

CMS Issues Final Rule on Revisit User Fees

On September 19, 2007, the Centers for Medicare & Medicaid Services (CMS) published a final rule establishing “revisit user fees.” These fees will be assessed against health care facilities participating in the Medicare program that, failing to meet federal standards relating to quality of care, are subject to follow-up inspections to ensure that the unsatisfactory conditions (deficiencies) were corrected. The fees went into effect on September 19, the day the rule was published.



CMS estimates that it will collect \$37.3 million annually through the revisit user fee program, covering the costs of conducting the revisit surveys. The fee for each provider type is based on “the average cost per revisit survey” per provider type and whether the revisit survey is on-site or off-site. The fee amounts are included within the final rule, and on-site revisit fees are highest for hospitals (\$2,554) and skilled nursing facilities (\$2,072) and lowest for rural health clinics (\$851). Off-site revisit fees are \$168 for all provider types. CMS states in the final rule that it does not believe that the fees “will have such an economic impact that it would create additional financial strains on providers.” Many providers, CMS notes, will not have to pay fees because “they consistently provide high quality care, have no deficiencies identified through the survey process, and therefore will require no revisits.”

Skilled nursing facilities (SNFs), hospitals, home health agencies, hospices, end-stage renal disease centers, rural health clinics and ambulatory surgical centers all are potentially subject to these fees. CMS expects that the vast majority of the fees will be paid by SNFs, which received almost 29,500 of the 33,500 revisit surveys conducted in 2006. In addition, almost 88 percent of SNFs required revisit surveys.

Providers that have been assessed a revisit user fee will have fourteen days within which to request a reconsideration if they believe that assessment of a fee is erroneous. These providers will receive a credit or a refund if the reconsideration request is found in their favor. Failure to pay a fee within 30 days may result in the provider’s termination from participation in the Medicare program.

A copy of the final rule is available at:

<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/E7-18458.pdf>

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