

**3630.5 Part E - Other Outpatient Diagnostic Procedures.**--This worksheet calculates reimbursement settlement for other outpatient diagnostic procedures for both hospital and/or subprovider, for services rendered prior to August 1, 2000; otherwise do not complete this worksheet. As required by §§1833(a)(2)(E) and 1833(n) of the Act, payment for other diagnostic procedures performed in a hospital on an outpatient basis is based on the lower of (1) the hospital's reasonable cost or customary charges (in the aggregate) net of cost sharing, or (2) a blend of the hospital's other outpatient diagnostic procedures costs or its charges, if less (hospital-specific), and 42 percent of the physician fee schedule, net of cost sharing for the same procedures as if the procedures were performed in a physician's office in the same locality. The blend consists of 50 percent hospital-specific cost and 50 percent fee schedule. For cost reporting periods that end on or after October 1, 1997, and on or before September 30, 1998, it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For cost reporting periods that **begin** on or after **October 1, 1997**, continue to use the subscripted column and no longer complete column 1.

**NOTE:** Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services and CAHs (see Worksheet S-2, lines 33 through 33.02) do not complete this worksheet.

#### Line Descriptions

Line 1--Enter the fee schedule amounts from the PS&R or from your records in columns 1 and 1.01 for services rendered before October 1 and on and after October 1, 1997, respectively.

Line 2--Enter 42 percent of the amount on line 1.

Line 3--Enter in column 1 the deductibles billed to program patients. Obtain this amount from the PS&R or from your records.

Line 4--Enter in column 1 80 percent of the result of line 2 minus line 3. No entry is required for column 1.01.

Line 5--This amount is the blended charge proportion. Enter 50 percent of line 4 in column 1 and 50 percent of line 2 in column 1.01.

Line 6--Enter the amount of the outpatient radiology cost from Worksheet D, Part V, columns 8 and 8.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services for other outpatient diagnostic procedures only if the amount is lower than the blended amount. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

**NOTE:** If the medical and other health services reported here qualify for exemption from LCC (see §3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges that relate to the reasonable cost on line 6 from Worksheet D, Part V, columns 4 and 4.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

**NOTE:** If the amounts on Worksheet D, Part V, include charges for professional services, eliminate the amount of the professional component from the charges entered on line 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of customary charges over reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

**NOTE:** If these services are exempt from LCC, enter the reasonable costs from line 6.

Line 15--Enter, in column 1, the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on line 15 reflects coinsurance based on 20 percent of full charges, not discounted charges.

**NOTE:** If these services are exempt from LCC, enter the Part B deductibles from line 3. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1. Enter the amount on line 14 for column 1.01.

**NOTE:** If these services are exempt from LCC, subtract the deductible on line 15 from line 14, and multiply the result by 80 percent.

Line 17--Enter 50 percent of line 16 for columns 1 and 1.01.

Line 18--Enter the sum of lines 5 and 17.

Line 19--Enter the lesser of lines 16 or 18 in column 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1 enter the amount reported on line 19. In column 1.01 subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductible on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII, to Worksheet E, Part B, line 20; and for titles V and XIX to Worksheet E-3, Part III, column 1, line 37.