DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Division of Financial Management and Program Initiatives, Region VI

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August 22, 2002

Ms. Rebecca, K. Lambeth
Haynes and Boone, LLP
600 Congress Avenue
Suite 1600
Austin, Texas 78701-3236

Dear Ms. Lambeth:

We are responding to your letter dated July 29, 2002 regarding Medicare

1. The language in PRM section 2203 that "the Medicare program cannot dictate to a provider what its charges or charge structure may be" comes from section 1801 of the Social Security Act which states that "nothing in this title shall be construed to authorize any Federal officer or employee ... to exercise any supervision or control over the administration or operation of any such institution..."

2. PRM Section 2204, Medicare Charges, which states, in part, that the "Medicare charge for a specific service must be the same as the charge made to non-Medicare patients...." It needs to be read in the light of section 2203 which makes clear that consistent charging is required for a proper determination of Medicare cost-based payment but that Medicare can't mandate consistent charging.

3. Medicare provisions to a large extent and in many ways address how a provider generally handles it charges and costs and therefore that the provisions generally apply to costing and charging for all of a provider's patients - but with the clear caveat that Medicare cannot force a provider to follow certain charging and costing policies but rather only can require adjustments, if necessary, for Medicare reimbursement purposes.

4. The policy on charges has been in the PRM for many years, long before 1990.

Medicare's position has always been that for Medicare payment purposes, a provider should have the same charge for the same service for all patients, in the inpatient or outpatient setting. The most important reason is a proper apportionment of a provider's costs to Medicare for providers reimbursed on a cost reimbursement basis. While few providers remain on a cost reimbursement basis, the

principle remains applicable for proper completion of Medicare cost reports, which still are required of most providers.

If a provider has a different charge structure for certain services provided in the inpatient setting than in the outpatient setting or for different classes of patients, e.g., Medicare patients v. other classes of patients, Medicare expects the provider to adjust the charges for Medicare reporting purposes to reflect the same consistent charge for all patients in all settings. If the provider does not do so, Medicare has always expected the Medicare intermediary to require the provider to do so or, if the provider does not, to make appropriate adjustments itself. The adjustments are often referred to as "grossing-up" the charges, i.e., raising/adjusting certain charges to reflect a consistent charge level for Medicare purposes.

If you have any other questions, please feel free to call me at (214) 767-4442 .

Sincerely,

Lorraine Lee

Lorraine Lee, Accountant
Medicare Financial Management Branch
Division of Financial Management and
Program Initiatives

PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

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SEC. 1801. *[42 U.S.C. 1395]* Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.