2412. ACCELERATED PAYMENTS

A provider may request accelerated payments where delays in payments by an intermediary for covered services rendered to beneficiaries have caused financial difficulties for the provider. An accelerated payment may also be made in highly exceptional situations where a provider has incurred a temporary delay in its bill processing beyond the provider's normal billing cycle. A request for an accelerated payment may not be approved unless the provider meets all eligibility requirements, including an assurance that recoupment of the payment will be made on a timely basis (see §24l2.4). The amount of the accelerated payment is computed as a percentage (sufficient to alleviate the impaired cash position but in no case to exceed 70 percent) of the amount of net reimbursement represented by unbilled discharges or unpaid bills applicable to covered services rendered to beneficiaries. Accelerated payments must be approved by the intermediary and HCFA. The HCFA regional office will review each request for an accelerated payment to assure that the accelerated payment provisions are being correctly and consistently applied and to provide the Administration with timely information concerning provider and intermediary bill processing. The information collected in an accelerated payment must be limited to the questions contained in §§2412.2 and 2412.3. These questions have been approved for use by the Office of Management and Budget (OMB). When preparing the accelerated payment form, intermediaries are to display the OMB control number 0938-0269. The number should be printed in the upper right-hand corner of the first page of the form. It should read:

Form Approved
OMB No. 0938-0269

2412.1 Eligibility for Payment.--Provider eligibility for accelerated payments is contingent on the provider meeting all of the following conditions;

A. a shortage of cash exists whereby the provider cannot meet current financial obligations; and

B. The impaired cash position described in "A" is due to abnormal delays in claims processing and/or payment by the intermediary. However, requests for accelerated payments based on isolated temporary provider billing delays may also be approved where the delay is for a period of time beyond the provider's normal billing cycle. In this instance, the provider must assure and demonstrate that the causes of its billing delays are being corrected and are not chronic; and

C. The provider's impaired cash position would not be alleviated by receipts anticipated within 30 days which would enable the provider to meet current financial obligations; and

D. The basis for financial difficulty is due to a lag in Medicare billing and/or payments and not to other third-party payers or private patients; and

E. The intermediary is assured that recovery of the payment can be accomplished according to the provisions of §2412.4.

NOTE: Each intermediary is cautioned that neither the revision of the current financing regulations nor the recovery of current financing payments is a basis for justifying a provider request for an accelerated payment.

24l2.2 Sample Format for Provider Request for Accelerated Payment.--

l. Provider: Provider No.:

Address:

2. Intermediary:

3. Check (a) or (b) or both if applicable:

Cash balance is seriously impaired due to:

(a) Abnormal delay in title XVIII claims processing and/or payment by the health insurance intermediary.

(b) Delay in provider billing process of an isolated temporary nature beyond the provider's normal billing cycle and not attributable to other third-party payers or private patients.

4. a. General fund cash position for provider as of_____ $_____

b. Anticipated receipts from all sources (exclusive of accelerated payments) in the next 30 days $_____

c. Anticipated expenditures in next 30 days $_____

d. Indicated cash position in next 30 days (a + b - c) $____

____

24l2.3 Computation of the Accelerated Payment.--To compute the accelerated payment on account:

l. Determine the amount of the interim reimbursement for unbilled and unpaid claims;

2. Subtract the deductibles and coinsurance amounts, and

3. Multiply by 70% to determine the net reimbursable amount which can be paid to the provider.

The following is illustrative of the accelerated payment computation:

a. Inpatient (hospital and skilled nursing facility)

	Per Diem Basis	Charges Basis
Unbilled		
Number of discharges unbilled	40	40
Number of patient days represented	300	---
Amount of charges	---	$20,000
Billed		
Number of bills not paid	50	50
Number of patient days represented	500	---
Amount of charges	---	$20,000
Total	800	$40,000
Interim reimbursement rate	$ 45	90%
Interim amount due	$ 36,000	$36,000
Less deductible and coinsurance	12,000	12,000
Net reimbursement	$ 24,000	$24,000
Authorized	70%	0%
Inpatient accelerated payment requested (a)	$ 16,800	$16,800

b. Outpatient or Home Health

	Charges Basis
Unbilled	
Amount of charges	$ 10,000
Number of visits or occasions of service	
Billed	
Amount of charges	$ 15,000
Number of visits or occasions of service	
Total	$ 25,000
Interim reimbursement rate	90%
Interim amount due	$ 22,500
Less: deductibles and coinsurance	5,000
Net reimbursement	$ l7,500
Authorized rate	70%
Outpatient accelerated payment request (b)	$ 12,250

c. Total Accelerated Payment requested: (a) and (b) $ 29,050

24l2.4 Recoupment of the Accelerated Payment.--The intermediary recovers any accelerated payment within 90 days after it is issued. To the extent that a delay in your billing process is the basis for the accelerated payment, recoupment is made by a l00 percent offset against your bills processed by the intermediary or other monies due you after the date of issuance of the accelerated payment. Any remainder is recovered by direct payment by you not later than 90 days after issuance of the accelerated payment. If the payment is necessitated by abnormal delays in claims processing and/or payment by the intermediary, recovery by offset will be reasonably scheduled to coincide with improvement in the intermediary's bill processing situation such recoupment will not impair your cash position. However, recovery will not be so delayed that you have in effect, an advance in funds or so slow that recovery is not completed within 90 days after the accelerated payment is issued.

2412.5 Accelerated Payments to Hospitals as a Result of the Temporary Delay in Periodic Interim Payments.--Due to the temporary delay in periodic interim payments (PIP), hospitals receiving PIP will experience a short-term interruption in cash flow that may result in financial hardship. (See §2407.12.) This situation will be particularly acute for hospitals that receive a substantial portion of their reimbursement revenues from the Medicare program.

Sections §2412.1-.4 describe the procedure for issuing accelerated payments to a provider when it has experienced financial difficulties due to the intermediary's delay in making payments. Under this temporary deferral, intermediaries are authorized to make accelerated payments to hospitals that are experiencing cash flow problems caused by the interruption of PIP when:

A. The provider received more than one-half of its total revenue from the Medicare program in the last cost-reporting period for which a completed cost report was submitted; and

B. The provider, to the intermediary's knowledge, cannot obtain a short-term loan from its usual lending sources to cover its cash flow shortfall resulting from the temporary deferral of PIP payments.

In these situations only, an intermediary may make accelerated payments to the hospital for the period between the last full PIP amount made for FY 1983 and FY 1984 and the date on which the deferred PIP payment is made in the following fiscal year.

In lieu of the process for computation of the accelerated payment in §2412.3, intermediaries will issue a payment equal to 70 percent of the deferred amount on the dates the deferred PIP payments were originally scheduled to be issued. The 30 percent or balance of PIP payment will be made in accordance with the dates in §2407.12.

24l3. DUE DATES FOR COST REPORTS

Providers of service participating in the Medicare program are required to submit information to achieve settlement of costs relating to health care services rendered to

Medicare beneficiaries (42 U.S.C. l395g (Section l8l5(a) of the Social Security Act). Regulations state that cost reports "will be required from providers on an annual basis...." (42 C.F.R. 405.406(b)). When you fail to file a timely cost report, all interim payments since the beginning of the cost reporting period can be deemed overpayments. (see Part II, §l00).

Cost reports are required following the close of your reporting period. (See §24l4). The due dates for cost reports are:

A. Provider Continues to Participate in Program.--

l. On or before the last day of the third month following the close of the period covered by the report.

2. A 30-day extension of the due date may, for good cause, be granted. Good cause is synonymous with a good reason or justifiable purpose in seeking an extension. A good cause is one that supplies a substantial reason, one that affords a legal excuse for delay, or an intervening action beyond your control. HCFA will not consider the following as "good causes": ignorance of the law, hardship, inconvenience, or a cost report preparer engaged in other work. To be granted this extension, submit a written request and obtain written approval from your intermediary prior to your cost report due date.

An extension of the cost report due date may not be granted based upon a pending review by the intermediary or HCFA of a non-Medicare cost reporting form. The fact that you or a forms preparation service is awaiting the intermediary's or HCFA's review and determination of acceptability of a non-Medicare cost reporting form does not constitute good cause for granting an extension of the due date. In this situation, use the official Medicare cost reporting forms and file your cost report in accordance with A.l above. (See Part II, §108, concerning use of substitute cost reporting forms.)

3. Where a hospital or hospital-based SNF or hospital-based HHA submits a certified cost report that has been audited by the independent auditors of the hospital, the cost reports are due on, or before, the last day of the fourth month following the close of the period covered by the report. Notify the intermediary in writing by the end of the cost reporting period if your intend to file a certified cost report.

B. Provider Agreement to Participate in Program Terminates (Voluntarily or Involuntarily) or Provider Experiences Change of Ownership.--

l. Cost reports are due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership.

2. An extension of the cost report due date cannot be granted when the provider agreement is terminated or a change in ownership occurs. (See Part II, §l04.)

24l4. COST REPORTING PERIOD

For cost reporting purposes, the program will require submission of annual reports covering a l2-month period of operations based upon the provider's accounting year. (See Part II, §l02.)

The provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other programs. Once a provider has made a selection and reported accordingly, it is required thereafter to report annually for periods ending as of the same date unless the intermediary approves a change in the provider's reporting period.

A cost reporting period under the program consisting of one of the following will be considered in compliance with the reporting periods cited above:

A. Twelve (l2) successive calendar months,

B. Thirteen (l3) four-week periods with an additional day (two in a leap year) added to the last week or period to make it coincide with the end of the calendar year or month,

C. A reporting period which will vary from 52 to 53 weeks because it must always end on the same day of the week (Monday, Tuesday, etc.) and always end on (l) whatever date this same day of the week last occurs in a calendar month, or (2) whatever date this same day of the week falls which is nearest to the last day of the calendar month, even though this same day falls in the first week of the following month. A new provider beginning operations on January l, l974, and entering the program as of that date, could choose a reporting period beginning with that date and ending, for example, Wednesday, December 25, l974. This provider's accounting period would end on the same day of the week (Wednesday) and on whatever date that day of the week last occurs in the final month of the year. Alternatively, the provider could elect to end its first reporting period on January l, l975; this would be based on the election to end the period on the same day of the week which is nearest to the last day of the calendar year, even though the last day falls in the first week of the following month. The method selected must be consistently followed.

A provider may prepare a short period cost report for part of a year under the circumstances described in §§2411.1 through 2414.3.

Where a provider did not furnish any covered services to Medicare beneficiaries or where it had low utilization of such services in a reporting period, a full cost report need not be filed. See §2414.4 for an explanation of this procedure.

Providers in a chain organization, or other group of providers, are required to file individual cost reports as explained in §2414.5.

2414.1 New Providers.--Upon entering the health insurance program, a new provider may select an initial cost reporting period of at least 1 month but not to exceed 13 months. For example, a new provider which starts with the Medicare program on September 15, 1974, and wishes to adopt a reporting period ending September 30, 1974, must file a report for the period September 15, 1974 to September 30, 1975. Such a provider cannot file a report for the 15-day period ending September 30, 1974.

2414.2 Cessation of Participation in Program.--

A. Final Cost Report.--When a provider ceases to participate in the health insurance program, it must file a cost report covering a period under the program up to the effective date of cessation of participation in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than 1 month and not more than 13 months.

B. Payment for Services after Provider Ceases to Participate in Program (Termination, Expiration, or Cancellation of Provider Agreement).--

1. Hospital and SNF.--Effective October 30, 1972, a hospital or skilled nursing facility whose provider agreement either voluntarily or involuntarily ceases (not a change of provider ownership) may be reimbursed under the agreement for up to 30 days of covered Part A inpatient services. These services must have been furnished on or after the effective date of cessation of participation in the program to patients who are admitted before the cessation date. No payment will be made for such services to patients admitted on or after the cessation date.

No payment will be made for hospital services to outpatients or for outpatient physical therapy or speech pathology services furnished by a provider on or after the effective date of cessation. However, payment may be made under Part B to a nonparticipating provider for the medical and other health services which it furnishes in compliance with specified requirements explained in the Nonparticipating Domestic Hospital Supplement (HCFA-30) of the Hospital Manual (HCFA-10).

2. Home Health Agency.--Payment can continue to be made to home health agencies for covered Part A and Part B home health services furnished through the calendar year in which the cessation is effective where the plan of treatment was established prior to the date of cessation. No payment will be made for home health services furnished under a plan of treatment established on or after the cessation date.

3. Interim Rate.--Payment for allowable covered services after cessation of participation will be made at an interim rate not to exceed the interim rate developed on the basis of the latest cost report submitted by the provider. No adjustment should be made to this interim rate until the cost report ending with the date of cessation has been audited, unless the intermediary obtains information that would justify a change in the interim rate. Settlement for such services will be on the basis of a per diem rate developed from Medicare data appearing in the provider's final settled cost report ending with the date of cessation. No cost report will be required for the services furnished following cessation.

2414.3 Changing of Cost Reporting Periods.--A provider must adhere to the cost reporting period initially selected unless a change has been authorized in writing by its intermediary. For the change to be effective, the provider's written request must be received by the intermediary 120 days or more before the close of the reporting period which the change proposes to establish. The intermediary must notify HCFA of the authorized change 30 days or more before the close of the reporting period which the change proposes to establish. For example, where a provider wishes to change the ending date of its cost reporting period from December 31 to July 31, the provider's request for a change must be received by the intermediary 120 days or more before the July 31st date on which the change is to take effect.

Such a change may be made only after the intermediary has established good cause. Good cause is synonymous with a good reason or justifiable purpose in seeking a change in the cost reporting period. Good cause requires that the reason for changing the cost reporting period be clearly consistent with the purposes and intent of the program. To establish good cause, a provider must show that there were specific circumstances which support and explain the basis for requesting a change in the cost reporting period. Good cause would be established, for example, when a chain has all its providers on the same fiscal year and wishes to change the cost reporting period of a newly acquired facility to the same year end. Good cause, however, would not be found to exist where a chain has been operating for some time with providers with varying year ends and requests a change to spread out the accounting work in a different manner. Good cause would not be found to exist where the purpose of the change is to maximize reimbursement. Good cause does not exist where the effect of the change is to delay or expedite the date by which a hospital becomes subject to the prospective payment system (PPS).

Providers owned and/or operated by governmental entities using fiscal year ending dates established by local law, may require changes in the reporting year ending dates as a result of legislative action. In such situations, a provider with the approval of its intermediary may revise its cost reporting period to conform to the new fiscal year established by the applicable lawmaking body.

Where a change in cost reporting periods is approved, the provider may file a cost report for a period of not less than 1-month and not more than 13-months.

2414.4 Conditions Under Which Less Than a Full Cost Report May be Filed.--

A. No Medicare Utilization.--A provider that has not furnished any covered services to Medicare beneficiaries during the entire cost reporting period need not file a full cost report to comply with program cost reporting requirements. The provider must submit to its intermediary a statement, signed by an authorized provider official, which identifies the reporting period to which the statement applies and states that (1) no covered services were furnished during the reporting period, and (2) no claims for Medicare reimbursement will be filed for this reporting period. This statement must

be accompanied by a completed page one of the applicable cost report forms (HCFA-2551 for providers using the Combination Method of cost apportionment, HCFA-2552 for providers using the Departmental RCCAC Method of cost apportionment, HCFA-1728 or HCFA-1729 for home health agencies, and HCFA-2088 for rehabilitation agencies, clinics, and public health agencies). The proper form and signed statement must be submitted within 30 days following the close of the reporting period. (See Part II, § 110.)

B. Low Medicare Utilization.--The intermediary may authorize less than a full cost report where a provider has had low utilization of covered services by Medicare beneficiaries in a reporting period and received correspondingly low interim reimbursement payments which in, the aggregate, appear to justify making a final settlement for that period based on less than a normally required full cost report. Based on the intermediary's knowledge of the provider's Medicare utilization and interim payments and the intermediary's conclusion that it can determine the reasonable cost of covered services furnished beneficiaries, the intermediary will advise the provider that less than a full cost report may be filed. Under this situation, the intermediary will require that the provider furnish all of the following information using program forms: (1) page one of the applicable cost report form, (2) the officer certification sheet,(3) the balance sheet, (4) the statement of income and expense and (5) other financial and statistical data the intermediary may deem appropriate depending upon the circumstances in the individual case. However, regardless of low Medicare utilization or the amount of aggregate interim reimbursement, the intermediary may require full cost reporting and auditing if that is necessary to serve the best interests of the program. Providers must submit the forms and data under this alternate procedure within the same time period required for full cost reports.

C. Implementation.--The procedures described in this section are effective only where, prior to the end of the reporting period or filing period for the cost report, the intermediary advises the provider that it may file less than a full cost report and the provider gives assurance that it will timely file such data. These procedures are not applicable to cost reporting periods where both the reporting period and the related filing period have expired even though a cost report has not yet been filed for such period. If the provider is required to file a full cost report for other Federal programs, e.g., titles XIX and/or V, the provider may be required by the intermediary to also file a full cost report with the Medicare program.

2414.5 Filing of Cost Reports by Providers of a Chain Organization or Other Group of Providers.--Each provider in a chain organization, or other group of providers, except as noted below, must file a separate, individual cost report (see HIR 405.406(b)). Such organizations are not permitted to file a combined or consolidated cost report under the Medicare program. The only exception under this rule applies to State health department home health agencies with subunits or branches, who are now permitted to file a combined cost report under the 7800 services of provider numbers. "Other group of providers" refers to an informal assembly of providers (hospitals, SNF's, and HHA's) not owned or controlled by a central group or related interest, but who join together to obtain the benefits of centralized cooperative buying, exchange of medical information, etc.

Multiple-facility complex providers (hospitals, hospital-based SNF's, and hospital-based HHA's) will use the cost report designated for this type of facility which will provide adequate cost data. Institutions which have multiple facilities but only one provider number, or one provider number so subprovider numbers for its related cost entities, are required to submit one cost report under that particular provider number together with the subprovider numbers, if any.

As the filing of a combined or a consolidated cost report for a chain organization or other group of providers has never been an acceptable practice under the Medicare program, a determination of the amount of program reimbursement based on the erroneous filing of all combined or consolidated cost report by a provider may be reopened by the intermediary within the 3-year period following the date of the notice of program reimbursement issued by the intermediary. (See Part II, § 112.).

2415. DISTINCT PART COST REPORT MUST NOT BE FILED BY FULLY CERTIFIED SNF'S

A fully certified SNF provider may not file a cost report claiming Medicare reimbursement as a distinct part provider. (Section 1861(j) of the Medicare law includes in the definition of the term "skilled nursing facility" a distinct part of a separately operating subunit of an institution.) The determination of program reimbursement due an SNF provider for covered extended care services furnished program beneficiaries during the provider's cost reporting period is dependent on whether the entire institution or only a portion of it is the certified provider.

The determination of whether the entire institution or only a portion of it is the Certified provider is made by the Office of the Regional Director servicing the facility and can be changed only by that office in accordance with the appropriate regulations and implementing procedures applicable to the certification process. This status is not subject to change or interpretation by the intermediary. (See Part II, § 114.).

2416. PAYMENTS TO NONPARTICIPATING HOSPITALS

The Hospital Manual (HIM-10), §§ 202.202.3, and its supplements, the Nonparticipating Domestic Hospital Supplement (HIM-30) and the Foreign Hospital Supplement (HIM-31), contain instructions dealing with payments to nonparticipating domestic hospitals and foreign hospitals for certain inpatient and outpatient services furnished to Medicare beneficiaries, including instructions on the coverage, billing, and reimbursement procedures for such services. Chapter 3 of the manual supplements describes the reimbursement procedures applicable to the affected nonparticipating hospitals.