the LVA payment amount), or $113,000.

EXAMPLE B: Hospital D is eligible for a VDA for cost reporting period ending September 30, 2010. Hospital D's Program inpatient operating costs for cost reporting period ending September 30, 2009, were $1,400,000 (Worksheet D-1, Part II, line 53). For cost reporting period ending September 30, 2010, the Program inpatient operating costs were $1,800,000. Hospital D did not receive a LVA payment amount. The total payment for inpatient operating costs (Form CMS-2552-96, Worksheet E, Part A, line 8) was $1,020,000. The VDA payment amount is calculated as follows:

Step 1: Determine maximum allowable cost.	
Cost reporting period ending September 30, 2009, Program inpatient operating costs (Worksheet D-1, Part II, line 53)	$1,400,000
FY 2010 IPPS update factor	1.021
Cost reporting period ending September 30, 2009, Program inpatient operating costs (updated)	$1,429,400
Hospital D cost reporting period ending September 30, 2010, Program inpatient operating costs (Worksheet D-1, Part II, line 53)	$1,800,000
Maximum allowable cost (lesser of $1,429,400 or $1,800,000)	$1,429,400
Step 2: Determine the payment ceiling.	
Cost reporting period ending September 30, 2010, total payment for inpatient operating costs (Form CMS-2552-96, Worksheet E, Part A, line 8)	$1,020,000
Payment ceiling ($1,429,400 - $1,020,000)	$ 409,400
Step 3: Determine the pre-ceiling VDA payment.	
Hospital D cost reporting period ending September 30, 2010, Program inpatient operating fixed costs (as identified by provider and verified by contractor)	$1,544,000
Cost of excess staffing	$ 15,000
Cost reporting period ending September 30, 2010, Program inpatient operating fixed costs excluding the cost of excess staffing ($1,544,000 - $15,000)	$1,529,000
Cost reporting period ending September 30, 2010, pre-ceiling VDA payment ($1,529,000 - $1,020,000)	$ 509,000
Step 4: Determine the VDA payment amount.	
VDA payment amount (lesser of $409,400 or $509,000)	$ 409,400

* From Form CMS-2552-96, Worksheet E, Part A, line 8; or Form CMS-2552-10, Worksheet E, Part A, line 49 (as applicable)

Application of the Payment Ceiling to VDA

Hospital D's cost reporting period ending September 30, 2010, Program inpatient operating costs exceeded that of cost reporting period ending September 30, 2009, increased by the IPPS update factor. Therefore, the payment ceiling is the difference between the cost reporting period ending September 30, 2009, Program inpatient operating costs adjusted by the IPPS update factor minus the cost period ending September 30, 2010, total payment for inpatient operating costs.

Hospital D's cost reporting period ending September 30, 2010, pre-ceiling VDA payment is greater than the payment ceiling. The VDA payment amount cannot exceed the payment ceiling; therefore, Hospital D's final VDA payment amount is equal to the payment ceiling of $409,400.

b. Cost Reporting Periods Beginning on or after October 1, 2017.--The contractor determines a provider's VDA payment amount as the difference between the Program inpatient operating fixed costs and the fixed cost portion of the total payment for inpatient operating costs (including the fixed cost portion of the operating portion of the LVA payment amount). The contractor calculates the VDA payment amount as follows:

Step 1--Determine the fixed cost ratio for the cost reporting period for which the provider requests the VDA by dividing the inpatient fixed and semi-fixed costs (as identified by the provider and verified by the contractor) for the period by the total inpatient operating costs for the period.

Step 2--Determine the fixed cost portion of the Program inpatient operating costs by applying the fixed cost ratio from Step 1 to the Program inpatient operating costs of the cost reporting period for which the provider requests the VDA.

Step 3--Determine the fixed cost portion of the Program payment for inpatient operating costs by applying the fixed cost ratio from Step 1 to the total payment for inpatient operating costs (including the operating portion of the LVA payment amount) of the cost reporting period for which the provider requests the VDA.

Step 4--Determine the VDA payment amount as the fixed portion of the Program inpatient operating costs from Step 2 minus the fixed portion of the Program payment for inpatient operating costs from Step 3.

EXAMPLE C: Hospital E is eligible for a VDA for cost reporting period ending September 30, 2018. Hospital E's total inpatient operating costs were $3,200,000 (inpatient operating fixed and semi-fixed costs, as identified by provider and verified by contractor, were $2,720,000; and variable costs were $480,000). The Program inpatient operating costs were $1,600,000, and the total payment for inpatient operating costs was $1,200,000. Hospital E received a LVA payment amount of $250,000 ($200,000 operating and $50,000 capital). The VDA payment amount is calculated as follows:

Step 1: Determine the fixed cost ratio.	
Cost reporting period ending September 30, 2018, total inpatient operating costs	$3,200,000
Cost reporting period ending September 30, 2018, inpatient operating fixed and semi-fixed costs (as identified by provider and verified by contractor)	$2,720,000
Fixed cost ratio ($2,720,000 ÷ $3,200,000)	.85
Step 2: Determine the fixed cost portion of the Program inpatient operating costs.	
Cost reporting period ending September 30, 2018, Program inpatient operating costs (Worksheet D-1, Part II, line 53)	$1,600,000
Cost reporting period ending September 30, 2018, fixed cost portion of the Program inpatient operating costs ($1,600,000 x .85)	$1,360,000
Step 3: Determine the fixed cost portion of the Program payment for inpatient operating costs.	
Cost reporting period ending September 30, 2018, total payment for inpatient operating costs (Worksheet E, Part A, line 49) plus the operating portion of the LVA payment amount ($1,200,000 + $200,000)	$1,400,000
Cost reporting period ending September 30, 2018, fixed portion of the Program payment for inpatient operating costs ($1,400,000 x .85)	$1,190,000
Step 4: Determine the VDA payment amount.	
VDA payment amount ($1,360,000 - $1,190,000)	$ 170,000

Application of the Fixed Cost Ratio:

Hospital E's cost reporting period ending September 30, 2018, fixed cost portion of the Program inpatient operating costs exceeded the fixed cost portion of the Program payment for for inpatient operating costs. Therefore, the VDA payment amount as determined using the fixed cost ratio is $170,000.

E. Reporting Final Determinations.--Within 5 working days of each VDA final determination, the contractor must complete and email a Volume Decrease Adjustment Report to CMS Central Office (VDADetermination@cms.hhs.gov) with a copy to the appropriate regional office.

When completing the report, the contractor must enter their name; the date of the hospital's VDA request; the hospital name, address, CCN, status (circle the applicable choice); the cost reporting period for which the VDA was requested; and the date of the VDA final determination. If the

contractor denies the VDA request, enter an explanation for the denial. If the contractor grants the VDA request, enter the data elements as applicable, and the provider's explanation for the volume decrease.

Sole Community Hospital / Medicare Dependent Hospital
Volume Decrease Adjustment Report
42 CFR 412.92 and 412.108

Medicare Contractor		
Date of Request		
Provider Name		
Address (City, State, ZIP code)		
CCN		
Status	SCH	MDH
Cost Reporting Period	From:	To:
Date of Final Determination		
Explanation for Denial:		
Granted (enter data elements)		
Total Inpatient Operating Costs		$
Fixed Inpatient Operating Costs		$
Fixed Cost Percentage		%
Program Inpatient Operating Costs		$
Program Inpatient Operating Costs - Fixed portion		$
Total Payment for Inpatient Operating Costs		$
Total Payment for Inpatient Operating Costs - Fixed portion		$
Amount of Adjustment		$
Explanation for Volume Decrease:		

Send to VDADetermination@cms.hhs.gov with a copy to the appropriate Regional Office.

F. Reconsideration.--A hospital that is dissatisfied with the determination on its request for additional payment may request a reconsideration by the contractor. A request for a reconsideration may be based on an alternative interpretation of previously submitted information, on new or additional information, or both. A request for a reconsideration of a contractor's determination must be made within 60 days of the date of the contractor's letter to the hospital notifying it of the determination. A contractor entertains only one request for reconsideration of its determination on each request for a payment adjustment.

G. Appeals.--A hospital that is dissatisfied with the determination on its adjustment request may appeal the determination in accordance with the procedures in 42 CFR 405 Subpart R.

H. A MDH, as defined under 42 CFR 412.108, may also qualify for a VDA in accordance with 42 CFR 412.108(d). The VDA payment amount is determined in accordance with the methodology set forth in 42 CFR 412.92(e)(3), and as described in preceding sections A through G.

2810.2 Reserved for future use.

2810.3 Reserved for future use.

IM 2807 TREATMENT OF RURAL HOSPITALS AS URBAN

Section 1886(d)(8)(B) of the Social Security Act, as enacted by §4005(a) of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), and as amended by §411(b)(4) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), provides that for the purposes of the prospective payment system provisions in §1886(d) of the Act, a hospital located in a rural county adjacent to one or more urban areas shall be treated as being located in the urban area. The amendment is effective October 1, 1988.

This provision does not change the status of small rural hospitals which have qualified to continue to receive periodic interim payments (PIP) under §1815(e) of the Act. Nor does it change the status of small rural hospitals that qualify as "swing-bed" hospitals under §1883 of the Act. We have listed below those counties that will be impacted by this provision. Hospitals located in these counties and which are receiving PIP or participating in the swing-bed program may continue to do so.

Rural County	MSA
Limestone, AL	Decatur, Al
Marshall, AL	Huntsville, AL
Charlotte, FL	Sarasota, FL
Indian River, FL	Fort Pierce, FL
Christian, IL	Springfield, IL
Macoupin, IL	St. Louis, MO-IL
Mason, IL	Peoria, IL
Clinton, IN	Lafayette, IN
Henry, IN	Anderson, IN
Owen, IN	Bloomington, IN
Jefferson, KS	Topeka, KS
Allegan, MI	Grand Rapids, MI
Barry, MI	Battle Creek, MI
Cass, MI	Benton Harbor, MI
Ionia, MI	Lansing-East Lansing, MI
Lenawee, MI	Ann Arbor, MI
Shiawassee, MI	Flint, MI
Tuscola, MI	Saginaw-Bay
City-Midland, MI	
Van Buren, MI	Kalamazoo, MI
Clinton, MO	Kansas City, KS-MO
Cass, NE	Omaha, NE
Caswell, NC	Danville, VA
Currituck, NC	Norfolk-Virginia
Beach-Newport News, VA	
Harnett, NC	Fayetteville, NC
Genesee, NY	Rochester, NY
Columbiana, OH	Beaver County, PA

Rural County	MSA
Morrow, OH	Mansfield, OH
Preble, OH	Dayton-Springfield, OH
Van Wert, OH	Lima, OH
Lawrence, PA	Beaver County, PA
Cherokee, SC	Greenville-Spartanburg, SC
Bedford, VA	Roanoke, VA
Fredericksburg City, VA	Washington, DC-MD-VA
Isle of Wight, VA	Norfolk-Virginia
Beach-Newport News, VA	
Spotsylvania, VA	Washington, DC-MD-VA
Jefferson, WI	Milwaukee, WI
Walworth, WI	Milwaukee, WI
Jefferson, WV	Washington, DC-MD-VA
Lincoln, WV	Charleston, WV

2830. PAYMENT FOR HOSPITAL OUTPATIENT SERVICES

2830.1 General.--Section 9343 of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) contains a number of provisions that have an impact on payments to hospitals for outpatient services. Section 9343(a) imposes a new payment methodology for certain ambulatory surgical procedures performed on an outpatient basis by hospitals. Section 9343(c) prevents unbundling of services furnished to hospital outpatients by requiring that hospitals furnish services to its Medicare patients either directly or under arrangements. Section 9343(f) requires that the Secretary develop designs and models for a prospective payment system for ambulatory surgery performed by hospitals on an outpatient basis by 1989 and to develop designs and models for a prospective payment system for other hospital outpatient services by 1991. Section 9343(g) requires hospitals to report claims for outpatient services using a HCFA Common Procedure Coding System. These provisions serve as the basis for a change in program payment for hospital outpatient services from a cost-based system to a prospective payment system.

Section 4066 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) establishes a new payment methodology for hospital outpatient radiology services furnished on or after October 1, 1988 and other diagnostic procedures performed by hospitals on an outpatient basis on or after October 1, 1989.

2830.2 Bundling of Services Furnished to Hospital Outpatients.--Effective for services furnished on or after July 1, 1987, all hospitals must agree to furnish either directly or under arrangements (as described in '1861(w)(1) of the Act) all items and nonphysician services received by Medicare patients that can be covered as hospital outpatient services when these services are (1) furnished during an encounter with a patient registered by the hospital as an outpatient, or (2) diagnostic procedures or tests (e.g., magnetic resonance imaging (MRI) procedures) furnished outside the hospital but ordered during or as a result of an encounter with an outpatient, if the results of the procedure or test must be returned to the hospital for evaluation. Bundling is required not only for diagnostic and therapeutic services furnished during such an encounter, but also for prosthetic devices (e.g., intraocular lenses (IOLs) implanted or fitted during an encounter in the hospital).

Ambulance service to or from a patient's residence is not subject to the bundling requirement. However, bundling is required for transportation of patients by ambulance or other vehicle regularly used between the hospital and a diagnostic testing site for a test that is bundled.

An encounter is defined as a direct personal exchange, for the purpose of seeking care and rendering health care services, between a patient, who is not an inpatient, and a physician or other practitioner operating within hospital staff bylaws and State licensure law.

The services of certified registered nurse anesthetists (CRNAs) employed by a physician as described in 42 CFR 405.553(b)(4) are not required to be furnished directly or under arrangements by a hospital. If the physician's practice has been to employ CRNAs and bill their services under Part B on a reasonable charge basis, the physician may continue to do so for CRNA services furnished before January 1, 1989.

2830.3 Ambulatory Surgical Procedures Performed On An Outpatient Basis by Hospitals.--Effective for cost reporting periods beginning on or after October 1, 1987, payment for covered ambulatory surgical center (ASC) procedures performed in a hospital on an outpatient basis are based, in part, on what the program pays for the same surgical procedures if performed in an approved ASC. See '2830.20 Exhibit A for the list of covered ASC procedures.

Payments to ASCs for covered ASC procedures are made on the basis of prospectively set rates known as the standard overhead amount, as provided in regulations at 42 CFR 416.125. The ASC facility services covered by the standard overhead amount are generally described in 42 CFR 416.61 and '424 of the Hospital Manual. Covered ASC procedures are classified into four standard overhead amounts or payment groups. The rates applicable to the payment groups are as follows:

Group 1 Procedures	$ 274.00
Group 2 Procedures	$ 326.00
Group 3 Procedures	$ 351.00
Group 4 Procedures	$ 399.00

NOTE: These are the rates which are effective July 1, 1987. ASC payment rates are reviewed and updated annually.

In general, facility services include, but are not limited to, nursing and technician services; use of the facility; drugs; biologicals; surgical dressings; splints, casts and equipment directly related to provision of the surgical procedure; materials for anesthesia; and administrative, recordkeeping and housekeeping items and services. Facility services do not include items and services such as physicians' services; laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure); prosthetic devices; ambulance services; leg, arm, back and leg braces; artificial limbs; and durable medical equipment for use in the patient's home.

Some providers perform simple diagnostic tests just before surgery, e.g., urinalysis and blood hemoglobin or hematocrit. To the extent that such simple tests are provided by the hospital and the charges are included in the operating room or comparable revenue center, they are included in the definition of outpatient hospital facility services.

All nonphysician medical and other health services furnished by an ASC that do not meet the definition of facility services are paid for in accordance with '1833(a)(1) of the Act, based on reasonable charges except for clinical diagnostic laboratory tests which are paid based on a fee schedule.

Effective for hospital cost reporting periods beginning on or after October 1, 1987, the aggregate amount of payment for facility services furnished by a hospital in connection with covered ASC procedures is based on a comparison between two amounts. The payment is the lesser of:

1. The amount that is paid to the hospital for the services under '1833(a)(2)(B) of the Act (i.e., the lower of the hospital's reasonable costs or customary charges for the services, reduced by deductibles and coinsurance); or

2. An amount based on a blend of

    o The amount that is paid to the hospital for the services under '1833(a)(2)(B) of the Act (referred to as the hospital-specific amount); and

- the amount that is paid to a freestanding ASC for the same procedure in the same geographic area, in accordance with '1833(i)(2)(A) of the Act, which is equal to 80 percent of the standard overhead amount net of deductibles (referred to below as the ASC payment amount).

For cost reporting periods beginning on or after October 1, 1987 but before October 1, 1988, the blended amount is determined by using 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount attributable to the procedure. For cost reporting periods beginning on or after October 1, 1988, the blended payment amount is based on 50 percent of the hospital-specific amount and 50 percent of the ASC payment amount. All covered ASC surgical procedures (see Exhibit A) performed in a hospital on an outpatient basis during a cost reporting period are aggregated for purposes of determining the proper payment amount.

For purposes of determining which hospital services are included in the definition of facility services and are subject to the payment limit, hospitals use the same definition of facility services that applies to ASCs. Any services furnished by a hospital in connection with a covered ASC procedure, but which are not within the definition of facility services continue to be paid based either on the lesser of the hospital's reasonable costs or customary charges, or the fee schedule applicable to clinical diagnostic laboratory tests.

The prospectively determined ASC payment rates used to pay ASC facility services are based on data that have been adjusted to remove the effects of differences in wage levels from area to area. Consequently, a wage index developed by the Bureau of Labor Statistics (see '2830.20 Exhibit B) must be applied to the labor component of the ASC payment amount to determine the ASC portion of the blend.

Consistent with payment for freestanding ASCs, if more than one covered ASC surgical procedure is performed on an outpatient by a hospital at one time, the ASC portion of the blended payment amount is based on the full ASC payment amount for the procedure with the highest standard overhead payment amount and 50 percent of the applicable amounts for the remaining procedures.

ASCs operated by hospitals that have an agreement with HCFA to be paid in accordance with 42 CFR 416.30(f) are unaffected by this rule. That is, if a hospital operates a separately certified ambulatory surgical center, the ASC continues to be paid as an ASC.

Surgical procedures furnished by a hospital on an outpatient basis that are not included in the covered ASC surgical procedure listing are reimbursed under existing regulations without regard to the blended payment amount. If any of these surgical procedures are subsequently included in the covered ASC surgical procedure listing, the payment methodology described in this section is applied.

2830.4 Illustration of Payment Method for ASC Procedures Performed by a Hospital.--In a hospital with a cost reporting period beginning on October 1, 1987, 100 covered ASC surgical procedures are performed on an outpatient basis during the cost reporting period. The facts relating to these procedures are as follows (all figures are hypothetical):

Medicare Customary Charges $30,000	(Total Medicare customary charges for facility services for 100 procedures)[1/]
Reasonable Cost $35,000	(Cost of facility services for 100 procedures based on Medicare cost finding and apportionment principles)
Standard Overhead Amounts	(100 procedures X $250, the ASC standard overhead $25,000 amount per procedure)[2/]
Deductibles $7,500	(100 procedures X $75, the Part B deductible)[3/]
Coinsurance $4,500	($30,000 - $7,500 (total deductibles) = $22,500 X 20 percent coinsurance)
Wage Index 1.1698	(Based on Bureau of Labor Statistics Index for an ASC located in Baltimore, Maryland)

1/ The customary charges reflect the accumulation of various hospital departmental charges such as operating room, anesthesia, recovery room, sterile supplies, etc.

2/ Example only - There are four different payment rates depending upon the procedures furnished.

3/ The deductible is charged only if it has not already been met.

The payment for outpatient facility services relating to covered ASC surgical procedures is the blended payment amount of $17,281 calculated as follows:

Lower of Cost/Charge

Customary Charges	$30,000 (Charges less than Cost-$35,000)
Deductibles and Coinsurance	-12,000 ($7,500 + $4,500)
Customary Charges Net of Deductibles and Coinsurance	$18,000

Blended Payment Amount

Standard Overhead Amounts	$25,000
Labor Component = 1/3 X $25,000 = 8,333 X 1.1698 (Wage Index)	$ 9,741
Non-Labor Component = 2/3 X $25,000 = $16,666	+16,666
Adjusted Standard Overhead Amounts	$ 26,407
Deductibles	-7,500
Net Standard Overhead Amounts	$ 18,907
	80%
ASC Payment Rates	$ 15,126
ASC Percentage of Blend	25%
ASC Portion of Blend	$ 3,781
Customary Charges Net of Deductibles and Coinsurance	$ 18,000
Hospital-Specific Percentage of Blend	75%
Hospital-Specific Portion of Blend	$ 13,500
Hospital-Specific Portion	$ 13,500
ASC Portion	+3,781
Blended Payment Amount	$ 17,281

In this example, the blended payment amount of $17,281 is less than the $18,000 amount determined as being the lower of reasonable cost or customary charges, reduced by deductibles and coinsurance. Therefore, the Medicare payment is $17,281.

2830.5 Treatment of Intraocular Lenses (IOLs) Furnished by a Hospital in Connection With An ASC Covered Procedure.--IOLs are subject to the bundling requirements of '2830.2, and must be furnished directly by a hospital or under arrangements. When an IOL is furnished in connection with a covered ASC procedure, the IOL is not considered to be a facility service and is not subject to the payment method described in '2830.3.

Hospitals are subject to the prudent buyer principle (see '2103) and should seek to minimize costs of purchasing IOLs, whenever possible. If a hospital purchases IOLs from a physician or other supplier rather than directly from a manufacturer, the burden of proof rests with the hospital to establish that its purchase is in conformance with the prudent buyer concept. That is, in the absence of extenuating circumstances, the hospital's costs of IOLs cannot exceed the cost of purchasing directly from the manufacturer.

2830.6 Application of ASC Payment Method to All-Inclusive Rate Hospitals.--All-inclusive rate hospitals are subject to the payment method for covered ASC procedures performed by a hospital on an outpatient basis described in '2830.3. That is, as with all other hospitals, facility services furnished in connection with covered ambulatory surgical procedures furnished by all-inclusive rate hospitals on an outpatient basis are reimbursed based on the lower of cost or charges or a blended payment amount. The blended payment amount is partially based on the standard overhead amounts paid to free-standing ambulatory surgical centers for the same surgical procedures.

All-inclusive rate hospitals may be using charges, occasions of service or other statistics to apportion outpatient service costs. Because the ASC payment method applies only to facility services furnished in connection with a covered ASC procedure, an all-inclusive rate hospital, regardless of which method of cost apportionment (i.e., Method A, B or E) it uses, must be able to separate its apportionment statistics (charges, occasions of service, etc.) for a covered ASC procedure to differentiate between the cost attributable to facility services and the cost attributable to other services furnished in connection with the procedure. A hospital must determine the cost of facility services based on appropriate statistics that are consistent with the hospital's current billing and cost apportionment method. Intermediaries are available to assist hospitals in this endeavor. Intermediaries will assure that the cost of facility services thus determined is reasonable in relation to the cost of total hospital outpatient services.

In addition, whether or not a hospital is using charges to apportion its costs, it must determine a charge(s) applicable to ASC facility services for purposes of applying the "lower of cost or charges" reimbursement provision to ASC facility services separately from the "lower of cost or charge" determination for all other Part B services. The separate charges applicable to ASC facility services are also needed for application of blended payment amount. (See '2830.3.)

2830.7 Adjustment of the Outpatient Interim Rate to Recognize the Change in Payment for Ambulatory Surgical Center (ASC) Procedures.--As explained in more detail in "2830.3 and 2830.4, effective for hospital cost reporting periods beginning on or after October 1, 1987, the aggregate amount of payment for facility services furnished by a hospital in connection with covered ASC procedures (ASC facility services) is based on a comparison between two amounts. The payment is the lesser of:

1. The amount that is paid to the hospital for the services under '1833(a)(2)(B) of the Act (i.e., the lower of the hospital's reasonable costs or customary charges for the services, reduced by deductibles and coinsurance); or

2. An amount based on a blend of

o The amount that is paid to the hospital for the services under '1833(a)(2)(B) of the Act (referred to below as the hospital-specific amount); and

o the amount that is paid to an ASC for the same procedure in the same geographic area, in accordance with '1833(i)(2)(A) of the Act, which is equal to 80 percent of the standard overhead amount net of deductibles (referred to below as the ASC payment amount).

For cost reporting periods beginning on or after October 1, 1987 but before October 1, 1988, the blended amount is determined by using 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount attributable to the procedure. For cost reporting periods beginning on or after October 1, 1988, the blended payment amount is based on 50 percent of hospital-specific amount and 50 percent of the ASC payment amount. All covered ASC surgical procedures performed in a hospital on an outpatient basis during a cost reporting period are aggregated for purposes of determining the proper payment amount.

Because the method described above results in payment based on the least of costs, charges or a blended amount, payments for ASC facility services may be reduced. Therefore, a hospital's outpatient interim payment rate may need to be adjusted to reflect a change in payment for ASC facility services. The hospital outpatient interim rate is a single rate applicable to all outpatient services and represents an estimate of the relationship between a hospital's customary charges and its reasonable cost of the services rendered. Therefore, program interim payments for hospital outpatient services are determined on a bill-by-bill basis by applying the interim rate to the hospitals' billed customary charges and subtracting therefrom any applicable deductible and coinsurance amounts.

If it is anticipated that the final program payment for ASC facility services is based on the blended payment amount, a revised interim rate applicable to all outpatient services (ASC facility services and other outpatient services) is determined by substituting the estimated payment for ASC facility services under the new blended payment method for the estimated cost of those services originally used in setting the interim rate. Generally, the adjustment is based on data for at least two months. In order to determine the estimated payment for ASC facility services to be used in calculating a new outpatient interim payment rate, it is necessary to add the estimated beneficiary deductible and coinsurance amounts applicable to the ASC facility services to the estimated blended payment amount.

The following illustrates calculation of payment for ASC facility services and recalculation of the outpatient interim rate based on data for three months:

Facts:

Outpatient interim rate prior to adjustment:

$$\frac{\text{Estimated allowable outpatient Medicare costs}}{\text{Estimated outpatient Medicare charges}} = \frac{\$144,000}{\$160,000} = 90\%$$

Data accumulated for three months from the beginning of the cost reporting period to the date of recalculation:

Medicare charges for ASC facility services (obtained from the Provider Statistical and Reimbursement Report (PS&R))	$20,000
Medicare estimated Cost of ASC facility services ($20,000 x 90% interim rate)	$18,000
ASC payment rates (obtained from PS&R)	$15,000
Deductibles (obtained from the PS&R)	$ 2,000

Calculation of ASC Payment:

Hospital Specific Portion		ASC Portion	
Estimated cost	$18,000	ASC payment rates	$15,000
Deductibles	(2,000)	Deductibles	(2,000)
	16,000		13,000
Coinsurance	(3,600)	ASC coinsurance reduction	x 80%
	12,400		10,400
Hospital specific proportion	x 75%	ASC proportion	x 25%
	$ 9,300		$ 2,600

Blend = $9,300 + $2,600 = $11,900

Recalculation of Interim Rate:

Projected payment for ASC facility services		$ 11,900
Add back coinsurance and deductibles (for interim rate setting purposes)		+ 5,600
Interim payment for ASC facility services based on the ASC payment amount		17,500
Interim payment for ASC facility services based on the lower of costs or charges ($20,000 x 90%)		18,000
Excess interim payments attributable to ASC facility services for 3 months (Note: This amount is recovered by the intermediary at time of adjustment)		500
Projected reduction in interim payment for ASC facility services for the cost reporting period (4 quarters x $500)		2,000
Revised estimated outpatient Medicare payment for the cost reporting period ($144,000 - $2,000)		142,000
Revised outpatient interim rate applicable to customary charges billed for all Medicare outpatient services, including ASC facility services ($142,000 ÷ $160,000)	=	88.75%

2830.8 Special Extension for Eye and Eye and Ear Specialty Hospitals.--Under '1833(i)(4) (previously '1833(i)(3)(B)(ii)) of the Act, a hospital is allowed an extension of the present blended payment of a 75 percent hospital-specific amount and a 25 percent ASC amount if the hospital meets specific requirements.

A. Qualifying for Extension Under OBRA 1987.--This extension is for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995. The requirements are:

- The hospital specializes in eye or eye and ear services to the extent that more than 60 percent of its total Medicare inpatient DRGs during the cost reporting period are DRGs 36 through 74;

- The hospital receives more than 30 percent of its total revenues from outpatient services; and

- The hospital was an eye or eye and ear specialty hospital on October 1, 1987.

For hospitals that qualified under the October 1, 1988, effective date, the above criteria are based on the hospital's cost reporting period beginning on or after October 1, 1986, and before October 1, 1987.

B. Qualifying for Extension Under OBRA 1993.--Effective for portions of cost reporting periods beginning on or after January 1, 1994, a hospital which operated as an eye or eye and ear specialty unit (an eye or eye and ear specialty unit is a physically separate or distinct unit containing separate surgical suites devoted solely to eye or eye and ear services) of a general acute hospital on October 1, 1987, may also apply for the 75/25 blended payment amount if it:

- o As of the date of application, operates fewer than 20 percent of the beds it operated on October 1, 1987, and has sold or otherwise disposed of at least 60 percent of its other acute care operations;

- o Specializes in eye or eye and ear services to the extent that more than 60 percent of its total Medicare inpatient DRGs during the cost reporting period are DRGs 36 through 74; and

- o Receives more than 30 percent of its total revenues from outpatient services.

The criteria are based on the most recent cost reporting period ending before January 1, 1994.

For all hospitals that qualify for the payment extension under subsections A and B, for cost reporting periods beginning after January 1, 1995, the blended payment amount reverts to a 50 percent hospital-specific amount and a 50 percent ASC amount.

For a hospital in a State receiving payment under a State reimbursement control system under '1814(b)(3) or 1886(c) of the Act, inpatient data comparable to the DRG data cited above must be used to demonstrate that this hospital meets the above requirements.

If you believe you qualify as an eye or eye and ear specialty hospital but are not subject to the prospective payment system, you may demonstrate that you specialize in eye or eye and ear services by demonstrating to your intermediary that more than 60 percent of your inpatient revenues are attributable to admissions pertaining to eye or eye and ear diagnoses.

In addition to meeting the requirements, you must submit a written request to your fiscal intermediary as soon as possible before you can begin to receive the 75/25 blended payment amount. After reviewing your request, the intermediary sends you written notification of an approval/disapproval.

2830.20 Exhibits.--

Exhibit A - List of Covered ASC Procedures
Exhibit B - Bureau of Labor Statistics Wage Index

EXHIBIT A

LIST OF COVERED SURGICAL PROCEDURES

NOTE: Procedure codes preceded by an asterisk indicate that the procedure has been covered since August 5, 1982.

Procedure codes without an asterisk indicate additions to the list of surgical procedures which are covered effective May 21, 1987. The covered procedures, listed by body system and payment, together with applicable CPT-4 codes, are as follows:

INTEGUMENTARY SYSTEM

SKIN, SUBCUTANEOUS AND AREOLAR TISSUES

INCISION

10141 2 Incision and drainage of hematoma; complicated

EXCISION DEBRIDEMENT

11042 1 Debridement; skin, and subcutaneous tissue
11043 1 Debridement; skin, subcutaneous tissue, and muscle
11044 1 Debridement; skin, subcutaneous tissue, muscle, and bone

EXCISION-BENIGN LESIONS

*	11200	1	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15
*	11201	1	Each additional ten lesions
*	11401	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, or legs; lesion diameter 0.6 to 1.0 cm
*	11402	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
*	11403	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 2.1 to 3.0 cm
*	11404	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 3.1 to 4.0 cm
*	11406	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter over 4.0 cm
*	11421	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
*	11422	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
*	11423	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm
*	11424	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm
*	11426	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm
*	11441	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

*	11442	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
*	11443	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm
*	11444	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm
*	11446	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm
	11471	2	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with other closure

EXCISION-MALIGNANT LESIONS

*	11600	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less
*	11601	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.6 to 1.0 cm
*	11602	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 1.1 to 2.0 cm
*	11603	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 2.1 to 3.0 cm
*	11604	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 3.1 to 4.0 cm
*	11606	2	Excision, malignant lesion, trunk, arms, or legs; lesion diameter over 4.0 cm
*	11620	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
*	11621	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
*	11622	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
*	11623	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm
*	11624	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm
*	11626	2	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm
*	11640	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm or less
*	11641	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.6 to 1.0 cm
*	11642	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 1.1 to 2.0 cm
*	11643	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 2.1 to 3.0 cm

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

*	11644	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 3.1 to 4.0 cm
*	11646	2	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter over 4.0 cm

NAILS

*	11750	1	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal

MISCELLANEOUS

*	11770	3	Excision of pilonidal cyst or sinus; simple
*	11771	3	Excision of pilonidal cyst or sinus; extensive
	11772	3	Excision of pilonidal cyst or sinus; complicated

REPAIR-SIMPLE

12006	2	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm
12007	2	Simple Repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm
12017	2	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12018	2	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm

REPAIR-INTERMEDIATE

12036	2	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm
12037	2	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm
12046	2	Layer closure of wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm
12047	2	Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm
12056	2	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12057	2	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm

REPAIR-COMPLEX

13101	1	Repair, complex, trunk; 2.6 cm to 7.5 cm
13121	1	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13132	2	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13152	3	Repair, complex, eyelids, nose, ears, and/or lips; 2.6 cm to 7.5 cm
13300	3	Repair, unusual, complicated, over 7.5 cm, any area

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

	14001	3	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
	14020	3	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
	14021	3	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
	14041	3	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
	14060	3	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
	14061	3	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
	14300	3	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area
	14350	3	Filleted finger or toe flap, including preparation of recipient site

FREE SKIN GRAFTS

*	15000	3	Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft (list as separate service in addition to skin graft)
*	15050	3	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or minimal open area (except on face), up to defect size 2 cm diameter
*	15100	3	Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits); 100 sq cm or less, or each one percent of body area of infants and children (except 15050)
*	15101	3	Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits); each additional 100 sq cm, or each one percent body area of infants and children, or part thereof
	15200	3	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
	15201	3	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm
	15220	3	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less
	15221	3	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm
	15240	3	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 20 sq cm or less
	15241	3	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 20 sq cm

15260	3	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15261	3	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm
15350	3	Application of allograft (homograft), skin
15410	3	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; 100 sq cm or less
15412	3	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; between 101 and 160 sq cm
15414	3	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; between 161 and 230 sq cm
15416	3	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; over 230 sq cm

REPAIR

PEDICLE FLAPS (SKIN AND DEEP TISSUES)

15500	4	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on trunk
15505	4	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on scalp, arms, or legs
15510	4	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on forehead, cheeks, chin, mouth, neck, axillae genitalia, hands, or feet
15515	4	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on eyelids, nose, ears, or lips
15540	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to trunk
15545	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to scalp, arms, or legs
15550	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to forehead, cheeks, chin, mouth, neck, axillae, genitalia, or hands, feet
15555	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to eyelids, nose, ears, or lips
15580	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; cross finger pedicle flap, including free graft to donor site
15600	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; at trunk
15610	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; at scalp, arms, or legs

15620	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; at forehead, cheeks, chin, neck, axillae, genitalia, hands (except 15625), or feet
15625	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; section pedicle of cross finger flap
15630	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; at eyelids, nose, ears. or lips
15650	4	Transfer, intermediate, of any pedicle flap (e.g., abdomen to wrist, Walking tube), any location
15700	4	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; trunk
15710	4	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; scalp, arms, or legs
15720	4	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet
15730	4	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; eyelids, nose, ears, or lips

OTHER GRAFTS

15740	3	Graft; island pedicle flap
15745	4	Graft; myocutaneous flap
15750	4	Graft; neurovascular pedicle flap
15755	4	Graft; free flap (microvascular transfer)
15760	3	Graft; composite (full thickness of external ear or nasal ala), including primary closure, donor area
15770	3	Graft; derma-fat-fascia

MISCELLANEOUS PROCEDURES

15840	4	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
15841	4	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)
15842	4	Graft for facial nerve paralysis; free muscle graft by microsurgical technique
15845	4	Graft for facial nerve paralysis; regional muscle transfer

PRESSURE ULCERS (DECUBITUS ULCERS)

15920	3	Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture
15922	3	Excision, coccygeal pressure ulcer, with coccygectomy; with local or regional skin flap closure
15931	3	Excision, sacral pressure ulcer, with primary suture;
15933	3	Excision, sacral pressure ulcer, with primary suture; with ostectomy

15941	3	Excision, ischial pressure ulcer, with primary suture; with ostectomy (ischiectomy)
15944	3	Excision, ischial pressure ulcer, with local or regional skin flap closure
15945	3	Excision, ischial pressure ulcer, with local or regional skin flap closure; with ostectomy
15946	3	Excision, ischial pressure ulcer, with ostectomy, with muscle flap or myocutaneous flap closure
15950	3	Excision, trochanteric pressure ulcer, with primary suture
15951	3	Excision, trochanteric pressure ulcer, with primary suture; with ostectomy
15952	3	Excision, trochanteric pressure ulcer, with local rotation skin flap closure
15953	3	Excision, trochanteric pressure ulcer, with local rotation skin flap closure; with ostectomy
15954	3	Excision, trochanteric pressure ulcer, with bipedicle flap closure
15955	3	Excision, trochanteric pressure ulcer, with bipedicle flap closure; with ostectomy
15956	3	Excision, trochanteric pressure ulcer, with muscle or myocutaneous flap closure
15958	3	Excision, trochanteric pressure ulcer, with muscle or myocutaneous flap closure; with ostectomy
15960	3	Excision, heel pressure ulcer, with primary suture
15961	3	Excision, heel pressure ulcer, with primary suture; with ostectomy
15964	3	Excision, heel pressure ulcer, with skin flap closure
15965	3	Excision, heel pressure ulcer, with skin flap closure; with ostectomy
15966	3	Excision, heel pressure ulcer, with other flap closure
15967	3	Excision, heel pressure ulcer, with other flap closure; with ostectomy
15970	3	Excision, leg pressure ulcer, with primary suture
15971	3	Excision, leg pressure ulcer, with ostectomy
15972	3	Excision, leg pressure ulcer, with local skin flap(s)
15973	3	Excision, leg pressure ulcer, with local skin flap(s); with ostectomy
15974	3	Excision, leg pressure ulcer, with muscle or myocutaneous flap closure
15975	3	Excision, leg pressure ulcer, with muscle or myocutaneous flap closure; with ostectomy
15980	3	Excision, knee pressure ulcer, with local skin flap closure
15981	3	Excision, knee pressure ulcer, with local skin flap closure; with ostectomy
15982	3	Excision, knee pressure ulcer, with other flap closure
15983	3	Excision, knee pressure ulcer, with other flap closure; with ostectomy

BURNS, LOCAL TREATMENT

16015	1	Dressing and/or debridement, initial or subsequent; under anesthesia, medium or large, or with major debridement

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

BREAST

INCISION

	19020	1	Mastotomy with exploration or drainage of abscess, deep

EXCISION

*	19101	3	Biopsy of breast; incisional
*	19120	3	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion or nipple lesion (except 19140), male or female, one or more lesions
*	19140	4	Mastectomy for gynecomastia through circumareolar or other incision
	19160	4	Mastectomy, partial
	19180	4	Mastectomy, simple, complete
	19182	4	Mastectomy, subcutaneous

MUSCULOSKELETAL SYSTEM

GENERAL

INCISION

	20005	1	Incision of soft tissue abscess (e.g., secondary to osteomyelitis); deep or complicated

EXCISION

	20205	1	Biopsy, muscle; deep
	20225	3	Biopsy, bone, trocar or needle; deep (vertebral body, femur)
	20240	2	Biopsy, excisional; superficial (e.g., ilium, sternum, spinous process, ribs, trochanter of femur)
	20245	3	Biopsy, excisional, deep (e.g., humerus, ischium, femur)
	20250	4	Biopsy, vertebral body, open; thoracic
	20251	4	Biopsy, vertebral body, open; lumbar or cervical

INTRODUCTION OR REMOVAL

	20525	2	Removal of foreign body in muscle; deep or complicated
	20650	2	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)
	20660	2	Application of tongs or caliper, including removal (separate procedure)
	20661	2	Application of halo; including removal cranial
	20662	2	Application of halo; pelvic
	20663	2	Application of halo; femoral
	20665	2	Removal of tongs or halo applied by another physician
	20680	3	Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

GRAFTS (OR IMPLANTS)			
	20900	3	Bone graft, any donor area; minor or small (e.g., dowel or button)
	20902	4	Bone graft, any donor area; major or large
	20912	4	Cartilage graft; nasal septum
	20920	4	Fascia lata graft; by stripper
	20922	4	Fascia lata graft; by incision and area exposure, complex or sheet
	20926	4	Tissue grafts, other (e.g., paratenon, fat, dermis, etc.)
MISCELLANEOUS			
	20955	4	Bone graft with microvascular anastomosis; fibula
	20960	4	Bone graft with microvascular anastomosis; rib
	20962	4	Bone graft with microvascular anastomosis; other bone graft (specify)
	20969	4	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, rib, metatarsal, or great toe
	20970	4	Free osteocutaneous flap with microvascular anastomosis; iliac crest
	20971	4	Free osteocutaneous flap with microvascular anastomosis; rib
	20972	4	Free osteocutaneous flap with microvascular anastomosis; metatarsal
	20973	4	Free osteocutaneous flap with microvascular anastomosis; great toe with web space
	20975	2	Electrical stimulation to aid bone healing; invasive (operative)
HEAD			
INCISION			
	21010	3	Arthrotomy, temporomandibular joint; unilateral
	21011	3	Arthrotomy, temporomandibular joint; bilateral
GENERAL			
EXCISION			
	21034	4	Excision of malignant tumor of facial bone other than mandible
*	21040	3	Excision of benign cyst or tumor of mandible; simple
	21044	4	Excision of malignant tumor of mandible
	21050	4	Arthrectomy, temporomandibular joint; unilateral
	21060	4	Meniscectomy, temporomandibular joint; unilateral
	21061	4	Meniscectomy, temporomandibular joint; bilateral
INTRODUCTION OR REMOVAL			
	21100	4	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
FRACTURE AND/OR DISLOCATION			
*	21310	1	Treatment of closed or open nasal fracture without manipulation
*	21315	1	Manipulative treatment, nasal bone fracture; without stabilization
	21320	1	Manipulative treatment, nasal bone fracture; with stabilization

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	21325	3	Open treatment of nasal fracture; uncomplicated
	21330	4	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation
	21335	4	Open treatment of nasal fracture; with concomitant open treatment of fractured septum
	21338	4	Open treatment of nasoethmoid fracture; without external fixation
	21340	4	Treatment of closed or open nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus
*	21355	2	Manipulative treatment of closed or open fracture of malar area, including zygomatic arch and malar tripod, towel clip technique
*	21360	2	Open treatment of closed or open depressed malar fracture, including zygomatic arch and malar tripod
	21365	4	Open treatment of closed or open complicated, (e.g., multiple fractures), of malar area, including zygomatic arch and malar tripod, with internal skeletal fixation and multiple surgical approaches
	21450	4	Treatment of closed or open mandibular fracture; without manipulation
	21451	4	Treatment of closed or open mandibular fracture; with manipulation, may include external fixation
	21452	4	Treatment of open mandibular fracture; without manipulation
	21453	4	Treatment of open mandibular fracture; with manipulation
	21480	2	Uncomplicated treatment of temporomandibular dislocation, initial or subsequent
	21485	3	Complicated manipulative treatment of temporomandibular dislocation, initial or subsequent
	21490	4	Open treatment of temporomandibular dislocation
	21494	3	Treatment of closed or open hyoid fracture; with manipulation
	21495	4	Open treatment of closed or open hyoid fracture

NECK (SOFT TISSUES) AND THORAX

INCISION

	21501	1	Incision and drainage, deep abscess or hematoma
	21502	3	Incision and drainage, deep abscess or hematoma; with partial rib ostectomy
	21510	3	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
	21555	1	Excision benign tumor; subcutaneous

EXCISION

	21556	2	Excision, benign tumor; deep, subfascial, intramuscular
	21600	3	Excision of rib, partial
	21610	3	Costotransversectomy (separate procedure)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

ABDOMEN

EXCISION			
	22900	2	Excision, abdominal wall tumor, subfascial (e.g., desmoid)

SHOULDER

INCISION			
	23000	3	Removal of subdeltoid (or intratendinous) calcareous deposits
	23020	3	Capsular contracture release (Sever type procedure) for Erb's palsy
	23030	1	Incision and drainage; deep abscess or hematoma
	23035	2	Incision, deep, with opening of cortex (e.g., for osteomyelitis or bone abscess)
	23040	4	Arthrotomy, glenohumeral joint, for infection, with exploration, drainage or removal of foreign body
	23044	4	Arthrotomy with exploration, drainage or removal of foreign body, acromioclavicular, sternoclavicular joint
EXCISION			
	23066	1	Biopsy, soft tissues; deep
	23076	1	Excision, benign tumor; deep, subfascial or intramuscular
	23100	4	Arthrotomy for biopsy, glenohumeral joint
	23101	4	Arthrotomy for biopsy or for excision of torn cartilage, acromioclavicular, sternoclavicular joint
	23130	4	Acromionectomy, partial or total
	23140	4	Excision or curettage of bone cyst or benign tumor of clavicle or scapula
	23150	4	Excision or curettage of bone cyst or benign tumor of proximal humerus
*	23170	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), clavicle;
*	23172	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess),scapula;
*	23174	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), humeral head to surgical neck;
	23180	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), clavicle
	23182	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), scapula
	23184	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), proximal humerus
	23190	3	Ostectomy of scapula, partial (e.g., superior medial angle)
	23195	3	Resection humeral head
INTRODUCTION OR REMOVAL			
	23331	2	Removal of foreign body; deep (e.g., Neer prosthesis removal)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

REPAIR, REVISION OR RECONSTRUCTION		
23405	3	Tenomyotomy; single
23406	3	Tenomyotomy; multiple through same incision
FRACTURE AND/OR DISLOCATION		
23505	2	Treatment of closed clavicular fracture; with manipulation
23515	4	Open treatment of closed or open clavicular fracture, with or without internal or external skeletal fixation
23605	2	Treatment of closed humeral (surgical or anatomical neck) fracture; with manipulation
23610	4	Treatment of open humeral (surgical or anatomical neck) fracture, with uncomplicated soft tissue closure
23625	2	Treatment of closed greater tuberosity fracture; with manipulation
23630	4	Open treatment of closed or open greater tuberosity fracture, with or without internal or external skeletal fixation
23655	1	Treatment of closed shoulder dislocation, with manipulation; requiring anesthesia
23658	4	Treatment of open shoulder dislocation, with uncomplicated soft tissue closure
23660	4	Open treatment of closed or open shoulder dislocation
23665	2	Treatment of closed shoulder dislocation, with fracture of greater tuberosity, with manipulation
23670	4	Open treatment of closed or open shoulder dislocation, with fracture of greater tuberosity
23675	2	Treatment of closed shoulder dislocation, with surgical or anatomical neck fracture, with manipulation
23680	4	Open treatment of closed or open shoulder dislocation, with surgical or anatomical neck fracture
MANIPULATION		
23700	2	Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)

HUMERUS (UPPER ARM) AND ELBOW

INCISION		
23930	1	Incision and drainage; deep abscess or hematoma
23935	2	Incision, deep, with opening of (e.g., cortex for osteomyelitis or bone abscess)
24000	2	Arthrotomy, elbow, for infection, with exploration, drainage or removal of foreign body

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

EXCISION			
	24075	2	Excision, benign tumor; subcutaneous
	24076	2	Excision, benign tumor; deep, subfascial or intramuscular
	24100	4	Arthrotomy, elbow; for synovial biopsy only
	24101	4	Arthrotomy, elbow; with joint exploration, with or without biopsy, with or without removal of foreign body
*	24105	3	Excision, olecranon bursa
	24110	3	Excision, or curettage of bone cyst or benign tumor, humerus
	24115	4	Excision or curettage of bone cyst or benign tumor, humerus; with primary autogenous graft (includes obtaining graft)
	24116	4	Excision or curettage of bone cyst or benign tumor, humerus; with homogenous or other nonautogenous graft
	24120	3	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process
	24125	4	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with primary autogenous graft (includes obtaining graft)
	24126	4	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with homogenous or other nonautogenous graft
	24130	3	Excision, radial head
*	24134	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), shaft or distal humerus;
*	24136	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), radial head or neck;
*	24138	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), olecranon process;
	24140	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis), humerus
	24145	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis), radial head or neck
	24147	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis), olecranon process;
	24155	4	Resection of elbow joint (arthrectomy)
INTRODUCTION OR REMOVAL			
	24160	2	Implant removal; elbow joint
	24164	2	Implant removal; radial head
	24201	1	Removal of foreign body; deep
REPAIR REVISION AND RECONSTRUCTION			
	24301	3	Muscle or tendon transfer, any type, single (excluding 24320-24331)
	24310	3	Tenotomy, open, elbow to shoulder, single, each
*	24320	4	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)
	24330	4	Flexor-plasty, elbow, (e.g., Steindler type advancement)
	24331	4	Flexor-plasty, elbow, (e.g., Steindler type advancement); with extensor advancement

	24340	4	Tenodesis for rupture of biceps tendon at elbow
	24342	4	Reinsertion of ruptured biceps tendon, distal, with or without tendon graft (includes obtaining graft)
*	24350	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis)
*	24351	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with extensor origin detachment
*	24352	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with annular ligament resection
*	24354	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with stripping
	24356	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with partial ostectomy
	24420	4	Osteoplasty, humerus (e.g., shortening or lengthening)(excluding 64876)
	24470	4	Hemiepiphyseal arrest (e.g., for cubitus varus or valgus, distal humerus)
	24495	3	Decompression fasciotomy, forearm, with brachial artery exploration
FRACTURE AND/OR DISLOCATION			
	24505	1	Treatment of closed humeral shaft fracture; with manipulation
	24506	2	Treatment of closed humeral shaft fracture; percutaneous insertion of pin or rod
	24510	3	Treatment of open humeral shaft fracture, with uncomplicated soft tissue closure
	24515	4	Open treatment of closed or open humeral shaft fracture, with or without internal or external skeletal fixation
	24530	1	Treatment of closed supracondylar or transcondylar fracture, without manipulation
	24531	2	Treatment of closed supracondylar or transcondylar fracture, without manipulation; with traction (pin or skin)
	24535	1	Treatment of closed supracondylar or transcondylar fracture, with manipulation
	24536	2	Treatment of closed supracondylar or transcondylar fracture, with manipulation; with traction (pin or skin)
	24538	2	Treatment of closed supracondylar or transcondylar fracture, with manipulation; with percutaneous skeletal fixation
	24540	4	Treatment of open supracondylar or transcondylar fracture, with uncomplicated soft tissue closure
	24542	4	Treatment of open supracondylar or transcondylar fracture, with uncomplicated soft tissue closure; with traction (pin or skin)
	24545	4	Open treatment of closed or open supracondylar or transcondylar fracture, with or without internal or external skeletal fixation
	24565	1	Treatment of closed epicondylar fracture, medial or lateral; with manipulation
	24570	3	Treatment of open epicondylar fracture, medial or lateral, with uncomplicated soft tissue closure
	24575	4	Open treatment of closed or open epicondylar fracture, medial or lateral, with or without internal or external skeletal fixation

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

24577	1	Treatment of closed condylar fracture, medial or lateral; with manipulation
24578	3	Treatment of open condylar fracture, medial or lateral, with uncomplicated soft tissue closure
24579	4	Open treatment of closed or open condylar fracture, medial or lateral, with or without internal or external skeletal fixation
24580	1	Treatment of closed comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), treatment with traction, (pin or skin); without manipulation
24581	1	Treatment of closed comminuted elbow fracture (fracture distal and/or proximal ulna and/or proximal radius), treatment with traction, (pin or skin); with manipulation
24583	4	Treatment of open comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), with uncomplicated soft tissue closure
24585	4	Open treatment of closed or open comminuted elbow fracture (fracture distal humerus and/or proximal ulna/radius), with or without internal or external skeletal fixation
24586	4	Open treatment of closed or open comminuted elbow fracture (fracture distal humerus and/or proximal ulna/radius), with or without internal or external skeletal fixation; with elbow resection
24605	1	Treatment of closed elbow dislocation; requiring anesthesia
24610	3	Treatment of open elbow dislocation, with uncomplicated soft tissue closure
24615	3	Open treatment of closed or open elbow dislocation
24620	2	Treatment of closed Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head)
24625	4	Treatment of open Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with uncomplicated soft tissue closure
24635	4	Open treatment of closed or open Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with or without internal or external skeletal fixation
24655	1	Treatment of closed radial head or neck fracture; with manipulation with complicated soft tissue closure
24665	4	Open treatment of closed or open radial head or neck fracture, with or without internal fixation or radial head excision
24666	4	Open treatment of closed or open radial head or neck fracture, with or without internal fixation or radial head excision; with implant
24675	1	Treatment of closed ulnar fracture, proximal end (olecranon process); with manipulation
24680	3	Treatment of open ulnar fracture, proximal end (olecranon process), with uncomplicated soft tissue closure
24685	4	Open treatment of closed or open ulnar fracture proximal end (olecranon process), with or without internal or external skeletal fixation

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

FOREARM AND WRIST

	INCISION		
*	25000	2	Tendon sheath incision; at radial styloid for deQuervain's disease
	25005	2	Tendon sheath incision; at wrist for other stenosing tenosynovitis
*	25020	4	Decompression fasciotomy, flexor and/or extensor compartment
*	25023	4	Decompression fasciotomy, flexor and/or extensor compartment; with debridement of nonviable muscle and/or nerve
	25028	1	Incision and drainage, deep abscess or hematoma
	25035	2	Incision, deep, with opening of cortex (e.g., for osteomyelitis or bone abscess)
	25040	2	Arthrotomy, radiocarpal or mediocarpal joint, for infection, with exploration, drainage, or removal of loose or foreign body
	EXCISION		
	25066	1	Biopsy, soft tissues; deep
	25076	1	Excision, benign tumor, deep, subfascial or intramuscular
	25085	3	Capsulotomy, wrist (e.g., for contracture)
	25100	2	Arthrotomy, wrist joint; for biopsy
	25101	3	Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of foreign body
	25107	3	Arthrotomy distal radioulnar joint for repair of triangular cartilage complex
	25110	3	Excision, lesion of tendon sheath
*	25111	3	Excision of ganglion, wrist (dorsal or volar); primary
*	25112	3	Excision of ganglion, wrist (dorsal or volar); recurrent
	25120	3	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process)
	25125	4	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with primary autogenous graft (includes obtaining graft)
	25126	4	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with homogenous or other nonautogenous graft
	25130	3	Excision or curettage of bone cyst or benign tumor of carpal bones
	25135	3	Excision or curettage of bone cyst or benign tumor of carpal bones; with primary autogenous graft (includes obtaining graft)
	25136	4	Excision or curettage of bone cyst or benign tumor of carpal bones; with homogenous or other nonautogenous graft
	25145	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess);
	25150	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis); ulna
	25151	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis); radius

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	25210	3	Carpectomy; one bone
	25215	3	Carpectomy; all bones of proximal row
	25230	3	Radial styloidectomy (separate procedure)
	25240	3	Excision distal ulna (Darrach type procedure)
	25248	2	Exploration for removal of deep foreign body
			REPAIR, REVISION OR RECONSTRUCTION
*	25260	3	Repair, tendon or muscle, flexor; primary, single, each tendon or muscle
*	25263	3	Repair, tendon or muscle, flexor; secondary, single, each tendon or muscle
*	25265	4	Repair tendon or muscle, flexor; secondary, with free graft (includes obtaining graft), each tendon or muscle
*	25270	3	Repair, tendon or muscle, extensor; primary, single, each tendon or muscle
*	25272	3	Repair, tendon or muscle, extensor; secondary, single, each tendon or muscle
	25274	4	Repair, tendon or muscle, extensor, secondary, with tendon graft (includes obtaining graft), each tendon
	25280	3	Lengthening or shortening of flexor or extensor tendon, single, each tendon
	25290	3	Tenotomy, open, single, flexor or extensor tendon, each tendon
	25295	3	Tenolysis, single flexor or extensor tendon, each tendon
	25300	3	Tenodesis at wrist; flexors of fingers
	25301	3	Tenodesis at wrist; extensors of fingers
*	25310	4	Tendon transplantation or transfer, flexor or extensor, single; each tendon
*	25312	4	Tendon transplantation or transfer, flexor or extensor, single; with tendon graft(s) (includes obtaining graft), each tendon
	25315	3	Flexor origin slide for cerebral palsy
	25316	3	Flexor origin slide for cerebral palsy; with tendon(s) transfer
	25317	3	Flexor origin slide for Volkmann contracture
	25318	3	Flexor origin slide for Volkmann contracture; with tendon(s) transfer
	25320	4	Capsulorrhaphy or reconstruction, capsulectomy, wrist (includes synovectomy, resection of capsule, tendon insertions)
	25390	4	Osteoplasty radius OR ulna; shortening
	25391	4	Osteoplasty, radius OR ulna; lengthening with autogenous bone graft
	25392	4	Osteoplasty, radius AND ulna; shortening (excluding 64876)
	25393	4	Osteoplasty, radius AND ulna; lengthening with autogenous bone graft
	25450	4	Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna
	25455	4	Epiphyseal arrest by epiphysiodesis or stapling; distal radius AND ulna

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

FRACTURE AND/OR DISLOCATION

25505	1	Treatment of closed radial shaft fracture; with manipulation
25510	3	Treatment of open radial shaft fracture, with uncomplicated soft tissue closure
25515	4	Open treatment of closed or open radial shaft fracture, with or without internal or external skeletal fixation
25535	1	Treatment of closed ulnar shaft fracture; with manipulation
25540	3	Treatment of open ulnar shaft fracture, with uncomplicated soft tissue closure
25545	4	Open treatment of closed or open ulnar shaft fracture, with or without internal or external skeletal fixation
25565	1	Treatment of closed radial and ulnar shaft fractures; with manipulation
25570	3	Treatment of open radial and ulnar shaft fractures, with uncomplicated soft tissue closure
25575	4	Open treatment of closed or open radial and ulnar shaft fractures, with or without internal or external skeletal fixation
25605	1	Treatment of closed distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation
25610	2	Treatment of closed, complex, distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning
25611	2	Treatment of closed, complex, distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; percutaneous pinning or pins and plaster technique
25615	3	Treatment of open distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with uncomplicated soft tissue closure
25620	4	Open treatment of closed or open distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external skeletal fixation
25626	3	Treatment of open carpal scaphoid (navicular) fracture, with uncomplicated soft tissue closure
25628	4	Open treatment of closed or open carpal scaphoid (navicular) fracture, with or without skeletal fixation
25635	1	Treatment of closed carpal bone fracture (excluding carpal scaphoid (navicular)); with manipulation, each bone
25640	4	Treatment of open carpal bone fracture (excluding carpal scaphoid (navicular)), with uncomplicated soft tissue closure, each bone
25645	4	Open treatment of closed or open carpal bone fracture (excluding carpal scaphoid (navicular)), each bone
25660	1	Treatment of closed radiocarpal or intercarpal dislocation, one or more bones, with manipulation

	25665	3	Treatment of open radiocarpal or intercarpal dislocation, one or more bones, with uncomplicated soft tissue closure
	25670	4	Open treatment of closed or open radiocarpal or intercarpal dislocation, one or more bones
	25675	1	Treatment of closed distal radioulnar dislocation with manipulation
	25676	3	Open treatment of closed or open distal radioulnar dislocation, acute or chronic
	25680	1	Treatment of closed trans-scaphoperilunar type of fracture dislocation, with manipulation
	25685	3	Open treatment of closed or open trans-scaphoperilunar type of fracture dislocation
	25690	1	Treatment of lunate dislocation, with manipulation
	25695	3	Open treatment of lunate dislocation

HANDS AND FINGERS

INCISION

	26011	1	Drainage of finger abscess; complicated (e.g., felon, etc)
	26020	1	Drainage of tendon sheath, one digit and/or palm
	26025	1	Drainage of palmar bursa; single, ulnar or radial
	26030	1	Drainage of palmar bursa; multiple or complicated
	26034	2	Incision, deep, with opening of cortex (e.g., for osteomyelitis or bone abscess)
	26035	2	Decompression fingers and/or hand, injection injury (e.g., grease gun, etc.)
*	26040	4	Fasciotomy, palmar, for Dupuytren's contracture; closed (subcutaneous)
*	26045	4	Faciotomy, palmar, for Dupuytren's contracture; open, partial
*	26055	1	Tendon sheath incision for trigger finger
*	26060	1	Tenotomy, subcutaneous, single, each digit
	26070	2	Arthrotomy, for infection, with exploration, drainage or removal of loose or foreign body; carpometacarpal joint
	26075	2	Arthrotomy with exploration, drainage or removal of loose or foreign body; metacarpophalangeal joint
	26080	2	Arthrotomy with exploration, drainage or removal of loose or foreign body; interphalangeal joint, each

EXCISION

	26100	3	Arthrotomy for synovial biopsy; carpometacarpal joint
	26105	3	Arthrotomy for synovial biopsy; metacarpophalangeal joint
	26110	3	Arthrotomy for synovial biopsy; interphalangeal joint, each
	26115	3	Excision of benign tumor; subcutaneous
	26116	3	Excision of benign tumor; deep, subfascial, intramuscular
*	26120	4	Fasciectomy, palmar, simple, for Dupuytren's contracture; partial excision

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

*	26122	4	Fasciectomy, palmar, simple, for Dupuytren's contracture; up to one-half palmar fascia, with single digit involvement, with or without Z-plasty or other local tissue rearrangement
	26124	4	Fasciectomy, palmar, complicated, requiring skin grafting (includes obtaining graft); with single digit involvement
	26126	4	Fasciectomy, palmar, complicated, requiring skin grafting (includes obtaining graft); each additional digit
*	26128	4	Fasciectomy, palmar, complicated, requiring skin grafting (includes obtaining graft); each finger joint release
	26135	4	Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit
*	26140	4	Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint
*	26145	4	Synovectomy tendon sheath, radical (tenosynovectomy), flexor, palm or finger, single, each digit
	26160	3	Excision of lesion of tendon sheath or capsule (e.g., cyst or ganglion)
	26170	3	Excision of tendon, palm, flexor, single (separate procedure), each
	26180	3	Excision of tendon, finger, flexor (separate procedure)
	26200	3	Excision or curettage of bone cyst or benign tumor of metacarpal
	26205	3	Excision or curettage of bone cyst or benign tumor of metacarpal; with autogenous graft (includes obtaining graft)
	26210	3	Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx
	26215	3	Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx; with autogenous graft (includes obtaining graft)
	26230	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); metacarpal
	26235	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); proximal or middle phalanx
	26250	4	Radical resection (ostectomy) for tumor, metacarpal
	26255	4	Radical resection (ostectomy) for tumor, metacarpal; with autogenous graft (includes obtaining graft)
	26261	4	Radical resection (ostectomy) for tumor, proximal or middle phalanx; with autogenous graft (includes obtaining graft)

REPAIR, REVISION OR RECONSTRUCTION

*	26350	3	Flexor tendon repair or advancement, single, not in "no man's land"; primary or secondary without free graft, each tendon
*	26352	4	Flexor tendon repair or advancement, single, not in "no man's land"; secondary with free graft (includes obtaining graft), each tendon
*	26356	3	Flexor tendon repair or advancement, single, in "no man's land"; primary, each tendon

*	26358	4	Flexor tendon repair or advancement, single, in "no man's land"; secondary with free graft (includes obtaining graft), each tendon
*	26370	3	Profundus tendon repair or advancement, with intact sublimis; primary
*	26372	4	Profundus tendon repair or advancement, with intact sublimis; secondary with free graft (includes obtaining graft)
*	26373	3	Profundus tendon repair or advancement, with intact sublimis; secondary without free graft
*	26390	3	Flexor tendon excision, implantation of plastic tube or rod for delayed tendon graft
*	26392	4	Removal of tube or rod and insertion of tendon graft (includes obtaining graft)
*	26410	3	Extensor tendon repair, dorsum of hand, single, primary or secondary; without free graft, each tendon
*	26412	4	Extensor tendon repair, dorsum of hand, single, primary or secondary; with free graft (includes obtaining graft), each tendon
*	26418	3	Extensor tendon repair, dorsum of finger, single, primary or secondary; without free graft, each tendon
*	26420	4	Extensor tendon repair, dorsum of finger, single, primary or secondary; with free graft (includes obtaining graft), each tendon
*	26426	4	Extensor tendon repair, central slip repair, secondary (boutonniere deformity); using local tissues
*	26428	4	Extensor tendon repair, central slip repair, secondary (boutonniere deformity); with free graft (includes obtaining graft)
*	26432	4	Extensor tendon repair, distal insertion ("mallet finger"), closed, splinting with or without percutaneous pinning
*	26433	3	Extensor tendon repair, open, primary or secondary repair; without graft
*	26434	4	Extensor tendon repair, open, primary or secondary repair; with free graft (includes obtaining graft)
	26440	3	Tenolysis, simple, flexor tendon; palm OR finger, single, each tendon
	26442	3	Tenolysis, simple, flexor tendon; palm AND finger, each tendon
	26445	3	Tenolysis, extensor tendon, dorsum of hand or finger; each tendon
	26449	4	Tenolysis, complex, extensor tendon, dorsum of hand or finger, including hand and forearm
*	26450	1	Tenotomy, flexor, single, palm, open, each
*	26455	1	Tenotomy, flexor, single finger, open, each
*	26460	1	Tenotomy, extensor, hand or finger, single, open, each
	26471	2	Tenodesis; for proximal interphalangeal joint stabilization
	26474	2	Tenodesis; for distal joint stabilization
	26476	3	Tendon lengthening, extensor, single, each
	26477	3	Tendon shortening, extensor, single, each
*	26480	4	Tendon transfer or transplant, carpometacarpal area
*	26483	4	Tendon transfer or transplant, carpometacarpal area
*	26485	4	Tendon transfer or transplant, palmar, single, each tendon; without free tendon graft

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

*	26489	4	Tendon transfer or transplant, palmar, single, each tendon; with free tendon graft (includes obtaining graft), each tendon
	26490	4	Opponens plasty; sublimis tendon transfer type
	26492	4	Opponens plasty; tendon transfer with graft (includes obtaining graft)
	26494	4	Opponens plasty; hypothenar muscle transfer
	26496	4	Opponens plasty; other methods
	26497	4	Tendon transfer to restore intrinsic function; ring and small finger
	26498	4	Tendon transfer to restore intrinsic function; all four fingers
	26499	4	Correction claw finger; other methods
	26500	4	Tendon pulley reconstruction; with local tissues (separate procedure)
	26502	4	Tendon pulley reconstruction; with tendon or fascial graft (includes obtaining graft) (separate procedure)
	26508	4	Thenar muscle release for thumb contracture
	26510	4	Cross intrinsic transfer
	26516	2	Capsulodesis for M-P joint stabilization; single digit
	26517	2	Capsulodesis for M-P joint stabilization; two digits
	26518	3	Capsulodesis for M-P joint stabilization; three or four digits
*	26520	3	Capsulectomy for contracture; metacarpophalangeal joint, single, each
*	26525	3	Capsulectomy for contracture; interphalangeal joint, single, each
*	26530	4	Arthroplasty, metacarpophalangeal joint; single, each
*	26531	4	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, single, each
*	26535	4	Arthroplasty interphalangeal joint; single, each
*	26536	4	Arthroplasty interphalangeal joint; with prosthetic implant, single, each
*	26540	4	Primary repair of collateral ligament, metacarpophalangeal joint
*	26541	4	Reconstruction, collateral ligament, metacarpophalangeal joint; with tendon or fascial graft (includes obtaining graft)
	26542	4	Primary repair of collateral ligament, metacarpophalangeal joint; with local tissue
*	26545	4	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint
	26552	4	Reconstruction thumb with toe
	26555	4	Positional change of other finger
	26557	4	Toe to finger transfer; first stage
	26558	4	Toe to finger transfer; each delay
	26559	4	Toe to finger transfer; second stage
*	26567	4	Osteotomy for correction of deformity; phalanx
	26568	4	Osteoplasty for lengthening of metacarpal or phalanx
	26570	4	Bone graft, (includes obtaining graft); metacarpal
	26574	4	Bone graft, (includes obtaining graft); phalanx

FRACTURES AND/OR DISLOCATIONS

	26605	1	Treatment of closed metacarpal fracture, single; with manipulation, each bone
	26607	2	Treatment of closed metacarpal fracture, single, with manipulation, with skeletal fixation, each bone

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

26610	2	Treatment of open metacarpal fracture, single, with uncomplicated soft tissue closure, each bone
26645	1	Treatment of closed carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
26650	2	Treatment of closed carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation; with skeletal fixation
26655	3	Treatment of open carpometacarpal fracture dislocation, thumb (Bennett fracture), with uncomplicated soft tissue closure
26660	3	Treatment of open carpometacarpal fracture dislocation, thumb (Bennett fracture), with uncomplicated soft tissue closure; with skeletal fixation
26665	3	Open treatment of closed or open carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external skeletal fixation
26675	1	Treatment of closed carpometacarpal dislocation, other than Bennett fracture, single, with manipulation; requiring anesthesia
26676	2	Treatment of closed carpometacarpal dislocation, other than Bennett fracture, single, with manipulation; with percutaneous pinning
26680	2	Treatment of open carpometacarpal dislocation, other than Bennett fracture,single, with uncomplicated soft closure
26685	3	Open treatment of closed or open carpometacarpal dislocation, other than Bennett fracture; single, with or without internal or external skeletal fixation
26686	3	Open treatment of closed or open carpometacarpal dislocation, other than Bennett fracture; complex, multiple or delayed reduction
26705	1	Treatment of closed metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia
26706	2	Treatment of closed metacarpalphalangeal dislocation, single, with manipulation; with percutaneous pinning
26710	2	Treatment of open metacarpophalangeal dislocation, single, with uncomplicated soft tissue closure
26715	3	Open treatment of closed or open metacarpophalangeal dislocation, single, with or without internal or external skeletal fixation
26727	2	Treatment of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, requiring traction or fixation, each
26730	2	Treatment of open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with uncomplicated soft tissue closure, each
26735	3	Open treatment of closed or open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external skeletal fixation, each
26744	2	Treatment of open articular fracture, involving metacarpophalangeal or proximal interphalangeal joint; with uncomplicated soft tissue closure, each
26746	3	Open treatment of closed or open articular fracture, involving metacarpophalangeal or proximal interphalangeal joint, each

	26765	3	Open treatment of closed or open distal phalangeal fracture, finger or thumb, each
	26780	2	Treatment of open interphalangeal joint dislocation, single, with uncomplicated soft tissue closure
	26785	3	Open treatment of closed or open interphalangeal joint dislocation, single

ARTHRODESIS

*	26820	4	Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)
*	26841	4	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation
*	26842	4	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autogenous graft (includes obtaining graft)
*	26843	4	Arthrodesis, carpometacarpal joint, digits, other than thumb
*	26844	4	Arthrodesis, carpometacarpal joint, digits, other than thumb; with autogenous graft (includes obtaining graft)
*	26860	4	Arthrodesis, interphalangeal joint, with or without internal fixation
*	26861	4	Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint
*	26862	4	Arthrodesis, interphalangeal joint, with or without internal fixation; with autogenous graft (includes obtaining graft)
*	26863	4	Arthrodesis, interphalangeal joint, with or without internal fixation; with autogenous graft (includes obtaining graft), each additional joint

AMPUTATION

*	26910	2	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseus transfer
*	26951	2	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure
*	26952	4	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)

PELVIS AND HIP JOINT

INCISION

	26990	2	Incision and drainage; deep abscess or hematoma
	26991	2	Incision and drainage; infected bursa
	26992	2	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
	27000	3	Tenotomy, adductor, subcutaneous, closed (separate procedure)
	27001	4	Tenotomy, adductor, subcutaneous, open; unilateral
	27002	4	Tenotomy, adductor, subcutaneous, open; bilateral
	27003	4	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy; unilateral

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	27004	4	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy; bilateral
	27030	4	Arthrotomy, hip, for infection, with drainage
	27033	4	Arthrotomy, hip, for exploration or removal of loose or foreign body
	27035	4	Hip joint denervation, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral or obturator nerves
EXCISION			
	27040	4	Biopsy, soft tissues; superficial
	27041	4	Biopsy, soft tissues; deep
	27047	4	Excision, benign tumor; subcutaneous
	27048	4	Excision, benign tumor; deep, subfascial, intramuscular
	27052	4	Arthrotomy for biopsy; hip joint
	27065	4	Excision of bone cyst or benign tumor; superficial (wing of ilium, symphysis pubis, or greater trochanter of femur) with or without autogenous bone graft
	27066	4	Excision of bone cyst or benign tumor; deep, with or without bone graft
	27080	4	Coccygectomy, primary
INTRODUCTION AND/OR REMOVAL			
	27087	2	Removal of foreign body; deep
	27095	1	Injection procedure for hip arthrography; with anesthesia
FRACTURES AND/OR DISLOCATIONS			
	27201	4	Treatment of open coccygeal fracture
	27202	4	Open treatment of closed or open coccygeal fracture
MANIPULATION			
	27275	2	Manipulation, hip joint, requiring general anesthesia
FEMUR (THIGH REGION) AND KNEE JOINT			
INCISION			
	27301	2	Incision and drainage of deep abscess, infected bursa, or hematoma
	27303	2	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
*	27305	4	Fasciotomy, iliotibial (tenotomy), open
*	27306	1	Tenotomy, subcutaneous, closed, adductor or hamstring, (separate procedure); single
*	27307	1	Tenotomy, subcutaneous, closed, adductor or hamstring, (separate procedure); multiple
	27310	4	Arthrotomy, knee, for infection, with exploration, drainage or removal of foreign body
*	27315	4	Neurectomy, hamstring muscle
*	27320	4	Neurectomy, popliteal (gastrocnemius)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

EXCISION		
27324	2	Biopsy, soft tissues; deep
27327	1	Excision, benign tumor; subcutaneous
27328	2	Excision, benign tumor; deep, subfascial, or intramuscular
27330	4	Arthrotomy, knee; for synovial biopsy only
27345	4	Excision of synovial cyst of popliteal space (Baker's cyst)
27350	4	Patellectomy or hemipatellectomy
27355	4	Excision or curettage of bone cyst or benign tumor of femur
27360	4	Partial excision (craterization, saucerization or diaphysectomy) of bone, (e.g., for osteomyelitis), femur, proximal tibia and/or fibula
INTRODUCTION AND/OR REMOVAL		
27372	3	Removal foreign body, deep
REPAIR, REVISION OR RECONSTRUCTION		
27390	4	Tenotomy, open, hamstring, knee to hip; single
27391	4	Tenotomy, open, hamstring, knee to hip; multiple, one leg
27392	4	Tenotomy, open, hamstring, knee to hip; multiple, bilateral
27393	4	Lengthening of hamstring, tendon; single
27394	4	Lengthening of hamstring, tendon; multiple, one leg
27395	4	Lengthening of hamstring, tendon; multiple, bilateral
27396	4	Transplant, hamstring tendon to patella; single
27397	4	Transplant, hamstring tendon to patella; multiple
27400	4	Tendon or muscle transfer, hamstrings to femur (Eggers type procedure)
27420	4	Reconstruction for recurrent dislocating patella; (Hauser type procedure)
27422	4	Reconstruction for recurrent dislocating patella; with extensor realignment and/or muscle advancement or release (Campbell, Goldwaite, etc., type procedure)
27424	4	Reconstruction for recurrent dislocating patella; with patellectomy
27425	4	Lateral retinacular release (any method)
27430	4	Quadriceps plasty (Bennett or Thompson type)
27435	4	Capsulotomy, knee, posterior capsular release
FRACTURES AND/OR DISLOCATIONS		
27522	3	Treatment of open pateller fracture, with uncomplicated soft tissue closure
27524	4	Open treatment of closed or open patellar fracture, with repair and/or excision
EXCISION		
27532	1	Treatment of closed tibial fracture, proximal (plateau); with manipulation
FRACTURES AND/OR DISLOCATIONS		
27534	3	Treatment of open tibial fracture, proximal (plateau), with uncomplicated soft tissue closure

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

EXCISION			
	27552	1	Treatment of closed knee dislocation; requiring anesthesia
	27562	1	Treatment of closed patellar dislocation; requiring anesthesia
FRACTURES AND/OR DISLOCATIONS			
	27564	4	Treatment of open patellar dislocation, with uncomplicated soft tissue closure
	27566	4	Open treatment of closed or open patellar dislocation, with or without partial or total patellectomy
MANIPULATION			
	27570	2	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)
LEG (TIBIA AND FIBULA) AND ANKLE JOINT			
INCISION			
	27603	2	Incision and drainage; deep abscess or hematoma
*	27605	1	Tenotomy, Achilles tendon, subcutaneous (separate procedure); local anesthesia
*	27606	1	Tenotomy, Achilles tendon, subcutaneous (separate procedure); general anesthesia
	27607	2	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
	27610	2	Arthrotomy, ankle, with exploration, drainage or removal of loose or foreign body
	27612	4	Arthrotomy, ankle, posterior capsular release, with or without Achilles tendon lengthening
EXCISION			
	27620	3	Arthrotomy, ankle, for biopsy
	27630	3	Excision of lesion of tendon sheath or capsule (e.g., cyst or ganglion)
	27635	3	Excision or curettage of bone cyst or benign tumor, tibia or fibula
	27637	4	Excision or curettage of bone cyst, or benign tumor, tibia or fibula; with primary autogenous graft (includes obtaining graft)
	27638	4	Excision or curettage of bone cyst, or benign tumor, tibia or fibula; with primary homogenous graft
	27640	4	Partial excision (craterization, saucerization, or diaphysectomy) of bone, (e.g., for osteomyelitis); tibia
	27641	4	Partial excision (craterization, saucerization, or diaphysectomy) of bone, (e.g., for osteomyelitis); fibula

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

REPAIR, REVISION OR RECONSTRUCTION

*	27650	3	Repair, primary, open or percutaneous, ruptured Achilles tendon
*	27652	4	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)
*	27654	4	Suture, secondary, ruptured Achilles tendon, with or without graft
*	27656	3	Repair, fascial defect of leg
*	27658	3	Repair or suture of flexor tendon of leg; primary, without free graft, single, each
*	27659	4	Repair or suture of flexor tendon of leg; secondary with or without free graft, single tendon, each
*	27664	3	Repair or suture of extensor tendon of leg; primary, without free graft, single, each
*	27665	4	Repair or suture of extensor tendon of leg; secondary with or without free graft, single tendon, each
*	27675	3	Repair for dislocating peroneal tendons; without fibular osteotomy
*	27676	4	Repair for dislocated peroneal tendons; with fibular osteotomy
	27680	3	Tenolysis, including tibia, fibula and ankle flexor; single
	27681	4	Tenolysis, including tibia, fibula and ankle flexor; multiple (through same incision), each
	27685	3	Lengthening or shortening of tendon; single (separate procedure)
	27686	4	Lengthening or shortening of tendon; multiple (through same incision), each
	27690	4	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (e.g., anterior tibial extensors into midfoot)
	27691	4	Transfer or transplant of single tendon (with muscle redirection or rerouting); anterior tibial or posterior tibial through interosseous space
	27692	4	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon

FRACTURES AND/OR DISLOCATIONS

	27756	4	Open treatment of closed or open tibial shaft fracture, with internal skeletal fixation; simple
	27758	4	Open treatment of closed or open tibial shaft fracture, with internal or external skeletal fixation; complicated
	27764	3	Treatment of open distal tibial fracture (medial malleolus), with uncomplicated soft tissue closure
	27766	3	Open treatment of closed or open distal tibial fracture (medial malleolus), with fixation
	27781	1	Treatment of closed proximal fibula or shaft fracture; with manipulation
	27782	3	Treatment of open proximal fibula or shaft fracture, with uncomplicated soft tissue closure
	27784	4	Open treatment of closed or open proximal fibula or shaft fracture, with or without internal or external skeletal fixation
	27790	3	Treatment of open distal fibular fracture (lateral malleolus), with uncomplicated soft tissue closure

	27792	4	Open treatment of closed or open distal fibular fracture (lateral malleolus), with fixation
	27802	1	Treatment of closed tibia and fibula fractures, shafts; with manipulation
	27804	3	Treatment of open tibia and fibula fractures, shafts, with uncomplicated soft tissue closure (e.g., "pins above and below")
	27842	1	Treatment of ankle dislocation; requiring anesthesia
	27844	3	Treatment of open ankle dislocation, with uncomplicated soft tissue closure
	27846	4	Open treatment of closed or open ankle dislocation
	27848	4	Open treatment of closed or open ankle dislocation; with fixation
MANIPULATION			
	27860	1	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)
FOOT			
INCISION			
	28002	2	Deep infection, below fascia, requiring deep dissection, with or without tendon sheath involvement; single bursal space, specify
	28003	2	Deep infection, below fascia, requiring deep dissection, with or without tendon sheath involvement; multiple areas
	28005	2	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
*	28008	4	Fasciotomy, plantar and/or toe, subcutaneous
*	28010	1	Tenotomy, subcutaneous, toe; single
*	28011	1	Tenotomy, subcutaneous, toe; multiple
*	28030	4	Neurectomy of intrinsic musculature of foot
	28035	4	Tarsal tunnel release (posterior tibial nerve decompression)
EXCISION			
	28045	2	Excision, benign tumor; deep, subfascial, intramuscular
	28050	3	Arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint
	28062	4	Fasciectomy, excision of plantar fascia; radical (separate procedure)
*	28072	4	Synovectomy; metatarsophalangeal joint, each
*	28080	3	Excision of Morton neuroma, single, each
*	28086	4	Synovectomy, tendon sheath; flexor
*	28088	4	Synovectomy, tendon sheath; extensor
*	28090	4	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) cyst or ganglion); foot
*	28092	4	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); toes
	28102	4	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autogenous bone graft (includes obtaining graft)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	28103	4	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with homogenous bone graft
	28107	3	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal bones, except talus or calcaneus; with homogenous bone graft
*	28110	3	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
*	28111	3	Ostectomy; complete excision; first metatarsal head
*	28112	3	Ostectomy; complete excision other metatarsal head (second, third, or fourth)
*	28113	3	Ostectomy; complete excision fifth metatarsal head
*	28114	3	Ostectomy; complete excision all metatarsal heads, with proximal phalangectomy, excluding first metatarsal (Clayton type procedure)
	28118	3	Ostectomy, calcaneus; partial
	28120	3	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) of bone (e.g., for osteomyelitis), talus or calcaneus
	28122	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), tarsal or metatarsal bone, except talus or calcaneus
	28140	3	Metatarsectomy
	28171	3	Radical resection for tumor; tarsal (except talus or calcaneus)
	28173	3	Radical resection for tumor; metatarsal
	28175	3	Radical resection for tumor; phalanx

INTRODUCTION AND/OR REMOVAL

	28193	2	Remove foreign body; complicated

REPAIR, REVISION OR RECONSTRUCTION

*	28200	3	Repair or suture of tendon, foot, flexor, single; primary or secondary, without free graft, each tendon
*	28202	4	Repair or suture of tendon, foot, flexor, single; secondary with free graft, each tendon (includes obtaining graft)
*	28208	3	Repair or suture of tendon, foot, extensor, single; primary or secondary, each tendon
*	28210	4	Repair or suture of tendon, foot, extensor, single; secondary with free graft, each tendon (includes obtaining graft)
*	28222	3	Tenolysis, flexor; multiple (through same incision)
*	28225	3	Tenolysis, extensor; single
*	28226	3	Tenolysis, extensor; multiple (through same incision),
*	28230	1	Tenotomy, open, flexor; foot, single or multiple (separate procedure)
*	28232	1	Tenotomy, open, flexor; toe, single (separate procedure)
*	28234	1	Tenotomy, open, extensor, foot or toe
*	28240	1	Tenotomy or release, abductor hallucis muscle
	28250	2	Division of plantar fascia and muscle ("Steindler stripping") (separate procedure)
	28260	3	Capsulotomy, midfoot; medial release only (separate procedure)

	28261	3	Capsulotomy, midfoot; with tendon lengthening
*	28264	3	Capsulotomy, midtarsal (Heyman type procedure)
*	28270	3	Capsulotomy for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint (separate procedure)
*	28272	3	Capsulotomy for contracture; interphalangeal joint, single, each joint (separate procedure)
*	28285	4	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)
*	28286	4	Hammertoe operation; for cock-up fifth toe with plastic skin closure, (Ruiz-Mora type procedure)
*	28290	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)
*	28292	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; Keller, McBride or Mayo type procedure
*	28293	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; resection of joint with implant
*	28294	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; with tendon transplants (Joplin type procedure)
	28296	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedures)
	28297	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; Lapidus type procedure
*	28298	4	Hallux valgus (bunion) correction with or without sesamoidectomy; by phalanx osteotomy
*	28299	4	Hallux valgus (bunion) correction with or without sesamoidectomy; by other methods (e.g., double osteotomy)
*	28306	4	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal
*	28308	4	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; other than first metatarsal
*	28310	4	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
*	28312	4	Osteotomy for shortening, angular or rotational correction; other phalanges, any toe
	28315	3	Sesamoidectomy, first toe (separate procedure)
	28320	4	Repair of nonunion or malunion; tarsal bones (calcaneus, talus, etc)
	28322	4	Repair of nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)

FRACTURE AND/OR DISLOCATION

	28405	1	Treatment of closed calcaneal fracture; with manipulation including Cotton or Bohler type reductions
	28406	2	Treatment of closed calcaneal fracture; with manipulation and skeletal fixation

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	28420	4	Open treatment of closed or open calcaneal fracture, with or without internal or external skeletal fixation; with primary iliac or other autogenous bone graft (includes obtaining graft)
	28435	1	Treatment of closed talus fracture; with manipulation
	28436	2	Treatment of closed talus fracture; with manipulation and percutaneous pinning
	28465	4	Open treatment of closed or open tarsal bone fracture (except talus and calcaneus), with or without internal or external skeletal fixation, each
	28485	4	Open treatment of closed or open metatarsal fracture, with or without internal or external skeletal fixation, each
	28500	3	Treatment of open fracture great toe, phalanx or phalanges, with uncomplicated soft tissue closure
	28505	3	Open treatment of closed or open fracture great toe, phalanx or phalanges, with or without internal or external skeletal fixation
	28520	2	Treatment of open fracture, phalanx or phalanges, other than great toe, with uncomplicated soft tissue closure, each
	28525	3	Open treatment of closed or open fracture, phalanx or phalanges, other than great toe, with or without internal or external skeletal fixation, each
	28545	1	Treatment of closed tarsal bone dislocation; requiring anesthesia
	28546	2	Treatment of closed tarsal bone dislocation, with percutaneous skeletal fixation
	28555	4	Open treatment of closed or open tarsal bone dislocation, with or without internal or external skeletal fixation
	28575	1	Treatment of closed talotarsal joint dislocation; requiring anesthesia
	28585	4	Open treatment of closed or open talotarsal joint dislocation, with or without internal or external skeletal fixation
	28605	1	Treatment of closed tarsometatarsal joint dislocation; requiring anesthesia
	28606	2	Treatment of closed tarsometatarsal joint dislocation, with percutaneous skeletal fixation
	28615	4	Open treatment of closed or open tarsometatarsal joint dislocation, with or without internal or external skeletal fixation
	28645	4	Open treatment of closed or open metatarsophalangeal joint dislocation
	28670	3	Treatment of open interphalangeal joint dislocation, with uncomplicated soft tissue closure
	28675	4	Open treatment of closed or open interphalangeal joint dislocation
ARTHRODESIS			
*	28750	4	Arthrodesis, great toe; metatarsophalangeal joint
*	28755	4	Arthrodesis, great toe; interphalangeal joint
*	28760	4	Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

AMPUTATION			
*	28810	2	Amputation, metatarsal, with toe, single
*	28820	2	Amputation, toe; metatar sophalangeal joint
*	28825	2	Amputation, toe; interphalanged joint
ARTHROSCOPY			
	29870	4	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
	29874	4	Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)
	29875	4	Arthroscopy, knee, surgical; synovectomy, limited (e.g., plica or shelf resection)
	29876	4	Synovectomy, major, two or more compartments (e.g., medial or lateral)
	29877	4	Debridement/shaving of articular cartilage (chondroplasty)
	29881	4	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving)
	29887	4	Drilling for intact osteochondritis dissecans lesion with internal fixation
RESPIRATORY SYSTEM			
NOSE			
EXCISION			
*	30115	2	Excision, nasal polyp(s), extensive; unilateral
	30116	2	Excision, nasal polyp(s), extensive; bilateral
	30117	2	Excision, intranasal lesion; internal approach
	30118	2	Excision, intransal lesion; external approach (lateral rhinotomy)
	30125	3	Excision dermoid cyst, nose; complex, under bone or cartilage
*	30130	1	Excision turbinate, partial or complete
*	30140	4	Submucous resection turbinate, partial or complete
	30150	4	Rhinectomy; partial
	30160	4	Rhinectomy; total
REMOVAL FOREIGN BODY			
	30310	1	Removal of foreign body, intranasal; requiring general anesthesia,
	30320	2	Removal foreign body; by lateral rhinotomy
REPAIR			
	30400	4	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	4	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	30420	4	Rhinoplasty, primary; including major septal repair
	30430	4	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	4	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
	30450	4	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
	30520	4	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
	30580	4	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
	30600	4	Repair fistula; oronasal
*	30620	4	Reconstruction, functional, internal nose (septal or other intranasal dermatoplasty) (does not include obtaining graft)
*	30630	4	Repair nasal septal perforations

OTHER PROCEDURES

	30915	4	Ligation arteries; ethmoidal
	30920	4	Ligation arteries; internal maxillary artery, transantral

ACCESSORY SINUSES

INCISION

*	31020	2	Sinusotomy, maxillary (antrotomy); intranasal, unilateral
*	31021	2	Sinusotomy, maxillary (antrotomy); intranasal, bilateral
*	31030	2	Sinusotomy, maxillary (antrotomy); radical, unilateral (Caldwell-Luc) without removal of antrochoanal polyps
*	31031	2	Sinusotomy, maxillary (antrotomy); radical, bilateral (Caldwell-Luc) without removal of antrochoanal polyps
	31032	4	Sinusotomy, maxillary (antrotomy); radical unilateral (Caldwell-Luc) with removal antrochoanal polyps
	31033	4	Sinusotomy, maxillary (antrotomy); radical, bilateral (Caldwell-Luc) with removal antrochoanal polyps
	31070	2	Sinusotomy frontal; external, simple (trephine operation)

EXCISION

*	31200	3	Ethmoidectomy; intranasal, anterior
*	31201	3	Ethmoidectomy; intranasal, total
*	31205	3	Ethmoidectomy; extranasal, total

LARYNX

ENDOSCOPY

*	31505	1	Laryngoscopy, indirect (separate procedure); diagnostic
*	31510	1	Laryngoscopy, indirect (separate procedure); with biopsy
*	31511	1	Laryngoscopy, indirect (separate procedure); with removal of foreign body

*	31512	1	Laryngoscopy, indirect (separate procedure); with removal of lesion
	31513	2	Laryngoscopy, indirect (separate procedure); with vocal cord injection
*	31515	1	Laryngoscopy direct; for aspiration
*	31525	1	Laryngoscopy, direct; diagnostic, except newborn
*	31526	1	Laryngoscopy, indirect; diagnostic, with operating microscope
	31527	2	Laryngoscopy, direct; with insertion of obturator
*	31530	1	Laryngoscopy, direct, operative, with foreign body removal
*	31531	1	Laryngoscopy, direct, operative, with foreign body removal; with operating microscope
*	31535	1	Laryngoscopy, direct, operative, with biopsy
*	31536	1	Laryngoscopy, direct, operative, with biopsy; with operating microscope
*	31540	1	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis
*	31541	1	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope
*	31560	1	Laryngoscopy, direct, operative, with arytenoidectomy
*	31561	1	Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope
*	31570	1	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic
*	31571	1	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope
	31576	1	Laryngoscopy, flexible fiberscopic; with biopsy
	31577	1	Laryngoscopy, flexible fiberscopic; with removal of foreign body
	31578	1	Laryngoscopy, flexible fiberscopic; with removal of lesion

TRACHEA AND BRONCHI

INCISION

31600	2	Tracheostomy, planned (separate procedure)
31612	1	Tracheal puncture, percutaneous for aspiration of mucus (transtracheal aspiration)
31613	2	Tracheostoma revision; simple, without flap rotation
31614	2	Tracheostoma revision; complex, with flap rotation

ENDOSCOPY

31615	1	Tracheobronchoscopy through established tracheostomy incision
31622	1	Bronchoscopy; diagnostic, (flexible original), with or without cell washing or brushing
* 31625	1	Bronchoscopy; with biopsy
31628	1	Bronchoscopy; with transbronchial lung biopsy, with or without fluoroscopic guidance
* 31630	1	Bronchoscopy; with tracheal or bronchial dilation or closed reduction of fracture

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	31631	1	Bronchoscopy; with tracheal dilation and placement of tracheal stent
*	31635	1	Bronchoscopy; with removal of foreign body
*	31640	1	Bronchoscopy; with excision of tumor
	31641	1	Bronchoscopy; with destruction of tumor or relief of stenosis by any method other than excision (e.g., laser)
*	31645	1	Bronchoscopy; with therapeutic aspiration of tracheobronchial tree, initial (e.g., drainage of lung abscess)
	31646	1	Bronchoscopy; with therapeutic aspiration of tracheobronchial tree, subsequent
	31656	1	Bronchoscopy; with injection of contrast material for segmental bronchography (fiberscope only)
	31659	1	Bronchoscopy; with other bronchoscopic procedures

INTRODUCTION

	31700	1	Catheterization, transglottic (separate procedure)
	31708	1	Instillation of contrast material for laryngography or bronchography, without catheterization
	31710	1	Catheterization for bronchography, with or without instillation of contrast material
	31715	1	Transtracheal injection for bronchography
	31717	1	Catheterization with bronchial brush biopsy
	31719	1	Transtracheal (percutaneous) introduction of indwelling tube for therapy (tickle tube)
	31720	1	Catheter aspiration (separate procedure); nasotracheobronchial

CARDIOVASCULAR SYSTEM

REPAIR, LIGATION AND OTHER PROCEDURES

	37609	1	Ligation or biopsy, temporal artery
*	37700	4	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions, unilateral
*	37701	4	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions, unilateral; bilateral
*	37720	4	Ligation and division and complete stripping of long or short saphenous veins; unilateral
*	37721	4	Ligation and division and complete stripping of long or short saphenous veins; bilateral
*	37730	4	Ligation and division and complete stripping of long and short saphenous veins; unilateral
*	37731	4	Ligation and division and complete stripping of long and short saphenous veins: bilateral
	37735	4	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia; unilateral

	37737	4	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep facia; bilateral
	37760	4	Ligation and perforators, subfascial, radical (Linton Type), with or without skin graft
*	37780	4	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure); unilateral
*	37781	4	bilateral. Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
	37785	3	Ligation, division and/or excision of secondary varicose veins (clusters) of leg; unilateral
	37787	3	Ligation, division and/or excision of secondary varicose veins (clusters) of leg; bilateral

HEMIC AND LYMPHATIC SYSTEM

LYMPH NODES AND LYMPHATIC CHANNELS

INCISION

	38305	1	Drainage of lymph node abscess or lymphadenitis; extensive
	38308	1	Lymphangiotomy or other operations on lymphatic channels

EXCISION

*	38500	2	Biopsy or excision of lymph node(s); superficial (separate procedure)
*	38510	2	Biopsy or excision of lymph node(s); deep, cervical node(s)
*	38520	2	Biopsy or excision of lymph node(s); deep cervical node(s) with excision scalene fat pad
	38530	3	Biopsy or excision of lymph node(s); internal mammary node(s) (separate procedure)
	38542	3	Dissection; deep jugular node(s)
	38550	3	Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection; simple
	38555	4	Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection; complex

RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)

38700	4	Suprahyoid lymphadenectomy; unilateral
38701	4	Suprahyoid lymphadenectomy; bilateral
38740	3	Axillary lymphadenectomy; superficial
38745	3	Axillary lymphadenectomy; complete
38760	3	Inguinofemoral lymphadenectomy, superficial, including Cloquet's node (separate procedure); unilateral
38761	3	Inguinofemoral lymphadenectomy, superficial, including Cloquet's node (separate procedure); bilateral

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

INTRODUCTION

	38790	1	Injection procedure for lymphangiography; unilateral
	38791	1	Injection procedure for lymphangiography; bilateral

DIGESTIVE SYSTEM

LIPS

EXCISION

*	40500	2	Vermilionectomy (lip shave), with mucosal advancement
*	40510	3	Excision of lip; transverse wedge excision with primary closure
*	40520	3	Excision lip; V-excision with primary direct linear closure
	40525	3	Excision lip; full thickness, reconstruction with local flap (Estlander or fan)
	40527	3	Excision lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
	40530	3	Resection of lip, more than one-fourth, without reconstruction

REPAIR (CHEILOPLASTY)

	40650	3	Repair lip, full thickness; vermilion only
	40654	4	Repair lip, full thickness; over one half vertical height, or complex

VESTIBULE OF MOUTH

INCISION

	40801	1	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated
	40805	1	Removal of embedded foreign body; complicated

EXCISION, DESTRUCTION

	40814	2	Excision of lesion of mucosa and submucosa; with complex repair
	40816	2	Excision of lesion of mucosa and submucosa; complex with excision of underlying muscle
	40818	2	Excision of mucosa as donor graft

REPAIR

	40831	2	Closure of laceration; over 2.6 cm or complex
	40840	2	Vestibuloplasty; anterior
	40842	2	Vestibuloplasty; posterior, unilateral
	40843	2	Vestibuloplasty; posterior, bilateral
	40844	3	Vestibuloplasty; entire arch
	40845	4	Vestibuloplasty; complex

TONGUE, FLOOR OF MOUTH

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	INCISION		
*	41000	1	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
*	41005	1	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial
	EXCISION		
*	41100	1	Biopsy of tongue; anterior two-thirds
*	41105	1	Biopsy of tongue; posterior one-third
	41114	2	Excision of lesion of tongue with closure; with local tongue flap
	41115	1	Excision of lingual frenum (frenectomy)
	41116	1	Excision lesion of floor of mouth
	41120	3	Glossectomy; less than one-half tongue
	REPAIR		
	41251	3	Repair laceration up to 2 cm; posterior one-third of tongue
			DENTOALVEOLAR STRUCTURES
	INCISION		
	41806	2	Removal embedded foreign body; from bone
	EXCISION, DESTRUCTION		
	41826	2	Excision of lesion or tumor (except listed above); with simple repair
	41827	3	Excision of lesion or tumor (except listed above); with complex repair
	PALATE, UVULA		
	INCISION		
*	42000	1	Drainage of abscess of palate, uvula
	EXCISION, DESTRUCTION		
	42104	1	Excision, lesion of palate, uvula; without closure
	42106	1	Excision, lesion of palate, uvula; with simple primary closure
	42107	1	Excision, lesion of palate, uvula; with local flap closure
	42120	2	Resection of palate or extensive resection of lesion
	42140	2	Uvulectomy, excision of uvula
	REPAIR		
	42182	1	Repair laceration of palate; over 2 cm or complex
	SALIVARY GLAND AND DUCTS		
	INCISION		
	42305	1	Drainage of abscess; parotid, complicated
	42320	1	Drainage of abscess; submaxillary external

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	42325	2	Fistulization of sublingual salivary cyst (ranula)
	42335	2	Sialolithotomy; submandibular (submaxillary), complicated, intraoral
	42340	2	Sialolithotomy; parotid, extraoral or complicated intraoral
EXCISION			
	42408	2	Excision of sublingual salivary cyst (ranula)
	42410	4	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection
	42440	4	Excision of submandibular (submaxillary) gland
	42450	4	Excision of sublingual gland
REPAIR			
	42500	3	Plastic repair of salivary duct, sialodochoplasty; primary or simple
	42505	4	Plastic repair salivary duct, sialodochoplasty; secondary or complicated
	42507	4	Parotid duct diversion, bilateral (Wilke type procedure)
	42508	4	Parotid duct diversion, bilateral (Wilke type procedure); with excision of one submandibular gland
	42509	4	Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands
OTHER PROCEDURES			
	42600	1	Closure salivary fistula
	42665	1	Ligation salivary duct, intraoral
PHARYNX, ADENOIDS, AND TONSILS			
INCISION			
	42720	1	Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach
	42725	1	Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach
EXCISION			
	42806	2	Biopsy; nasopharynx, survey for unknown primary lesion
	42808	1	Excision of lesion of pharynx
*	42810	2	Excision branchial cleft cyst or vestige; confined to skin and subcutaneous tissues
*	42815	2	Excision branchial cleft cyst or vestige; extending beneath subcutaneous tissues
	42860	2	Excision of tonsil tags
	42870	2	Excision lingual tonsil (separate procedure)
	42880	2	Excision nasopharyngeal lesion (e.g., fibroma)
REPAIR			
	42900	2	Suture pharynx for wound or injury
	42950	4	Pharyngoplasty (plastic or reconstructive operation on pharnyx)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

OTHER PROCEDURES			
	42955	2	Pharyngostomy (fistulization of pharynx, external for feeding)
ESOPHAGUS			
ENDOSCOPY			
*	43200	1	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure
*	43202	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for biopsy and/or collection of specimen by brushing or washing
	43204	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for injection sclerosis of esophageal varices
*	43215	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of foreign body
*	43217	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of polypoid lesion(s)
	43219	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for insertion of plastic tube or stent
*	43220	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for dilation, direct
	43226	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for insertion of wire to guide dilation
	43227	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	43228	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for ablation of tumor or mucosal lesion
	43235	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic
	43239	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for biopsy and/or collection of specimen by brushing or washing
	43247	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for removal of foreign body
	43251	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for removal of polypoid lesion(s)
	43255	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	43258	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for ablation of tumor or mucosal lesion (e.g., electrocoagulation, with laser photocoagulation)
	43260	2	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection

	43262	2	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection; for sphincterotomy/papillotomy
	43263	2	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection; for pressure measurement of sphincter of Oddi
	43264	2	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection; for removal of stone(s) from biliary and/or pancreatic ducts

MANIPULATION

	43450	1	Dilation of esophagus, by unguided sound or bougie single or multiple passes; initial session
	43451	1	Dilation of esophagus, by unguided sound or bougie single or multiple passes; subsequent session
	43453	1	Dilation of esophagus, over guide wire or string
	43455	1	Dilation of esophagus, by balloon or Stark dilator
	43456	1	Dilation of esophagus by balloon or Stark dilator; retrograde

INTESTINES (EXCEPT RECTUM)

ENTEROSTOMY-EXTERNAL FISTULIZATION OF INTESTINES (SEPARATE PROCEDURE)

*	44340	3	Revision of colostomy; simple (release of superficial scar)
	44345	4	Revision of colostomy; complicated reconstruction in depth
	44346	4	Revision of colostomy; with repair of paracolostomy Lernia

ENDOSCOPY, SMALL BOWEL AND STOMAL

	44360	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; diagnostic
	44361	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for biopsy and/or collection of specimen by brushing or washing
	44363	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for removal of foreign body
	44364	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for removal of polypoid lesion(s)
	44366	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	44369	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for ablation of tumor or mucosal lesion (e.g., laser)
	44380	1	Fiberoptic ileoscopy through stoma
	44382	1	Fiberoptic ileoscopy through stoma; with biopsy and/or collection of specimen by brushing or washing

44388	1	Fiberoptic colonoscopy through colostomy
44389	1	Fiberoptic colonoscopy through colostomy; for biopsy and/or collection of specimen by brushing or washing
44390	1	Fiberoptic colonoscopy through colostomy; for removal of foreign body
44391	1	Fiberoptic colonoscopy through colostomy; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
44392	1	Fiberoptic colonoscopy through colostomy; for removal of polypoid lesion(s)

RECTUM

INCISION

45000	3	Transrectal drainage of pelvic abscess
45005	1	Incision and drainage of submucosal abscess, rectum
45020	2	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess

EXCISION

45170	3	Excision of rectal tumor, simple, transanal approach
45180	3	Excision and/or electrodesiccation of malignant tumor of rectum, transanal approach; palliative
45181	3	Excision and/or electrodesiccation of malignant tumor of rectum, transanal approach; therapeutic

ENDOSCOPY

45355	1	Colonoscopy, with standard sigmoidoscope, transabdominal via colotomy, single or multiple
45360	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; diagnostic procedure
45365	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; for biopsy and/or collection of specimen by brushing or washing
45367	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; for removal of foreign body
45368	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
45370	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; for removal of polypoid lesion(s)
45378	1	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure
45379	1	Colonoscopy, fiberoptic, beyond splenic flexure; for removal of foreign body
45380	1	Colonoscopy, fiberoptic, beyond splenic flexure; for biopsy and/or collection of specimen by brushing or washing
45382	1	Colonoscopy, fiberoptic, beyond splenic flexure; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	45385	1	Colonoscopy, fiberoptic, beyond splenic flexure; for removal of polypoid lesion(s)
REPAIR			
	45500	4	Proctoplasty; for stenosis
	45505	4	Proctoplasty; for prolapse of mucous membrane
	45521	1	Perirectal injection of sclerosing solution for prolapse; hospital
	45560	4	Repair of rectocele (separate procedure)
MANIPULATION			
	45900	1	Reduction of procidentia (separate procedure) under anesthesia
*	45910	1	Dilation of rectal structure (separate procedure) under anesthesia other than local
	45915	1	Removal of fecal impaction or foreign body (separate procedure) under anesthesia
ANUS			
INCISION			
	46000	2	Fistulotomy, subcutaneous
	46040	2	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)
	46045	2	Incision and drainage of intramural, intramuscular or submucosal abscess, transanal, under anesthesia
*	46060	2	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy, submuscular
	46080	2	Sphincterotomy, anal, division of sphincter (separate procedure)
EXCISION			
	46200	2	Fissurectomy, with or without sphincterotomy
	46211	2	Cryptectomy; multiple (separate procedure)
*	46250	3	Hemorrhoidectomy, external, complete
*	46255	3	Hemorrhoidectomy internal and external, simple
*	46257	3	Hemorrhoidectomy internal and external, simple; with fissurectomy
*	46258	3	Hemorrhoidectomy internal and external, simple; with fistulectomy, with or without fissurectomy
	46260	2	Hemorrhoidectomy, internal and external, complex or extensive
	46261	2	Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy
*	46262	2	Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy
*	46270	2	Fistulectomy; subcutaneous
*	46275	2	Fistulectomy; submuscular

*	46280	2	Fistulectomy; complex or multiple
	46285	2	Fistulectomy; second stage

ANUS

INTRODUCTION

	46750	4	Sphincteroplasty, anal, for incontinence or prolapse; adult
	46753	4	Graft (Thiersch operation) for rectal incontinence and/or prolapse
	46754	4	Removal of Thiersch wire or suture
	46760	4	Sphincteroplasty, anal, for incontinence, adult, muscle transplant

DESTRUCTION

	46924	1	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method
	46937	2	Cryosurgery of rectal tumor; benign
	46938	2	Cryosurgery of rectal tumor; malignant

LIVER

INCISION

*	47000	2	Biopsy of liver, percutaneous needle

ABDOMEN, PERITONEUM, AND OMENTUM

INCISION

	49000	4	Exploratory laparotomy, exploratory celiotomy (separate procedure)

ENDOSCOPY

*	49300	4	Peritoneoscopy; without biopsy
*	49301	4	Peritoneoscopy; with biopsy
	49302	4	Peritoneoscopy with guided transhepatic cholangiography; without biopsy
	49303	4	Peritoneoscopy with guided transhepatic cholangiography; with biopsy

INTRODUCTION

	49400	1	Pneumoperitoneum; initial
	49401	1	Pneumoperitoneum; subsequent
	49420	1	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary
	49421	1	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent
	49425	1	Peritoneal-venous shunt (e.g., Le Veen shunt)
	49426	1	Revision of peritoneal-venous shunt

REPAIR

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY

*	49505	4	Repair inguinal hernia, age 5 or over
	49510	4	Repair inguinal hernia, age 5 or over; with orchiectomy, with or without implantation of prosthesis
*	49515	4	Repair inguinal hernia, age 5 or over; with excision of hydrocele or spermatocele
*	49520	4	Repair inguinal hernia, any age; recurrent
*	49525	4	Repair inguinal hernia, any age; sliding
	49540	4	Repair lumbar hernia
*	49550	4	Repair femoral hernia, groin incision
	49552	4	Repair femoral hernia, Henry approach
*	49555	4	Repair femoral hernia, recurrent, any approach
*	49560	4	Repair ventral (incisional) hernia (separate procedure)
*	49565	4	Repair ventral (incisional) hernia (separate procedure); recurrent
	49570	4	Repair epigastric hernia, properitoneal fat (separate procedure); simple
	49575	4	Repair epigastric hernia, properitoneal fat (separate procedure); complex
	49581	4	Repair umbilical hernia; age 5 or over
	49590	4	Repair spigelian hernia

URINARY SYSTEM

KIDNEY

INCISION

50020	3	Drainage of perirenal or renal abscess (separate procedure)
50040	4	Nephrostomy, nephrotomy with drainage

EXCISION

50200	1	Renal biopsy, percutaneous by trocar or needle
50205	4	Renal biopsy, percutaneous; by surgical exposure of kidney

INTRODUCTION

50390	1	Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous
50392	1	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous
50393	1	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous
50394	1	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)
50396	1	Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
50398	1	Change of nephrostomy or pyelostomy tube

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

ENDOSCOPY		
50553	1	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50559	1	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance with or without biopsy and/or fulguration
50561	1	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50570	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
50572	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50576	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration, with or without biopsy
50578	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration
50580	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
URETER		
INTRODUCTION		
50684	1	Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter (separate procedure)
50690	1	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure)
ENDOSCOPY		
50953	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50955	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

50957	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration, with or without biopsy
50959	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance with or without biopsy and/or fulguration (not including provision of material)
50961	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50970	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
50972	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50974	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50976	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration, with or without biopsy
50978	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of materal)
50980	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus

BLADDER

INCISION

51005	1	Aspiration of bladder; by trocar or intracatheter
51010	1	Aspiration of bladder; with insertion of suprapubic catheter

INTRODUCTION

51600	1	Injection procedure for cystography or voiding urethrocystography
51605	1	Injection procedure and placement of chain for contrast and/or chain urethrocystography
51610	1	Injection procedure for retrograde urethrocystography
51710	1	Change of cystostomy tube; complicated

BLADDER

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

REPAIR			
	51865	4	Cystorrhaphy, suture of bladder wound, injury or rupture; complicated
	51900	4	Closure of vesicovaginal fistula, abdominal approach
URETER			
ENDOCOPY-CYSTOSCOPY, URETHROSCOPY CYSTOURETHROSCOPY NOTES			
*	52000	1	Cystourethroscopy; (separate procedure)
	52005	1	Cystourethroscopy; with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
	52007	1	Cystourethroscopy; with ureteral catheterization and brush biopsy of ureter and/or renal pelvis
	52010	1	Cystourethroscopy: with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service
BLADDER			
TRANSURETHRAL SURGERY (URETHRA, AND BLADDER)			
	52204	3	Cystourethroscopy, with biopsy
	52214	3	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
	52224	3	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s), with or without biopsy
	52234	3	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)
	52235	3	Cystourethroscopy, with fulguration (including cryosurgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
	52240	3	Cystourethroscopy, with fulguration (including cryosurgery) and/or resection of; LARGE bladder tumor(s)
	52250	3	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
	52260	3	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
	52270	3	Cystourethroscopy, with internal urethrotomy; female
	52275	3	Cystourethroscopy, with internal urethrotomy; male
	52276	3	Cystourethroscopy with direct vision internal urethrotomy
	52277	3	Cystourethroscopy, with resection of external sphincter (sphincterotomy)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

52281	3	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female
52283	3	Cystourethroscopy, with steroid injection into stricture
52285	3	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52290	3	Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral
52300	3	Cystourethroscopy; with resection or fulguration of ureterocele(s), unilateral or bilateral
52305	3	Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple
52310	4	Cystourethroscopy, with removal of foreign body calculus or ureteral stent from urethra or bladder; simple
52315	4	Cystourethroscopy, with removal of foreign body calculus or ureteral stent from urethra or bladder; complicated
52317	4	Litholapaxy: crushing of fragmentation or calculus by any means in bladder and removal of fragments, simple; small (less than 2.5 c.m.)
52318	4	Litholapaxy: crushing of fragmentation or calculus by any means in bladder and removal of fragments, simple; complicated or large (over 2.5 c.m.)
52320	4	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
52330	4	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus
52332	4	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)
52335	3	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method)

TRANSURETHERAL SURGERY (VESICAL NECK AND PROSTATE)

52340	3	Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic mucosal folds)
52500	3	Transurethral resection of bladder neck (separate procedure)

TRANSURETHRAL SURGERY(URETHA AND BLADDER)

52601	4	Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

52606	4	Transurethral fulguration for postoperative bleeding occurring after the usual follow-up time
52612	4	Transurethral resection of prostate; first stage of two-stage resection (partial resection)
52614	4	Transurethral resection of prostate; second stage of two-stage resection (resection completed)
52620	4	Transurethral resection; of residual obstructive tissue after 90 days postoperative
52630	4	Transurethral resection; of regrowth of obstructive tissue longer than one year postoperative
52640	4	Transurethral resection; of postoperative bladder neck contracture
52650	4	Transurethral cryosurgical removal of prostate (postoperative irrigations and aspiration of sloughing tissue included)
52700	4	Transurethral drainage of prostatic abscess

URETHRA

INCISION

53000	2	Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra
53010	2	Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external
53020	2	Meatotomy, cutting of meatus (separate procedure); except infant
53040	2	Drainage of deep periurethral abscess

EXCISION

53220	3	Excision or fulguration of carcinoma of urethra
53230	3	Excision of urethral diverticulum (separate procedure); female
53235	3	Excision of urethral diverticulum (separate procedure); male
53240	3	Marsupialization of urethral diverticulum, male or female
53265	3	Excision or fulguration; urethral caruncle
53275	3	Excision or fulguration; urethral prolapse

REPAIR

53400	4	Urethroplasty; first stage, for fistula, diverticulum, or stricture, e.g., Johannsen type
53405	4	Urethroplasty; second stage (formation of urethra), including urinary diversion
53410	4	Urethroplasty, one-stage reconstruction of male anterior urethra
53420	4	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	4	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	4	Urethroplasty, reconstruction of female urethra
53440	4	Operation for correction of male urinary incontinence, with or without introduction of prosthesis

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	53447	4	Removal, repair or replacement of inflatable sphincter including pump and/or reservoir and/or cuff
	53449	4	Surgical correction of hydraulic abnormality of inflatable sphincter device
	53450	4	Urethromeatoplasty, with mucosal advancement
	53460	4	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
SUTURE			
	53502	4	Urethrorrhaphy, suture of urethral wound or injury, female
	53510	4	Urethrorrhaphy, suture of urethral wound or injury; perineal
	53515	4	Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous
	53520	4	Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)
MANIPULATION			
*	53600	1	Dilation of urethral stricture by passage of sound or urethral dilator male; initial
*	53601	1	Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent
*	53605	1	Dilation of urethral stricture of vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia
*	53620	1	Dilation of urethral stricture by passage of filiform and follower, male; initial
*	53621	1	Dilation of urethral stricture by passage of filiform and follower, male; subsequent
*	53660	1	Dilation of female urethra including suppository and/or instillation; initial
*	53661	1	Dilation of female urethra including suppository and/or instillation; subsequent
*	53665	1	Dilation of female urethra, general or conduction (spinal) anesthesia

MALE GENITAL SYSTEM

PENIS

INCISION			
	54001	1	Slitting of prepuce, dorsal or lateral, (separate procedure); except newborn
EXCISION			
	54105	1	Biopsy of penis; deep structures
	54110	3	Excision of penile plaque (Peyronie disease)
	54115	3	Removal foreign body from deep penile tissue (e.g., plastic implant)

	54120	3	Amputation of penis; partial
	54125	4	Amputation of penis; complete
	54152	2	Circumcision, clamp procedure; except newborn
	54161	2	Circumcision, surgical excision other than clamp or dorsal slit; except newborn
INTRODUCTION			
	54205	1	Injection procedure for Peyronie disease; with surgical exposure of plaque
	54220	1	Irrigation of corpora cavernosa for priapism
	54230	1	Injection procedure for corpora cavernosography
REPAIR			
	54440	4	Plastic operation of penis for injury
TESTIS			
EXCISION			
	54505	1	Biopsy of testis, incisional (separate procedure; unilateral
	54506	1	bilateral
	54510	1	Excision of local lesion of testis
*	54520	2	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; unilateral
*	54521	2	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; bilateral
	54530	3	Orchiectomy, radical, for tumor; inguinal approach
REPAIR			
	54670	2	Suture or repair of testicular injury
	54680	4	Transplantation of testis(es) to thigh (because of scrotal destruction)
EPIDIDYMIS			
EXCISION			
	54700	2	Incision and drainage of epididymis, testis and/or scrotal space (e.g., abscess or hematoma)
	54820	1	Exploration of epididymis, with or without biopsy
	54830	2	Excision of local lesion of epididymis
*	54840	3	Excision of spermatocele, with or without epididymectomy
	54860	3	Epididymectomy; unilateral
	54861	3	Epididymectomy; bilateral

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

REPAIR			
	54900	3	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
	54901	3	Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral
TUNICA VAGINALIS			
EXCISION			
*	55040	3	Excision of hydrocele; unilateral
*	55041	3	Excision of hydrocele; bilateral
REPAIR			
	55060	3	Repair of hydrocele (Bottle type)
INCISION			
	55120	1	Removal of foreign body in scrotum
SCROTUM			
EXCISION			
	55150	3	Resection of scrotum
REPAIR			
	55175	3	Scrotoplasty; simple
	55180	3	Scrotoplasty; complicated
VAS DEFERENS			
REPAIR			
	55400	3	Vasovasostomy, vasovasorrhaphy; unilateral
	55401	3	Vasovasostomy, vasovasorrhaphy; bilateral
SPERMATIC CORD			
EXCISION			
	55500	3	Excision of hydrocele of spermatic cord, unilateral (separate procedure)
	55520	3	Excision of lesion of spermatic cord (separate procedure)
*	55530	4	Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)
	55535	4	Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach
	55540	4	Excision of varicocele or ligation of spermatic veins for varicocele; with hernia repair

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

SEMINAL VESICLES

INCISION			
	55605	1	Vesiculotomy; complicated
EXCISION			
	55650	4	Vesiculectomy, any approach; unilateral
	55651	4	Vesiculectomy, any approach; bilateral
	55680	4	Excision of Mullerian duct cyst

PROSTATE

INCISION

*	55700	1	Biopsy, prostate; needle or punch, single or multiple, any approach
*	55705	1	Biopsy, prostate; incisional any approach
	55720	1	Prostatotomy, external drainage of prostatic abscess, any approach; simple

FEMALE GENITAL SYSTEM

VAGINA

PERINEUM			
	56000	2	Incision and drainage of perineal abscess (nonobstetrical)

VULVA AND INTROITUS

INCISION			
	56440	3	Marsupialization of Bartholin's gland cyst
DESTRUCTION			
	56515	3	Destruction of lesion(s), vulva; extensive, any method
EXCISION			
	56740	3	Excision of Bartholin's gland or cyst

VAGINA

INCISION			
	57020	1	Colpocentesis (separate procedure)
EXCISION			
	57105	3	Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)
	57130	3	Excision of vaginal septum

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

REPAIR			
	57268	4	Repair of enterocele, vaginal approach (separate procedure)
MANIPULATION			
*	57400	1	Dilation of vagina under anesthesia
*	57410	1	Pelvic examination under anesthesia
ENDOSCOPY			
*	57450	1	Culdoscopy, diagnostic
CERVIX UTERI			
EXCISION			
	57520	2	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair
REPAIR			
	57720	3	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach
MANIPULATION			
	57820	2	Dilation and curettage of cervical stump
CORPUS UTERI			
EXCISION			
*	58120	3	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
OVARY			
EXCISION			
	58900	4	Biopsy of ovary, unilateral or bilateral (separate procedure)
ENDOSCOPY-LAPAROSCOPY			
*	58980	4	Laparoscopy for visualization of pelvic viscera
*	58984	4	Laparoscopy for visualization of pelvic viscera; with fulguration of ovarian or peritoneal lesions
*	58985	4	Laparoscopy for visualization of pelvic viscera; with lysis of adhesions
*	58986	4	Laparoscopy for visualization of pelvic viscera; with biopsy (single or multiple)
*	58987	4	Laparoscopy for visualization of pelvic viscera; with aspiration (single or multiple)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

ENDOCRINE SYSTEM

THYROID GLAND

EXCISION

	60200	3	Excision of cyst or adenoma of thyroid, or transaction of isthmus
	60220	4	Total thyroid lobectomy, unilateral
	60225	4	Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmus
*	60280	3	Excision of thyroglossal duct cyst or sinus

NERVOUS SYSTEM

SKULL, MENINGES, AND BRAIN

PUNCTURE FOR INJECTION, DRAINAGE OR ASPIRATION

61020	1	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection
61026	1	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular chatheter/reservoir; with injection of drug or other substance for diagnosis or treatment
61050	1	Cisternal or lateral cervical puncture; without injection (separate procedure)
61070	1	Puncture of shunt tubing or reservoir for aspiration or injection procedure

SPINE AND SPINAL CORD

PUNCTURE FOR INJECTION, DRAINAGE, OR ASPIRATION

62270	1	Spinal puncture, lumbar, diagnostic
62273	1	Injection, lumbar epidural, of blood or clot patch
62274	1	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural, simple
62276	1	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural, differential
62277	1	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural, continuous
62278	1	Injection of anesthetic substance, diagnostic or therapeutic; epidural or caudal, single
62279	1	Injection of anesthetic substance, diagnostic or therapeutic; epidural or caudal, continuous
62288	1	Injection of substance other than anesthetic, contrast, or neurolytic solutions; subarachnoid (separate procedure)

62289	1	Injection of substance other than anesthetic, contrast, or neurolytic solutions; epidural or caudal

EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM

INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC

SOMATIC NERVES

64408	1	Injection, anesthetic agent; vagus nerve
64410	1	Injection, anesthetic agent; phrenic nerve
64415	1	Injection, anesthetic agent; brachial plexus
64417	1	Injection, anesthetic agent; axillary nerve
64420	1	Injection, anesthetic agent; intercostal nerve, single
64421	1	Injection, anesthetic agent; intercostal nerves, multiple, regional block
64430	1	Injection, anesthetic agent; pudendal nerve
64442	1	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level
64443	1	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, each additional level

SYMPATHETIC NERVES

64510	2	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64520	2	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	2	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring

DESTRUCTION BY NEUROLYTIC AGENT (E.G., CHEMICAL, THERMAL, ELECTRICAL, RADIOFREQUENCY)

SOMATIC NERVES

64600	2	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64605	2	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale
64610	2	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring
64622	2	Destruction by neurolytic agent; paravertebral facet joint nerve, lumbar, single level

	64630	2	Destruction by neurolytic agent; pudendal nerve
	EXPLORATION, NEUROLYSIS OR NERVE DECOMPRESSION (NEUROPLASTY)		
*	64702	3	Neurolysis; digital, one or both, same digit
*	64704	3	Neurolysis; nerve of hand or foot
*	64708	3	Neurolysis, major peripheral nerve, arm or leg; other than specified
	64712	3	Neurolysis, major peripheral nerve, arm or leg; sciatic nerve
	64713	3	Neurolysis, major peripheral nerve, arm or leg; brachial plexus
	64714	3	Neurolysis, major peripheral nerve, arm or leg; lumbar plexus
*	64716	4	Neurolysis and/or transposition; cranial nerve (specify)
*	64718	4	Neurolysis and/or transposition; ulnar nerve at elbow
*	64719	4	Neurolysis and/or transposition; ulnar nerve at wrist
*	64721	3	Neurolysis and/or transposition; median nerve at carpal tunnel
	64722	3	Decompression; unspecified nerve(s) (specify)
	64726	3	Decompression; plantar digital nerve
	64727	4	Internal neurolysis by dissection, with or without microdissection (list separately in addition to code for primary neuroplasty)
	TRANSECTION OR AVULSION OF NERVE		
	64732	3	Transection or avulsion of; supraorbital nerve
	64734	3	Transection or avulsion of; infraorbital nerve
	64736	3	Transection or avulsion of; mental nerve
	64738	3	Transection or avulsion of; inferior alveolar nerve by osteotomy
	64740	3	Transection or avulsion of; lingual nerve
	64742	3	Transection or avulsion of; facial nerve, differential or complete
	64744	3	Transection or avulsion of; greater occipital nerve
	64772	3	Transection or avulsion of other spinal nerve, extradural
	EXCISION-SOMATIC NERVES		
	64774	3	Excision of neuroma; cutaneous nerve, surgically identifiable
	64776	3	Excision of neuroma; digital nerve, one or both, same digit
	64778	3	Excision of neuroma; digital nerve, each additional digit (list separately by this number)
*	64782	3	Excision of neuroma; hand or foot, except digital nerve
	64784	3	Excision of neuroma; major peripheral nerve, except sciatic
	64786	3	Excision of neuroma; sciatic nerve
	64787	3	Insertion of plastic cap on nerve end
	64788	3	Excision of neurofibroma or neurolemmoma; cutaneous nerve
	64790	3	Excision of neurofibroma or neurolemmoma; major peripheral nerve
	64795	3	Biopsy of nerve
	EXCISION-SYMPATHETIC NERVES		
	64802	4	Sympathectomy, cervical; unilateral
	64803	4	Sympathectomy, cervical; bilateral

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

NERVE REPAIR BY SUTURE (NEURORRHAPHY)

64830	4	Microdissection and/or microrepair of nerve (list separately in addition to code for nerve repair)
64831	4	Suture of digital nerve, hand or foot; one nerve
64832	4	Suture of digital nerve, hand or foot; each additional digital nerve
64834	4	Suture of one nerve, hand or foot; common sensory nerve
64835	4	Suture of one nerve, hand or foot; median motor thenar
64836	4	Suture of one nerve, hand or foot; ulnar motor
64837	4	Suture of each additional nerve, hand or foot
64840	4	Suture of posterior tibial nerve
64856	4	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64857	4	Suture of major peripheral nerve, arm or leg, except sciatic; without transposition
64872	4	Suture of nerve; requiring secondary or delayed suture (list separately in addition to code for primary neurorrhaphy)
64874	4	Suture of nerve; requiring extensive proximal mobilization, or transposition of nerve (list separately in addition to code for nerve suture)
64876	4	Suture of nerve; requiring shortening of bone of extremity (list separately in addition to code for nerve suture)

NEURORRHAPHY WITH NERVE GRAFT

64890	4	Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length
64891	4	Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length
64892	4	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64893	4	Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length
64895	4	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length
64896	4	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
64897	4	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length
64898	4	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length
64901	4	Nerve graft, each additional nerve; single strand
64902	4	Nerve graft, each additional nerve; multiple strands (cable)
64905	4	Nerve pedicle transfer; first stage
64907	4	Nerve pedicle transfer; second stage

EYE/OCULAR ADNEXA

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

EYEBALL

REMOVAL OF EYE

*	65091	4	Evisceration of ocular contents; without implant
*	65093	4	Evisceration of ocular contents; with implant
*	65101	4	Enucleation of eye; without implant
*	65103	4	Enucleation of eye; with implant, muscles not attached to implant
*	65105	4	Enucleation of eye; with implant, muscles attached to implant
	65110	4	Exenteration of orbit (does not include skin graft), removal of orbital contents; only

SECONDARY IMPLANT PROCEDURES

	65130	3	Insertion of ocular implant secondary; after evisceration, in scleral shell
	65135	3	Insertion of ocular implant secondary; after enucleation, muscles not attached to implant
	65140	3	Insertion of ocular implant secondary; after enucleation, muscles attached to implant
	65150	3	Reinsertion of ocular implant; with or without conjunctival graft
	65155	3	Reinsertion of ocular impant; with use of foreign material for reinforcement and/or attachment of muscles to implant
	65175	3	Removal of ocular implant

REMOVAL OF OCULAR FOREIGN BODY

*	65230	1	Removal of foreign body, intraocular; from anterior chamber, magnetic extraction
*	65235	1	Removal of foreign body, intraocular; from anterior chamber, nonmagnetic extraction
	65245	4	Removal of foreign body, intraocular; from lens (without extraction lens), nonmagnetic extraction
	65260	4	Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route
	65265	4	Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction

REPAIR OF LACERATION OF EYEBALL

	65272	2	Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization
	65280	4	Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue
	65285	4	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue
	65290	3	Repair of wound, extraocular muscle, tendon and/or Tenon's capsule

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

ANTERIOR SEGMENT - CORNEA

EXCISION

	65400	1	Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium
	65410	1	Biopsy of cornea
*	65420	1	Excision or transposition of pterygium; without graft
	65426	1	Excision or transposition of pterygium; with graft

KERATOPLASTY

	65710	4	Keratoplasty (corneal transplant), lamellar; autograft
	65720	4	Keratoplasty (corneal transplant), lamellar; homograft, fresh
	65725	4	Keratoplasty (corneal transplant), lamellar; homograft, preserved
	65730	4	Keratoplasty (corneal transplant), penetrating (except in aphakia); autograft
	65740	4	Keratoplasty (corneal transplant), penetrating (except in aphakia); homograft, fresh
	65745	4	Keratoplasty (corneal transplant), penetrating (except in aphakia); homograft, preserved
	65750	4	Keratoplasty (corneal transplant), penetrating, in aphakia

ANTERIOR SEGMENT-ANTERIOR CHAMBER

INCISION

	65800	1	Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous
	65805	1	Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous
	65810	4	Paracentesis of anterior chamber of eye (separate procedure); with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection
	65815	1	Paracentesis of anterior chamber of eye (separate procedure); with removal of blood, with or without irrigation and/or air injection

OTHER PROCEDURES

	65865	1	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure; goniosynechiae
	65870	1	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae
	65875	1	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechiae

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	65880	1	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); corneovitreal adhesions
	65900	4	Removal of epithelial downgrowth, anterior chamber eye
	65920	4	Removal of implanted material, anterior segment eye
	65930	4	Removal of blood clot, anterior segment eye
	66020	1	Injection, anterior chamber (separate procedure); air or liquid
	66030	1	Injection, anterior chamber (separate procedure); medication

ANTERIOR SEGMENT-ANTERIOR SCLERA

EXCISION

	66130	4	Excision of lesion, sclera
	66150	4	Fistulization of sclera for glaucoma; trephination with iridectomy
	66155	4	Fistulization of sclera for glaucoma; thermocauterization with iridectomy
	66160	4	Fistulization of sclera for glaucoma; sclerectomy with punch or scissors, with iridectomy
	66165	4	Fistulization of sclera for glaucoma; iridencleisis or iridotasis
	66170	4	Fistulization of sclera for glaucoma; trabeculectomy ab externo

REPAIR

	66220	4	Repair of scleral staphyloma; without graft
	66225	4	Repair of scleral staphyloma; with graft

REVISION OPERATION WOUND

	66250	4	Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure

ANTERIOR SEGMENT-IRIS, CILIARY BODY

IRIDOTOMY, IRIDECTOMY

	66500	1	Iridotomy by stab incision (separate procedure); except transfixion
	66505	1	Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe
*	66600	4	Iridectomy, with corneoscleral or corneal section; for removal of lesion
	66605	3	Iridectomy with corneoscleral or corneal section; with cyclectomy
*	66625	4	Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure)
*	66630	4	Iridectomy, with corneoscleral or corneal section; sector for glaucoma (separate procedure)
*	66635	4	Iridectomy, with corneoscleral or corneal section; "optical" (separate procedure)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

REPAIR			
	66680	4	Repair of iris, ciliary body (as for iridodialysis)
	66682	4	Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (e.g., McCannel suture)
DESTRUCTION			
	66700	1	Cyclodiathermy; initial
	66701	1	Cyclodiathermy; subsequent
	66720	1	Cyclocryotherapy; initial
	66721	3	Cyclocryotherapy; subsequent
	66741	3	Cyclodialysis; subsequent
	66762	3	Coreoplasty by photocoagulation (one or more sessions) (e.g., for improvement of vision)
ANTERIOR SEGMENT-LENS			
INCISION			
*	66800	1	Discission of lens capsule; incisional technique (needling of lens); initial
*	66801	1	Discission of lens capsule; incisional technique (needling of lens); subsequent
	66821	1	Discission of secondary membraneous cataract ("after cataract") and/or anterior hyaloid; laser surgery (one or more stages)
REMOVAL CATARACT			
*	66830	4	Removal of secondary membranous cataract ("after cataract"), with corneoscleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
*	66840	4	Removal of lens material; aspiration technique, one or more stages
*	66850	4	Removal of lens material; phacofragmentation technique (mechanical or ultrasonic, e.g., phacoemulsification), with aspiration
	66915	4	Expression of lens, linear, one or more stages
*	66920	4	Extraction of lens with or without iridectomy; intracapsular, with or without enzymes
*	66930	4	Extraction of lens with or without iridectomy; intracapsular, for dislocated lens
*	66940	4	Extraction of lens with or without iridectomy; extracapsular (other than 66840, 66850, 66915)
	66945	4	Extraction of lens with or without iridectomy; in presence of fistulization bleb and/or by temporal, inferior or inferotemporal route, intracapsular or extracapsular
*	66983	4	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	66984	4	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or phacoemulsification technique
*	66985	4	Insertion of intraocular lens subsequent to cataract removal (separate procedure)

POSTERIOR SEGMENT-VITREOUS

	67005	4	Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal
	67010	4	Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy (such as VISC or Rotoextractor)
	67015	2	Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)
	67025	2	Injection of vitreous substitute, pars plana approach (separate procedure) excludes air or balanced salt solutions
	67030	2	Discission of vitreous strands (without removal), pars plana approach
	67036	4	Virectomy, mechanical, pars plana approach

POSTERIOR SEGMENT-RETINAL DETACHMENT

REPAIR

	67101	4	Repair of retinal detachment, one or more sessions, same hospitalization, cryotherapy or diathermy, with or without drainage or subretinal fluid
	67107	4	Repair of retinal detachment (one or more stages, same hospitalization); scleral buckling (such as lamella excision, imbrication or encircling procedure), with or without implant, may include procedures 67101-67105
	67108	4	Repair of retinal detachment (one or more stages, same hospitalization); with vitrectomy, any method, with or without air tamponade, may include procedures 67101-67107 and/or removal of lens by same technique
	67109	4	Repair of retinal detachment (one or more stages, same hospitalization); by technique other than 67101-67108
	67120	4	Removal of implanted material, posterior segment, extraocular

POSTERIOR SEGMENT-OTHER PROCEDURES

DESTRUCTION-RETINA, CHOROID

	67208	1	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors), one or more sessions; cryotherapy, diathermy

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

	67218	4	Destruction of localized lesion, retina or choroid (e.g., choroidopathy), one or more stages; radiation by implantation of source (includes removal of source)
	67227	1	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions; cryotherapy, diathermy

SCLERAL REPAIR

	67250	4	Scleral reinforcement (separate procedure); without graft
	67255	4	Scleral reinforcement (separate procedure); with graft
*	67311	4	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); one muscle
*	67312	4	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); two muscles, one or both eyes
*	67313	4	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); three or more muscles, and/or adjustable suture, one or both eyes

OCULAR ADNEXA-EXTRAOCULAR MUSCLES

	67320	3	Transposition of extraocular muscle (e.g., for paretic muscle), one or more stages, one or more muscles, with displacement of plane of action more than 5mm
	67331	3	Strabismus surgery on patient previously operated on; not involving reoperation of muscles
	67332	3	Strabismus surgery on patient previously operated on; involving reoperation of muscles

OTHER PROCEDURES

	67350	3	Biopsy of extraocular muscle

OCULAR ADNEXA-ORBIT

EXPLORATION, EXCISION

	67400	4	Orbitotomy without bone flap (frontal approach); for exploration, with or without biopsy
	67405	4	Orbitotomy without bone flap (frontal approach); with drainage only
	67412	4	Orbitotomy without bone flap (frontal approach); with removal of lesion
	67413	4	Orbitotomy without bone flap (frontal approach); with removal of foreign body
	67415	1	Transconjunctival or aspirational biopsy

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

OTHER PROCEDURES			
	67550	4	Orbital implant (implant outside muscle cone); insertion
	67560	4	Orbital implant (implant outside muscle cone); removal or revision
OCULAR ADNEXA-EYELIDS			
INCISION			
	67715	1	Canthotomy (separate procedure)
EXCISION OR REMOVAL OF LESION INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)			
*	67801	1	Excision of chalazion; multiple, same lid
*	67808	1	Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple
	67830	3	Correction of trichiasis; incision of lid margin
	67835	2	Correction of trichiasis; incision of lid margin, with free mucous membrane graft
TARSORRHAPHY			
	67880	1	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;
	67882	3	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; with transposition of tarsal plate
REPAIR BLEPHAROPTOSIS, LID RETRACTION			
	67901	1	Repair of blepharoptosis; frontalis muscle technique with suture
	67902	3	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)
	67903	3	Repair of blepharoptosis; (tarso)levator resection, internal approach
	67904	3	Repair of blepharoptosis; (tarso)levator resection, external approach
	67906	3	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
	67907	3	Repair of blepharoptosis; superior rectus tendon transplant
	67908	1	Repair of blepharoptosis; conjunctivo-tarso-levator resection (Fasanella-Servat type)
	67909	1	Reduction of overcorrection of ptosis
REPAIR ECTROPION, ENTROPION			
*	67914	3	Repair of ectropion; suture
*	67916	3	Repair of ectropion; blepharoplasty, excision tarsal wedge
*	67917	3	Repair of ectropion; blepharoplasty, extensive (e.g., Kuhnt-Szymanowski operation)

LIST OF COVERED SURGICAL PROCEDURES

*	67921	3	Repair of entropion; suture
*	67923	3	Repair of entropion; blepharoplasty, excision tarsal wedge
*	67924	3	Repair of entropion; blepharoplasty, extensive (e.g., Wheeler operation)

RECONSTRUCTIVE SURGERY, BLEPHAROPLASTY INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)

	67935	2	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva) direct closure; full thickness
*	67950	2	Canthoplasty (reconstruction of canthus)
	67961	3	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin
	67966	3	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin
	67971	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage
	67973	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, one stage or first stage
	67974	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, one stage or first stage
	67975	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage

OCULAR ADNEXA-CONJUNCTIVA

EXCISION, DESTRUCTION

	68130	1	Excision of lesion, conjunctiva; with adjacent sclera

CONJUNCTIVOPLASTY

	68320	2	Conjunctivoplasty; with conjunctival graft or extensive rearrangement
	68325	2	Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft)
	68326	2	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
	68328	3	Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)

OTHER PROCEDURES

	68360	2	Conjunctival flap; bridge or partial (separate procedure)
	68362	2	Conjunctival flap; total (such as Gunderson thin flap or purse string flap)

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

OCULAR ADNEXA-LACRIMAL SYSTEM

EXCISION

	68500	3	Excision of lacrimal gland (dacryoadenectomy), except for tumor; total
	68505	3	Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial
	68510	3	Biopsy of lacrimal gland
	68520	3	Excision of lacrimal sac (dacryocystectomy)

EXCISION

	68540	4	Excision of lacrimal gland tumor; frontal approach involving osteotomy.
	68550	4	Excision of lacrimal gland tumor; frontal approach

REPAIR

*	68700	1	Plastic repair of canaliculi
	68720	3	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)
	68745	3	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube
	68750	3	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); with insertion of tube or stent

PROBING AND RELATED PROCEDURES

*	68830	1	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; with insertion of tube or stent (without general anesthesia)

AUDITORY SYSTEM

EXTERNAL EAR

EXCISION

	69105	1	Biopsy external auditory canal
	69110	2	Excision external ear; partial, simple repair
	69120	3	Excision external ear; complete amputation
	69140	2	Excision exostosis(es), external auditory canal
	69145	2	Excision soft tissue lesion, external auditory canal
	69150	4	Radical excision external auditory canal lesion; without neck dissection

MIDDLE EAR

INCISION

*	69420	1	Myringotomy including aspiration and/or eustachian tube inflation
	69440	3	Middle ear exploration through postauricular or ear canal incision
	69450	3	Tympanolysis, transcanal

EXHIBIT A (CONT.)

LIST OF COVERED SURGICAL PROCEDURES

EXCISION			
*	69501	4	Transmastoid antrotomy ("simple" mastoidectomy)
REPAIR			
*	69620	4	Myringoplasty (surgery confined to drumhead and donor area)
*	69631	4	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
	69632	4	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction, e.g., postfenestration
	69633	4	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (e.g., total ossicular replacement prosthesis, TORP)
	69635	4	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
	69636	4	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction
	69637	4	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (e.g., total ossicular replacement prosthesis, TORP)
	69641	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
	69642	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction
	69643	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction
	69644	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction
	69645	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction
	69646	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction
*	69650	4	Stapes mobilization

*	69660	4	Stapedectomy with reestablishment of ossicular continuity, with or without use of foreign material;
	69661	4	Stapedectomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out
	69666	4	Repair oval window fistula
	69667	4	Repair round window fistula
	69670	4	Mastoid obliteration (separate procedure)
	69676	4	Tympanic neurectomy; unilateral
	69677	4	Tympanic neurectomy; bilateral

EXTERNAL EAR

OTHER PROCEDURES

69700	2	Closure postauricular fistula, mastoid (separate procedure)

MIDDLE EAR

OTHER PROCEDURES

69720	4	Decompression facial nerve, intratemporal; lateral to geniculate ganglion
69725	4	Decompression facial nerve, intratemporal; including medial to geniculate ganglion
69740	4	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion
69745	4	Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion

EXHIBIT B

BUREAU OF LABOR STATISTICS WAGE INDEX FOR URBAN AREAS

MSA AREA	WAGE INDEX
Abilene, TX	.8485
Akron, OH	1.0417
Albany, GA.	.8566
Albany-Schenectady-Troy, NY.	.9624
Albuquerque, NM.	1.0009
Alexandria, LA.	.9218[5/]
Allentown-Bethlehem-Easton, PA-NJ.	1.0569
Altoona, PA	1.0219
Amarillo, TX.	.9233
Anaheim-Santa Ana-Garden Grove, CA	1.2115
Anchorage, AK.	1.6461
Anderson, IN.	.9812
Anderson, SC.	.8814[2/]
Ann Arbor, MI.	1.2446[5/]
Anniston, AL	.8400
Appleton-Oshkosh, WI.	1.0124
Asheville, NC.	.9678
Athens, GA.	.8812[2/]
Atlanta, GA.	.9162
Atlantic City, NJ.	1.0174
Augusta, GA-SC.	.9237
Austin, TX	.9589
Bakersfield, CA.	1.1223
Baltimore, MD.	1.1698
Bangor, ME.	.9239[3/]
Baton Rouge, LA.	.8813
Battle Creek, MI.	1.0229
Bay City, MI.	1.1238
Beaumont-Port Arthur-Orange, TX.	.8530
Bellingham, WA.	1.0124[2/]
Benton Harbor, MI.	.8569[2/]
Billings, MT.	.9506*[5/]
Biloxi-Gulfport, MS.	.8143
Binghamton, NY-PA.	.9769
Birmingham, AL.	.9658
Bismarck, ND.	.9118[5/]
Bloomington, IN.	.9481*
Bloomington-Normal, IL.	.8913[5/]
Boise City, ID.	.9334
Boston-Lowell-Brockton-Lawrence-Haverhill,MA-NH	1.1277[3/]
Bradenton, FL.	.8631*
Bremmerton, WA.	.8899[2/]
Bridgeport-Stamford-Norwalk-Danbury, CT.	1.1647
Brownsville-Harlingen-San Benito, TX.	.9312
Bryan-College Station, TX.	.8377
Buffalo, NY.	.9926
Burlington, NC.	.8899

EXHIBIT B (CONT.)

BUREAU OF LABOR STATISTICS WAGE INDEX FOR URBAN AREAS

MSA AREA	WAGE INDEX
Burlington, VT.	.9441[3/]
Canton, OH.	.9447
Casper, WY.	1.0506[2/]
Cedar Rapids, IA.	.9193*
Champaign-Urbana-Rantoul, IL.	1.1197
Charleston-North Charleston, SC.	.9751
Charleston, WV.	1.0628
Charlotte-Gastonia, NC.	.9456
Charlottesville, VA.	.9943[2/]
Chattanooga, TN-GA.	1.0226
Chicago, IL.	1.2061[5/]
Chico, CA.	1.0327[2/]
Cincinnati, OH-KY-IN.	1.0819[5/]
Clarksville-Hopkinsville, TN-KY.	.8397
Cleveland, OH.	1.1957
Colorado Springs, CO.	.9743
Columbia, MO.	1.1712
Columbia, SC.	.9743
Columbus, GA-AL.	.9021
Columbus, OH.	1.1184
Corpus Christi, TX.	.9337
Cumberland, MD-WU.	.8594[2/]
Dallas-Fort Worth, TX.	.9403
Danville, VA.	.8807[2/]
Davenport-Rock Island-Moline, IA-IL.	.9695[5/]
Dayton, OH.	1.1064
Daytona Beach, FL.	.9423
Decatur, IL.	.9506[5/]
Denver-Boulder, CO.	1.0960
Des Moines, IA.	1.0156
Detroit, MI.	1.2280
Dubuque, IA.	.9426
Duluth-Superior, MN-WI.	.9193
Eau Claire, WI.	.9806
El Paso, TX.	.8714
Elkhart, IN.	.8372*[5/]
Elmira, NY.	.9642
Enid, OK. .8785[5/]	
Erie, PA	.9652
Eugene-Springfield, OR.	.9639
Evansville, IN-KY.	1.0742
Fargo-Moorehead, ND-MN.	.9478[5/]
Fayetteville, NC.	.8353*
Fayetteville-Springdale, AR.	.7997
Flint, MI.	1.1919
Florence, AL.	.8056
Florence, SC.	.8328[2/]
Fort Collins, CO.	.8353
Fort Lauderdale-Hollywood, FL.	1.0506
Fort Myers, FL.	.9391
Fort Smith, AR-OK.	.8899

EXHIBIT B (CONT.)

BUREAU OF LABOR STATISTICS WAGE INDEX FOR URBAN AREAS

MSA AREA	WAGE INDEX
Fort Wayne, IN.	.8985[5/]
Fort Walton Beach ,FL.	.7997[2/]
Fresno, CA.	1.1265
Gadsden, AL.	.9264
Gainsville, FL.	.9019
Galveston-Texas City, TX.	1.0607
Gary-Hammond-East Chicago, IN.	1.1664
Glen Falls, NY.	.9023[2/]
Grand Forks, ND-MN.	.8779
Grand Rapids, MI.	.9463
Great Falls, MT.	.9162*
Greeley, CO.	.9312*
Green Bay, WI.	.9740
Greensboro-Winston-Salem-High Point, NC.	.9232
Greenville-Spartanburg, SC.	.9371
Hagerstown MD.	1.0742[2/]
Hamilton-Middleton, OH.	1.0620
Harrisburg, PA.	1.0534
Hartford-New Britain-Bristol, CT.	1.1601[3/]
Hickory, NC.	.8454[2/]
Honolulu, HI.	1.1645
Houston, TX.	1.0630
Huntington-Ashland, WV-KY-OH.	.9270
Huntsville, AL.	.8593
Indianapolis, IN.	1.0519[5/]
Iowa City, IA.	1.1780[5/]
Jackson, MI.	1.0173*
Jackson, MS.	.8699
Jacksonville, FL.	.9331
Jacksonville, NC.	.8936[2/]
Janesville-Beloit, WI.	.8579
Jersey City, NJ.	1.1180
Johnson City-Kingsport-Bristol, TN-VA	.8786[5/]
Johnstown, PA.	1.0445
Joplin, MO.	.8500[2/]
Kalamazoo-Portage, MI.	1.1695
Kankakee, IL.	1.0073
Kansas City, MO-KS.	.9427[5/]
Kenosha, WI.	1.0789*[5/]
Killeen-Temple, TX.	.8868
Knoxville, TN.	.9100
Kokomo, IN.	.9846[5/]
La Crosse, WI.	.9016*
Lafayette, LA.	.8622
Lafayette-West Lafayette, IN.	.9141
Lake Charles, LA.	.8706
Lakeland-Winter Haven, FL.	.9749
Lancaster, PA.	1.0674
Lansing-East Lansing MI.	1.0811
Laredo, TX.	.8593*

EXHIBIT B (CONT.)

BUREAU OF LABOR STATISTICS WAGE INDEX FOR URBAN AREAS

MSA AREA	WAGE INDEX
Las Cruces, NM.	.8129*
Las Vegas, NV.	1.1884
Lawrence, KS.	.9193*
Lawton, OK.	.8377*
Lewiston-Auburn, ME.	.8899*
Lexington-Fayette, KY.	.9016
Lima, OH.	.9932
Lincoln, NE.	.9259
Little Rock-North Little Rock, AR.	1.0205
Long Branch-Asbury Park, NJ.	1.0648
Long View, TX.	.8129
Lorain-Elyrie, OH.	1.0207
Los Angeles-Long Beach, CA.	1.2899
Louisville, KY-IN.	.9920[5/]
Lubbock, TX.	.9042
Lynchburg, VA.	.8876
Macon, GA.	.9637
Madison, WI.	1.0257
Manchester-Nashua, NH.	.9441[3/]
Mansfield, OH.	.9196
McAllen-Pharr-Edinburg, TX.	.8165
Medford, OR.	.9668[2/]
Melbourne-Titusville-Cocoa, FL.	.9374
Memphis, TN-AR-MS.	1.0371
Miami, FL.	1.1050
Midland, TX.	.9141*
Milwaukee, WI.	1.0080
Minneapolis-St. Paul, MN-WI.	.9802
Mobile, AL.	.9416
Modesto, CA.	1.0508[5/]
Monroe, LA.	.9451
Montgomery, AL.	.9626
Muncie, IN.	.9852*
Muskegon-Norton Shores-Muskegon Heights, MI.	.9658
Nashville-Davidson, TN.	1.0187
Nassau-Suffolk, NY.	1.2758
New Bedford-Fall River, MA.	.9687
New Brunswick-Perth Amboy-Sayreville, NJ.	1.0409
New Haven-Waterbury-Meriden, CT.	1.0990
New London-Norwich, CT.	1.0903
New Orleans, LA.	.9644
New York, NY-NJ.	1.3956
Newark, NJ.	1.2099
Newark, OH.	.9592[2/]
Newburgh-Middletown, NY.	1.0789[2/]
Newport News-Hampton, VA.	.8974[5/]
Norfolk-Virginia Beach-Portsmouth, VA-NC.	.9887[5/]
Northeast Pennsylvania.	1.0598
Ocala, FL.	.9306[2/]

EXHIBIT B (CONT.)

BUREAU OF LABOR STATISTICS WAGE INDEX FOR URBAN AREAS

MSA AREA	WAGE INDEX
Odessa, TX	.9506*[5]
Oklahoma City, OK.	.9252
Olympia, WA.	1.0142[2]
Omaha, NE-IA.	.9425[5]
Orlando, FL.	.9087
Owensboro, KY.	.8377*[5]
Oxnard-Simi Valley-Ventura, CA.	1.3788
Panama City, FL.	.8777*
Parkersburg-Marietta, WV-OH.	1.0461
Pascagoula-Moss Point, MS.	1.1547*[5]
Patterson-Clifton-Passaic, NJ	1.0959
Pensacola, FL.	.8841
Peoria, IL.	1.1130[5]
Petersburg-Colonial Heights-Hopewell, VA.	.9484
Philadephia, PA-NJ.	1.1810
Phoenix, AZ.	1.1100
Pine Bluff, AR.	.7997*
Pittsburgh, PA.	1.1275
Pittsfield, MA.	1.0276[5]
Portland, ME.	1.0032[3]
Portland, OR-WA.	1.1034[5]
Portsmouth-Dover-Rochester, NH-ME.	.8115[3]
Poughkeepsie, NY.	1.1151[5]
Providence-Warwick-Pawtucket, RI.	1.0349[3]
Provo-Orem, UT.	.9454
Pueblo, CO.	1.09815
Racine, WI.	.9240
Raleigh-Durham, NC.	1.0173
Rapid City, SD.	.8680*[1]
Reading, PA.	1.0101
Redding, CA.	1.0271[2]
Reno, NV.	1.2428*
Richland-Kennewick, WA.	.9935[5]
Richmond, VA.	.9252
Riverside-San Bernadino-Ontario, CA.	1.1729
Roanoke, VA.	.9614
Rochester, MN.	.9852
Rochester, NY.	1.0653
Rockford, IL.	1.0222[5]
Rock Hill, SC.	.9136[2]
Sacremento, CA.	1.2231[5]
Saginaw, MI.	1.1279
St. Cloud, MN.	.8680
St. Joesph, MO.	.9749
St. Louis, MO-IL.	.9977(.9975[4])
Salem, OR.	1.1083
Salinas-Seaside-Monterey, CA.	1.2428
Salisbury-Concord, NC.	1.0368[2]
Salt Lake City-Ogden, UT.	.8550
San Angelo, TX.	.8364
San Antonio, TX.	.9509

EXHIBIT B (CONT.)

BUREAU OF LABOR STATISTICS WAGE INDEX FOR URBAN AREAS

MSA AREA	WAGE INDEX
San Diego, CA.	1.1426[5/]
San Francisco-Oakland, CA.	1.3153
San Jose, CA.	1.3055
Santa Barbara-Santa Maria-Lompoc, CA.	1.0628[5/]
Santa Cruz, CA.	1.0985[5/]
Santa Rosa, CA.	1.4037
Sarasota, FL.	.9835[5/]
Savannah, GA.	.9414
Seattle-Everett, WA.	1.0500
Sharon, PA.	.9618[2/]
Sheboygan, WI.	.8439[2/]
Sherman-Denison, TX.	.8277
Shreveport, LA.	.9292
Sioux City, IA-NE.	.9306
Sioux Falls, SD.	.8844
South Bend, IN.	.9156[5/]
Spokane, WA.	1.0921
Springfield, IL.	1.0230[5/]
Springfield, MO.	.8933(.8932[4/])
Springfield, OH.	.9821
Springfield-Chicopee-Holyoke, MA.	1.0285[5/]
State College, PA.	1.1034[2/]
Steubenville-Weirton, OH-WV.	.9750[5/]
Stockton, CA.	1.3046
Syracuse, NY.	1.3209
Tacoma, WA.	1.0558[5/]
Tallahasee, FL.	.9264*[5/]
Tampa-St. Petersburg, FL.	.9898
Terre Haute, IN.	.8734[5/]
Texarkana-TX-Texarkana, AR.	1.0929
Toledo, OH-MI.	1.1157
Topeka, KS.	1.0602
Trenton, NJ.	1.1708
Tucson, AZ.	.9977
Tulsa, OK.	.9626
Tuscaloosa, AL.	1.0142
Tyler, TX.	.9481
Utica-Rome, NY.	1.0145
Vallejo-Fairfield-Napa, CA.	1.5862
Victoria, TX.	.8356
Vineland-Millville-Bridgeton, NJ.	1.0083
Visalia-Tulare-Portenville, C.	1.3627[2/]
Waco, TX.	.8593
Washington, DC-MD-VA.	1.1547[5/]
Waterloo-Ceder Falls, IA.	.8631
Wausau, WI.	.9769[2/]
West Palm Beach-Boca Raton, FL.	.9630
Wheeling, WV-OH.	1.0158[5/]
Wichita, KS.	1.0248
Wichita Falls, TX.	.8282
Williamsport, PA.	.9749

EXHIBIT B (CONT.)

BUREAU OF LABOR STATISTICS WAGE INDEX FOR URBAN AREAS

MSA AREA	WAGE INDEX
Wilmington, DE-NJ-MD.	1.0917[5/]
Wilmington, NC.	.8936
Worchester-Fitchburg-Leominster, MA.	.9769[5/]
Yakima, WA.	.9523
York, PA.	.9884
Youngstown-Warren, OH.	1.1090
Yuba City, CA.	1.0726[2/]

*Approximate value for area

1/ Eff. 06/19/81 no longer qualified as an SMSA.
2/ Eff. 06/19/81 newly designated SMSA.
3/ Eff. 06/19/81 newly and revised NECMA.
4/ Recomputed wages index in parentheses based on corrected reporting data .....
from BLS resulting in lower than published index. Higher wage index used to compute the limit.
5/ Revised wage index based on corrected reporting data from BLS.

EXHIBIT B (CONT.)

BUREAU OF LABOR STATISTICS WAGE INDEX FOR URBAN AREAS

MSA AREA	WAGE INDEX
Alabama.	.8960
Alaska.	1.5579
Arizona.	1.0289
Arkansas.	.8686
California.	1.2415
Colorado.	.8990
Connecticut.	1.18173
Delaware.	1.0370
Florida.	.9980
Georgia.	.9463
Hawaii.	1.3452[3/]
Idaho.	.9669
Illinois.	.9650[3/]
Indiana.	.9863[3/]
Iowa.	.9220
Kansas.	.9009[3/]
Kentucky.	.9233[3/]
Louisiana.	.9216
Maine.	.9926
Maryland.	1.1028
Massachusetts.	1.1722
Michigan.	1.1535[3/]
Minnesota.	.9052
Mississippi.	.8751
Missouri.	.9156(.9151[2/])
Montana.	.9595[3/]
Nebraska.	.8130
Nevada.	1.0790
New Hampshire.	1.1301[3/]
New Jersey.	1.0820
New Mexico.	1.0073
New York.	1.0327
North Carolina.	.9917
North Dakota.	.9045
Ohio.	1.0086
Oklahoma.	.9111
Oregon.	1.0673
Pennsylvania.	1.1371[3/]
Rhode Island.	(1)
South Carolina.	.9180
South Dakota.	.8237[3/]
Tennessee.	.8779
Texas.	.8979

EXHIBIT B (CONT.)

BUREAU OF LABOR STATISTICS WAGE INDEX FOR URBAN AREAS

MSA AREA	WAGE INDEX
Utah	.8552[3/]
Vermont	.9993
Virginia	.9792
Washington	1.0465
West Virginia	1.0123[3/]
Wisconsin	.9179
Wyoming	1.0402

[1/] Not Applicable. All of Rhode Island is classified as urban.
[2/] Recomputed wage index lower than the published index.
[3/] Revised wage index based on corrected reporting data from BLS.

2830.30 Radiology Services and Other Diagnostic Procedures.--Payment for hospital outpatient radiology services furnished on or after October 1, 1988 and for other diagnostic procedures furnished by hospitals on an outpatient basis on or after October 1, 1989, is based, in part, on what the program pays for the same services and procedures as if they were furnished in a physician's office in the same locality.

2830.31 Payment for Hospital Outpatient Radiology Services.--For purposes of this provision, radiology services include diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, MRI (magnetic resonance imaging), ultrasound and other imaging services. (See §IM 423.1 G of the Hospital Manual for a detailed list of the radiology services that are subject to this payment method.) Also considered to be part of the radiology procedure and subject to the payment method are any items or services that are furnished in conjunction with the radiological procedure being performed, such as contrast agents or media, anesthesiology and other supplies.

Effective for services furnished on or after October 1, 1988, the aggregate amount of payment for hospital outpatient radiology services furnished during a cost reporting period is based on a comparison between two amounts. The payment is the lesser of:

1. The amount that is paid to the hospital for the services under §1833(a)(2)(B) of the Act (i.e., the lower of the hospital's reasonable costs or customary charges for the services, reduced by deductibles and coinsurance); or

2. An amount based on a blend of

o The amount that is paid to the hospital for the services under §1833(a)(2)(B) of the Act (referred to as the hospital-specific amount); and

o An amount equal to 80 percent of the amount determined by subtracting deductibles from 62 percent of the amount that is paid to participating physicians for the same services as if they were furnished in a physician's office in the same locality. (NOTE: The calculation uses 62 percent of the prevailing charge in order to recognize the facility or technical component and exclude the physician component. The calculation also applies an 80 percent factor in order to exclude beneficiary coinsurance.)

Effective for services furnished on or after April 1, 1989, radiologists are paid for services furnished in their offices based on a fee schedule amount instead of prevailing charges. Therefore, for hospital outpatient radiology services furnished on or after April 1, 1989, the blend is based on the radiology fee schedule amounts instead of prevailing charges.

For radiology services furnished on or after October 1, 1988 and before October 1, 1989, the blended amount is calculated as 65 percent of the hospital-specific amount plus 35 percent of the prevailing charge or fee schedule amount. For radiology services furnished on or after October 1, 1989, the blended amount is calculated as 50 percent of the hospital-specific amount plus 50 percent of the fee schedule amount.

2830.32 Illustration of Payment Method for Hospital Outpatient Radiology Services.--

Assumptions (For radiology services furnished from 10/1/88 through 12/31/88):

Hospital's customary charges for outpatient radiology services	$ 55,000
Hospital's reasonable costs for outpatient radiology services	50,000
Deductibles	7,000
Coinsurance(($55,000 charges - $7,000 deductibles) x 20%)	9,600
Prevailing charges for radiology services	72,000

Calculation of Aggregate Payment for Outpatient Radiology Services for Cost Reporting Period Ending 12/31/88:

Payment is the lesser of:

(1)	Lower of hospital's cost or charges (Net of coinsurance and deductibles)	$ 50,000 -16,600 $ 33,400
	OR	
(2)	Blended amount:	
	65% x hospital specific amount (65% x $33,400)	$ 21,710
	35% x 80% x ((62% x prevailing charges) - deductibles) 35% x 80% x ((62% x $72,000) - $7,000)	+10,539 $ 32,249

In this example, the blended amount of $32,249 is less than the amount determined as the lower of the hospital's reasonable costs or customary charges, reduced by deductibles and coinsurance of $33,400. Therefore, Medicare payment is $32,249.

2830.33 Payment for Other Diagnostic Procedures.--Although the other diagnostic procedures subject to the new payment method have not yet been identified, they include diagnostic procedures other than diagnostic laboratory tests and diagnostic radiology procedures.

Effective for other diagnostic procedures furnished by hospitals on an outpatient basis on or after October 1, 1989, the aggregate payment is based on a comparison between two amounts. The aggregate payment is the lesser of:

1. The amount that is paid to the hospital for the procedures under §1833(a)(2)(B) of the Act (i.e., the lower of the hospital's reasonable costs or customary charges for the services, reduced by deductibles and coinsurance); or

2. An amount based on a blend of

o The amount that is paid to the hospital for the services under §1833(a)(2)(B) of the Act (referred to as the hospital-specific amount); and

o An amount equal to 80 percent of the amount determined by subtracting deductibles from 42 percent of the prevailing charge amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality (referred to as the prevailing charge amount). (NOTE: The calculation of the prevailing charge amount uses 42 percent of the prevailing charge in order to recognize the facility or technical component and exclude the physician component. The calculation also applies an 80 percent factor in order to exclude beneficiary coinsurance.)

For other diagnostic procedures furnished on or after October 1, 1989 and before October 1, 1990, the blended amount is calculated as 65 percent of the hospital-specific amount plus 35 percent of the prevailing charge amount. For other diagnostic procedures furnished on or after October 1, 1990, the blended amount is calculated as 50 percent of the hospital-specific amount plus 50 percent of the prevailing charge amount.

2830.34 Illustration of Payment Method for Other Diagnostic Procedures Furnished by Hospitals on an Outpatient Basis.--

Assumptions (For other diagnostic procedures furnished from 10/1/89 through 12/31/89):

Hospital's customary charges for outpatient other diagnostic procedures	$ 19,000
Hospital's reasonable costs for outpatient other diagnostic procedures	25,000
Deductibles	3,000
Coinsurance (($19,000 charges - $3,000 deductibles) x 20%)	3,200
Prevailing charges for other diagnostic procedures	50,000

Calculation of Aggregate Payment for Outpatient "Other Diagnostic" Procedures for Cost Reporting Period Ending 12/31/89:

Payment is the lesser of:

(1)	Lower of hospital's cost or charges (Net of coinsurance and deductibles)	$ 19,000 - 6,200 $ 12,800
	OR	
(2)	Blended amount:	
	65% x hospital specific amount (65% x $12,800)	$ 8,320
	35% x 80% x ((42% prevailing charges) - deductibles) 35% x 80% x ((42% x $50,000) - $3,000)	+ 5,040 $ 13,360

In this example, the amount of $12,800 determined as the lower of the hospital's reasonable cost or customary charges, reduced by deductibles and coinsurance, is less than the blended amount of $13,360. Therefore, Medicare payment is $12,800.

Skilled Nursing Facility Prospective Payment System

2831. GENERAL PROVISIONS

Section 4432 of the Balanced Budget Act of 1997 (BBA) established provisions for a prospective payment system (PPS) for skilled nursing facilities (SNFs) under Section 1888(e) of the Social Security Act (the Act) effective with cost reporting periods beginning on or after July 1, 1998. Under these provisions, covered Medicare Part A SNF services *are* no longer paid based on reasonable cost or through low volume prospectively determined rates, but rather through case-mix adjusted per-diem prospective payment rates for all SNFs. The payment rates represent payment in full (subject to applicable coinsurance as described in subpart G of part 409 of 42 CFR (Code of Federal Regulations)) for all costs (routine, ancillary, and capital-related) associated with furnishing covered SNF services to Medicare beneficiaries other than costs associated with operating approved educational activities as described in *the regulations at 42 CFR* §413.85. Covered SNF services include posthospital SNF services for which benefits are provided under Part A and all items and services (*other than the excluded service categories set forth in the regulations at 42 CFR 411.15(p)(2))* for which prior to July 1, 1998, payment had been made under Part B but furnished to SNF residents during a Part A covered stay, regardless of source.

The following section*s* describe policies related to the establishment of the Federal rate and the transition rate. The transition rate is the sum of the provider's Part A cost and the Part B add-on, more commonly referred to as the facility-specific per diem. *Those* section*s* also provide operational instructions and further clarification of the applicable rules contained in *the regulations at* 42 CFR *Part* 413 Subpart J. For the initial period of the PPS beginning on July 1, 1998 and ending on September 30, 1999, payment rates and associated rules *appeared in the SNF PPS interim final rule that was* published in the *Federal Register* (FR) on May 12, 1998 (see FR Vol. 63, No. 91 page 26252 *available online at www.gpo.gov/fdsys/pkg/FR-1998-05-12/pdf/98-12208.pdf*). For each succeeding fiscal year, the rates are published in the *Federal Register* before August 1 of the year preceding the affected fiscal year.

2832. METHODOLOGY FOR DETERMINING PER DIEM PROSPECTIVE PAYMENT RATES EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 1998

The BBA sets forth the formula for establishing the rates as well as the data on which they are based. In addition, it requires adjustments to such rates based on geographic variation and case-mix and prescribes the methodology for updating the rates in future years. Under *the SNF* PPS, the resident classification system is the means by which residents are classified into mutually exclusive groups based on clinical, functional and resource-based criteria. For purposes of *the* SNF PPS, this term refers to the current version of the *resident classification system* as set *forth in the annual publication of the Federal prospective rates for SNFs in the Federal Register and discussed in the paragraph entitled "Case Mix Adjustment" on the SNF PPS home page, at https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/SNFPPS/index.html.*

A. Establishment of Federal Per Diem.-- *As explained in the May 12, 1998 interim final rule (63 FR 26255ff., available online at www.gpo.gov/fdsys/pkg/FR-1998-05-12/pdf/98-12208.pdf), the BBA established per diem Federal rates for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included a "Part B add-on" (an estimate of the cost of those services that, before July 1, 1998, were paid under Part B, but furnished to Medicare beneficiaries in a SNF during a Part A covered stay). We adjust the rates annually using a SNF market basket index to reflect changes in the costs of goods and services used to provide SNF care, and we also adjust the rates using hospital inpatient wage data to account for geographic variation in wages. Effective FY 2012, we include an annual multifactor productivity adjustment to ensure that the annual market basket update also accounts for increases in provider productivity. We also apply a case-mix adjustment to account for the relative resource utilization of different patient types. Originally, this adjustment involved the 44-group Resource Utilization Groups, version 3 (RUG-III) case-mix classification system, using information obtained from the required resident assessments under version 2.0 of the Minimum Data Set (MDS 2.0). For dates of service beginning in FY 2011 and ending on or before September 30, 2019, this adjustment utilized the 66-group version 4 of the RUG model (RUG-IV), as well as version 3.0 of the MDS (MDS 3.0). For dates of service beginning on or after October 1, 2019, SNFs must use the patient driven payment model to classify beneficiaries for payment purposes (see 83 FR39162), as well as version MDS 3.0.*

B. Establishment of Facility-Specific Per Diem.-- *Under sections 1888(e)(1)(A) and (e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the Federal case-mix adjusted rate. The transition extended through the facility's first three cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full Federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments entirely on the adjusted Federal per diem rates, the SNF PPS no longer utilizes adjustment factors related to facility-specific rates*.

2833. DETERMINATION OF FACILITY-SPECIFIC PER DIEM RATES

As discussed below, the step-by-step procedures for calculating the facility-specific per diem rate*s used during the transition for various provider types appears in successive clauses of section III.A.1. of the May 12, 1998 interim final rule, which is available online at www.gpo.gov/fdsys/pkg/FR-1998-05-12/pdf/98-12208.pdf.*

Calculations to determine Medicare Part A costs have been established for the following types of providers.

- Freestanding SNFs without an exception for medical or paramedical education (§413.30(f)(4)) or a new provider exemption in the base year.
- Freestanding SNFs with an exception for medical or paramedical education (§413.30(f)(4) in the base year.
- Freestanding SNFs with new provider exemptions from the cost limits in the base year.
- Hospital-based SNFs without an exception for medical and paramedical education or a new provider exemption.
- Hospital-based SNFs with an exception for medical and paramedical education in the base year.
- Hospital-based SNFs with new provider exemptions from the cost limits in the base year.
- Medicare low volume SNFs electing prospectively determined payment rate (fewer than 1500 days) in the base year.
- Providers participating in the Multistate Nursing Home Case-Mix and Quality Demonstration.

A. Freestanding Skilled Nursing Facilities.--The *applicable* instructions *appear at clause (a)(63 FR 26286-87).*

B. Hospital-Based Skilled Nursing Facilities.--The *applicable* instructions *appear at clause (b) (63 FR 26287).*

C. Determination of Medicare Part A Costs for Medicare Low Volume Skilled Nursing Facilities Electing Prospectively Determined Payment Rate (Fewer Than 1500 Medicare Days.--*The applicable instructions appear at clause (c)(63 FR 26288).*

D. Calculation of the Prospective Payment System Rate for Providers Participating in the Multistate Nursing Home Case-Mix and Quality Demonstration.--*The applicable instructions appear at clause (d) (63 FR 26288).*

2834. CALCULATING PAYMENT UNDER SNF PPS

A. *Calculating* Payment Under SNF PPS.--Section 1888(e)(4)(G)(ii) of the Act requires that we provide for adjustments to the Federal rates to account for differences in area wage levels using "an appropriate wage index" as determined by the Secretary. *The individual wage index values formerly displayed as Tables A and B in the annual SNF PPS rulemaking are now made available through the Internet on CMS's SNF PPS website, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

To compute a wage adjusted Federal rate, *the contractor* shall take the labor-related portion of the payment rate applicable to the resident classification system group in which the beneficiary classifies and multiply this amount by the SNF's appropriate wage index factor. The product of the calculation is added to the corresponding non-labor related portion. The resulting amount is the Federal rate applicable to a beneficiary in that resident classification system group for that SNF.

B. Short Period Adjustments.--*The applicable instructions for short period adjustments appear in section IV.B.1 of the May 12, 1998 interim final rule (63 FR 26294), which is available online at www.gpo.gov/fdsys/pkg/FR-1998-05-12/pdf/98-12208.pdf.*

2835. USE OF SNF PRICER

CMS has developed a SNF Pricer program that calculates the daily Medicare rate upon which the Medicare SNF prospective payment is made. *Information about the SNF pricer appears in §§30.4ff. of the Medicare Claims Processing Manual, Chapter 6, and on the SNF PC Pricer home page at the following web address https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/SNF.html.*

2836. SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM - PAYMENT REQUIREMENTS AND ADJUSTMENTS

Payment is made to SNFs for services rendered to Medicare beneficiaries for cost reporting periods beginning on or after July 1, 1998 based upon a prospective payment system (PPS*) using a resident classification system based on data from the Resident Assessment Instrument (MDS 3.0) and relative weights developed from staff time data. The SNF PPS includes an administrative presumption under which beneficiaries who are correctly assigned to designated case-mix classifiers on the initial Medicare assessment (commonly referred to as the "5-day" assessment) are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) for that assessment.* Thus, the *case-mix* classification system allows for an expedited determination that a beneficiary in one of the *designated* payment groups *initially* meets the SNF level of care requirements, and for assignment to an appropriate payment category. However, it does not supersede any coverage requirements related to a specific service, or the overall requirement that the services provided to the beneficiary be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. *Additional information on the administrative level of care presumption appears in §30.1 of the Medicare Benefit Policy Manual, Chapter 8 (available online at*

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf).

A. General Requirements.--All SNFs that are currently paid on the basis of an all-inclusive rate, must have a charge structure in place by their first cost reporting period beginning on or after July 1, 1998, that allows for detail billing of UB-92 inpatient accommodation/resources and inpatient ancillary revenue codes for posting to the Provider Statistical and Reimbursement Report (PS&R) for cost reporting purposes, in order to meet operational requirements for consolidated billing and SNF PPS. This requirement relates to payment for Part B items or services, under the fee schedule and listing charges for certain services on the Part A bill.

B. Health Insurance Prospective Payment System Rate Code (HIPPS) Defined.--The HIPPS rate code consists of the case-mix classifier code (s) which are obtained from the "Grouper" software program and a*n* assessment indicator. SNFs must use the version of the Grouper software program identified by *CMS* for national PPS as described in the Federal Register for that year. The Grouper translates the minimum data set (MDS) data into a case-mix group and assigns the correct case-mix classifier code (s). Both components of the HIPPS rate code must be present on a claim or the claim will be rejected. *Effective for dates of service on or after October 1, 2010, the Grouper automatically assigns the assessment indicator. Prior to this date, the SNF assigned the assessment indicator manually.* The HIPPS rate code that appears on the *UB-04* must *match the assessment that has been transmitted and accepted by the State in which the facility operates.* The SNF cannot put a HIPPS rate code on the *UB-04* that does not *match the assessment that was transmitted and accepted by the State in which the facility operates.* Additional information on HIPPS codes and billing using the HIPPS rate code appears in §30.1 of the Medicare Claims Processing Manual, Chapter 6 (available online at

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf) and in the MDS RAI Manual, Chapter 6 (available online at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html*)*

C. Assessment *Schedule*.--*For the current* rules *that* govern when an MDS must be completed for purposes of payment *please refer to the following portions of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (available online at https://downloads.cms.gov/files/MDS-30-RAI-Manual-v115-October-2017.pdf):*

- *Section 2.8 ("The Skilled Nursing Facility Medicare Prospective Payment System Assessment Schedule");*
- *Section 2.9 ("MDS Medicare Assessments for SNFs"); and Chapter 6 ("Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)").*

D. Post Pay Adjustments.--

1. *CMS* finds that the beneficiary was assigned to an incorrect HIPPS rate code. *See Section 5.4 ("Additional Medicare Submission Requirements that Impact Billing Under the SNF PPS") of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (available online at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html*

2. The *contractor or CMS* finds that services provided to the beneficiary do not meet medical necessity requirements.

The *contractors* shall conduct a review of those claims where a beneficiary does not meet medical necessity requirements using the current SNF bill review instructions, including *§6.1 ("Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills") of the Medicare Program Integrity Manual, Chapter 6 (available online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf),* as well as the *contractor's* standard operating procedures for soliciting additional documentation, time limitations for receipt of the solicited documentation, claim adjudication, and recoupment of overpayments. The only exception to the current medical review guidelines is that *contractors* must use the minimum data set as part of the medical documentation used to help determine medical necessity of services billed. When the *contractor's* determine that the review of the associated medical documentation does not support the level of services billed (e.g., review of the MDS, nursing and therapy documentation does not support the medical necessity or appropriateness of care reflected in the billed HIPPS rate code) the *contractor* adjusts the billed HIPPS rate code to the HIPPS rate code that most accurately describes the case-mix groups that the beneficiary classifies into, so long as the beneficiary meets all eligibility and coverage requirements. However, the entire claim could be denied if it is determined that none of the services were found to be reasonable and necessary for the diagnosis or treatment of an injury or to improve the functioning of a malformed body member.

E. Payment Rules for Beneficiaries Already in a Part A Stay Prior to Implementation of *the SNF* PPS.-- *The applicable instructions regarding transition to the SNF PPS appear in section II.B.9 of the May 12, 1998 interim final rule (63 FR 26268), which is available online at www.gpo.gov/fdsys/pkg/FR-1998-05-12/pdf/98-12208.pdf.*

F. Demand Bills.-- *As discussed in §40.9.A ("Demand Bills") of the Medicare Claims Processing Manual, Chapter 6 (available online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf), where the SNF believes that a covered level of care has ended but the beneficiary disagrees,* demand bills should be submitted with a Condition Code 20 in the FL position 24 indicating the beneficiary requested the non-covered claim to be submitted by the SNF to the *contractor* for consideration and approval after the beneficiary was issued a written notice of non-coverage by the SNF. A HIPPS rate code (s) must be present on the demand bill. This requires that the SNF perform an assessment of the beneficiary in order to classify the beneficiary for purposes of payment. A SNF does not have to classify a beneficiary into *a case-mix classifier (s)* if he or she does not meet the eligibility requirement for *a qualifying* three day hospital stay. When disposition of the demand bill has been completed, and if the demand bill is approved, it will be paid based on the HIPPS rate code corresponding to the *case-mix classification group (s)* the beneficiary was in for the approved covered days. Where the *contractor* determines during its review of the associated medical documentation that the medical record does not support the level of services billed (e.g., review of the MDS, nursing and therapy documentation does not support the medical necessity or appropriateness of care reflected in the billed HIPPS rate code) the *contractor* denies the demand bill. If the beneficiary disagrees with the *contractor's* denial of the demand bill, the beneficiary can appeal the determination.

G. Payment for Services Provided to Beneficiaries Who Have Elected Hospice Who are Admitted to a SNF.--Medicare beneficiaries who have elected the hospice benefit are not covered by the inpatient Part A SNF `benefit (*and*, therefore, the SNF PPS rules do not apply), *unless* that beneficiary is admitted for care *that is unrelated to the terminal condition*. If the beneficiary is admitted for care *that is unrelated to the terminal condition*, the SNF must follow the Medicare required assessment schedule *for standard or scheduled assessments* in order to bill the *contractor* using the HIPPS rate code.

H. Medicare Beneficiaries Enrolled In HMOs Who are Admitted to a SNF.--A Medicare beneficiary in a RISK HMO (Option C) will be covered (or not) based on the policies of the insurer; however, the risk HMO may never offer the beneficiary anything less than what is provided to the fee-for-service beneficiary. If a beneficiary who is enrolled in a risk HMO enters a SNF, the risk HMO must preauthorize coverage and make payment to the SNF based on the contract, not based on the SNF PPS rates. Furthermore, the assessment rules do not apply to Medicare beneficiaries enrolled in risk HMOs receiving SNF services.

A Medicare beneficiary who is enrolled in a COST HMO (Option1) has a choice of where to receive services. If a beneficiary who is enrolled in a cost HMO enters a SNF, the cost HMO must submit the claim to the *contractor* for processing using the HIPPS rate code. Consequently, the assessment rules do apply to Medicare beneficiaries who are admitted to a SNF and are enrolled in a cost HMO.

I. Medicare Secondary Payer (MSP).--Medicare regulations require SNFs to follow admission practices which include a survey for coverage by another insurer. If another insurer is responsible for the payment of the SNF stay, the SNF will bill the insurer according to the rules of the insurer. When a specific time period is guaranteed by an insurer other than Medicare, the assessment schedule for purposes of Medicare coverage and payment begins when that coverage ends. When the time paid by another insurer is based on dollars available on the policy or medical limitations of the policy, it is recommended (but not required) that the SNF follow the Medicare required assessment schedule during the period of coverage by another insurer to insure correct billing to Medicare if the other insurer denies payment. If the SNF does not follow the Medicare required schedule, and payment is retroactively denied by the primary insurer, the SNF may use the most recent assessment that was completed in accordance with the schedule outlined in 42 CFR 483.20(b)(2) in order to receive payment under the Medicare program for those days that were denied by the secondary insurer, as long as the beneficiary meets all applicable eligibility and coverage requirements.