CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1072	**Date: OCTOBER 6, 2006**
	Change Request 5286

Subject: Inpatient Prospective Payment System (IPPS) Outlier Reconciliation Technical Corrections

I. SUMMARY OF CHANGES: CMS is making procedural and other minor corrections to outlier payments under the Inpatient Prospective Payment System.

Clarification
Effective Date: November 6, 2006
Implementation Date: November 6, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/20.1.2.1/Cost-toCharge Ratios
R	3/20.1.2.2/Statewide Average Cost-to-Charge Ratios
R	3/20.1.2.5/Reconciliation
R	3/20.1.2.7/Procedure for Fiscal Intermediaries to Perform and Record Outlier Reconciliation Adjustments

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1072	Date: October 6, 2006	Change Request 5286

SUBJECT: Inpatient Prospective Payment System (IPPS) Outlier Reconciliation Technical Corrections

I. GENERAL INFORMATION

A. Background:

Section 1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. This additional payment known as an "Outlier" is designed to protect the hospital from large financial losses due to unusually expensive cases. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers), which is published in the annual Inpatient Prospective Payment System final rule. The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.

Under 42 CFR §412.84(i)(4), for discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the cost-to-charge ratio (CCR) used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred.

In addition, under 42 CFR §412.84(i)(4), effective for discharges occurring on or after August 8, 2003, at the time of reconciliation under paragraph (i)(3) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based on a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

B. **Policy:** This transmittal is a follow up to change request 3966 and further clarifies the instructions to FIs on how to implement the policies of IPPS reconciliation and applying the time value of money to reconciliation.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5286.1	For non-IPPS hospitals (e.g., long term care, psychiatric, or rehabilitation hospitals, etc.) that convert to IPPS status, or IPPS hospitals that maintain their IPPS status but receive a new IPPS provider number, FIs may apply the Statewide average.	X								A/B MAC
5286.1.2	As noted in section 20.1.2.1 part C, the FI or the hospital may request use of a different CCR (as an alternative to the Statewide average or the tentatively settled CCRs), such as a CCR based on the cost and charge data from the hospital’s cost report before it converted to IPPS status, or received a new provider number. The FI shall verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS central and regional offices.	X								A/B MAC
5286.2	If it is determined by the FI that a hospital meets the criteria of reconciliation, the FI shall send notification to the CMS central (not the hospital) via the street address or email address provided in section 20.1.2.1 (B) and CMS Regional Office that a hospital has met the criteria for reconciliation.	X								A/B MAC
5286.2.1	If the FI receives approval from the CMS central office that reconciliation is appropriate, the FI shall follow steps 3-8 in section 20.1.2.7.	X								A/B MAC

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies:

F. Testing Considerations:

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: November 6, 2006 **Implementation Date:** November 6, 2006 **Pre-Implementation Contact(s):** Michael Treitel 410-786-4552 michael.treitel@cms.hhs.gov Brian Slater 410-786-5229 brian.slater@cms.hhs.gov **Post-Implementation Contact(s):** Michael Treitel 410-786-4552 michael.treitel@cms.hhs.gov Brian Slater 410-786-5229 brian.slater@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

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Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

(Rev. 1072, 10-06-06)

20.1.2.1 - Cost to Charge Ratios
(Rev. 1072, Issued: 10-06-06; Effective/Implementation Date: 11-06-06)

A. Calculating a Cost-to-Charge Ratio

For IPPS outlier calculations, Medicare's portion of hospital costs *is* determined by using hospital specific cost-to-charge ratios (CCRs). At the end of the cost reporting period, the hospital prepares and submits a cost report to its FI, which includes Medicare allowable costs and charges. The FIs complete a preliminary review of the as-submitted cost report and issue a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and an NPR is issued.

The FI shall update the PSF using the CCR calculated from the final settled cost report or from the latest tentative settled cost report (whichever is from the later period). Effective November 7, 2005, the following methodology shall be used to calculate a hospital's operating and capital CCRs.

Inpatient PPS Operating CCR

1) Identify total Medicare inpatient operating costs from the Medicare cost report, from Worksheet D-1, Part II, line 53. (If a positive amount is reported on line 42 for nursery costs, subtract this amount on line 42 from the amount on line 53).

2) Identify total Medicare inpatient operating charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.

3) Determine the Inpatient PPS operating CCR by dividing the amount in step 1 by the amount in step 2.

Inpatient Capital CCR

1) Identify total Medicare inpatient capital cost from Worksheet D Part 1, column 10, sum of lines 25 through 30, plus column 12, sum of lines 25 through 30 plus Medicare inpatient ancillary capital costs from Worksheet D Part II, column 6, line 101 plus column 8 line 101.

2) Identify total Medicare inpatient capital charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.

3) Determine the Inpatient PPS capital CCR by dividing the amount in step 1 by the amount in step 2.

B. Use of Alternative Data in Determining CCRs For Hospitals and Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS

For discharges before August 8, 2003, FIs used the latest final settled cost report to determine a hospital's CCRs. For those hospitals that met the criteria in part I. A. of PM A-03-058 (July 3, 2003), effective for discharges occurring on or after August 8, 2003 FIs are to use alternative CCRs rather than one based on the latest settled cost report when determining a hospital's CCR (to download PM A-03-058, visit our Web site at *http://www.cms.hhs.gov/Transmittals/Downloads/A03058.pdf*). For all other hospitals, effective October 1, 2003, FIs are to use CCRs from the latest final settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a hospital's operating and capital CCRs.

The FIs shall continue to update a hospital's operating and capital CCRs each time a more recent cost report is settled (either final or tentative). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCRs.

Effective August 8, 2003, the central office may direct FIs to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, if the FI finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the FI shall notify the CMS regional office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs and/or charges. The regional office, in conjunction with the central office, must approve the FI's request before the FI may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all IPPS claims processed after the update. FIs shall send notification to the central office via the following address and email address:

CMS
C/O Division of Acute Care- IPPS Outlier Team
7500 Security Blvd
Mail Stop C4-08-06
Baltimore, MD 21244
outliersIPPS@cms.hhs.gov

C. Request for use of a Different CCR

Effective August 8, 2003, *CMS (or the FI) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition,* a hospital will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The hospital is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the

FI has evaluated the evidence presented by the hospital, the FI notifies the CMS regional office and CMS Central Office of any such request. The CMS regional office, in conjunction with the CMS Central Office, will approve or deny any request by the hospital *or FI* for use of a different CCR. FIs shall send requests to the CMS Central Office using the address and email address provided above.

D. Notification to Hospitals Under the IPPS of a Change in the CCR

The FI shall notify a hospital whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. FIs can also issue separate notification to a hospital about a change to their CCR(s).

E. Hospital Mergers*, Conversions,* and Errors with CCRs

Effective November 7, 2005, for hospitals that merge, FIs shall continue to use the operating and capital CCRs from the hospital with the surviving provider number. If a new provider number is issued, as explained in §20.1.2.2 below, FIs *may* use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR 412.84 (i)(3)(i), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement). F*or non-IPPS hospitals (e.g., long term care, psychiatric, or rehabilitation hospitals) that convert to IPPS status, or IPPS hospitals that maintain their IPPS status but receive a new IPPS provider number the Statewide average CCR may be applied to that hospital. However, as noted in part C above, the FI or the hospital may request use of a different CCR, such as a CCR based on the cost and charge data from the hospital's cost report before it converted to IPPS status, or received a new provider number. The FI must verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS central and regional offices.*

In instances where errors related to CCRs and/or outlier payments are discovered, FIs shall contact the CMS Central Office to seek further guidance. FIs may contact the CMS Central Office via the address and email address listed in part B of this section.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, FIs should contact the CMS regional and Central Office for further instructions. FIs may contact the CMS Central Office via the address and email address listed in part B of this section.

F. Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, FIs shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on

a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 -Operating Cost to Charge Ratio -27 -SSI Ratio -28 -Medicaid Ratio -47 -Capital Cost to Charge Ratio 49 -Capital IME and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary.

20.1.2.2 - Statewide Average Cost-to-Charge Ratios

(Rev. 1072, Issued: 10-06-06; Effective/Implementation Date: 11-06-06)

For discharges prior to August 8, 2003, Statewide average CCRs are used in those instances in which a hospital's operating or capital CCRs fall above or below reasonable parameters. CMS sets forth these parameters and the Statewide average CCRs in each year's annual notice of prospective payment rates.

For discharges occurring on or after August 8, 2003, the FI may use a Statewide average CCR if it is unable to determine an accurate operating or capital CCR for a hospital in one of the following circumstances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18.)
2. Hospitals whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b) of the CFR.
3. Other hospitals for whom accurate data with which to calculate either an operating or capital CCR (or both) are not available.

However, the policies of §20.1.2.1 part C *and part E* can be applied as an alternative to the Statewide average.

For those hospitals assigned the Statewide average operating and/or capital CCRs, these CCRs must be updated every October 1 based on the latest Statewide average CCRs published in each year's annual notice of prospective payment rates until the hospital is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of §20.1.2.1 part C of this manual.

A hospital is *not* assigned the Statewide average CCR if its CCR falls below 3 standard deviations from the national mean CCR. In such a case, the hospital's actual operating or capital CCR is used.

20.1.2.5 - Reconciliation

(Rev. 1072, Issued: 10-06-06; Effective/Implementation Date: 11-06-06)

A. General

Under 42 CFR § 412.84(i)(4), for discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. This new regulation was implemented in two phases (further explanation on these two phases is provided below). Hospitals that FIs identified using the criteria in section I.A. of PM A-03-058 (under which FIs identified hospitals whose charges appeared to have been increasing at an excessive rate) are subject to the reconciliation policies described in this section for discharges occurring on or after August 8, 2003. For all other hospitals, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

Subject to the approval of the CMS central office, a hospital's outlier claims will be reconciled at the time of cost report final settlement if they meet the following criteria:

1. The actual operating CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

2. Total outlier payments in that cost reporting period exceed $500,000.

To determine if a hospital meets the criteria above, the FI shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual operating CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, FIs shall follow the instructions below in §20.1.2.7. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.

The first criterion requires a 10 percentage point fluctuation in the operating CCR *only* (and not the capital CCR). However, if a hospital meets both criteria, claims will be reconciled using the operating and capital CCRs from the final settled cost report.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), FIs shall notify the CMS regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent to the address and email address provided in §20.1.2.1 (b).

Any cost report that has been final settled prior to the *initial* issuance of this manual revision *(CR 3966, Transmittal 707 October 12, 2005)* that meets the qualifications for reconciliation shall be reopened. FIs shall notify the CMS Central Office and regional office that the outlier payments need to be reconciled, using the procedures in §*20.1.2.7*. *After CMS's approval of the reconciliation, the FI shall issue a reopening notice to the provider.*

B. Reconciling Outlier Payments for those Hospitals Identified in PM A-03-058

As stated above, for a hospital that met the criteria in section I.A. of PM A-03-058, reconciliation begins for discharges occurring on or after August 8, 2003. To establish whether a hospital's outlier payments are subject to reprocessing, FIs determine if the CCR and total outlier payments from the entire cost reporting period meet the two criteria in part A of this section. However, if both criteria for reconciliation are met, only the discharges that occurred between August 8, 2003 and the end of the cost reporting period will be reconciled. These hospitals will be subject to reconciliation in subsequent cost reporting periods if they meet the two criteria outlined in part A of this section. See example A below.

The FIs shall notify the regional office and CMS Central Office of any hospital that meets the criteria for reconciliation. Notification to the CMS Central Office shall be sent to the address and email address provided in *§*20.1.2.1. Further instructions for FIs on reconciliation and the time value of money are provided below in §§20.1.2.6 *and 20.1.2.7*.

EXAMPLE A:

Cost Reporting Period: 09/01/2002-08/31/2003

Operating CCR used to pay original claims submitted during cost reporting period: 0.40
(In this example, this CCR is from the tentatively or final settled 2002 cost report)
Final settled operating CCR from 09/01/2002-08/31/2003 cost report: 0.50

Total outlier payout in 09/01/2002-08/31/2003 cost reporting period: $600,000
Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the provider's claims for discharges from August 8, 2003 through August 31, 2003 shall be reconciled using the correct CCR of 0.50. The same criteria shall be applied to the cost report beginning on 09/01/2003 to determine whether reconciliation of outlier payments for that cost reporting period is necessary. For details on how to apply multiple CCRs in a cost reporting period, see example C below.

C. Reconciling Outlier Payments for those Hospitals Not Identified in PM A-03-058

Beginning with the first cost reporting period starting on or after October 1, 2003, all hospitals are subject to the reconciliation policies set forth in this section. If a hospital meets the criteria in part A of this section, the FIs shall notify the regional office and central office at the address and email address provided in *§*20.1.2.1. Further instructions for FIs on reconciliation and the time value of money are provided below in *§§*20.1.2.6, 20.1.2.7 and 20.1.2.8. The following examples demonstrate how to apply the criteria for reconciliation:

EXAMPLE B:

Cost Reporting Period: 01/01/2004-12/31/2004

Operating CCR used to pay original claims submitted during cost reporting period: 0.40
(In this example, this CCR is from the tentatively settled 2002 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the criteria has been met to trigger reconciliation, and therefore, the FI notifies the regional office and central office. The provider's outlier payments for this cost reporting period will be reconciled using the correct CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period, FIs should calculate a weighted average of the CCRs in that cost reporting period. (See Example C below for instructions on how to weight the CCRs). The FI shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

EXAMPLE C:

Cost Reporting Period: 01/01/2004-12/31/2004
Operating CCR used to pay original claims submitted during cost reporting period:

- 0.40 from 01/01/2004-03/31/2004 (This CCR could be from the tentatively settled 2001 cost report)
- 0.50 from 04/01/2004-12/31/2004 (This CCR could be from the tentatively settled 2002 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.35
Total Outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000
Weighted Average CCR: 0.474

CCR	Days	Weight	Weighted CCR
0.40	91	0.248 (91 Days / 366 Days)	(a) 0.099= (0.40 * 0.248)
0.50	275	0.751 (275 Days / 366 Days)	(b) 0.375= (0.50 * 0.751)
TOTAL	**366**		**(a)+(b) =0.4742**

The hospital meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed from 0.474 to 0.35 (which is greater than 10 percentage points) at the time of final settlement, and the provider received an outlier payment greater than $500,000 for the entire cost reporting period.

Even if a hospital does not meet the criteria for reconciliation in part A of this section, subject to approval of the regional and central office, the FI has the discretion to request that a hospital's outlier payments in a cost reporting period be reconciled if the hospital's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The FI sends notification to the central office via the address and email address provided in §20.1.2.1 (b). Upon approval of the regional and central office that a hospital's outlier claims need to be reconciled, FIs should follow the instructions in §20.1.2.7.

20.1.2.7 - Procedure for Fiscal Intermediaries to Perform and Record Outlier Reconciliation Adjustments

(Rev. 1072, Issued: 10-06-06; Effective/Implementation Date: 11-06-06)

The following is a step-by-step explanation of how FIs are to notify CMS and hospitals that reconciliation should be performed and to record reconciled outlier claims for hospitals that meet the criteria for reconciliation:

1) *The FI sends notification to the CMS central office (not the hospital), via the street address and email address provided in §20.1.2.1 (B)) and regional office that a hospital has met the criteria for reconciliation.*

2) *If the FI receives approval from the CMS central office that reconciliation is appropriate, the FI follows steps 3-8 below.*

3) The FI shall notify the hospital and copy the CMS regional office and central office in writing and via email (through the addresses provided in §*20.1.2.1 (B))* that the hospital's outlier claims are to be reconciled.

4) The FI shall submit to the central office PSF data that were used for discharges to compute outlier payments during the cost reporting year being final settled as well as new CCR data that have been determined as part of the settlement process of that cost report. The FI submits this data (preferably in electronic format) to the central office via the addresses provided above. Data fields that shall be submitted include PSF fields 23, Intern to Bed Ratio, 24, Bed Size, 25, all relevant Operating Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report), 27, SSI Ratio, 28, Medicaid Ratio, 47, all relevant Capital Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report) 49, Capital IME and 21, Case Mix Adjusted Cost Per Discharge.

5) Central office will use data from National Claims History (NCH) to reprocess claims in a Pricer utility program to determine the correct outlier payment amounts.

6) CMS will calculate the time value of money attributable to the adjustment. CMS will provide the FI with a log of individual claims on which the total adjustment was determined.

7) The FI shall record the reconciled amount, the original outlier amount from Worksheet E, Part A line 2.01, the time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E, Part A of the cost report.

8) The FI shall finalize the cost report, *issue a* NPR and make the necessary adjustment from or to the provider.

The central office will work as quickly as possible to reconcile these claims in order to allow FIs *to* finalize the cost report and issue an NPR within the normal CMS timeframes. If *an* FI *has* any questions regarding this process *it* should contact the central and regional *office*, using the address and email address provided in *§20.1.2.1 (B).*

The following is an example of the procedures for reconciliation and computation of the adjustment to account for the time value of money:

EXAMPLE D:

Cost Reporting Period: 01/01/2004-12/31/2004
Midpoint of Cost Reporting Period: 07/01/2004
Date of Reconciliation: 12/31/2005

Number of days from Midpoint until date of Reconciliation: 549

Rate from Social Security Web site: 4.625%

Operating CCR used to pay actual original claims in cost reporting period: 0.40 (This CCR could be from the tentatively settled 2002 or 2003 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR fluctuated from .40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has an outlier payout greater than $500,000, the criteria have been met to trigger reconciliation. The FI notifies the regional and central office.

The central office reprocesses the claims. The reprocessing indicates the revised outlier payments are $700,000.

Using the values above, determine the rate that will be used for the time value of money:
(4.625 / 365) * 549 = 6.9565%
Based on the claims reconciled, the provider is owed $100,000 ($700,000-$600,000) for the reconciled amount and $6,956.50 ($100,000 * 6.9565 %) for the time value of money.