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)
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REVISED COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: CMHC changes effective for cost reporting periods ending on or after January 1, 2002.

This transmittal clarifies Chapter 18, Outpatient Rehabilitation Provider Cost Reporting Form CMS-2088-92 and instructions to accommodate community mental health centers (CMHCs) where the cost reporting period overlaps a transitional corridor date.

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.

Partial hospitalization services provided by CMHCs reimbursed based on a Prospective Payment System (PPS).--For CMHC services (lines 29-38) rendered on or after August 1, 2000, reimbursement is based on PPS subject to a transitional corridor payment. Vaccines furnished by CMHCs are reimbursed based on outpatient PPS. To facilitate completion of this worksheet, the heading for columns 5, 6, and 8 will change (identified as the pre transition, date and the on or after date) based on the cost reporting period.

Column 5, lines 29-38.--For each cost center, enter the Title XVIII charges (from your records) for services rendered on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004. For cost reporting periods beginning on or after January 1, 2004, enter zero (0).

Column 6, lines 29-38.--Determine the title XVIII cost for services rendered on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004 by multiplying the charges in column 5 by the ratio in column 2, and enter the result. For cost reporting periods beginning on or after January 1, 2004, enter zero (0).

Column 8, lines 29-38.--Determine the title XVIII pre transition date (August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004) cost by subtracting the amount in column 6 from the amount in column 3, subline .01, and enter the result. For lines 29 through 38 and line 43, transfer the cost from column 3, subline .01 to the corresponding line in column 8. For cost reporting periods beginning on or after January 1, 2004, this column must equal zero (0).

Line 39.--Enter the total of lines 29 through 38, and transfer the amount on line 39 in accordance with the instructions for Worksheet D, Part I, line 1.

Line 43.--Enter in column 8 the cost from column 3, subline .01 to the corresponding line in column 8.

Line 44.--Enter the total of lines 40 through 43, columns 5 through 8 and transfer the amount on line 44, column 8 to Worksheet D in accordance with the instructions for Worksheet D, Part I, line 1.

1810. WORKSHEET D - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR OUTPATIENT REHABILITATION SERVICES - TITLE XVIII

Worksheet D applies to title XVIII only and provides for the reimbursement calculation of outpatient rehabilitation services rendered to Medicare beneficiaries.

NOTE: CORFs with cost reporting periods overlapping January 1, 1998, complete Part I and lines 22 through 27 of Part II for services rendered prior to January 1, 1998. For CORF services rendered on or after January 1, 1998, complete lines 21 through 29 as applicable as the Lesser of Reasonable Cost or Customary Charges (LCC) applies to these services.

Worksheet D consists of two parts:

Part I - Computation of Reimbursement Settlement
Part II - Computation of the Lesser of Reasonable Cost or Customary Charges

1810.1 Part I - Computation of Reimbursement Settlement.--

Line Descriptions

Line 1.--Enter the total expenses applicable to the health insurance program obtained from Worksheet C, column 8, line as appropriate (other providers from line 44). CORFs & OPTs use column 1 only. CORFs enter cost of services provided on or after January 1, 1998 by subtracting the amount in column 7, line 28 from the amount in column 6, line 28.

CMHCs with cost reporting periods ending prior to August 1, 2000, enter the applicable cost from Worksheet C, column 3, line 39.01. CMHCs with cost reporting periods overlapping August 1, 2000,enter in the applicable column the cost of services provided prior to the applicable transition date from Worksheet C, column 8, line 39 and enter in the applicable column the cost of services provided on or after the applicable transition date from Worksheet C, column 6, line 39. CMHCs with cost reporting periods beginning on or after January 1, 2004, enter zero (0) as CMHC services are reimbursed under 100% PPS.

NOTE: For CMHCs only, column 1 is subscripted for lines 1 through 12 for cost reporting periods which overlap August 1, 2000, January 1, 2002, January 1, 2003, and December 31, 2003, to accommodate the transitional corridor payment calculation associated with the portion of the cost reporting period which overlaps any of the aforementioned dates. For cost reporting periods which overlap a transition date enter in column 1 any data applicable to CMHC services rendered prior to the transition and enter in column 1.01 data applicable to CMHC services rendered on or after the transition date. For cost reporting periods that do not overlap transition dates and for cost reporting periods beginning on or after January 1, 2004, only complete column 1.

Lines 1.01 through 1.05 are to be completed by CMHCs for title XVIII services rendered on or after August 1, 2000.

Line 1.01.--Enter the gross PPS payments (includes deductible and coinsurance) received including payments for drugs and outliers.

Line 1.02.--Enter the 1996 CMHC specific payment to cost ratio (to 3 decimal places) provided by your intermediary.

Line 1.03.--Line 1, column 1.01 times line 1.02.

Line 1.04.--Line 1.01 divided by line 1.03.

Line 1.05.-- Enter the transitional corridor payment amount calculated based on the following:

For services rendered on or after August 1, 2000 through December 31, 2001:
a. If line 1.04 is => 90% but < 100% enter 80% of the result of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .71 times line 1.03 minus .70 times line 1.01.
c. If line 1.04 is => 70% but < 80% enter the result of .63 times line 1.03 minus .60 times line 1.01.
d. If line 1.04 is < 70% enter 21% of line 1.03.

For services rendered on or after January 1, 2002 through December 31, 2002:
a. If line 1.04 is => 90% but < 100% enter 70% of the result of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .61 times line 1.03 minus .60 times line 1.01.
c. If line 1.04 is < 80% enter 13% of line 1.03.

For services rendered on or after January 1, 2003 through December 31, 2003:
a. If line 1.04 is => 90% but < 100% enter 60% of the result of line 1.03 minus line 1.01.
b. If line 1.04 is < 90% enter 6% of line 1.03.

Line 1.1.--CORFs with cost reporting periods overlapping January 1, 1998, enter the total expenses for services provided prior to January 1, 1998 by subtracting the amount in column 6, line 28 from the amount in column 3, line 28.01. CORFs with cost reporting periods beginning on or after January 1, 1998, enter zero (0). CMHCs and OPTs make no entry on this line.

Line 2.--Enter the amounts paid or payable by primary payers when Medicare liability is secondary to that of the primary payer. There are several situations, as explained fully in 42 CFR 411, in which Medicare liability is secondary to a primary payer.

Medicare is not the primary payer under the following situations:

1. If the items of services have been, or can reasonably be expected to be paid under a worker's compensation law of a State or of the United States, including the Federal Black Lung Program;

2. If the items of services have been, or can reasonably be expected to be paid by automobile medical or no-fault insurance, or any liability insurance;

3. If the beneficiary is entitled to Medicare solely on the basis of end stage renal disease (ESRD) and is covered by an employer group health plan (EGHP), Medicare is the secondary payer for the first 18 months (See §1862(b)(1)(C) of the Act);

4. If the beneficiary is age 65 or over and either employed, or the spouse of an employed individual of any age, and the beneficiary is thereby covered by an EGHP; and

5. If the beneficiary is under age 65 and disabled and is covered by a large group health plan (LGHP) as a current employee, self-employed individual, or family member of such an employee, or self-employed individual.

When payment by the primary payer satisfies the total liability of the beneficiary, the services are treated as if they were non-Medicare services. The patient charges are included in total patient charges but are not included in Medicare charges, and no primary payer payment is entered on line 2.

If the primary payment does not satisfy the beneficiary's liability, include the covered charges in Medicare charges, and include the total charges in total charges for cost apportionment purposes. Enter the primary payment on line 2 to the extent the primary payer payment is not applied to the beneficiary's deductible and coinsurance.

Any part of the payment by the primary payer that satisfies some or all of the beneficiary's Medicare deductible and coinsurance is applied against the deductible and coinsurance. Do not enter primary payer payments that are applied against the deductible or the coinsurance on line 2. The providers must familiarize themselves with primary payer situations because they have a legal responsibility to attempt to recover their costs from the primary payer before seeking payment from Medicare. The primary payer rules are more fully explained in 42 CFR 411.

Line 3--For cost based CMHC services rendered prior to August 1, 2000, enter in the applicable column the total expenses for CMHC services by subtracting line 2 from line 1. Enter in the applicable column the total PPS payment for CMHC services furnished on or after August 1, 2000, by adding lines 1.01 and 1.05 minus line 2. CORFs and OPTs enter the result of line 1 plus line 1.1 minus line 2.

Line 4.--Enter the total amount of deductibles billed to program patients.

Line 6.--CMHCs (only the portion of the reporting period reimbursed under cost during the beginning transition year) enter in the applicable column the amount from line 29 of Part II. For CMHCs with cost reporting periods beginning on or after August 1, 2000, do not complete this line as PPS reimbursed services are not subject to LCC. CORFs, and other providers enter in column 1 the amount from line 29 of Part II.

Line 8.--CORFs, OPTs, and CMHCs (only the portion of the reporting period reimbursed under cost during the beginning transition year), enter in the applicable column 80 percent of the amount shown on line 7. CMHCs enter 0 (zero) for services reimbursed under PPS.

Line 9.--CORFs and OPTs enter in the applicable column the coinsurance amount billed to Medicare beneficiaries, but this amount may not exceed 20 percent of the customary charges as shown on line 27, Part II. For CMHCs, enter in the applicable the column the gross coinsurance amount billed to Medicare beneficiaries.

Line 11.--Enter reimbursable bad debts, net of bad debt recoveries, applicable to any Medicare deductibles and coinsurance. The amount entered applicable to CMHC PPS must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

Line 12.--CORFs, OPTs and CMHCs for cost reimbursed services only, enter in the appropriate column the result of line 11 plus the lesser of the amounts on line 8 or 10. For CMHC PPS reimbursed services, enter in the appropriate column the result of line 11 plus the lesser of the amounts on line 7 or 10.

Line 15.--Enter the sum of columns 1 and 1.01, line 12 plus line 14.

Line 16.--Enter the sequestration adjustment as required by the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177). (See §120 of CMS Pub. 15-II).

Line 16.5.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4)

Line 17.--Subtract lines 16 and 16.5 from line 15 and enter the result.

Line 18.--Enter the total interim payments applicable to this cost reporting period from Worksheet S-1, line 4. For intermediary final settlement, report on line 18.5 the amount from Worksheet S-1, line 5.99.

Line 19.--Subtract the total amount entered on line 18 from the amount entered on line 17 and enter the resulting amount. This represents the amount due to or from the provider before any tentative or final settlement. Transfer this amount to Worksheet S, Part III, line 6.

1810.2 Part II - Computation of Lesser of Reasonable Cost or Customary Charges.--Part II provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

NOTE: For CORF services rendered prior to January 1, 1998, complete lines 22 through 27 as these services are not subject to LCC but are reimbursed based on Reasonable Costs. For CORF services rendered on or after January 1, 1998, complete lines 21 through 29, as these services are subject to LCC.

Line Descriptions

Line 21.--CMHCs enter the reasonable cost of Title XVIII services as follows: Reporting periods overlapping August 1, 2000, from Part I, line 1, column 1; Reporting periods beginning on or after August 1, 2000 do not complete Part II of this worksheet. For CORFs this line represents the reasonable cost of Title XVIII services rendered on or after January 1, 1998 from line 1. OPTs enter the reasonable cost of Title XVIII services from Worksheet C, column 8, line 44.

Line 21.1.--This line is the CORF reasonable cost of Title XVIII services rendered prior to January 1, 1998 from Part I, line 1.1.

Line 22.--This line provides for the charges which relate to the reasonable cost on line 21. CMHCs with cost reporting periods which overlap August 1, 2000, enter the result of Worksheet C, column 3, line 39.02 minus column 5, line 39 and for reporting periods beginning on or after August 1, 2000 do not complete Part II of this worksheet. OPTs enter the amount from Worksheet C, column 3, line

44.02. Do not include the charges for any services that are reimbursed under any method other than cost reimbursement. CORFs enter the total charges for Medicare services provided on or after January 1, 1998 from Worksheet C, column 5, line 28.

Line 22.1.--This line provides for CORF charges prior to January 1, 1998, which relate to the reasonable cost on line 21.1. Enter the result of Worksheet C, column 3, line 28.02 minus Worksheet C, column 5, line 28. Do not include the charges for any services that are reimbursed under any method other than cost reimbursement.

Lines 23 through 27.--These lines provide for the reduction of Medicare charges when you do not actually impose such charges in the case of most patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 24 through 26, but enter on line 27 the amount from line 22 and enter on line 27.1 the amount from line 22.1. See 42 CFR 413.13(b). In no instance may the customary charges on line 27 exceed the actual charges on line 22, or the customary charges on line 27.1 exceed the actual charges on line 22.1.

1812. WORKSHEET G - STATEMENT OF REVENUE AND EXPENSES

Worksheet G is prepared from your accounting books and records. Additional worksheets may be supplied if necessary.

Worksheet G is completed by all providers.

You may substitute your own forms for Worksheet G. However, you must provide the minimum detail contained in Worksheet G.

1813. SUPPLEMENTAL WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 405.480, 42 CFR 405.481, 42 CFR 405.482, and 42 CFR 405.550(e), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider. 42 CFR 405.482 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Supplemental Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost incurred. 42 CFR 405.481 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services, e.g., research. Only provider services are reimbursable to you through the cost report. If you are a CORF, see 42 CFR 410.100(a) for an explanation of which services constitute provider services. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 405.482. The methodology used in this worksheet is to apply the RCE limit to the total physician compensation attributable to provider services that are reimbursable on a reasonable cost basis.

NOTE: Where several physicians work in the same department, see CMS Pub. 15-I, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

Column Descriptions

Columns 1 and 10.--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians subject to RCE limits. Enter the line numbers in the same order as displayed on Worksheet A.

Columns 2 and 11.--Enter (on the same line as the cost center) the description of the cost center used on Worksheet A.

When RCE limits are applied on an individual basis to each physician in a department, each physician must be listed on successive lines below the cost center. Each physician must be listed using an individual identifier which is not necessarily either the name or social security number of the individual (e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to the fiscal intermediary upon audit.

When RCE limits are applied on a departmental basis, insert the word "aggregate" instead of the physician identifiers on the line below the cost center description.

Columns 3 through 9 and 12 through 18.--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center.

Column 3.--Enter the total physician compensation paid by the provider for each cost center. Physician compensation is monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services. (See 42 CFR 405.481(a).) Include the compensation in column 3 of Worksheet A or, if necessary ,through appropriate reclassifications or as a cost paid by a related organization through Worksheet A-3-1.

Column 4.--Enter the amount of total remuneration included in column 3 which is applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 405.550(b). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 405.481(f).)

Column 5.--For each cost center, enter the amount of the total remuneration included in column 3 which is applicable to general services to the provider (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 405.481(f).)

NOTE: 42 CFR 405.481(b) requires that physician compensation be allocated between physician services to patients, the provider and nonallowable services such as research. A physician's nonallowable services must not be included in columns 4 or 5 above. The instructions for column 18 ensure that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-3.

Column 6.--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the **Federal Register** before any allowable adjustments.

The RCE limits are updated annually on the basis of updated economic index data. A notice is published in the **Federal Register**, which sets forth the new limits. The RCE applicable to the various specialties is obtained from that notice. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable (non metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million).

Column 7.--Enter, for each line of data, the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040.

The hours entered are the actual hours for which the physician is compensated by the provider for furnishing services of a general benefit to its patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered in this column. Time records, or other documentation that supports this allocation, must be available for verification by the intermediary upon request. (See CMS Pub. 15-I, §2182.3E.)

Column 8.--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 6 and the ratio of the physician's provider component hours entered in column 7 to 2080 hours.

Column 9.--Enter, for each line of data, five percent of the amounts entered in column 8.

Column 12.--The computed RCE limit in column 8 may be adjusted upward, up to five percent of the computed limit (column 9), to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by the provider.

Enter, for each line of data, the actual amounts of these expenses which you paid.

Column 13.--Enter, for each line of data, the result of multiplying the amount in column 5 by the amount in column 12 and divide the result by the amount in column 3.

Column 14.--The computed RCE limit in column 8 may also be adjusted upward to reflect the actual malpractice expense incurred by you for the physician's (or a group of physicians,) services to your patients. In making this adjustment, the intermediary determines the ratio of that portion of compensated physician time spent in furnishing services in the provider (both to you and to your patients) to the physician's total working time in the provider and adjusts the total malpractice expense proportionately.

Enter, for each line of data, the actual amounts of these malpractice expenses which you paid.

Column 15.--Enter, for each line of data, the result of multiplying the amount in column 5 by the amount in column 14 and divide the result by the amount in column 3.

Column 16.--Enter, for each line of data, the sum of the amounts in columns 8 and 15 plus the lesser of the amounts in columns 9 or 13.

Column 17.--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from the provider component remuneration in column 5. If the result is a negative amount, enter zero in this column.

Column 18.--The adjustment for each cost center to be entered represents the provider-based physician (PBP) elimination from provider costs entered on Worksheet A-3, column 2, line 14. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.

Line Descriptions

Total Line.--Total the amounts in columns 3 through 5, 7 through 9 and 12 through 18.

To download the file associated with this instruction, click here.