DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

DEC 22 2004

Mr. Michael P. Lewis
Financial Review Services, Inc.
4295 San Felipe
Suite 250
Houston, Texas 77027-2924

Dear Mr. Lewis:

Thank you for your letters regarding the reporting of hospital charges. Although you have received responses from several regional offices in the Centers for Medicare & Medicaid Services (CMS), and agree with those responses, you have requested a separate response from the CMS central office. Specifically, you raise an issue regarding the difference between "routine services" as defined in section 2202.6 of the Provider Reimbursement Manual (PRM), Part 1, and items that are "routinely used."

The PRM section 2202.4 provides that a provider's charges should be related consistently to the cost of the services and uniformly applied to all patients, inpatient or outpatient, and that those uniform charges are used in determining Medicare's payment on the Medicare cost report. The PRM section 2203 emphasizes that while Medicare does not dictate a provider's charge structure, it determines if the charges are appropriate for the cost report.

The PRM sections 2202.6 and 2202.8 address routine and ancillary services. In particular, they address items and services furnished to patients in the general routine care and intensive care areas as part of the "room and board" charge and to additional items and services for the patients which are charged separately as ancillary services by the provider's ancillary departments. They also encompass the concept of routine versus ancillary charges in ancillary departments; i.e., a basic "routine" charge for a department plus additional charges for items and services to specific patients.

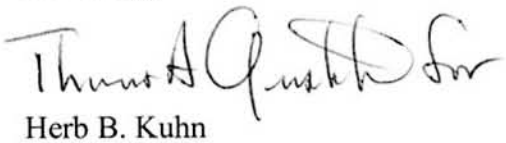
Medicare does not dictate a provider's charge structure or how it itemizes charges but does determine whether charges are acceptable for Medicare purposes. A hospital's fiscal intermediary is the first recourse to discuss specific issues of routinely furnished items and services versus separate charges for additional items and services, both for inpatient general routine room and board services and for services in ancillary departments. However, for ancillary departments, section 2202.8 does not specifically address which items and services are part of the basic "routine" charge and which are charged in addition to the basic charge. Therefore, we do not see an issue in your examples of a hospital's having a basic ancillary department charge for the room with additional charges for other items and services furnished to patients depending on the procedure, as long as the various charges are reasonably and consistently related to the cost of the services to which they apply and are uniformly applied

(sections 2202.4 and 2203). This applies to any ancillary department, including the departments you cited.

As the regional offices indicated, in billing Medicare, the charges are aggregated by revenue code on Form CMS-1450, known as the UB-92. Total charges for each revenue code are later associated with the corresponding ancillary cost centers (departments) on the cost report to be used in determining Medicare cost. While most Medicare payment is now made on a prospective payment system (PPS) basis, cost report data continue to be used in a variety of ways, including cost reimbursement for some types of providers and for certain services in other providers and in making outlier payments under PPS.

Thank you for your interest in this issue. If you have further comments or questions, please contact John Eppinger of my staff at 410-786-4518.

Sincerely,



Herb B. Kuhn
Director
Center for Medicare Management

cc:
Paula Hammond-McNatt, Dallas RO
Christine Davidson, Chicago RO
Mike Taylor, Atlanta RO
Nanette Foster Reilly, Kansas City RO