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