LESSER OF COST OR CHARGES

Regulation Reference: 42 CFR 413.13, 413.30 and 413.35

GENERAL: Under the regular Medicare payment system, in the determination of allowability of provider costs, the costs determined to be in excess of those necessary in the efficient delivery of needed health care services are excluded. Therefore, cost limits could be imposed on direct or indirect overall costs, costs of specific items or services or groups of items or services. Cost limits on inpatient operating cost do not apply to outpatient services or to the cost of research.

The provision of lesser of cost or charges is effective for all providers except for the following:

- Public providers furnishing services free of charge or at a nominal charge that are paid fair compensation for services furnished to beneficiaries.
- Providers furnishing services to a significant portion of low-income patients. A provider furnishing services at a nominal charge is paid fair compensation upon request for services furnished to beneficiaries if the provider can demonstrate to its intermediary that a significant portion of its patients are low income and that its charges are less than costs because its customary practice is to charge patients based on their ability to pay.
- Part A inpatient hospital services subject to:
  - The rate-of-increase limits or PPS

  Notes: 1. The aggregation method for Parts A and B of computing the lesser of cost or charges may not be used.

  2. Separate aggregation is required for each of the following hospital outpatient services:
     - Ambulatory surgical procedures
     - Radiology services
     - Other diagnostic services
     - Providers may no longer carry forward costs that are unreimbursed from previous periods. However, unreimbursed costs that had previously been carried forward at the beginning of this period are still recoverable under the normal two-year rule (five years for new providers). See 42 CFR 413.13(h)(1) and (5).

OBJECTIVES: 1. To ensure that reimbursement primarily for outpatient services is limited to the lesser of the reasonable cost of providing services to beneficiaries or the customary charges made by the provider for the same services.

OTHER REFERENCES:

PRM-I, §§2500 and 2600

Cost Report Forms: Hospital:

HCFA-2552, Worksheet S-3
HCFA-2552, Worksheet D-1, Part I
HCFA-2552, Worksheet E, Parts B, C, D and E
HCFA-2552, Worksheet E-3
HCFA-2552, Worksheet E-4

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HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

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LESSER OF COST OR CHARGES

1. Ascertain whether the lesser of cost or charges policy is applicable.

   A. If not done at desk review, determine if this provider has a nominal charge structure (see first two bullets under the General section).

   B. Review the provider's procedures for billing and collecting from other third party payers and private patients to determine customary charges (see Exhibit 2).

   C. Where it is determined that the provider's gross charges do not represent customary charges, determine on an overall basis (inpatient ancillary and routine, and outpatient ASC, outpatient radiology, outpatient other diagnostic, and all other Part B services) the percentage that customary charges are of gross charges. Propose an adjustment to reduce Medicaid charges to customary charges using this percentage for comparison with Medicaid reasonable cost.

   D. Ascertain that the Medicaid charges exclude noncovered items and services, professional charges and the PBP component (see Exhibit 2). Propose an audit adjustment, where necessary.

NOMINAL CHARGE/SLIDING SCALE PROVIDERS

2. For those providers subject to the lesser of cost or charges with a nominal charge structure, verify:

   A. Reimbursement of fair compensation - Public providers and providers with a significant portion of low-income patients that request payment under this paragraph are reimbursed fair compensation if total charges are 60 percent or less of the reasonable cost of services or items represented by these charges.

   B. Separate determination of nominal charges - The determination of nominal charges based on charges actually billed to charge-paying, non-Medicare patients, is made separately with respect to inpatient and outpatient services (other than clinical diagnostic laboratory tests).

   C. For providers that have a sliding scale or discounted schedule of charges based on the patients' ability to pay -

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The determination of nominal charges is based on charges billed to all charge-paying patients. This determination is made using the ratio of sliding scale or discounted charges to the provider's full customary charges. For determining nominal charges, the ratio is applied to the provider's Medicare charges to equate those charges to customary charges.

D. Propose an audit adjustment, where necessary.

EXCEPTIONS TO COST

3. Tests should be made to determine the reasonableness of cost for comparison with customary charges.

   A. Adjustments made to cost during the audit must be properly reflected on the lesser of cost or charges computation.

   B. Further adjustments must be made to these costs prior to comparison with customary charges. These adjustments are as follows:

      1. Costs resulting from (see Exhibit 6):

         a. Recovery of excess of depreciation when a provider terminates or has a reduction in its Medicare utilization, as described in PRM-I, §136.

         b. Disposition of depreciable assets, as described in PRM-I, §§130 and 132.

      2. Administrative costs incurred after a provider terminates participation in the Medicare program and that are included in the final cost report as provided for in PRM-I, §2176 (see Exhibit 6).

      3. Payments to funds for donated services of teaching physicians, as described in PRM-I, §2608.C.

      4. Unanticipated extraordinary expenditures immediately following the end of the final cost reporting period for unemployment compensation paid to former employees described in PRM-I, §2608.E.

      5. Costs incurred before cessation of operations and termination of program participation, represented by

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a subsequent lump-sum pension plan payment as described in PRM-I, §2608.F.

6. Severance pay due to cessation of operations and termination of program participation described in PRM-I, §2608.G.

Propose an audit adjustment, where necessary.