GRADUATE MEDICAL EDUCATION (GME) AND INDIRECT MEDICAL EDUCATION (IME) HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

GRADUATE MEDICAL EDUCATION (GME) AND INDIRECT MEDICAL EDUCATION (IME)

Regulation References: 42 CFR 415.162, 415.164, 415.200, 415.202, 415.206,415.208, 413.24(f)(5) and 413.86

GENERAL:

1. A hospital (either PPS or TEFRA) with an approved graduate medical education (GME) program receives payment for the program on a per-resident amount basis for cost reporting periods beginning on or after July 1, 1985. The per-resident amount is based on a cost per resident in the base year, usually the FY beginning in FY 84, trended forward.

   Hospitals that had no GME programs during the base period, but which start a GME program during a cost reporting period beginning on or after July 1, 1985, are paid on a reasonable cost basis until the per-resident amount is established (see 42 CFR 413.86(e)(4)). The base year in that case is the first Medicare cost reporting period in which residents are on duty during the first month of the period.

   When GME is paid on a cost basis, FIs must verify GME costs, statistics and resident FTEs. FIs must verify and/or audit the intern and resident (I&R) full-time-equivalency units for all hospitals with an approved GME program.

2. The educational costs of I&Rs (and related teaching physician costs) that are in programs that are not approved are not allowable under the Medicare program. The costs associated with the services that the I&Rs in this type of program provide to patients are reimbursed under Part B and should be included in the "I&R Service - Not in Approved Program" cost center. (See 42 CFR 415.202 and PRM-I, §404.1B.) These costs are reimbursed on Worksheet D-2.

3. The FTE count of I&Rs in approved GME programs is counted differently for purposes of the per-resident amount and the IME adjustment. In addition, the way FTEs are counted, for IME purposes, changed effective with cost reporting periods beginning on or after July 1, 1991, from a September 1 count to a total time based FTE count for the cost reporting period. The FTE count for both purposes must be documented in the audit working papers. The FI must also document the number of available bed days during the cost reporting period, excluding beds assigned to newborns, custodial care and PPS excluded units, if not covered in Exhibit 1.

4. The Balanced Budget Act of 1997 (BBA97) revised the laws governing the computation of total direct GME amount and the IME adjustment.

   A. BBA97 GME provisions include: certain limits on the number of FTE I&Rs counted by each hospital; and counting I&Rs on a three-year rolling average except for fiscal year (FY) 1998, when a two-year average will be used.

   B. BBA97 IME provisions include: gradual reduction of the indirect teaching adjustment factors over several FYs; certain limits on the number of FTE I&Rs counted by each hospital; limits on the resident-to-bed ratio; allowance of time spent by I&Rs in non-hospital settings to

be included in the IME adjustment; and counting I&Rs on a three-year rolling average except for FY 1998, when a two-year average will be used.

HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

OBJECTIVES:

1. To verify the approval certificate of (GME) program.
2. Where the GME program is still subject to cost (pass-through) reimbursement, to verify that costs and allocation statistics are accurate.
3. To verify that the counts of intern and resident FTEs used by the provider in its cost report are accurate and correctly applied for both direct GME and IME adjustment purposes.
4. To verify the number of beds reported by the provider in its IME calculation amount, if not covered in Exhibit 1.
5. To verify that intern and resident time allocations are properly supported.
6. To determine that the cost and statistics of patient care services of interns and residents who are in a program that is not approved are properly reimbursed under Part B and any teaching costs associated with the nonapproved programs are excluded from allowable costs.

OTHER REFERENCES:

PRM-I, Section 400, 500, 2100, 2200 and 2500

Cost Report Forms: HCFA-2552, Worksheet A
HCFA-2552, Worksheet A-6
HCFA-2552, Worksheet A-8
HCFA-2552, Worksheet B-1
HCFA-2552, Worksheet D-2
HCFA-2552, Worksheet E, Part A
HCFA-2552, Worksheet E-3, Part IV
HCFA-2552, Worksheet S-3

GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION INDEX

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APPROVAL OF EDUCATIONAL PROGRAMS

1. Identify the approved GME programs in which the hospital participates. An approved GME teaching program is one that meets the criteria stated in 42 CFR 413.86(b). The costs associated with I & Rs who are not in approved programs are not allowable as GME costs. If a GME program has not been approved in accordance with 42 CFR 413.86 at either the provider or the parent institution (that is, another provider, university, or other entity that a provider is associated with for the purpose of participating in GME programs), the educational costs are not allowable under Medicare. Note that the provider does not have to operate the GME program to be able to claim costs for the I&Rs. The program, however, must be approved. Each year under audit, an update to this certification should be obtained for the permanent file.

   Note: Steps 2 through 7 are to be used only if the provider is still subject to cost reimbursement (pass-through) for GME. These steps must also be used to audit a GME base period cost report for hospitals that had no GME programs during Federal FY 1984.

DIRECT GRADUATE MEDICAL EDUCATION (GME)

2. Determine the amount of direct GME costs, by category, included on lines 22 and 23, Worksheet A (Trial Balance of Expenses), of the provider's cost report. You must review the provider's working trial balance of expenses, cost report reclassifications and adjustments (Worksheets A-6 and A-8), general ledger, payroll records and any other hospital accounting records that may be necessary to identify the amount of I&R salaries, teaching physicians' salaries and fees, teaching physician support costs, other teachers' salaries and costs, related medical school costs, and all other salaries and costs that the provider charged to GME.

INTERN AND RESIDENT SALARIES

3. Verify the accuracy of I&R salaries included on Worksheet A, column 1, using the applicable line.

   A. Compare the amount of I&R salaries charged to GME to the sum of the salaries of each individual I&R included based upon the hospital's payroll records.

   B. Review the resident assignment schedules and/or provider documentation to ensure that the following costs are not included in GME: 1.

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Salaries of I&Rs who are employed to replace nonphysician anesthetists.

2. Salaries of I&Rs who are moonlighting (such costs are reimbursable as physician services under Part B; and IRS Form 1099 would indicate that the I&R is not a salaried employee).

3. Salaries of individuals designated as "fellows" who have elected to remain at a teaching hospital/university complex for additional work to gain expertise in a particular field, but who are no longer in a formally organized program to fulfill certification requirements (the services of such an individual are generally covered as physicians' services payable on a reasonable charge basis).

C. Determine that only the salaries of I&Rs who are in approved programs are included in GME. Identify the teaching programs in which the I&Rs are participating, and trace these programs to the program approvals identified in Step 1 above.

PHYSICIAN COMPENSATION

4. Determine that the amount of teaching physicians' compensation included in the GME cost center is reasonable and proper.

A. Verify that the amount of teaching physicians' compensation allocated to GME is attributable only to physicians who have a written allocation agreement with the hospital. Working from the provider's records, identify the physicians whose compensation is charged in whole or part to GME, and ensure there is an allocation agreement for each of these physicians. If there is no allocation agreement for a physician whose compensation is charged to GME, make an adjustment classifying the total compensation as professional component (42 CFR 415.60(f)(2)).

B. Review the reasonableness of the time/percentage of the physicians' services apportioned to GME. Base your review on the provider's records that support the apportionment. Other review procedures that may be performed as a further verification of physician apportionments include face-to-face discussions with the appropriate physicians, and contacting the Medicare carrier to determine the extent of Part B billing.

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Note 1: 42 CFR 415.60(g) requires hospitals to maintain time records or other information that it used to allocate physicians' compensation. In the absence of verifiable records, the physicians' compensation is to be charged entirely to patient services (professional component). See 42 CFR 415.60(f)(2).

Note 2: Only the time a physician spends teaching and supervising I&Rs in approved programs can be included in GME. Time spent in supervising residents in the care of individual patients with whom the supervising physician has established an attending physician relationship is not allowable.

Note 3: Hospitals may claim that the time, or part of the time, reported on line 3 (Administration) of Form HCFA-339, Exhibit 2, represents administrative activities such as scheduling of I&Rs, related to the GME program. This is acceptable if the provider can furnish auditable documentation substantiating such a claim; otherwise, the time from line 3 should not be used to allocate compensation to the GME cost center.

C. Determine if the amount of physicians' compensation allocated to GME is accurate.

1. Review the provider's records and verify the total amount of compensation of each physician whose compensation is included in GME (see PRM-I, §§2108.2, 2182.3A and 2182.6).

2. Apply "Reasonable Compensation Equivalents (RCEs)" to the total amount of physicians' compensation determined in Step C1. RCEs are to be applied by specialty, rather than I&R cost center. This means that you must determine each physician's specialty and apply the appropriate RCE limits to either each physician, or in the aggregate to a group of physicians in the same specialty, but not a group of physicians in various specialties whose compensation was included in the GME cost center (see PRM-I, §2182.6).

RELATED MEDICAL SCHOOL COSTS

5. Allowable medical school costs consist primarily of faculty physician compensation costs but may include some support staff and space costs as well, if they are not duplicative of costs directly incurred by the hospital, and if they are directly related to the provision of patient care services in the

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hospital. Costs incurred by a medical school related to the teaching hospital that are not associated with the training of interns and residents in the hospital must be removed from GME base period costs. Some costs of a related medical school are allowable to the teaching hospital as either operating costs or direct medical education pass-through costs.

Review the accuracy and propriety of costs transferred from a related medical school to the hospital's GME program.

A. Review I&R salaries and physicians' compensation that has been allocated to the hospital's GME program.

B. Review the salary costs of medical school staff, other than teaching physicians, that are allocated in whole or part to the hospital's GME program.

1. Identify the names of the university employees whose salaries are allocated to the hospital's GME program.

2. Review the job descriptions of the individuals identified in Step B1 and other documentation that may be available such as personnel records, time records and agreements between the hospital and university to determine how much or what percentage of the employees' time is devoted to activities associated with the training of I&Rs.

3. Verify the accuracy of the amount of salary costs charged to the hospital's GME program by applying the percentage determined in Step B2 to the individuals' salaries. (It is not necessary to review the university's payroll records to verify the accuracy of the salaries if they appear reasonable.)

C. Verify the accuracy and propriety of the amount of space and occupancy costs charged to GME.

1. Review the university workpapers/documentation and identify the specific areas of the university allocated to the hospital's GME program and the amount of costs associated with each area.

2. Verify the appropriateness of the allocations by determining what portion (or percentage of time, etc.) of the space is used for services relating to the supervision and training of I&Rs. This procedure may require an on-site review of the university

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space and interviews with university and hospital personnel.

3. Review the space and occupancy costs to determine if they are reasonable. This does not mean that you must verify the accuracy of the university's costs, but that the costs apportioned to GME appear consistent with the cost-finding methodology on the university's workpapers, and that no costs that are not reasonably related to the training and supervision of I&Rs are included in the allocation to the hospital.

4. Verify the propriety of the amount of costs allocated to the hospital by applying the percentages in Step C2 to the amount of costs determined in Step C3.

D. Review the reasonableness and propriety of any other medical school costs charged to the hospital's GME program.

E. Ensure that medical school costs allocated to GME were not previously borne by the university.

OTHER GME COSTS

6. Review the propriety of other costs included in GME. Perform tests, as necessary, to determine if other costs are allowable as GME costs, or if they are misclassified or unallowable costs. As stated in 42 CFR 413.85(d), the following activities do not qualify as direct medical education:

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 or graduate work;

C. Costs, including the associated travel expense, of sending employees to educational seminars and workshops for the purpose of increasing the quality of medical care or operating efficiency of the provider;

D. Maintenance of a medical library;

E. Training of a patient or patient's family in the use of medical appliances;

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F. Clinical training of students (that is, medical students and externs) not enrolled in an approved education program operated by the provider; and

G. Other activities that do not involve the actual operation of an approved education program including the costs of interns and residents in anesthesiology who are employed to replace anesthetists.

WORKSHEET B ALLOCATIONS

7. Verify the accuracy of the allocation statistics (Form HCFA-2552, Worksheet B-1) used to allocate indirect costs to GME. Watch for the following activities:

A. The total square feet of hospital-based physicians' offices has been included in the I&R cost center for the purpose of allocating capital-related costs and operating costs such as Operation and Maintenance of Plant, and Housekeeping.

Only a proportional share of the office space should have been included in the I&R cost center based upon the percentage of the physicians' time spent teaching and supervising I&Rs. If a physician is not teaching or supervising I&Rs, none of the physician's office space can be included in the I&R cost center.

B. Classroom and conference room square feet included in the I&R cost center was not proportional to the actual use of the rooms for I&R activities.

C. The square footage of the medical library was included in the GME cost center.

D. The statistics used to allocate cafeteria costs to GME included a disproportionate amount of teaching physicians' time (or meals) instead of reflecting the proportionate amount of time that the physicians actually spend teaching and supervising I&Rs.

GME INTERN & RESIDENT FTE COUNT

8. Review the provider's current year listing of all interns and residents to be included in the GME count (submitted in accordance with 42 CFR 413.86(I)). Review the provider's records, such as assignment schedules, IRIS diskette or equivalent documentation, to verify the accuracy of the listing. Ensure that residents physically located at the

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provider site are counted for GME purposes even though payment may not be made by the provider. Residents not working at the provider site should not be included in the count except as provided in 42 CFR 413.86(f)(3) and (4).

A. Obtain a listing of residents in approved programs working at the hospital during the cost reporting period (42 CFR 413.86(I)).

B. Test that the following interns and residents are not included in the medical education count:

- those in unapproved programs
- those replacing nonphysician anesthetists
- moonlighting interns and residents or fellows no longer in a formally organized program fulfilling certification requirements

C. Ensure residents are not claimed by more than one hospital for the same time period, and are not counted as more than one GME-FTE.

Note: The FI should identify and resolve these potential duplications through the use of data from the Intern and Resident Information System (IRIS). Each hospital is required to submit this data on an IRIS diskette along with its Medicare cost report.

D. Verify the full-time or part-time status of each resident who qualifies to be included in the count under Step 8B. To make this determination, obtain from the hospital, or the entity operating each GME specialty program, copies of the residents' employment contracts and/or other reliable documentation. The contracts generally contain information regarding the residents' part-time status.

Using this information, verify that the appropriate base FTE number was computed for each resident. For example, if other residents in the same specialty work an average number of 60 hours each week and the resident whose full/part time status is being determined works 35 hours each week, that resident is counted at 0.58 FTE. Note that a resident may not be counted as more than one FTE regardless of the number of hours the resident works.

E. Determine the total number of years the resident has completed in all types of approved residency programs

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and compare it to the initial residency period specified in 42 CFR 413.86(g)(1). The initial residency period refers to the minimum number of years necessary to satisfy the requirements for initial board eligibility for a specialty initially chosen by the resident during the first year (or second year for those residents in first year transitional or rotating internship) of post graduate training.

Obtain information on the minimum number of years required for board eligibility for residency programs in allopathy, osteopathy, podiatry, and dentistry from the Table of Initial Residency Limitations in the September 29, 1989 Federal Register (54 FR 40320-40321) for residents beginning training before July 1, 1995, and the August 30, 1996 Federal Register (61 FR 46208-46211) for residents beginning training on or after July 1, 1995.

Note: In the case where a discrepancy exists between the length of an initial residency period for a specialty published in the Federal Register and in the most recent edition of the Graduate Medical Education Directory (allopathic specialties only) or other applicable publications for non-allopathic specialties, the Directory or other publications should be the guiding source.

In all cases, the initial residency period cannot exceed five years except for fellows in an approved geriatric program whose initial residency period may last up to two additional years. (See 42 CFR 413.86(g)(1)).

Verify that the appropriate initial residency weighting factor was applied to each resident.

Note: Subject to special rules concerning foreign medical graduates (FMGs), in Step 8F, the weighting factor for each resident in an initial residency period is 1.0. Residents not in an initial residency period are assigned a weight of 0.5.

F. Determine whether the interns and residents data submitted by the provider identifies FMGs. If so, check whether the FMGs passed the FMGEMS, or USMLE before being counted as FTEs.

G. Using copies of GME contracts with nonhospital (previously referred to as nonprovider) entities and intern and resident assignment schedules (or similar documents), verify whether the hospital accurately determined the proportion of total time worked by each

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resident that can be used in the final computation of an FTE for that resident.

Note: On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999, in addition to the time the residents work at the hospital complex, the hospital can include the time worked by the residents in patient-care activities in nonhospital settings (for example, freestanding clinics, nursing homes and physicians' offices) if there is a written agreement between the hospital and the entity specifying that the hospital will compensate the residents for training time spent in the outside setting (42 CFR 413.86(f)(3)).

For portions of cost reporting periods occurring on or after January 1, 1999, in addition to the time the residents work at the hospital complex, the hospital can include the time worked by the residents in patient-care activities in nonhospital sites if there is a written agreement between the hospital and the nonhospital site. The agreement must indicate (1) the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities, and (2) the compensation the hospital is providing to the nonhospital site for supervisory teaching activities. In order for the hospital to count residents at the nonhospital site, it must **actually** incur all or substantially all of the costs for the training program, as defined in 42 CFR 413.86(b), in the nonhospital site. (See 42 CFR 413.86(f)(4).)

H. Test the computation of the final FTE count to ensure that part-time status percentages, weighting factors for initial residency period and FMGs, and the proportion of time percentages (Step 8.G.) were accurately incorporated into this computation.

I. Verify the hospital's unweighted FTE count of residents in a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine for cost reporting periods beginning on or after October 1, 1997 is limited to the unweighted hospital's FTE count of allopathic and osteopathic residents for the most recent cost reporting period ending on or before December 31, 1996. This limit does not apply to residents in dentistry and podiatry.

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Note: The hospital must have submitted to their FI auditable documentation verifying its FTE count of residents (before application of the initial residency period limit) for the most recent cost reporting period ending on or before December 31, 1996. The documentation should be compared with assignment schedules, data from IRIS diskette or equivalent documentation as part of that audit by the FI.

J. Adjustments (increases) to the hospital's unweighted FTE resident count (Step 8.I.) may be made for the following circumstances:

1. A hospital that had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new residency training program on or after January 1, 1995. The program is considered newly established if it receives initial accreditation by the appropriate accrediting body, or begins training residents on or after January 1, 1995. The auditor is to determine whether the program is newly established as described above, and whether the hospital made correct adjustments to the FTE limit as specified in 42 CFR 413.86(g)(6)(I).

2. A hospital that had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and established new residency training programs on or after January 1, 1995 and on or before August 5, 1997. The auditor is to determine whether the hospital does have newly established programs as described above, and made correct adjustments to the FTE limit as specified in 42 CFR 413.86(g)(6)(ii).

   Note: For new medical residency training programs established after August 5, 1997, adjustments to the FTE limit for hospitals located in rural areas (or other hospitals located in rural areas which added residents under 42 CFR 413.86(g)(6)(I)) may be made in the same manner as specified in 42 CFR 413.86(g)(6)(ii). Refer to 42 CFR 413.86(g)(6)(iii).

3. A hospital that began construction of its facility on or before August 5, 1997, sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate

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accrediting body or temporarily trained residents at another hospital(s) until the facility was completed.

The auditor is to determine whether the hospital made correct adjustments to the FTE limit as specified in 42 CFR 413.86(g)(7).

Note: This provision is applicable during portions of cost reporting periods occurring on or after October 1, 1999.

4. A hospital that assumed the training of displaced residents from a hospital that closed on or after July 1, 1996. The auditor is to determine whether the hospital has submitted a timely and satisfactory request to their FI for a temporary adjustment to the FTE limit in accordance with 42 CFR 413.86(g)(8).

K. Determine whether the hospital is a member of an affiliated group for GME purposes from FI records. (Refer to 42 CFR 413.86(b) for a definition of an affiliated group.) If so, the hospital may adjust (increase/**decrease**) its unweighted FTE resident count (Step 8.I.) in accordance with the group's agreement on implementing the FTE limit or cap on an aggregate basis. The auditor is to validate the adjustment to the FTE limit for GME purposes.

Note: Specific instructions for implementing the affiliated group FTE cap are included in the May 12, 1998 Federal Register (63 FR, Pages 26338-26341), and in the July 30, 1999 Federal Register (63 FR, page 41524).

L. Compare the updated per-resident amounts from the FI files to the amounts shown on the cost report and propose any necessary adjustment.

M. For cost reporting periods beginning on or after October 1, 1997, ensure the computation of total direct GME amount on Worksheet E-3, Part IV is done correctly in accordance with line instructions in PRM-II, § 3633.4.

BED COUNT FOR INDIRECT MEDICAL EDUCATION (IME) PAYMENT

Do not perform the following if already covered in Exhibit 1, Step 10.

9. Ascertain the number of beds approved and available for

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patient care during the cost reporting period. Determine the number of beds in a hospital by counting the number of available bed days during the cost reporting period. Exclude beds assigned to newborns, custodial care and PPS excluded distinct part hospital units. Divide that number by the number of days in the cost reporting period. If you cannot be reasonably certain of the bed count or where changes have taken place:

A. Ensure that the bed count at the end of the period for each accommodation area is properly recorded on the cost report.

B. Compare the number of beds with the number in the prior year. Where there is a difference, obtain an explanation.

C. Check board minutes to see if any areas of the hospital were closed or if the number of beds were reduced during the cost reporting period.

D. Ensure that neo-natal intensive care unit beds are included in the bed count for IME when the beds represent a separate cost center qualified as a special care unit. If neo-natal beds are nursery beds, they should be excluded from the count.

IME INTERN & RESIDENT FTE COUNT

10. Review the provider's current year listing of all interns and residents to be included in the IME count (submitted in accordance with 42 CFR 412.105(f)(2)). Review the provider's records, such as assignment schedules, IRIS diskette or equivalent documentation, to verify the accuracy of the listing. Ensure that residents physically located at the provider site are counted for IME purposes even though payment may not be made by the provider. Residents not working at the portion of the hospital subject to PPS or the outpatient department of the hospital should not be included in the count except as provided in 42 CFR 412.105(f)(1)(ii)(C).

A. Obtain a listing of interns & residents in approved programs working at the hospital during the cost reporting period (42 CFR 412.105(f)(2)).

B. Verify that the following interns and residents are not included in the listing:

- Those in unapproved programs.

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- Those employed to replace nonphysician anesthetists.
- Moonlighting I&Rs or fellows no longer in a formally organized program fulfilling certification requirements.

C. Ensure residents are not claimed by more than one hospital for the same time period, and are not counted as more than one IME-FTE.

Note: The FI should identify and resolve these potential duplications through the use of data from the Intern and Resident Information System (IRIS). Each hospital is required to submit this data on an IRIS diskette along with its Medicare cost report.

D. Determine the full-time or part-time equivalent status of each intern and resident who worked at the hospital (inpatient and outpatient areas) during the cost reporting period in accordance with 42 CFR 412.105(f)(1)(iii).

E. Using the information from the I&R listing (Step 10A) and assignment schedules (or similar documentation), verify the number of days or hours during the cost reporting period worked by each resident in the part of the hospital subject to PPS and the hospital's outpatient departments. Test to ensure that time worked by the I&Rs in the following is not classified as time worked in the part of the hospital subject to PPS:

- Other hospitals (take IRIS data into account).
- Other freestanding providers (see note).
- Nonhospital (previously referred to as nonprovider) setting (see note).
- Excluded units of the hospital.
- Hospital-based SNF, ICF, HHA, CORF, or hospice.
- Research.

Note: Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth at 42 CFR 413.86(f)(4) are met.

Also, verify the <u>total</u> time worked by each resident in all settings during the cost reporting period.

F. Determine whether the provider correctly computed the

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proportion of time worked by each resident in the portion of the hospital subject to PPS and the hospital's outpatient departments. Use information from Step E to make this test.

G. Verify the computation of the final FTE count to ensure that part-time status percentages and the proportion of time percentages (Step 10.F.) were accurately incorporated into this computation.

H. Verify the hospital's FTE count of residents in a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine for discharges occurring on or after October 1, 1997 is limited to the hospital's FTE count of such residents for the most recent cost reporting period ending on or before December 31, 1996.

I. Determine whether the hospital (1) established new residency training programs on or after January 1, 1995, or (2) assumed the training of displaced residents from a hospital that closed on or after July 1, 1996. If so, repeat Step 8.J. for validating the adjustment to the FTE limit for IME purposes.

J. Determine whether the hospital is a member of an affiliated group for IME purposes from FI records. (Refer to 42 CFR 413.86(b) for a definition of an affiliated group.) If so, the hospital may adjust (increase/**decrease**) its FTE resident count (Step 10.H.) in accordance with the group's agreement on implementing the FTE limit or cap on an aggregate basis. Repeat Step 8.K. for validating the adjustment to the FTE limit for IME purposes.

K. For cost reporting periods beginning on or after October 1, 1997, ensure the computation of indirect medical education adjustment on Worksheet E, Part A is done correctly in accordance with line instructions in PRM-II, § 3630.1.

NONAPPROVED PROGRAMS

11. If cost was reported in the Interns and Residents Not In Approved Teaching Program cost center, determine whether it pertains to an educational program that is not approved or to moonlighting residents.

A. If the cost applies to an educational program(s) that is

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not approved, determine through a review of the general ledger subaccounts for the Interns and Residents in Nonapproved Programs account, teaching physicians records and any other documentation, whether teaching and other educational costs were included in the cost center.

In accordance with PRM-I, §404.2B, the teaching and other educational costs associated with the nonapproved programs are not allowable. Therefore, propose an audit adjustment to transfer these costs to a nonallowable cost center (if overhead is applicable) or delete them through a Worksheet A-8 entry.

Note: The cost (salaries, fringe benefits and overhead) related to services provided to program beneficiaries by I&Rs either employed by a hospital without a teaching program or in conjunction with a teaching program that is not approved, are reimbursable under Part B. The costs related to services provided to Program beneficiaries by I&Rs, who are fully licensed medical doctors acting outside the scope of their residency program (moonlighting) are not reimbursable through the cost report; however, these services are billable to the Part B carrier as any other provider-based physician service.

B. Verify that the provider maintained "assignment records" for the I&Rs and the percentages shown in Worksheet D-2, Part I, Column 1, are accurately reported for each area.

C. Review the provider's documentation supporting the Part B days shown on Worksheet D-2 and propose an audit adjustment if those days were incorrectly reported.