4033. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

The five parts of Worksheet E-3 are used to calculate reimbursement settlement:

Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA
Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS
Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS
Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS
Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement
Part VI - Calculation of Reimbursement Settlement - Title XVIII Part A PPS SNF Services
Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services

4033.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA.--Use Worksheet E-3, Part I, to calculate Medicare reimbursement settlement under TEFRA for cancer hospitals, children's hospitals, and extended neoplastic disease care hospitals.

The "TEFRA" payment system includes long term care hospitals (LTCH) classified as extended neoplastic disease care hospitals (previously referred to as "subclause (II)" LTCHs), children's hospitals, cancer hospitals, Religious Non-Medical Health Care Institutions (RNHCIs), and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (i.e., hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa).

Line Descriptions

Line 1--Enter the amount from Worksheet D-1, Part II, line 63.

Line 1.01--Enter the amount of Nursing and Allied Health Managed Care payments if applicable. Only complete this line if your facility is a freestanding/ independent non-PPS provider that does not complete Worksheet E, Part A.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-4, Part III, column 1, line 69. If you are not an approved CTC do not complete line 2.

Line 3--Teaching hospitals participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Enter the amounts paid or payable by workers' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program

services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.)

Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance.

Line 10--Enter the result of subtracting line 9 from line 8.

Line 11--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 11 and 12 will be negative. (See 42 CFR 413.89.)

Line 12--Multiply the amount (including negative amounts) from line 11 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 13--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11.

Line 14--Enter the sum of lines 10 and 12.

Line 15--Enter the amount from Worksheet E-4, line 49, for the hospital component only.

Line 16--DO NOT USE THIS LINE.

Line 17--Enter any other adjustments. Specify the adjustment in the space provided. See line 17.98 to report the recovery of accelerated depreciation. Do not report adjustments resulting from permanent or other adjustments to the TEFRA target amount per discharge on this line.

Line 17.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 17.99 or line 18.02, accordingly.

Line 17.98--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136-136.16 and 42 CFR 413.134(d)(3)(i).) This line is identified as "Recovery of accelerated depreciation."

Line 17.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 18--Enter the sum of lines 14, 15, and 16, plus or minus line 17, and minus lines 17.50, 17.98, and 17.99.

Line 18.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 18]. Do not apply the sequestration calculation when gross reimbursement (line 18) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times lines 18]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 18].

Line 18.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 19--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 20 the amount on line 5.99.

Line 20--Contractor use only: Report the amount from Worksheet E-1, column 2, line 5.99.

Line 21--Enter line 18 minus the sum of lines 18.01, 18.02, 19, and 20. Transfer this amount to Worksheet S, Part III, line 1.

Line 22--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

4033.2 Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS.--Use Worksheet E-3, Part II, to calculate Medicare reimbursement settlement under IPF PPS for hospitals and subproviders. (See 42 CFR 412, Subpart N.)

Use a separate copy of Worksheet E-3, Part II, for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part II, to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.