# Medicare
# Provider Reimbursement Manual
## Part 2, Provider Cost Reporting Forms and Instructions, Chapter 18, Form CMS-2088-92

**Department of Health and Human Services (DHHS)**
**Centers for Medicare & Medicaid Services (CMS)**

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| HEADER SECTION NUMBERS | PAGES TO INSERT | PAGES TO DELETE |
|---|---|---|
| 1800 - 1802 | 18-3 - 18-6 (4 pp.) | 18-3 - 18-6 (4 pp.) |

**REVISED COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: Changes effective for cost reporting periods ending on or after June 30, 2001.**

This transmittal revises Chapter 18, Outpatient Rehabilitation Provider Cost Reporting Form CMS-2088-92 to eliminate the cost reporting requirement for comprehensive outpatient rehabilitation facilities (CORFs) and outpatient physical therapy (OPTs) providers (includes outpatient occupational therapy (OOT) providers and outpatient speech pathology (OSP) providers) where 100 percent of the services are reimbursed on a fee schedule basis. Community mental health centers (CMHCs) must continue to file cost reports in accordance with PRM, Part II, Chapter 100.

**DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.**

1800. GENERAL

This cost report provides for the determination of allowable costs which are reimbursable by the health insurance program under title XVIII, Part B, of the Act. These worksheets are used only by rehabilitation agencies, clinics and public health agencies certified as outpatient physical therapy (OPT), outpatient occupational therapy (OOT) and outpatient speech pathology (OSP) providers, comprehensive outpatient rehabilitation facilities (CORF), and community mental health centers (CMHC) providing partial hospitalization services. Form CMS-2088-92 is used only by freestanding providers.

**NOTE**: Effective for cost reporting periods ending on or after June 30, 2001, CORFs and OPTs (includes OOT and OSP) where 100 percent of the services rendered are reimbursed on a fee schedule basis are no longer required to complete the Form CMS 2088-92 cost report. However, such providers with cost reimbursed services must file a low utilization cost report in accordance with PRM, Part II, chapter 110. CMHCs must continue to file cost reports in accordance with PRM, Part II, chapter 100.

A. Effective Date.--

1. Rehabilitation agencies, clinics and public health agencies certified as OPT, OOT, or OSP providers must use these worksheets for cost reporting periods ending on or after April 30, 1993.

2. CORFs must use these worksheets for the facility's first cost reporting period which ends on or after April 30, 1993, and for which a facility is certified as a comprehensive outpatient rehabilitation provider.

3. CMHCs must use this cost report for the facility's first cost reporting period on or after October 1, 1991, provided that the CMHC has filed a request for Medicare participation and has met all Federal requirements for partial hospitalization services to be reimbursable by the Medicare program

Reasonable cost as used in this discussion of reimbursement is the remaining reasonable cost after subtracting any applicable deductible.

Effective for services rendered prior to January 1, 1999, OPT, OOT, and OSP providers are reimbursed on the basis of the lower of reasonable cost or customary charges or reasonable cost minus amounts that may be billed to Medicare beneficiaries for providing services to Medicare beneficiaries In no case may the reimbursement exceed 80 percent of the reasonable cost.

CMHCs are reimbursed (for partial hospitalization services) the lesser of reasonable cost or customary charges, less the amount of coinsurance that may be charged to the beneficiaries. In no case may the reimbursement exceed 80 percent of the reasonable cost.

Effective for services rendered prior to January 1, 1999 (and some services rendered on or after January 1, 1999 that continue to be reimbursed on a cost basis) CORF reimbursement is based on the reasonable cost that remains after subtracting any applicable deductibles and is the lesser of:

- Eighty percent of the remaining reasonable cost, or
- The remaining reasonable cost minus 20 percent of reasonable charges.

Part I of the Provider Reimbursement Manual (CMS Pub. §15-I) and the applicable regulations issued by CMS set forth the criteria to use to determine reimbursable costs under the health insurance program.

Form CMS-2088-92 is used to effect provider reimbursement, using cost finding with cost

apportionment based on gross charges.

The gross charges method is the ratio of Medicare program charges to total charges applied to total allowable costs. This ratio is developed for each individual reimbursable cost center. Each of the different types of providers using this cost report has specific services for which they may be

reimbursed under the Act. Therefore, a provider develops the ratio only for those cost centers for which it may be reimbursed.

In order for a provider to properly complete its Medicare cost report, a record of its Medicare billing must be maintained. Providers generally maintain their own records of billings, but in addition, the intermediary keeps a record, known as the Provider Statistical & Reimbursement (PS&R) report. The PS&R report compiles the provider's Medicare claims data and summarizes it for use by the provider in the cost report. Throughout these instructions and the related forms, there have been references to the provider's records as a source for entries in a cost center. In order for any such entries to be accurate, reconcile the provider's records and the intermediary's PS&R.

The cost finding calculations provide for the allocation of the cost of services rendered by each general service cost center to other cost centers which utilize such services. Once the costs of a general service cost center have been allocated, that cost center is considered closed. Once closed, it does not receive any of the costs subsequently allocated from the remaining general service cost centers. This method of cost finding is the stepdown method.

You may use a more sophisticated method of cost finding designed to allocate costs more accurately upon approval of the intermediary. However, having elected to use the more sophisticated method, you may not thereafter use the stepdown method without approval of the intermediary.

The cost report form contains the methodology in which covered charges, deductibles, and coinsurance amounts for services rendered are considered in the calculation of Medicare reimbursement.

Form CMS-2088-92 consists of 26 pages. Generally, complete these pages in sequence. However, some pages must be started but cannot be completed until some of the succeeding pages are first completed. The instructions point out these differences.

In completing the worksheets, show reductions to expenses in parentheses ( ).

Where you did not furnish any covered services to Medicare beneficiaries, or where there is low Medicare utilization of such services during the entire cost reporting period, a full cost report need not be filed. Your intermediary may authorize less than a full cost report if you have had low utilization of covered services by Medicare beneficiaries in a reporting period and you received correspondingly low interim reimbursement payments. This authorization is only effective if, prior to the end of the cost reporting period or filing period, the intermediary advises you that you may file less than a full cost report and you give assurance that you will timely file such data as may be required by the intermediary. See CMS Pub. 15-I, Chapter 24, §2414.4 and 42 CFR §413.24(h) for a further explanation of this procedure.

1800.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in the use of fractions. The following rounding standards must be employed for such computation.

1. Round to 2 decimal places
   a. Percentages
   b. Averages
   c. Full time equivalent employees
   d. Per diems, hourly rates

2. Round to 5 decimal places
   a. Payment reduction (e.g., outpatient cost reduction)

3. Round to 6 decimal places
   a. Ratios (e.g., unit cost multipliers, cost/charge ratios)

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost being allocated. Adjust this residual to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount being allocated.

1801. RECOMMENDED SEQUENCE FOR COMPLETING FORM HCFA-2088-92

| Step | Worksheet | |
|---|---|---|
| 1 | S | Complete Parts I and IV. |
| 2 | S-1 | Complete lines 1 through 4. |
| 3 | A | Complete columns 1 through 3, all lines. |
| 4 | A-1 | Complete entire worksheet if applicable. |
| 5 | A | Complete columns 4 and 5, all lines. |
| 6 | A-3 | Complete lines 1 through 12. |
| 7 | A-3-1 | Complete Part A. If the answer to Part A is "Yes," complete Parts B and C. |
| 8 | A-3 | Complete lines 13 through 19. |
| 9 | Supp. A-8-2 | Complete entire worksheet, if applicable. |
| 10 | Supp. A-8-3 | Complete entire worksheet, if applicable. |
| 11 | Supp. A-8-4 | Complete entire worksheet, if applicable. |
| 12 | Supp. A-8-5 | Complete entire worksheet, if applicable. |
| 13 | A-3 | Complete remainder of Worksheet A-3. |
| 14 | A | Complete columns 6 and 7, all lines. |
| 15 | B & B-1 | Complete entire worksheets. |
| 16 | C | Complete entire worksheet. |
| 17 | D | Complete lines 1 through 5, 9, 11, 18, and 20 through 29. |
| 18 | D | Complete lines 6 through 8, 10, 12 through 17, and 19. |
| 19 | G | Complete entire worksheet. |
| 20 | S | Complete Part III, then complete Part II. |

## 1802. WORKSHEET S - OUTPATIENT REHABILITATION PROVIDER COST REPORT

The intermediary indicates in the appropriate box whether this is the initial cost report (first cost report filed for the period), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened.

1802.1 Part I - Identification Data.--

The information required in this section is needed to properly identify the provider.

Line 1.--Enter the Outpatient Rehabilitation Facility name.

Line 1.01.--Enter the street address. and P.O. Box (if applicable) of the facility.

Line 1.02.--Enter the city, state, and zip code of the facility.

Line 2.--

Column 1.--Enter the provider identification number.

Column 2.--Type of Control.--Indicate the ownership or auspices of the provider by entering the number below that corresponds to the type of control of the facility.

Voluntary Nonprofit:
- 1 = Church
- 2 = Other (specify)

Proprietary:
- 3 = Individual
- 4 = Corporation
- 5 = Partnership
- 6 = Other (specify)

Government (Non-Federal):
- 7 = State
- 8 = Hospital District
- 9 = County
- 10 = City
- 11 = City-County
- 12 = Other (specify)

If item 12 is selected, "Other (specify)" category, specify the type of provider in column 3 of the worksheet.

Column 4.--Type of Provider.--Enter the number which corresponds to the type of provider as defined in the conditions of participation.

OPT/OSP/OOT Provider:
- 1 = Rehabilitation Agency
- 2 = Public Health Agency
- 3 = Clinic
- 4 = Comprehensive Outpatient Rehabilitation Facility (CORF)
- 5 = Community Mental Health Center (CMHC)

OPT, OOT, OSP Provider.--This is a provider furnishing either outpatient physical therapy, outpatient occupational therapy and/or outpatient speech pathology services. These services are furnished through one of the following:

Rehabilitation Agency.--This is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy, occupational therapy or speech pathology services, and a rehabilitation program which, in addition to OPT, OOT, or OSP services, includes social or vocational adjustment services.