User Manual

Providers

Medicare Provider Statistical and Reimbursement System (PS&R)

Centers for Medicare and Medicaid Services

Version 2.0

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1 Introduction

The Provider Statistical and Reimbursement (PS&R) System produces a variety of reports for Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), the Centers for Medicare and Medicaid Services (CMS), and Medicare Part A providers. These reports accumulate statistical and payment data for hospitals, hospital complexes, skilled nursing facilities, hospices, end-stage renal disease facilities, comprehensive outpatient rehabilitation facilities, and home health agencies.

The PS&R system is comprised of many web pages that allow Fiscal Intermediary/Medicare Administrative Contractor users, CMS users, and Medicare Part A providers to request the generation of summary and detail reports for inpatient and outpatient services. The reports that can be generated by a specific user are determined by the user's access authority assigned to the user ID.

The PS&R system provides the following:

- Users can define report selection criteria such as the report groups, report types, service types and date ranges to include in the reports using the graphical user interface.
- All providers can request summary reports directly in the system.
- Providers can submit online requests for detail reports. The provider's FI/MAC then either approves or denies the request. If the request is approved, the FI/MAC sends the reports to the provider on acceptable media.
- FI/MACs can request detail reports directly in the system. The FI/MAC's PS&R administrative representative then either approves or denies the request. If the request is approved, the FI/MAC administrative representative routes the reports to the requesting provider.
- Reduces the time to complete cost reports by providing a central repository for all claims data.
- Provides an efficient means for flexible definition of business rules that allow changes to the business rules without changing core software.

1.1 Document Conventions

The following conventions have been used throughout this document:

- To represent text that is dynamic, the text is enclosed in angle brackets (<>) as follows: Period <n> From, where <n> is 1-4 for the number of the corresponding reporting period included in the report.
- Field names are represented as bold text (for example, Select the **By Service Type** option and then select the service type to include in the report).
- Button names are represented as bold text (for example, Click **OK**).

1.2 About this Manual

This manual provides detailed instructions for using CMS's PS&R system. The remainder of the document is organized as follows:

- **Chapter 2, System Overview and Common Features**: provides a description of the system in addition to a discussion about features that you find throughout the PS&R system (for example, menu options, button navigation, etc.).
- **Chapter 3, Performing Tasks in the PS&R**: presents the step-by-step instructions necessary to perform day-to-day tasks using the PS&R system, for example, submitting report requests and viewing resulting reports.
- **Chapter 4, Inpatient Reports**: provides a summary of the processing sequence for claim data for presentation on inpatient reports and provides a description of each inpatient report template in addition to the reports generated based on each template.
- **Chapter 5, Outpatient Reports**: provides a summary of the processing sequence for claim data for outpatient and home health agency reports and provides a description of each report template in addition to the reports generated based on each template.
- **Chapter 6, Consolidation Reports**: provides a description of the consolidation reports available in the PS&R system.
- **Appendix A, Report Details**: provides the following information for each report available in the PS&R system: report group, report type, report name, service category, provider type, provider number range, and an indicator specifying whether the report is included in the cost report.
- **Appendix B, Report Data**: provides a list of the data elements that appear on inpatient or outpatient reports in the PS&R system. The appendix provides a description of each data element along with the type of data (character, numeric, date, etc.).
- **Appendix C, Error Messages**: lists the error messages used in the PS&R system and provides corrective action for each error message.
- **Appendix D, Glossary**: provides an explanation of terms used throughout the PS&R system and this User Manual.

2 System Overview and Common Features

This chapter provides:

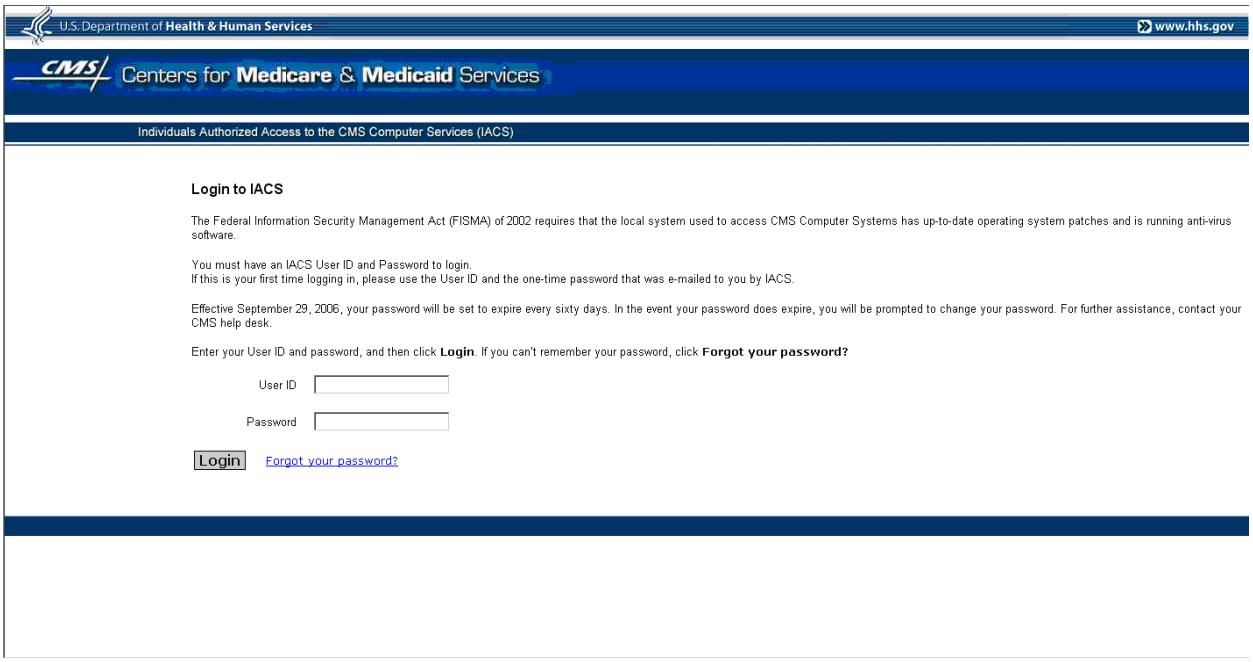
- an overview of the PS&R System,
- the startup procedure to follow when accessing the PS&R System, and
- a description of common features and menu options of the system.

If you do not already have access to the PS&R System, you must first register for Individuals Authorized Access to CMS Computer Services (IACS). IACS is CMS' identification and authorization system for web-based applications. Providers will be instructed by their FI/MAC when and how they should register. If you would like more information regarding IACS, prior to receiving instructions from the FI/MAC, you may view the IACS webpage, http://www.cms.hhs.gov/IACS/.

2.1 Access the PS&R System Website

Perform the following steps to access the PS&R System.

1. Login to the PS&R system via the Individuals Authorized Access to CMS computer Services (IACS) system login screen as displayed below. IACS is a CMS-wide enterprise security and authentication system that is the gateway to many CMS systems, including the PS&R system.



2. To login to the system, enter your registered IACS User ID and Password into the appropriate fields, and then click the "Login" button. IACS will validate your credentials. If the credentials are valid, IACS will log you in. For problems related to IACS login/accounts, CMS has established an External User Services

(EUS) Help Desk to assist with access to IACS. The EUS Help Desk may be reached by E-mail at EUSSupport@cgi.com or by phone at 1-866-484-8049 or TTY/TDD at 1-866-523-4759.

3. Once logged in to IACS, you may request access to the PS&R system following the instructions in the IACS system.
4. Refer to Section 3, Performing Tasks in the PS&R, for instructions about using the PS&R system.

Note: Maximize the size of your browser window so the PS&R system pages display properly.

2.2 Page Layout

The PS&R system utilizes a consistent page layout across all pages. This layout is comprised of three primary sections:

- **Header**: The Header area is displayed horizontally across the top of all pages and displays "Provider Statistical & Reimbursement System", the user's organization, the user's ID, the current date, the name of the page currently loaded in the Content section, and links to other support pages in the system.
- **Menu Bar**: The menu bar is displayed horizontally across the top of all pages just below the page header. The menu bar provides hyperlinks to the system functions applicable to the user's type.
- **Content**: The Content area is the section with which the user interacts to perform system functions; the Content's appearance varies by page.

The header and menu bar are discussed in this chapter. The individual options available from the menu bar and the contents areas are discussed in Chapter 3, Performing Tasks in the PS&R.

The web pages throughout the system use common controls familiar to most internet users. For example, the **Tab** key can be used to move the cursor from field-to-field, moving across the page from left to right and from top to bottom. If a button is highlighted, you can press **Enter** to activate the button. In drop-down lists, press the up- and down-arrows to move the previous or next value. For check boxes and radio buttons, press the space bar to toggle the selection of the value.

2.2.1 Header Area

The Header portion of the PS&R System contains basic information that is displayed on each page within the system. An example of the header information that appears on all pages is provided as follows.

Exhibit 2-1 Page Header

The following table provides a description of the fields in the page header.

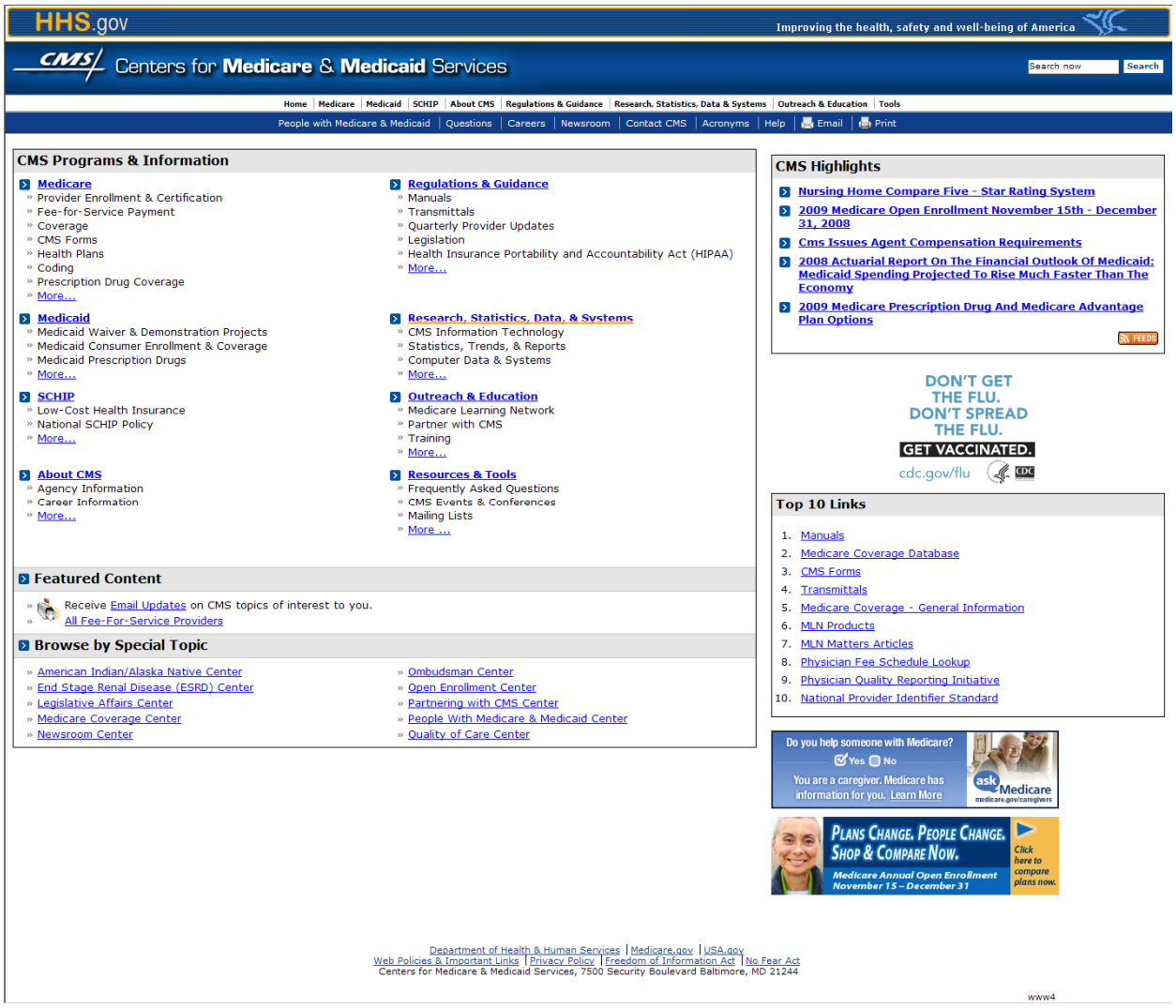
Exhibit 2-2 Page Header Fields

Field	Definition
Site Map	Displays a visual structure of the pages within the PS&R System to assist users to navigate within the PS&R System.
Announcements	Displays announcements pertaining to the type of user currently accessing the PS&R System.
FAQ	Displays answers to a list of frequently asked questions.
Help	Launches the PS&R System's online Help. Online Help presents a list of common tasks you can perform while using the PS&R System. By clicking a task, you can view detailed instructions for completing the task.
Logout	Logs the user out of the PS&R System and displays the login page.
<User's Organization>	Displays the name of the user's organization. If the user is a provider, the provider organization name and number is displayed. If the user is a Fiscal Intermediary/Medicare Administrative Contractor, the name of the Fiscal Intermediary/Medicare Administrative Contractor organization is displayed. If the user is a CMS user, "Centers for Medicare and Medicaid Services" is displayed.
<User ID>	Displays the identification number of the user currently logged on to the PS&R System.
<Current Page>	Displays the name of the page currently being accessed by the user.
<Date>	Displays the current system date.

2.2.1.1 CMS.HHS.gov

Clicking the CMS logo located in the upper left corner of the header opens a new browser window displaying the Centers Medicare and Medicaid Services website. The following exhibit provides an example of the home page for the Centers for Medicare and Medicaid Services website.

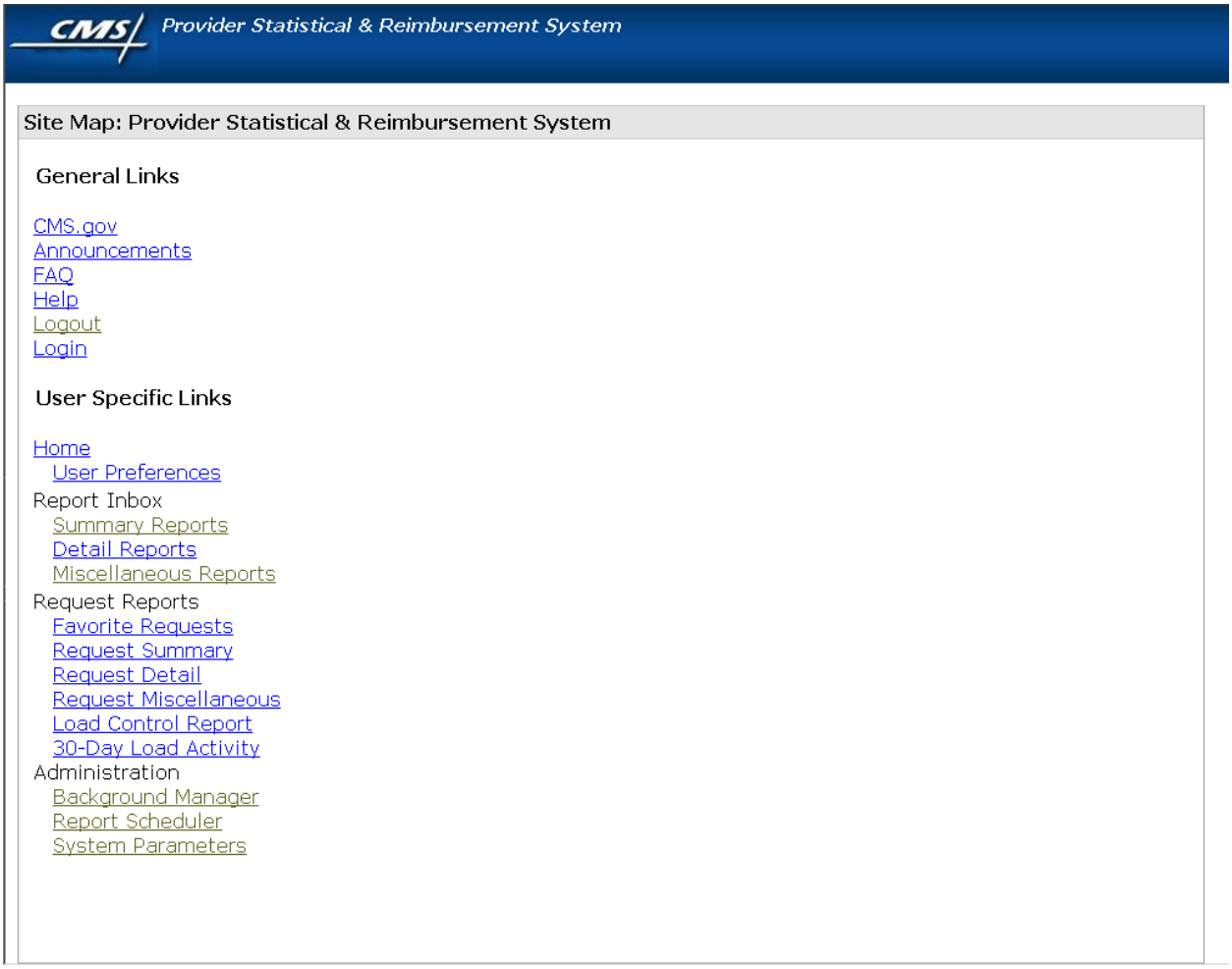
Exhibit 2-3 Centers for Medicare and Medicaid Services Website



2.2.1.2 Site Map

The **Site Map** hyperlink, when selected, displays a visual structure of the pages within the PS&R System to assist users to navigate within the PS&R System. The Site Map page follows.

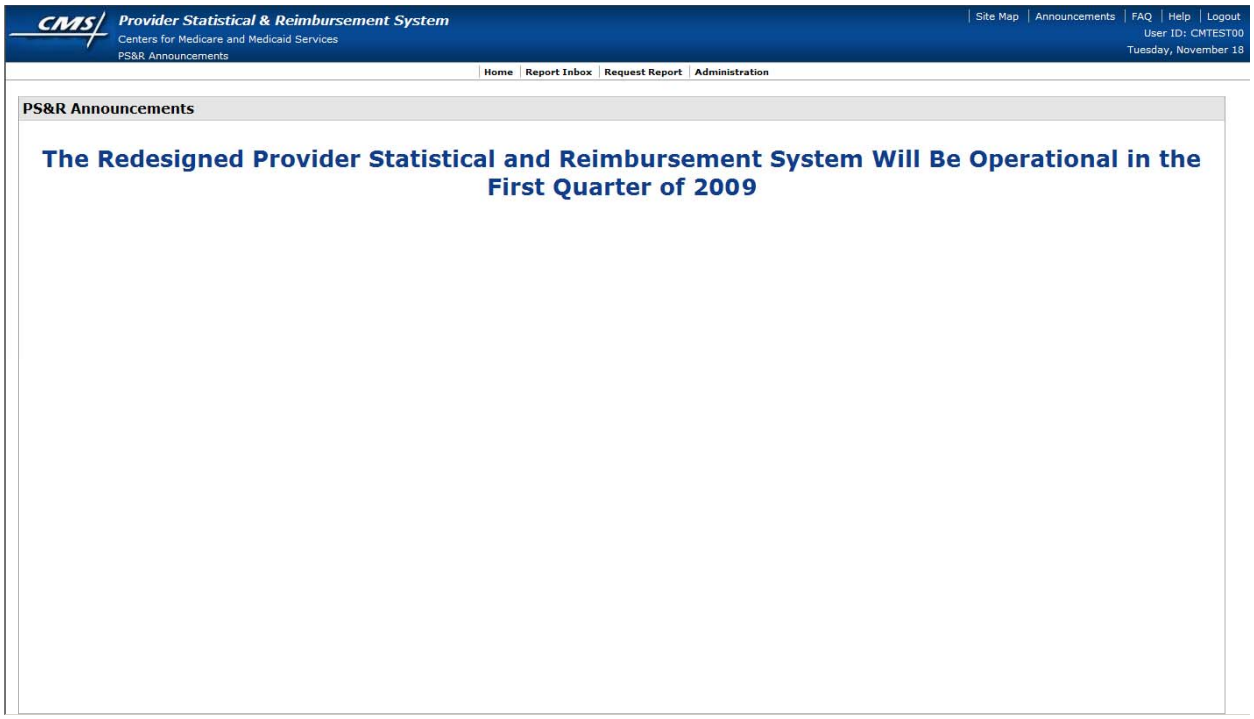
Exhibit 2-4 Site Map Page



2.2.1.3 Announcements

When selected, the **Announcements** hyperlink displays announcements pertaining to the type of user currently accessing the PS&R System. The following exhibit provides an example of the Announcements page in the PS&R System.

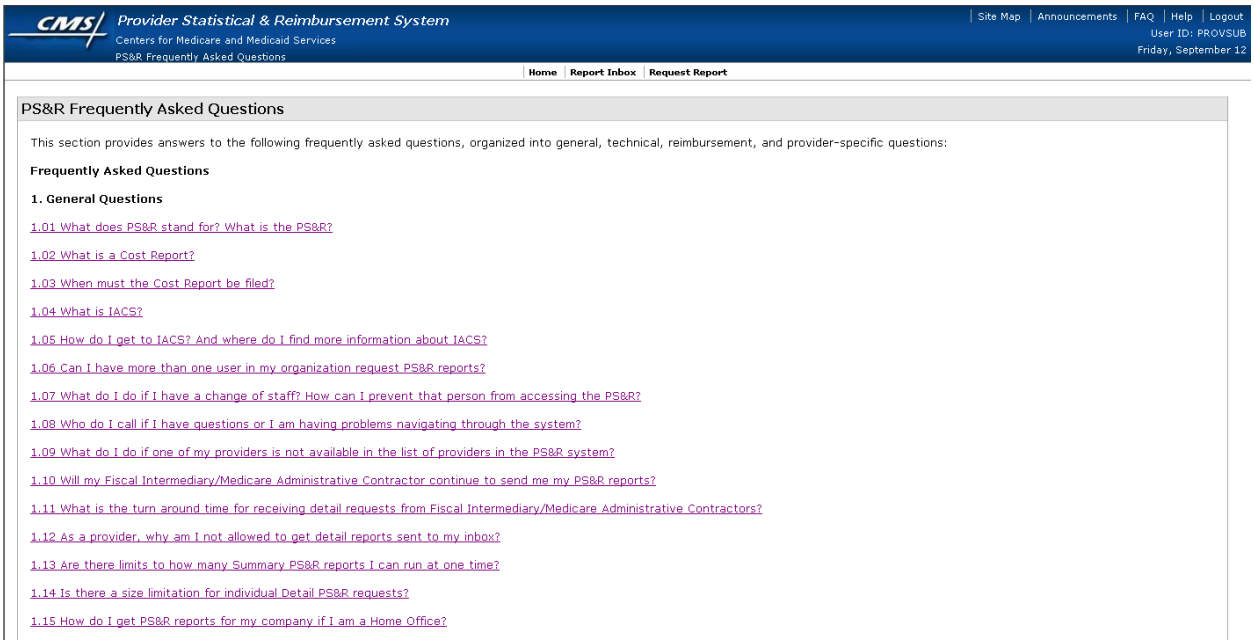
Exhibit 2-5 Announcements Page



2.2.1.4 FAQ

The **FAQ** hyperlink, when selected, displays a list of frequently asked questions relating to the PS&R System. Click the question hyperlink to display the answer to the question. Click **Back to Top** to return to the top of the page. The FAQ page follows.

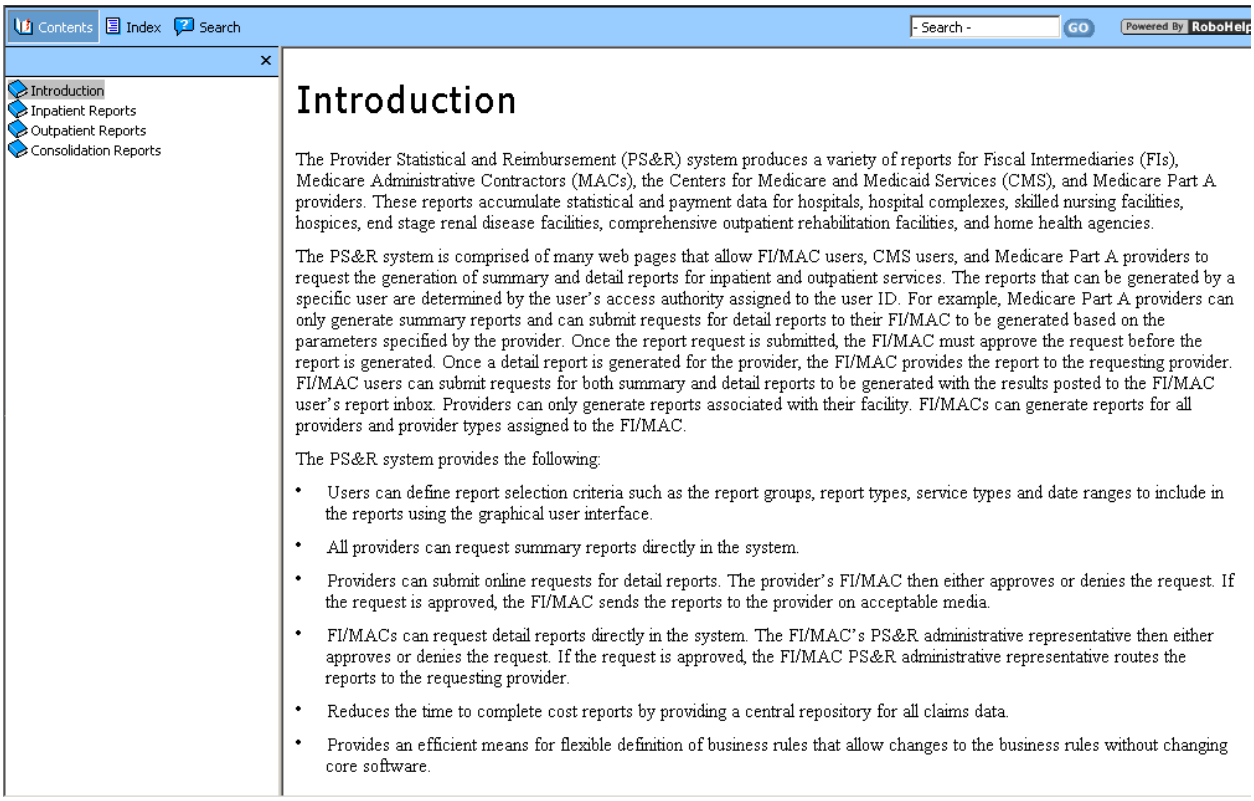
Exhibit 2-6 FAQ Page



2.2.1.5 Help

The **Help** hyperlink, when selected, opens the PS&R System online Help. Online Help opens in a new Browser window. The following exhibit displays an example of online Help displaying the Introduction topic.

Exhibit 2-7 Online Help Example



2.2.1.6 Logout

The **Logout** hyperlink, when selected, logs the user out of the PS&R System and displays the login page.

2.2.2 Menu Bar

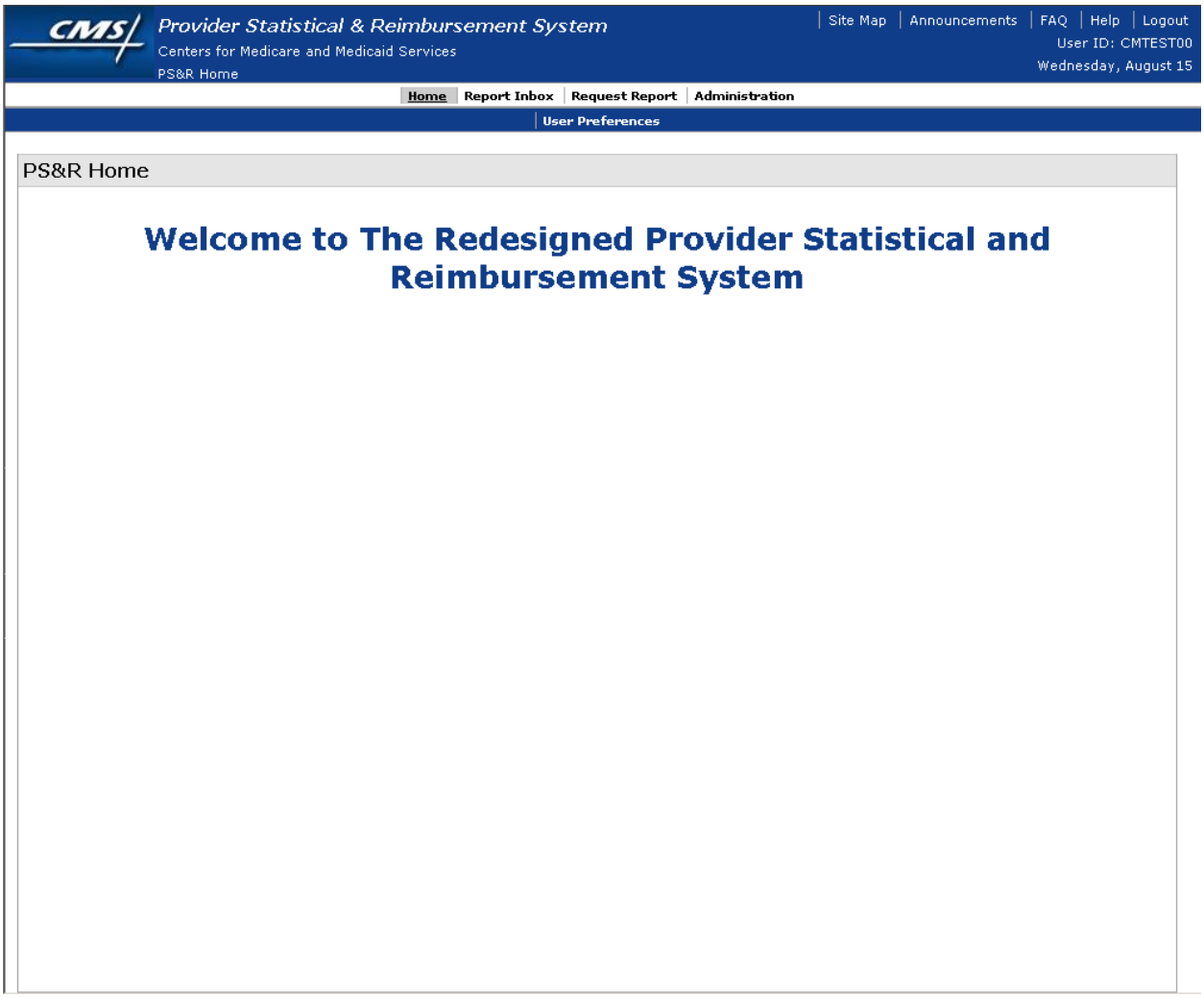
The options available from the menu bar vary by user type. The menu bar is located just below the PS&R page's header area. The types of users who can access the PS&R System are:

- CMS
- Fiscal Intermediary/Medicare Administrative Contractor Administrators
- Fiscal Intermediary/Medicare Administrative Contractors
- Providers

2.2.3 Home

When selected from the menu bar, the **Home** menu option returns the user to the PS&R System home page. The contents of the menu bar changes depending on the type of user that is logged in. The menu option available from the Home menu is **User Preferences**. The following exhibit provides an example of the PS&R System Home page when logged in as a provider user. Refer to Chapter 3, Performing Tasks in the PS&R, for additional details about setting user preferences.

Exhibit 2-8 Home Page



2.3 Field and Control Overview

There are several standard forms with which users interact throughout the PS&R System to select report parameters and to maintain administrative data (for authorized users). The subsequent sections provide a description of the following control types and system conventions utilized in the PS&R System:

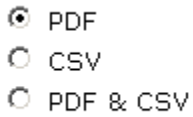
- Radio buttons
- Check boxes
- Drop-down menus
- List box
- Transfer list box
- Calendar
- Command buttons

- Keyboard shortcuts
- Special characters

2.3.1 Radio Buttons

Radio buttons allow a user to select one of a limited number of mutually exclusive options. The following exhibit provides an example of radio buttons used in the PS&R System.

Exhibit 2-9 Radio Buttons



The example in the exhibit above contains three radio button options – “PDF”, “CSV”, and “PDF & CSV”. To the left of each option is the radio button, a small empty circle. To select one of the options, the user selects the appropriate radio button. When a radio button is selected, a solid circle appears inside of the circle.

In the PS&R System report request pages, radio buttons are often the first control type with which a user must interact before making additional selections in other standard forms. In these instances, until the user selects a radio button, all of the other standard forms on the page are unavailable and appear “grayed out”. Once a radio button is selected, the user can interact with remaining control types that become available and appear darkened.

2.3.2 Check Boxes

Check boxes enable a user to select any number of choices (zero, one, several, or all) from a list of options. The following exhibit provides an example of check boxes used within the PS&R System.

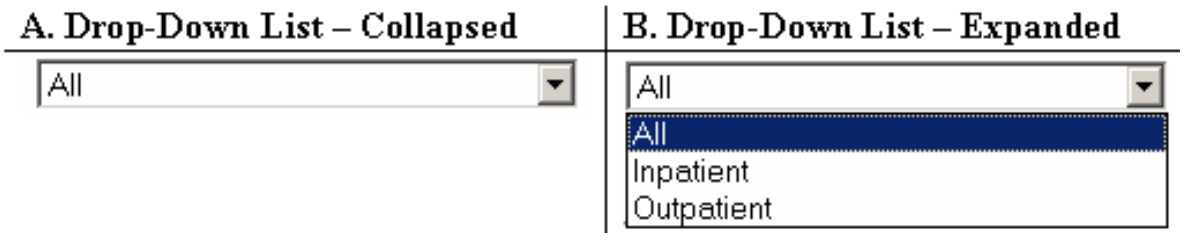
Exhibit 2-10 Check Boxes

The example in the exhibit above shows three check box options –“Exclude 329 and 339 Patient CBSA Visit Section” “Include 110 DRG Section”, , and “Include 1000 Report”. To the left of each option is the check box, a small empty square. To select one of the options, the user clicks the appropriate check box. When a check box is selected, a check mark appears inside the box (as displayed for the “Include 110 DRG Section” check box in the exhibit above). To clear a check box, the user clicks the check box again; removing the check mark.

2.3.3 Drop-Down List

Drop-down lists allow a user to choose one item from a list of items. The following exhibit provides an example of a drop-down list demonstrating both collapsed and expanded views of the drop-down list.

Exhibit 2-11 Drop-Down List (Collapsed and Expanded)



Part "A" of the exhibit above shows a "collapsed" drop-down list showing how the control appears by default. Part "B" of the exhibit shows an "expanded" drop-down list, listing all of the items that are available from which the user chooses.

To view the drop-down list, the user must click the down-arrow ("▼") on the right-hand side of the drop-down list. Once the user clicks the down arrow, the control displays the list of available items. To choose an item, the user must click the item's name. Once the user clicks an item, the drop-down menu returns to the collapsed position and displays the selected item.

2.3.4 List Box

A List Box enables a user to choose one item or multiple items from a list. The following exhibit provides an example of a list box.

Exhibit 2-12 List Box

The example in the previous exhibit displays a list box containing report types.

A list box contains a list of items in alphabetical or numerical order that are available from which the user chooses. The user can select one or multiple items. An item is considered selected when the item is highlighted. To highlight a single item the user clicks the name of the item. To highlight multiple items, the user can scroll through the list and use Window's standard "Ctrl + click" to select non-continuous items or "shift + click" to select continuous items. The user can remove the highlight from any highlighted item by clicking a different item. Any item that is highlighted in the list box is considered a selected item.

2.3.5 Transfer List Boxes

Transfer list boxes enable a user to choose one item or multiple items from an "available items" list box and transfer the items to another "selected items" list box. The exhibit below provides an example of a transfer list box.

Exhibit 2-13 Transfer List Box

The exhibit displays an example of a generic transfer list box. In this example, three labels have been added for descriptive purposes: "Text Box 1 – Search", "List Box 1 – Available Items", and "List Box 2 – Selected Items". List Box 1 contains all items from which the user can choose in alphabetical or numerical order; the user indicates the choice by transferring one or more of these items to List Box 2. Any item in List Box 2 is considered a selected item.

To transfer one item from List Box 1 to List Box 2, the user must first locate the specific item in List Box 1. This can be performed either by manually scrolling through the list box until the desired item is located or by typing the selection criteria in the **Search** text box. The list box automatically scrolls to the location in the list based on the data entered in the **Search** text box.

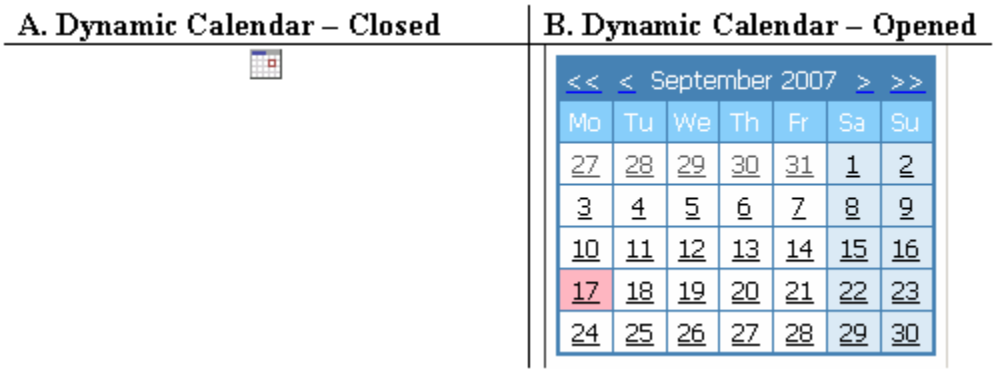
Once the item is located in List Box 1, the user must transfer the item to List Box 2 in order for the item to be selected. To do this the user must first click the item to select the item. Then the user must click the right-transfer button ("»") to move the item from List Box 1 to List Box 2. Multiple items can be selected using Microsoft Window's standard "CTRL + click" or "SHIFT + click" functions.

Any or all items that are moved to List Box 2 can be removed by highlighting the item(s) to be removed and clicking the left-transfer button ("«"). This moves the highlighted item(s) from List Box 2 to List Box 1.

2.3.6 Calendar

The Calendar enables a user to scroll through a calendar to locate and select a specific date.

Exhibit 2-14 Calendar



Clicking the icon shown in Part A of the exhibit pops-up the interactive calendar shown in Part B of the exhibit. The user can use this calendar to scroll through different calendar years and months and locate a particular date. Once the desired date (month, date, and year) is located, the user selects that date by clicking on the date's day number; this loads the desired date into the Calendar's associated date entry box.

2.3.7 Command Buttons

Command buttons allow a user to move backward or forward through the pages, complete and submit a request, reset default values, apply values across report ranges, or perform other functions as noted. The following buttons are available to all users:

- **Apply** – Clicking **Apply** applies entered date ranges to all providers and report periods.
- **Back** – Clicking **Back** returns the user to the previous page.
- **Continue** – Clicking **Continue** takes the user to the next page.
- **Refresh** – Clicking **Refresh** reloads the current page.
- **Reset** – Clicking **Reset** restores the values on the page to the default values.
- **Submit** – Clicking **Submit** submits the request parameters and starts the report generation process.

The following buttons are only available to FI/MAC administrative users:

- **Decline** – Clicking **Decline** allows the FI/MAC administrative user to decline a report request.
- **Modify** – Clicking **Modify** allows the FI/MAC administrative user to change a report request.

The following buttons are only available to CMS users granted access to the Administration pages:

- **Add** – Clicking **Add** allows the CMS user to add information to the PS&R System database.
- **Search** – Clicking **Search** allows the CMS user to search for information in the PS&R System database.
- **Update** – Clicking **Update** allows the CMS user to update information in the PS&R System database.

2.3.8 Keyboard Shortcuts

The following keyboard shortcuts can be entered to perform the same function as clicking the corresponding button throughout the PS&R System:

Button	Keyboard Equivalent
<<	ALT + L
>>	ALT + R
Add	ALT + A
Back	ALT + B
Continue	ALT + C
Decline	ALT + D
Modify	ALT + M
Refresh	ALT + R
Reset	ALT + R
Search	ALT + S
Submit	ALT + S
Update	ALT + U

2.3.9 Special Characters

The following special characters can be used in any data entry fields within the PS&R System:

- & (ampersand)
- ? (question mark)
- = (equals sign)
- . (period)
- : (colon)
- / (slash)
- (space)
- , (comma)
- @ (at sign)
- * (asterisk)
- \ (backslash)
- ((left parenthesis)
-) (right parenthesis)
- % (percent sign)

If any special characters not defined above (for example, “{“, “}”, “<”, “>”) are entered in any data entry fields the system returns the E331 error and redirects the user to the Login page. The “Your Request Name” field cannot contain any of the following characters: \ / : * ? " < > |. Refer to Appendix C, Error Messages, for additional information about this error message.

2.4 Useful Internet Explorer Keystrokes

The following table provides a summary of useful Internet Explorer keystrokes used to navigate pages in the FID.

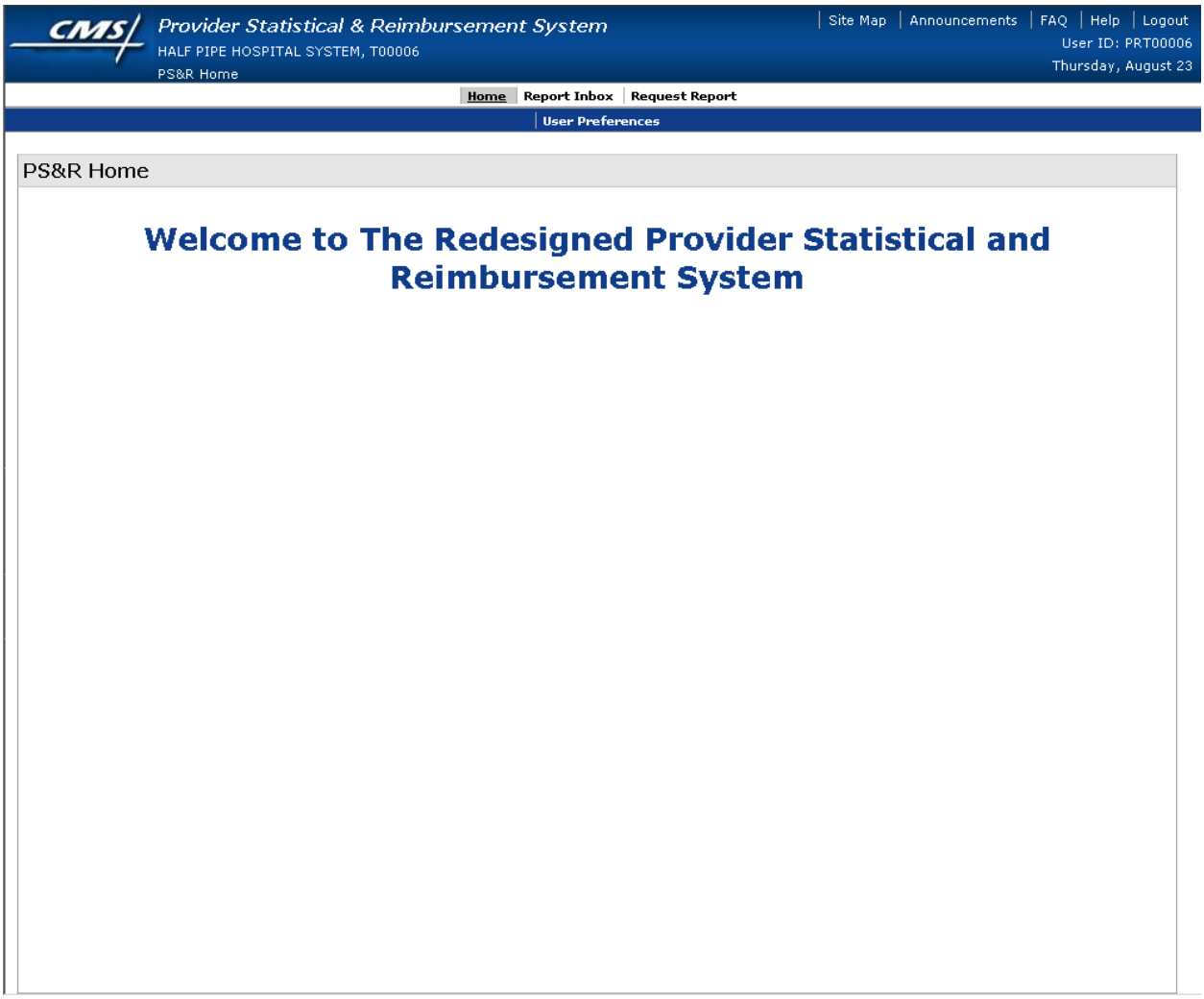
Table 2-1 Useful IE Keystrokes

Action	Key
Move forward and backward through links and form controls on a page	Tab (to move forward), Shift+Tab (to move backward)
Activate a link*	Enter
Select and deselect checkboxes.	Spacebar
Select from a group of radio buttons	Up Arrow, Down Arrow
Select a choice from a selection box	Up Arrow, Down Arrow or the First Letter Alternatively, the Alt+Down Arrow key combination can also be used to first open the list of choices
To make multiple selections in a list box	Tab to move into the list box. Shift+F8 to move into Multi-Select mode. Up Arrow, Down Arrow to move through the list, and press Spacebar to make your selections. Shift+F8 again when finished.
Top of page	Ctrl+Home
Bottom of page	Ctrl+End
Scroll page down	Page Down
Scroll page up	Page Up

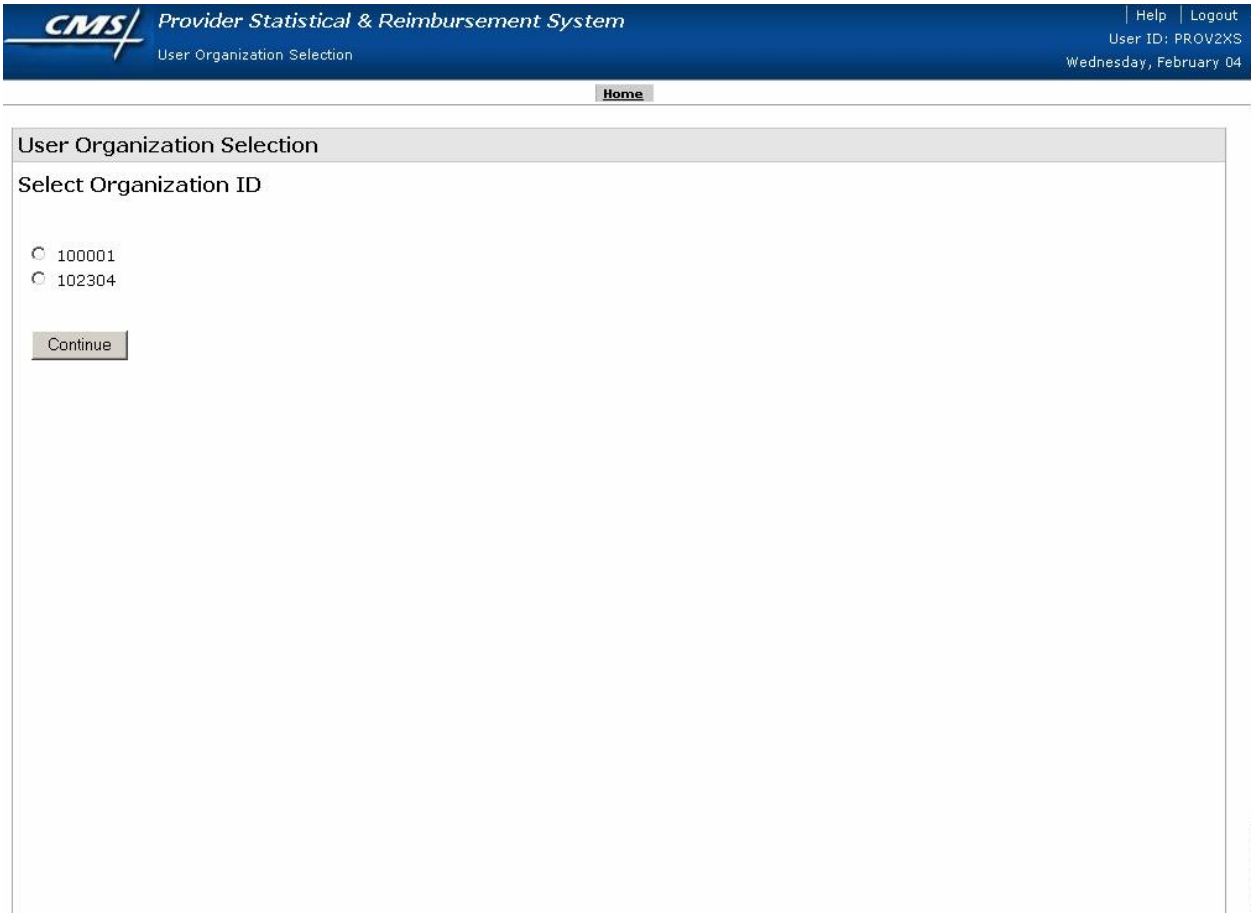
* Visual browsers highlight the current link with a "focus". In Internet Explorer it appears as a dotted border around the link. It is the link with the focus that will be acted upon when the user presses **Enter**.

3 Performing Tasks in the PS&R

Providers assigned a valid user ID and password can access data for their provider number and any child providers associated with the provider number. If you log on to the PS&R System using a provider user ID and password, the following page appears.



Note: Users associated with multiple provider organizations are prompted to select the provider ID for which to generate report requests and view report output when logging in to the PS&R System. Click the radio button corresponding to the provider with which to work. Click **Continue** to proceed to the PS&R System Home Page. The follow page appears when you log in to the PS&R System.



The options available from the main menu are:

- Home
  - User Preferences
- Report Inbox
  - Summary Report Inbox
  - Details Report Inbox
- Request Report
  - Favorite Requests
  - Request Summary
  - Request Detail

The high-level steps that are performed to request summary and detail reports and to view the report output are:

1. Select provider(s) to include in the report(s)

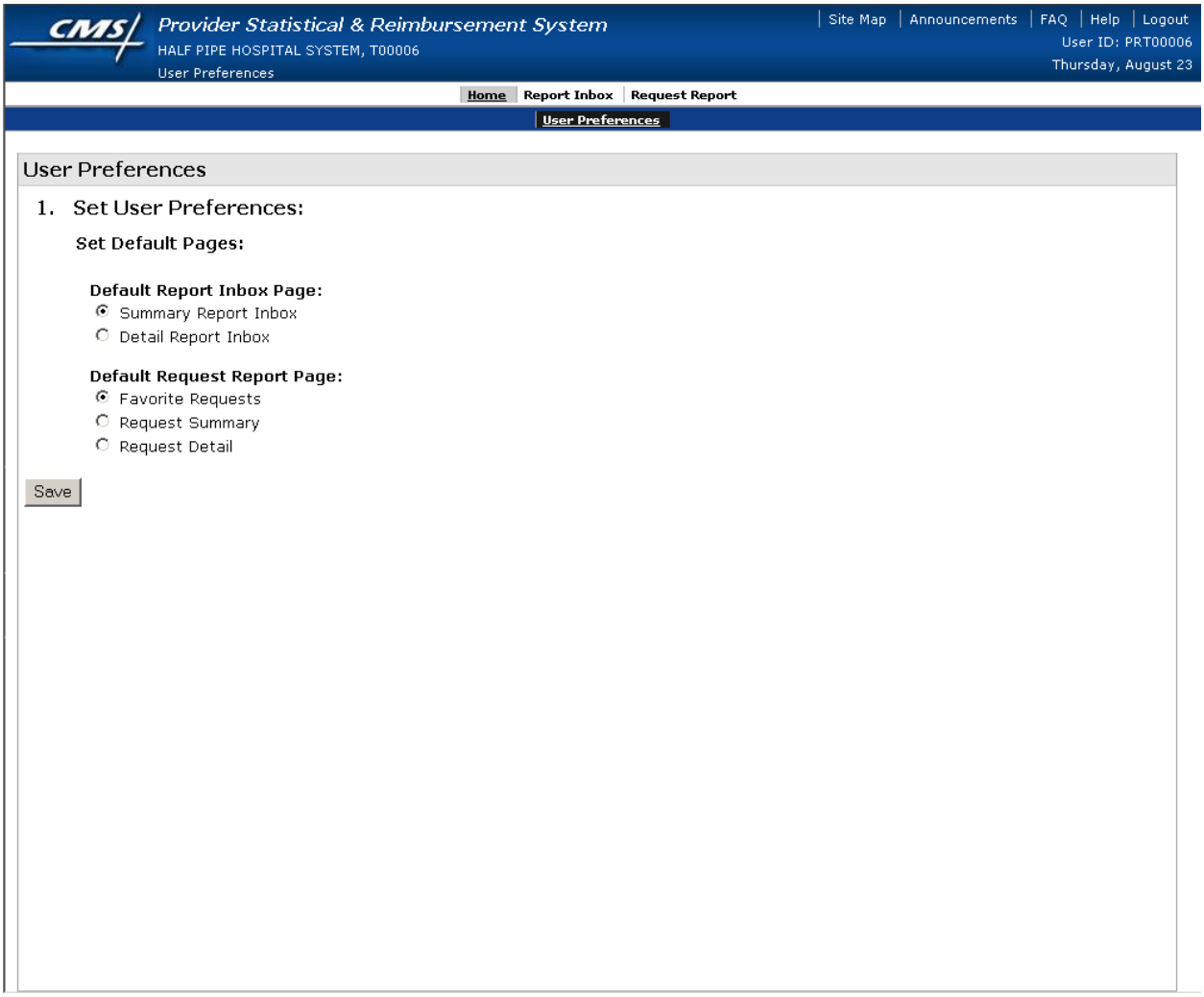
2. Select report(s) to generate
3. Select service periods for the report(s)
4. Select paid dates for the report(s)
5. Select the report format
6. Type the name to assign to the request (optional) and submit the request
7. Check the report status and view the report output

The following sections provide the steps to:

- Request a summary report
- Request a detail report
- Request a report using a favorite request
- View requested summary reports in the Report Inbox

3.1 User Preferences

To change the settings for default pages that display when you access the PS&R System, select the **User Preferences** option from the **Home** menu. The following page appears. You can specify the default Report Inbox page and the default Detail Report Inbox page to display when you select the Report Inbox or Request Report menus in the PS&R System. Select the radio button corresponding to the desired default pages to access when working in the PS&R System. Click **Save** to save your preferred pages to access in the PS&R System.

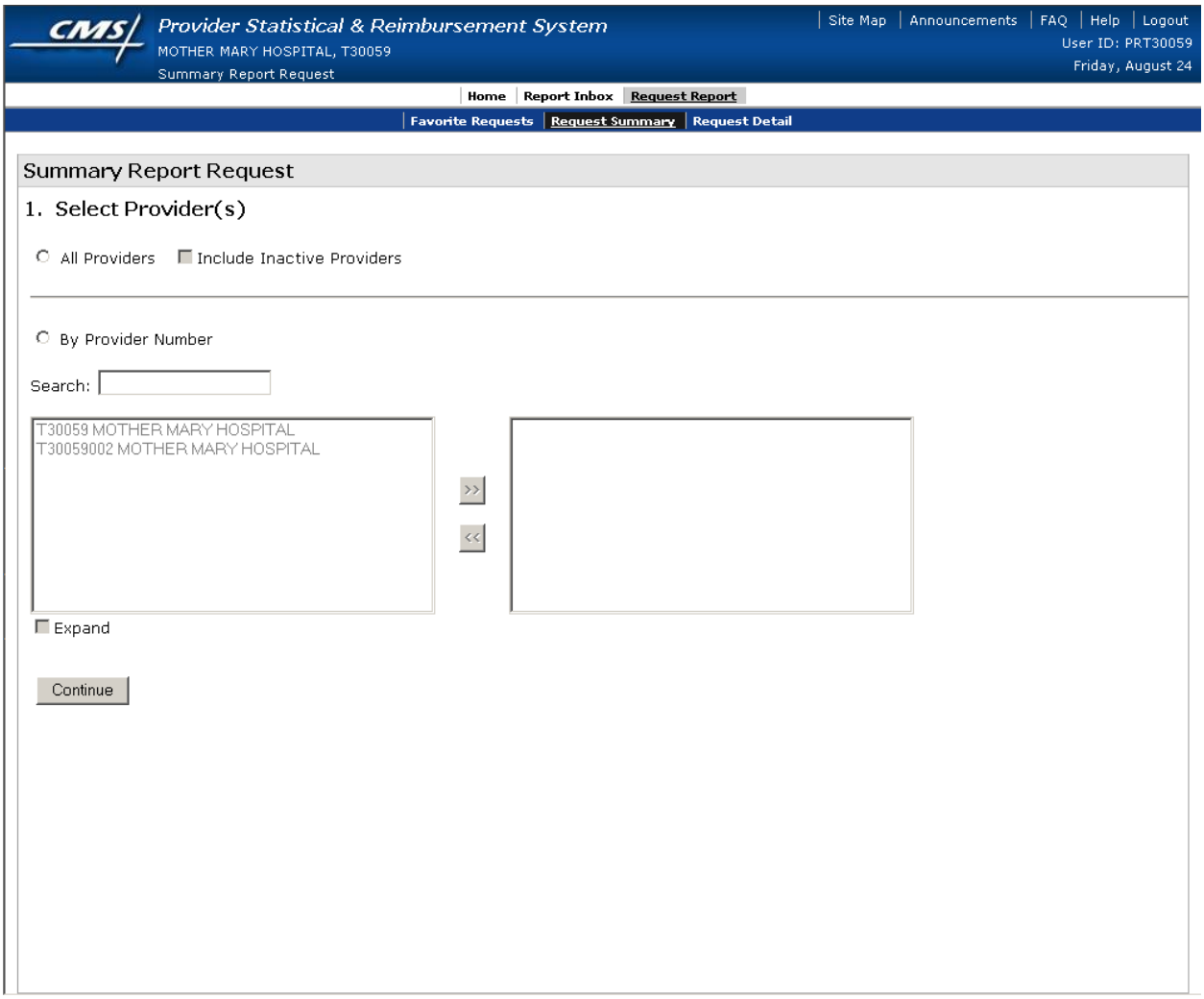


The following section provides the instructions to change the default contractor ID when working in the PS&R System.

3.2 Request Summary Reports

Perform the following steps to request summary reports:

1. Select the **Request Summary** option from the **Request Report** menu. The following page appears for providers with a parent provider. Freestanding or child providers skip to Step 3.

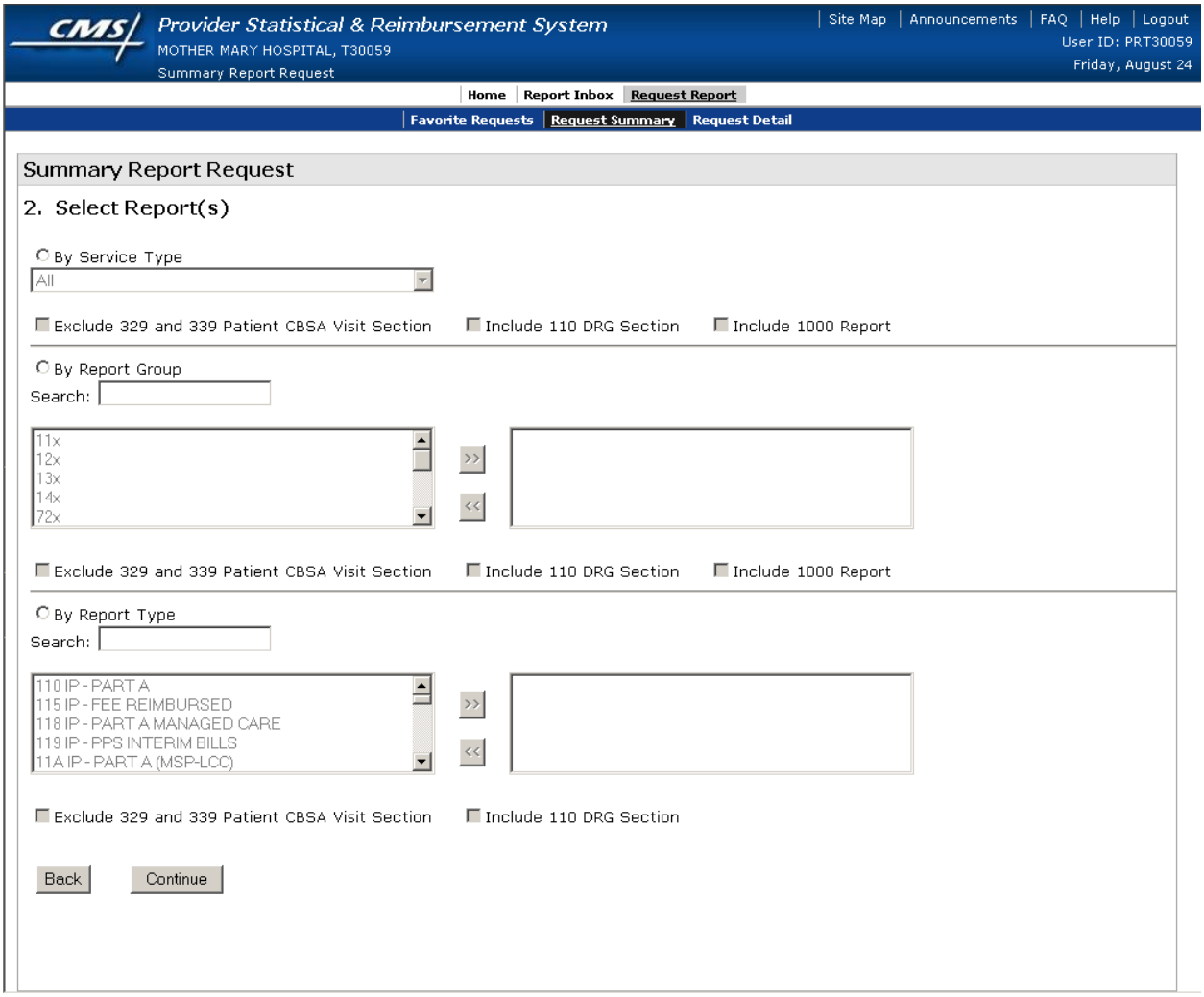


2. Select the provider(s) for which to generate a report. The following table contains a description of each field on the page.

Field	Definition
All Providers	Required if the **By Provider Number** is not selected. Select the **All Providers** option to include all child providers associated with the logged-in provider number. (This option is only available for parent provider users.)

Field	Definition
Include Inactive Providers	Optional. Select the check box to include both active and inactive providers associated with the logged-in provider number. (The check box is only available for parent provider users.)
By Provider Number	Required if **All Providers** is not selected. Select the **By Provider Number** option to select providers by provider number. If a provider number in the list of provider numbers is listed in red text, the parent provider no longer services the provider but can generate reports for the time period of its ownership. Once a provider number is highlighted, click the **>>** button to select the provider number. Once a provider number is selected, highlight the provider number from the list of selected provider numbers and click the **<<** button to remove the provider number. To locate a provider number in the list of providers, type the desired provider number in the **Search** text box to scroll to the provider number based on the entered criteria. (This option is only available for parent provider users.)
Expand	Optional. Select the check box to increase the width of the list box containing providers, allowing the complete provider name to display in the list box.

3. Once the provider(s) have been selected, click **Continue**. The following page appears.

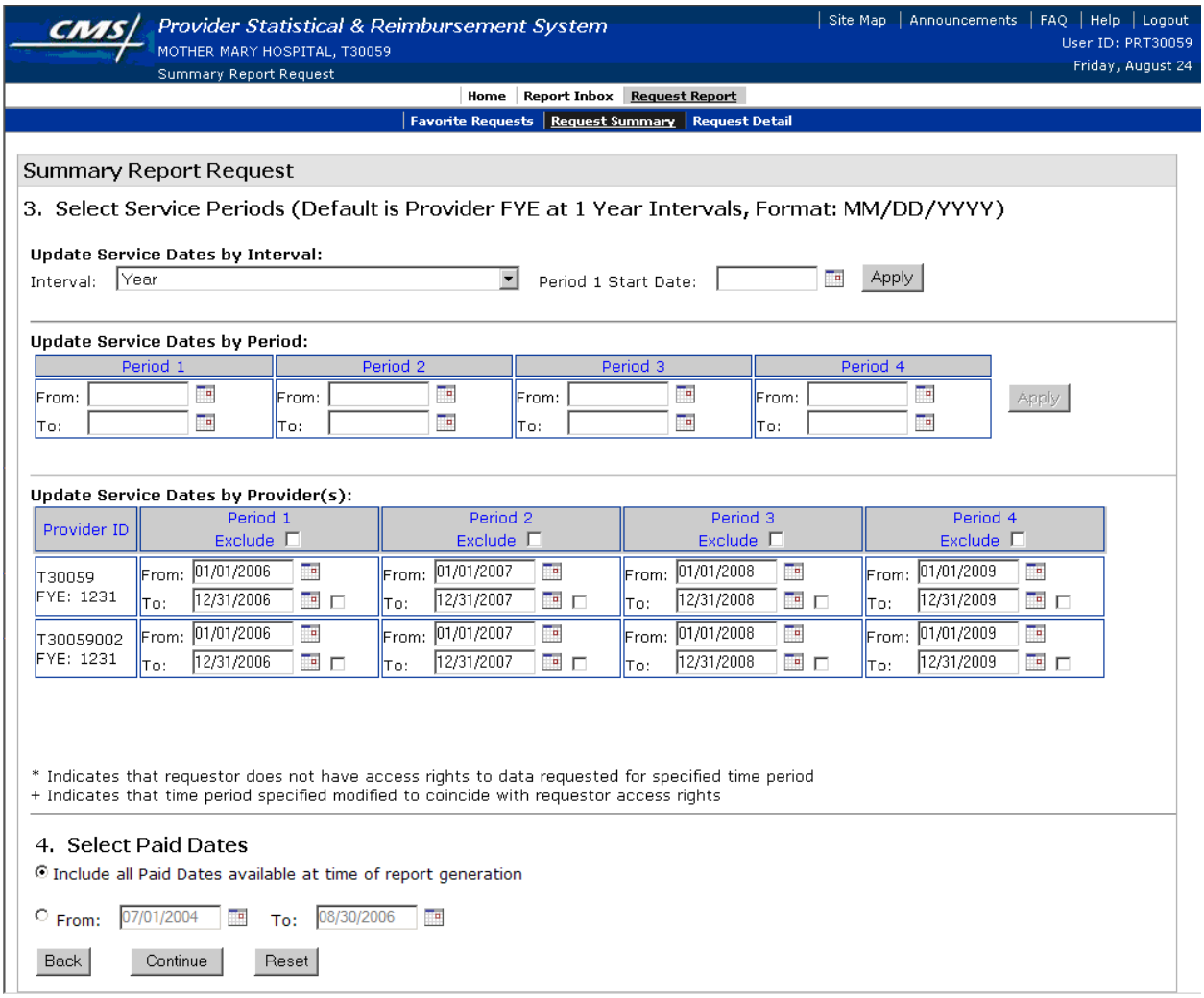


4. Select the report(s) to generate for the selected provider(s). The following table contains a description of each field on the page.

Field	Definition
By Service Type	Required if neither **By Report Group** nor **By Report Type** is selected. Select the **By Service Type** option and then select the service type to include in the report.
Exclude 329 and 339 Patient CBSA Visit Section	Optional. Select the check box to exclude the 329 and 339 Patient CBSA visit section.
Include 110 DRG Section	Optional. Select the check box to include the DRG section on the 110 reports in the request. **Include 110 DRG Section** is only valid if **By Service Type** is “All” or “Inpatient”.
Include 1000 Report	Optional. Select the check box to include the Consolidated Summary of All Report Types Report (1000) with the request.

Field	Definition
By Report Group	Required if neither **By Service Type** nor **By Report Type** is selected. Select the **By Report Group** option and then select the report group to generate. Once a report group is highlighted, click the **>>** button to select the report group. Once a report group is selected, highlight the report group from the list of selected report groups and click the **<<** button to remove the report group. To locate a report group in the list of report groups, type the desired report group in the **Search** text box to scroll to the report group based on the entered criteria.
Exclude 329 and 339 Patient CBSA Visit Section	Optional. Select the check box to exclude the 329 and 339 Patient CBSA visit section.
Include 110 DRG Section	Optional. Select the check box to include the DRG section on the 110 reports in the request. **Include 110 DRG Section** is valid only if **By Report Group** is “11x”.
Include 1000 Report	Optional. Select the check box to include the Consolidated Summary of All Report Types Report (1000) with the request.
By Report Type	Required if neither **By Service Type** nor **By Report Group** is selected. Select the **By Report Type** option and then select the report type to include in the report. Once a report type is highlighted, click the **>>** button to select the report type. Once a report type is selected, highlight the report type from the list of selected report types and click the **<<** button to remove the report type. To locate a report type in the list of report types, type the desired report type in the **Search** text box to scroll to the report type based on the entered criteria.
Exclude 329 and 339 Patient CBSA Visit Section	Optional. Select the check box to exclude the 329 and 339 Patient CBSA visit section.
Include 110 DRG Section	Optional. Select the check box to include the DRG section on the 110 reports in the request. **Include 110 DRG Section** is valid only if **By Report Type** is “110”.

5. Click **Continue** to continue to the next page to specify the service periods and claim paid dates to include in the report(s) or click **Back** to return to the previous page. The following page appears if you click **Continue**.



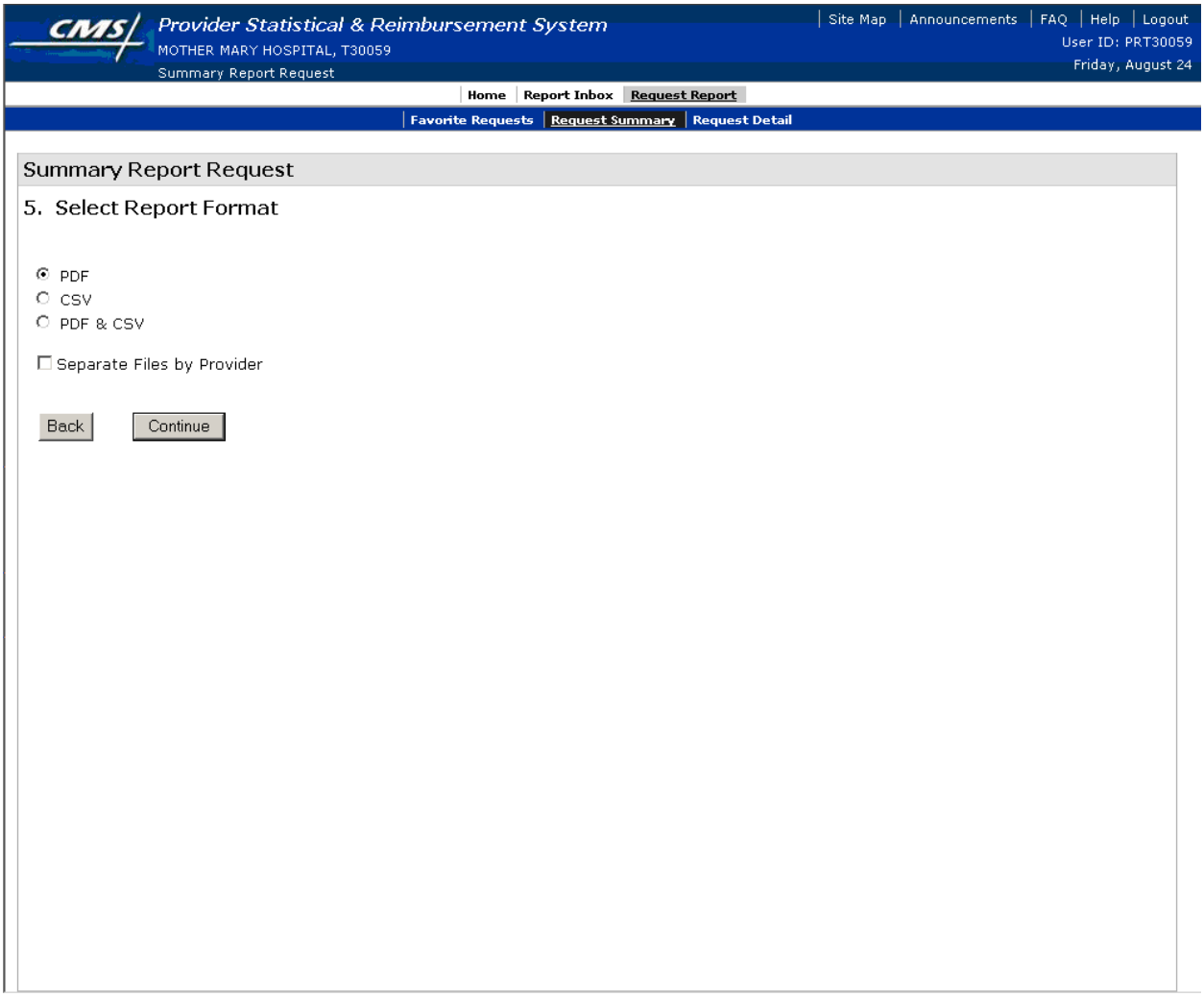
6. Select the service periods and claim paid dates to include in the report(s). You can specify the service period by selecting the interval and period start date and applying these date ranges to all providers and periods; by selecting the From and To dates for each of the four periods and applying the date ranges to all providers, or by specifying the From and To dates for all periods and providers. The following table contains a description of each field on the page.

Field	Definition
Update Service Dates by Interval	
Interval	Optional. Select the interval (year, quarter, or month) to use for the From and To date ranges for each of the four reporting periods. If interval and start dates are not applied, the report is generated using the default dates populated when you accessed the page.

Field	Definition
Period 1 Start Date	Optional. Type the start date in MM/DD/YYYY format for the first reporting period or click the calendar icon to select the start date using the calendar. Scroll through the months and select the date to use. Click **Apply** to apply the dates to all providers for the From and To dates for each of the four reporting periods. If interval and start dates are not applied, the report is generated using the default dates populated when you accessed the page.
Update Service Dates by Period	
Period <n> From	Optional. Type the start date in MM/DD/YYYY format for each of the four reporting periods to assign the reporting period range individually or click the calendar icon to select the start date using the calendar. Scroll through the months and select the date to use. Click **Apply** to apply the dates to all providers for the From and To dates for each of the four reporting periods.
Period <n> To	Optional. Type the end date in MM/DD/YYYY format for each of the four reporting periods to assign the reporting period range individually or click the calendar icon to select the end date using the calendar. Scroll through the months and select the date to use. Click **Apply** to apply the dates to all providers for the From and To dates for each of the four reporting periods.
Update Service Dates by Provider(s)	
<Provider ID> From	Optional. Type the start date in MM/DD/YYYY format for each of the four reporting periods to assign the reporting period range individually for a provider.
<Provider ID> To	Optional. Type the end date in MM/DD/YYYY format for each of the four reporting periods to assign the reporting period range individually for a provider.
Exclude	Optional. Select the **Exclude** check box to exclude any provider or reporting periods from the report(s).
Select Paid Dates	
Include all Paid Dates at time of report generation	Required if the **Select Paid Dates** option is not selected. Select the **Include all Paid Dates at time of report generation** option to include all available paid dates in the report.
(Paid Dates) From	Required if the **Include all Paid Dates at the time of report generation** option is not selected. The default value is the earliest date in the paid/cycle date from the paid claims file loaded for the selected providers. Click the radio button and type the start date in MM/DD/YYYY format for the paid date range to include in the report or click the calendar icon to select the start date to use in the paid date range using the calendar. Scroll through the months and select the date to use. Note that only dates later than the default date can be selected.

Field	Definition
(Paid Dates) To	Required if the **Include all Paid Dates at the time of report generation** option is not selected. The default value is the latest paid/cycle date from the paid claim files loaded for the provider's FI/MAC. Type the end date in MM/DD/YYYY format for the paid date range to include in the report or click the calendar icon to select the end date to use in the paid date range using the calendar. Scroll through the months and select the date to use. Note that only dates before the default date can be selected.

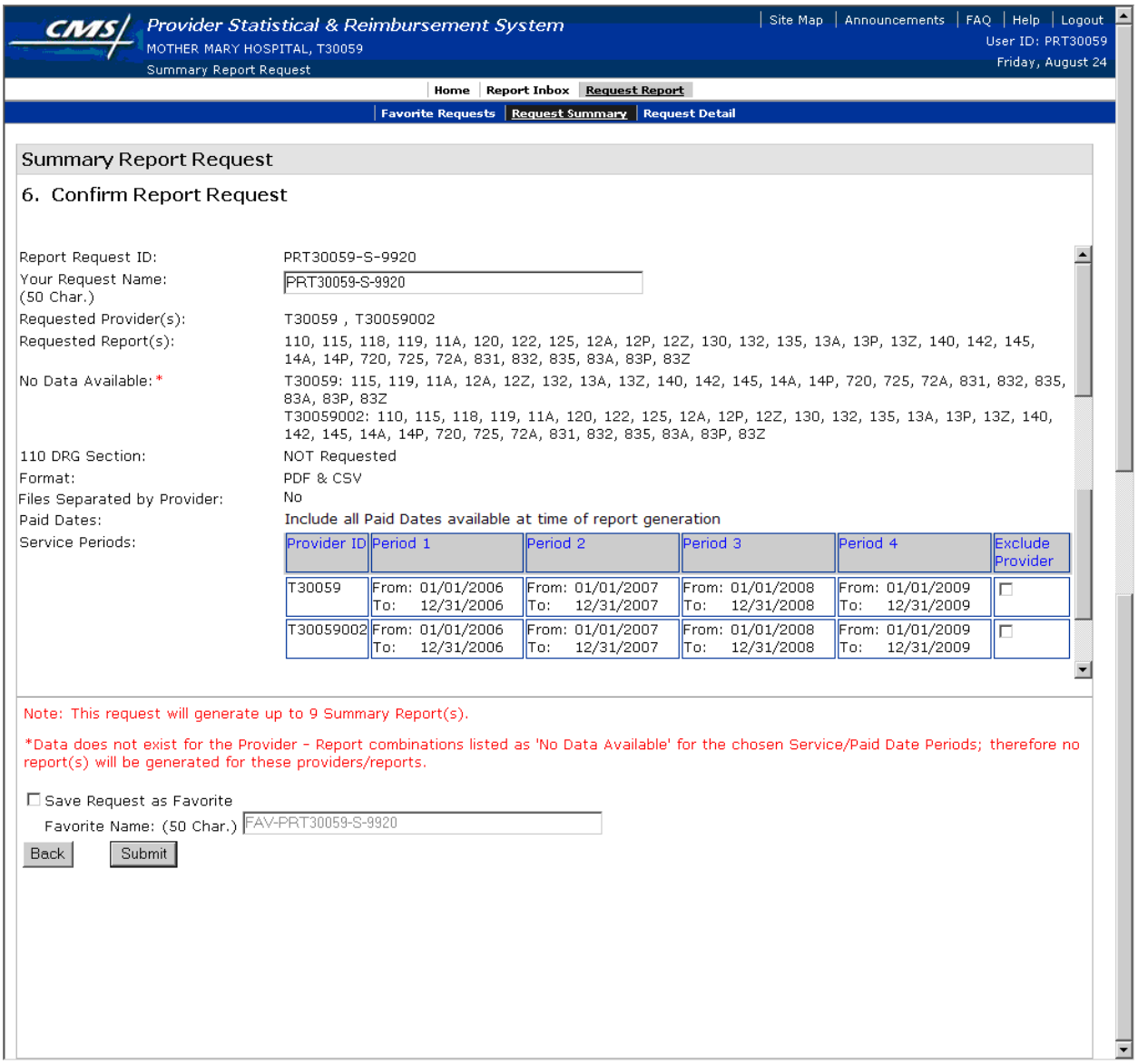
7. Click **Continue** to continue to the next page to specify the report format or click **Back** to return to the previous page. Click **Reset** to restore the values on the page to the default values. The following page appears if you click **Continue**.



8. Select the report format radio button to specify the type of report format: portable document format (PDF), comma-separated values (CSV), or both PDF and CSV formats. Note: if you select to generate a PDF file that results in an excessively large PDF file, you will be prompted to change your reporting parameters or to

select the CSV option. Click the **Separate Files by Provider** check box to produce a single ZIP file containing a separate output file for each provider.

9. Click **Continue** to continue to the next page to specify the request name and to view the selection criteria for the report(s) or click **Back** to return to the previous page. The following page appears if you click **Continue**.



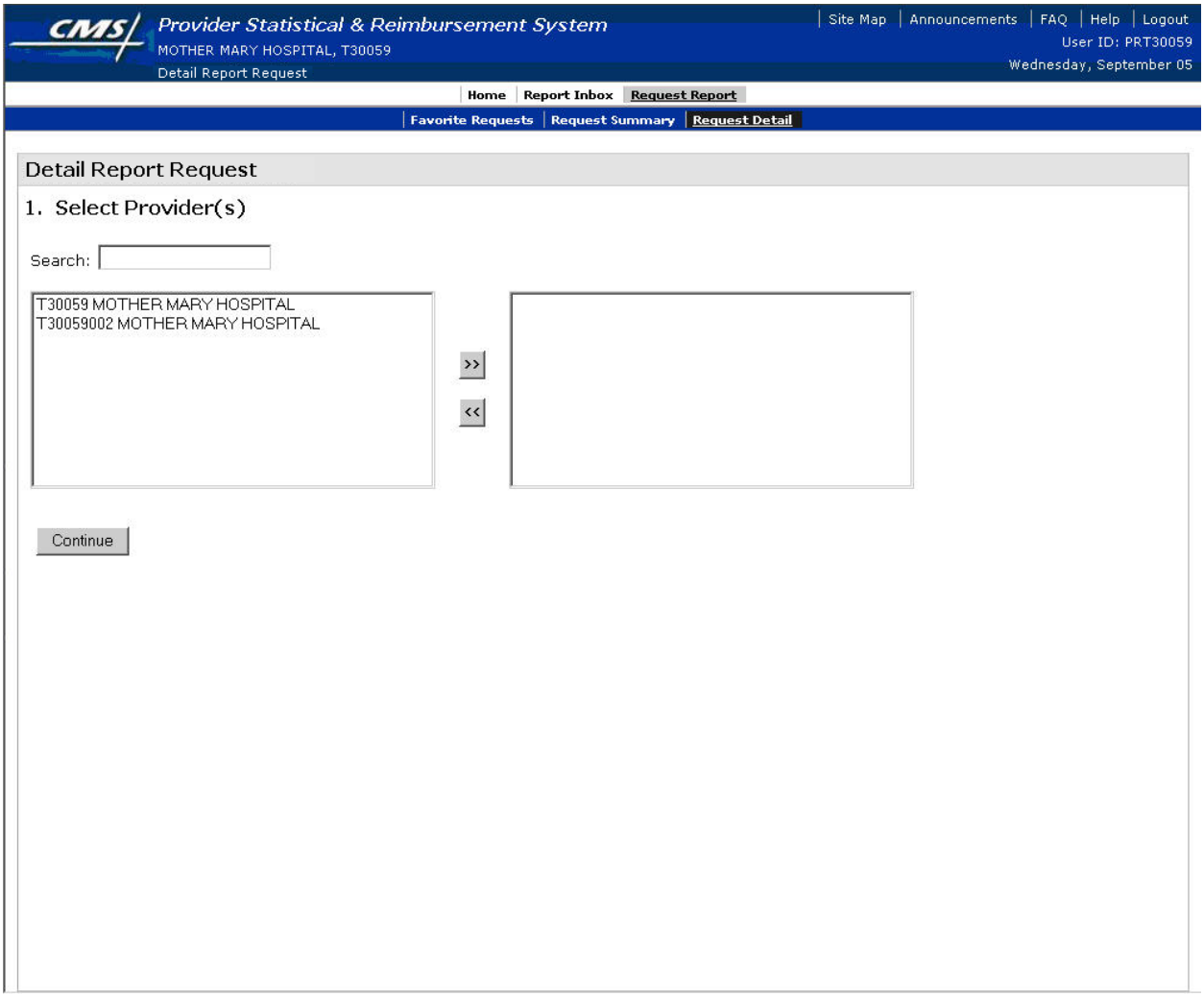
10. Type the request name or accept the default name. The request name can be up to 50 characters. Select the **Exclude** check box to exclude any providers from the report(s). To save the request to your **Favorite Requests** list, select the **Save Request as Favorite** check box. Type the request name or accept the default name. Up to 100 favorite report requests can be saved. To access a saved report, select the **Favorite Requests** option from the **Request Report** menu. Refer to Section 3.4, Favorite Requests, for additional information.

11. Click **Submit** to submit the report request or click **Back** to return to the previous page. Once **Submit** is selected, the report request is submitted and the PS&R Home page appears. Reports generated from this page can be viewed by accessing the **Summary Report Inbox** option from the **Report Inbox** menu.

3.3 Request Detail Reports

Perform the following steps to request detail reports:

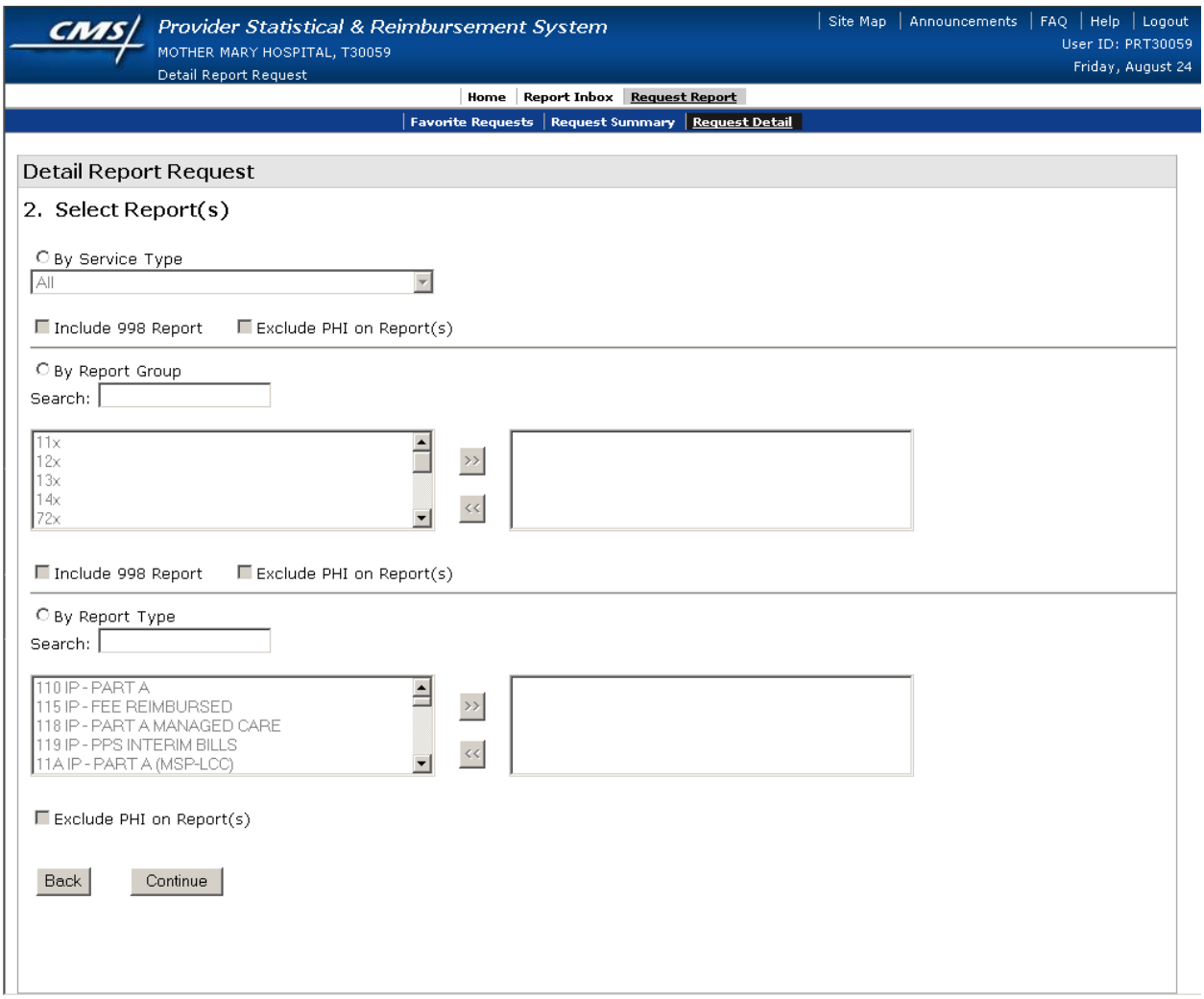
1. Select the **Request Detail** option from the **Request Report** menu. The following page appears for providers with a parent provider. Freestanding or child providers skip to Step 3.



2. Select the provider(s) for which to generate a report. The following table contains a description of each field on the page.

Field	Definition
(Providers)	Select the provider number(s) to include in the report. If a provider number is listed in red text, the parent provider no longer services the provider but can generate reports for the time period of its ownership. Once a provider number is highlighted, click the **>>** button to select the provider number. Once a provider number is selected, highlight the provider number from the list of selected provider numbers and click the **<<** button to remove the provider number. To locate a provider number in the list of providers, type the desired provider number in the **Search** text box to scroll to the provider number based on the entered criteria.
Expand	Optional. Select the check box to increase the width of the list box containing providers, allowing the complete provider name to display in the list box.

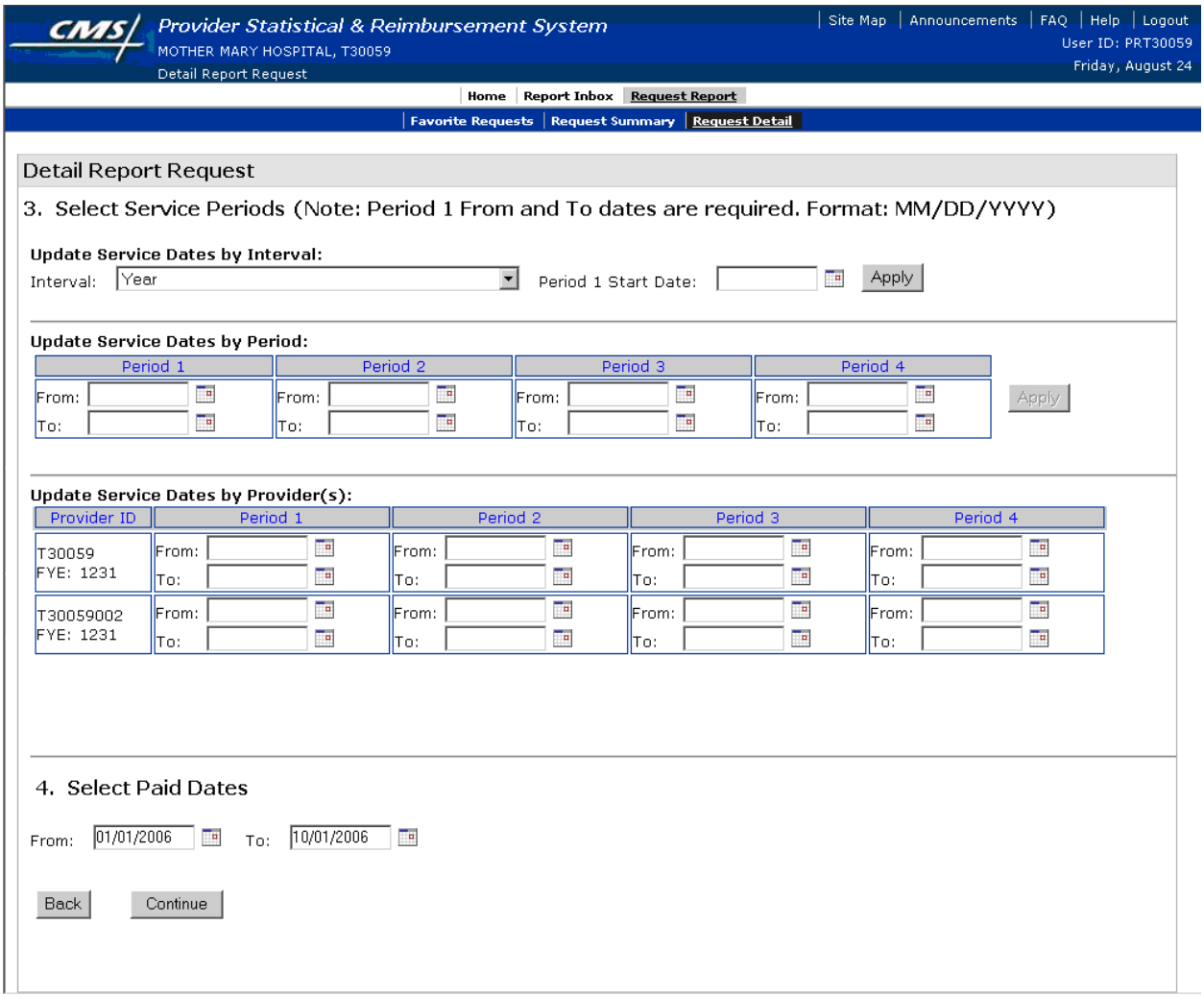
3. Once the provider(s) have been selected, click **Continue**. The following page appears.



4. Select the report(s) to generate for the selected provider(s). The following table contains a description of each field on the page.

Field	Definition
By Service Type	Required if neither **By Report Group** nor **By Report Type** is selected. Select the **By Service Type** option and then select the service type to include in the report.
Include 998 Report	Optional. Select the check box to include the Consolidation of Outpatient Claims (Excluding MSP-LCC) (998) report in this request.
Exclude PHI on Report(s)	Optional. Select the check box to exclude all personal health information on the reports generated in this request.
By Report Group	Required if neither **By Service Type** nor **By Report Type** is selected. Select the **By Report Group** option and then select the report group to generate. Once a report group is highlighted, click the **>>** button to select the report group. Once a report group is selected, highlight the report group from the list of selected report groups and click the **<<** button to remove the report group. To locate a report group in the list of report groups, type the desired report group in the **Search** text box to scroll to the report group based on the entered criteria.
Include 998 Report	Optional. Select the check box to include the Consolidation of Outpatient Claims (Excluding MSP-LCC) (998) report in this request.
Exclude PHI on Report(s)	Optional. Select the check box to exclude all personal health information on the reports generated in this request.
By Report Type	Required if neither **By Service Type** nor **By Report Group** is selected. Select the **By Report Type** option and then select the report type to include in the report. Once a report type is highlighted, click the **>>** button to select the report type. Once a report type is selected, highlight the report type from the list of selected report types and click the **<<** button to remove the report type. To locate a report type in the list of report types, type the desired report type in the **Search** text box to scroll to the report type based on the entered criteria.
Exclude PHI on Report(s)	Optional. Select the check box to exclude all personal health information on the reports generated in this request.

5. Click **Continue** to continue to the next page to specify the service periods and claim paid dates to include in the report(s) or click **Back** to return to the previous page. The following page appears if you click **Continue**.

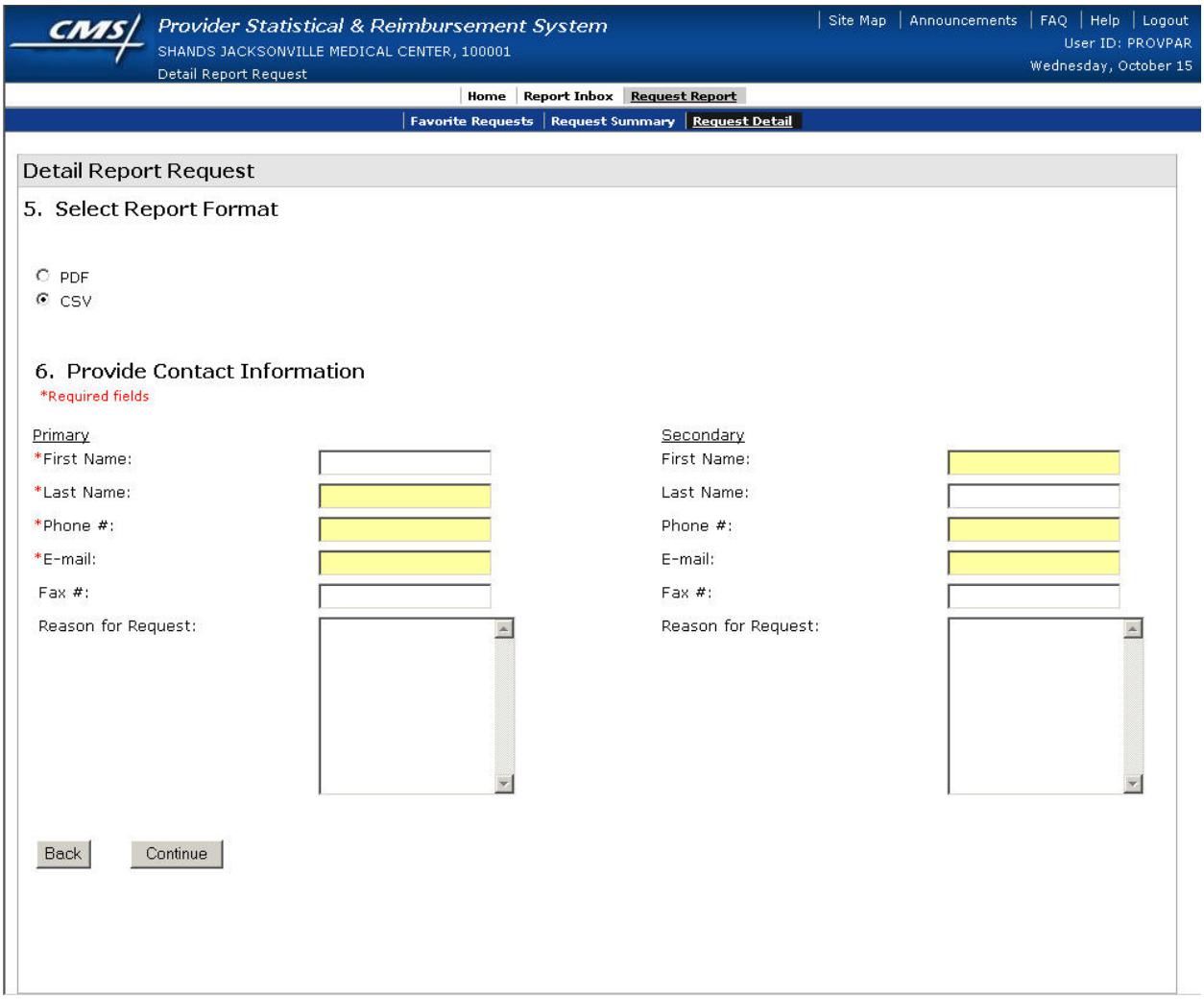


6. Select the service periods and claim paid dates to include in the report(s). The following table contains a description of each field on the page.

Field	Definition
Update Service Dates by Interval	
Interval	Optional. Select the interval (year, quarter, or month) from the drop-down list to use for the from and to date ranges for each of the four reporting periods. If interval and start dates are not applied, the report is generated using the default dates populated when you accessed the page.

Field	Definition
Period 1 Start Date	Optional. Type the start date in MM/DD/YYYY format for the first reporting period or click the calendar icon to select the start date using the calendar. Scroll through the months and select the date to use. Click **Apply** to apply the dates to all providers for the from and to dates for each of the four reporting periods. If interval and start dates are not applied, the report is generated using the default dates populated when you accessed the page.
Update Service Dates by Period	
Period <n> From	Optional. Type the start date in MM/DD/YYYY format for each of the four reporting periods to assign the reporting period range individually or click the calendar icon to select the start date using the calendar. Scroll through the months and select the date to use. Click **Apply** to apply the dates to all providers for the From and To dates for each of the four reporting periods.
Period <n> To	Optional. Type the end date in MM/DD/YYYY format for each of the four reporting periods to assign the reporting period range individually or click the calendar icon to select the end date using the calendar. Scroll through the months and select the date to use. Click **Apply** to apply the dates to all providers for the From and To dates for each of the four reporting periods.
Update Service Dates by Provider(s)	
<Provider ID> From	Optional. Type the start date in MM/DD/YYYY format for each of the four reporting periods to assign the reporting period range individually for a provider.
<Provider ID> To	Optional. Type the end date in MM/DD/YYYY format for each of the four reporting periods to assign the reporting period range individually for a provider.
(Paid Dates) From	The default value is the earliest date in the paid/cycle date from the paid claims file loaded for the selected providers. Type the start date in MM/DD/YYYY format for the claim paid date range or click the calendar icon to select the start date using the calendar. Scroll through the months and select the date to use.
(Paid Dates) To	The default value is the latest paid/cycle date from the paid claim files loaded for the provider's FI/MAC. Type the end date in MM/DD/YYYY format for the claim paid date range or click the calendar icon to select the end date using the calendar. Scroll through the months and select the date to use.
Exclude	Optional. Select the **Exclude** check box to exclude any providers or reporting periods from the report(s).

7. Click **Continue** to continue to the next page to specify the report format and contact information or click **Back** to return to the previous page. The following page appears if you click **Continue**.

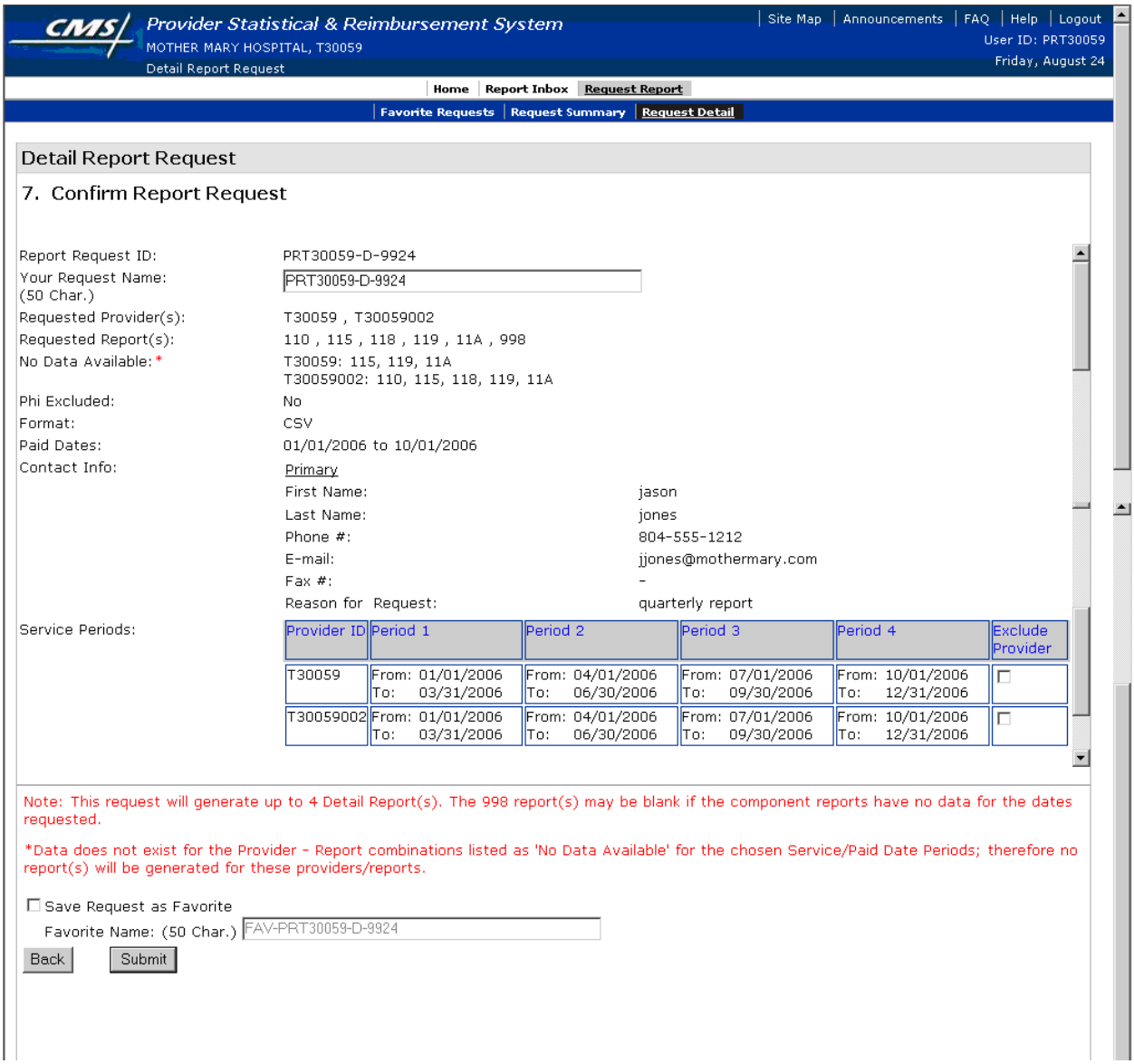


8. Select the report format and type the contact information for the report output. The following table contains a description of each field on the page.

Field	**Definition**
(Output Report Format)	Required. Select the report format radio button to specify the type of report format: portable document format (PDF) or comma-separated values (CSV). Note: if you select to generate a PDF file that results in an excessively large PDF file, you will be prompted to change your reporting parameters or to select the CSV option. If the CSV option is selected, the report output is automatically generated as a ZIP file.
Primary	
First Name	Required. Type the first name of the primary contact for the report request.
Last Name	Required. Type the last name of the primary contact for the report request.

Field	Definition
Phone #	Required. Type the telephone number of the primary contact for the report request in ########## or ###-###-####. **Phone #** can be up to ten (10) digits.
E-mail	Required. Type the e-mail address of the primary contact for the report request in the format <recipient name>@<domain>.<qualifier> (for example, john.doe@cms.gov where <recipient name> is “john.doe”, <domain> is “cms”, and <qualifier> is “gov”).
Fax #	Optional. Type the fax number of the primary contact for the report request in ########## or ###-###-####. **Fax #** can be up to ten (10) digits.
Reason for Request	Optional. Type the reason for the request to include with the report request. **Reason for Request** can be up to 250 characters.
Secondary	
First Name	Optional. Type the first name of the secondary contact for the report request.
Last Name	Optional. Type the last name of the secondary contact for the report request.
Phone #	Optional. Type the telephone number of the secondary contact for the report request in ########## or ###-###-####. **Phone #** can be up to ten (10) digits.
E-mail	Optional. Type the e-mail address of the primary contact for the report request in the format <recipient name>@<domain>.<qualifier> (for example, john.doe@cms.gov where <recipient name> is “john.doe”, <domain> is “cms”, and <qualifier> is “gov”).
Fax #	Optional. Type the fax number of the secondary contact for the report request in ########## or ###-###-####. **Fax #** can be up to ten (10) digits.
Reason for Request	Optional. Type the reason for the request to include with the report request. **Reason for Request** can be up to 250 characters.

9. Click **Continue** to continue to the next page to specify the request name and to view the selection criteria for the report(s) or click **Back** to return to the previous page. The following page appears if you click **Cotinue**.



10. Type the request name or accept the default name. The request name can be up to 50 characters. Select the **Exclude** check box to exclude any providers from the report(s). To save the request to your **Favorite Requests** list, select the **Save Request as Favorite** check box. Type the request name or accept the default name. Up to 100 favorite report requests can be saved. To access a saved report, select the **Favorite Requests** option from the **Request Report** menu. Refer to Section 3.4, Favorite Requests, for additional information.

11. Click **Submit** to submit the report request or click **Back** to return to the previous page. Once **Submit** is selected, the report request is submitted and the PS&R Home page appears. Reports generated from this page can be viewed by accessing the **Detail Reports** hyperlink after the FI/MAC Administrator has approved the request.

3.4 Report Inbox

Once a report request is submitted, you can view the status of the request in the Reports Inbox by selecting the **Summary Report Inbox** or **Detail Report Inbox** option from the **Report Inbox** menu.

A report is listed in the Summary Report Inbox as soon as the report request has been submitted. The summary request statuses are:

- **Queued** – the request is queued for processing but has not begun processing
- **Processing** – the request has not completed processing
- **Complete** – the request has been submitted and has completed processing
- **Error** – the request contains technical problems and was not completed

For detail report requests, the Detail Report Inbox lists the status of the request. The following statuses are available for detail requests:

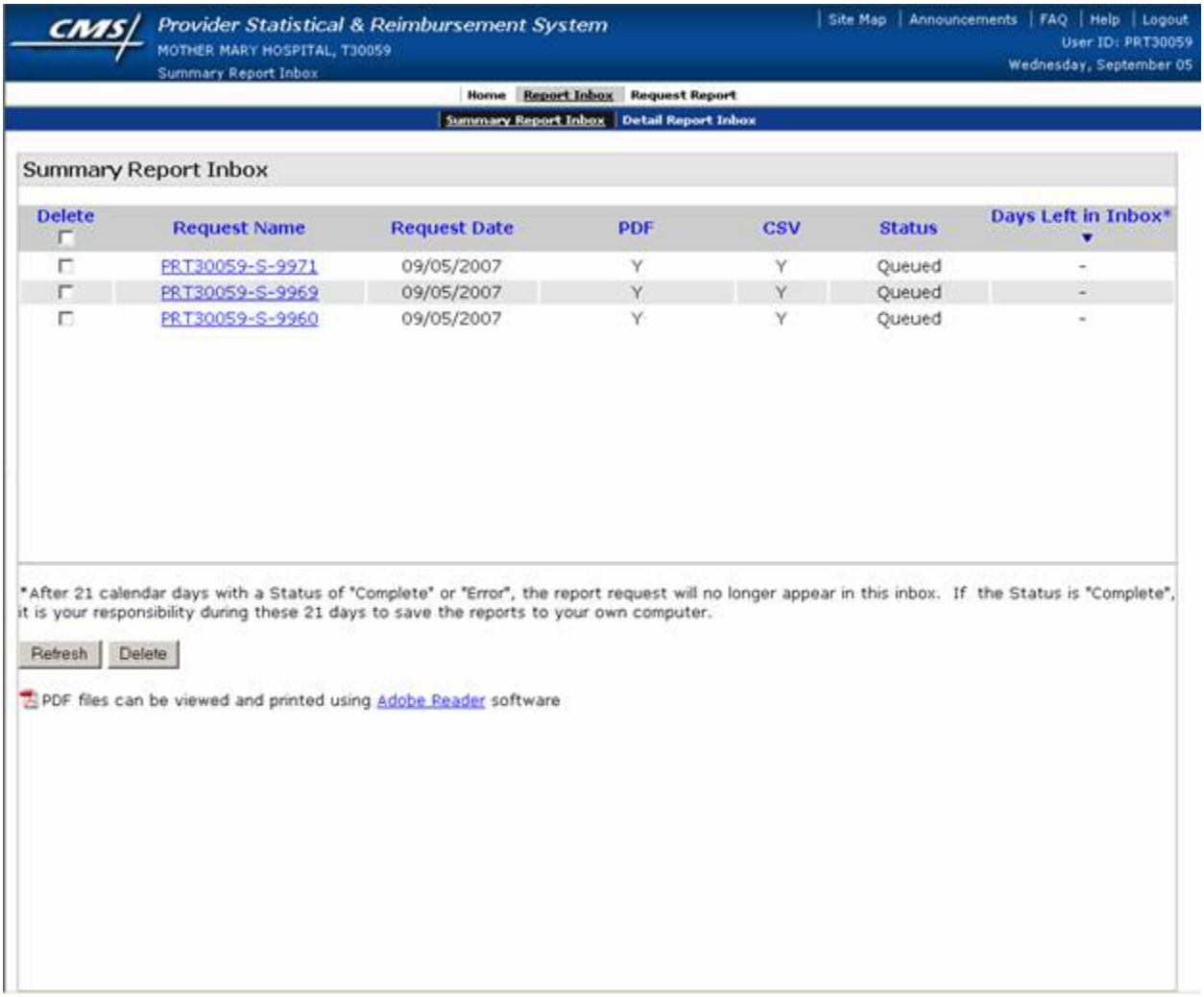
- **Queued** – the request is queued for processing but has not begun processing
- **Pending** – your FI/MAC Administrator has not approved or declined the request
- **Processing** – your FI/MAC has approved the request and the report is being processed by the system
- **Processing/Modified** – your FI/MAC Administrator has submitted the request but modified the request prior to submission for processing
- **Complete/Modified** – your FI/MAC Administrator modified the request prior to submission for processing and the request has completed processing
- **Complete** – your FI/MAC Administrator has submitted the request and the request has completed processing
- **Declined** – your FI/MAC Administrator declined the request; any comments your FI/MAC Administrator included with the request can be viewed by clicking the status hyperlink corresponding to the request
- **Error** – the request contains technical problems and was not completed

The report requests listed in either inbox can be sorted in ascending or descending order by clicking the column heading associated with the desired column to sort. Clicking the column heading acts as a toggle to reverse the sort order with each click of the column heading. An up- or down-arrow appears to the right of the column heading indicating the column that is currently sorted and whether the column is sorted in ascending or descending order.

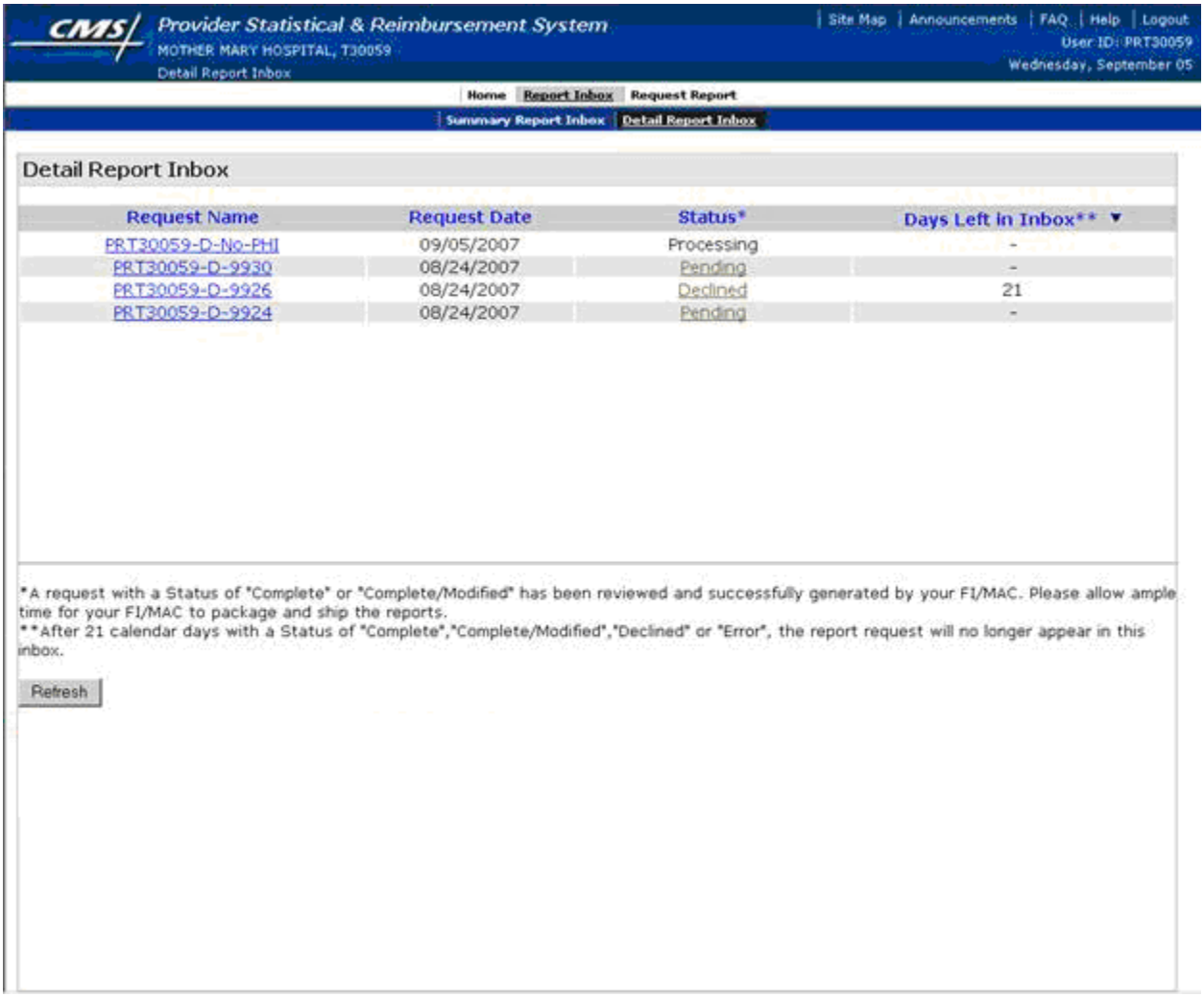
Once the FI/MAC Administrator approves a detail request and reports are generated, the FI/MAC Administrator mails the report(s) to the address the FI/MAC Administrator has on file for the provider submitting the request. Detail reports may contain protected health information that is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA); therefore, detail reports **cannot** be sent electronically to a user's email address and **cannot** be sent to the Report Inbox in the PS&R System.

Note: Adobe Reader is required to be installed on your computer in order to view PDF files. If you do not have Adobe Reader installed, click the **Adobe Reader** hyperlink to download the software.

An example of the Summary Report Inbox follows.

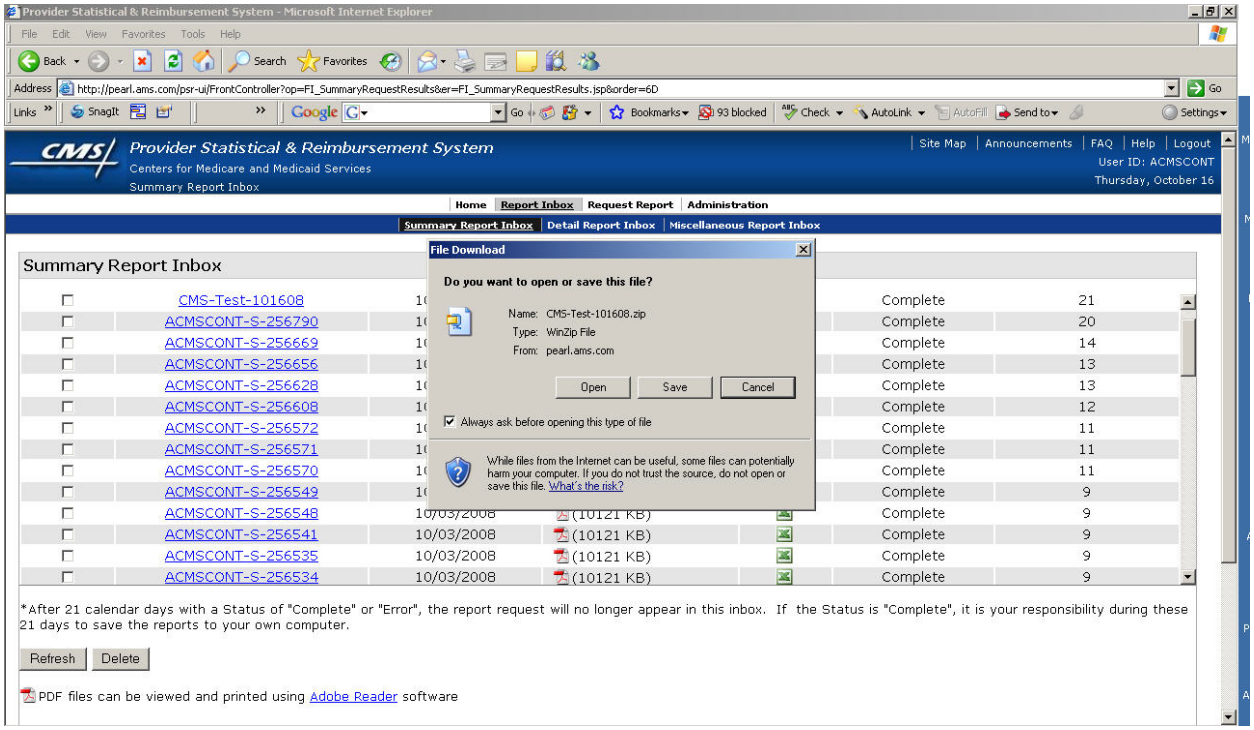


An example of the Detail Report Inbox follows.

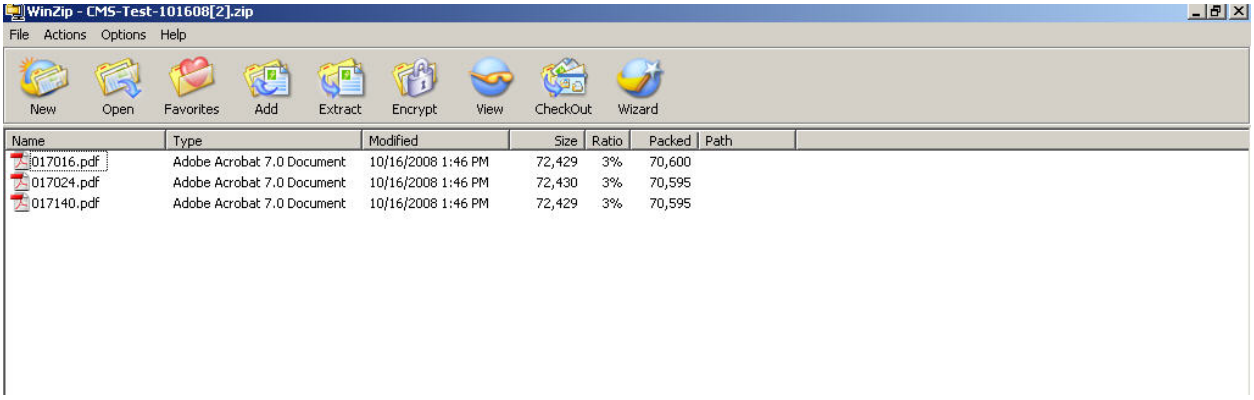


The inbox pages display the request name specified when the request was submitted, the date of the request, the report format, the status of the report, and the number of days the report remains in your inbox. To save the report, open the report by selecting the corresponding icon in the “PDF” or “CSV” column and then select the desired “save” option based on the report format. If the report format is “PDF”, click **Save a Copy** or select the **Save as** menu option from the **File** menu. If the report format is “CSV”, click **Save** in the File Download dialog box.

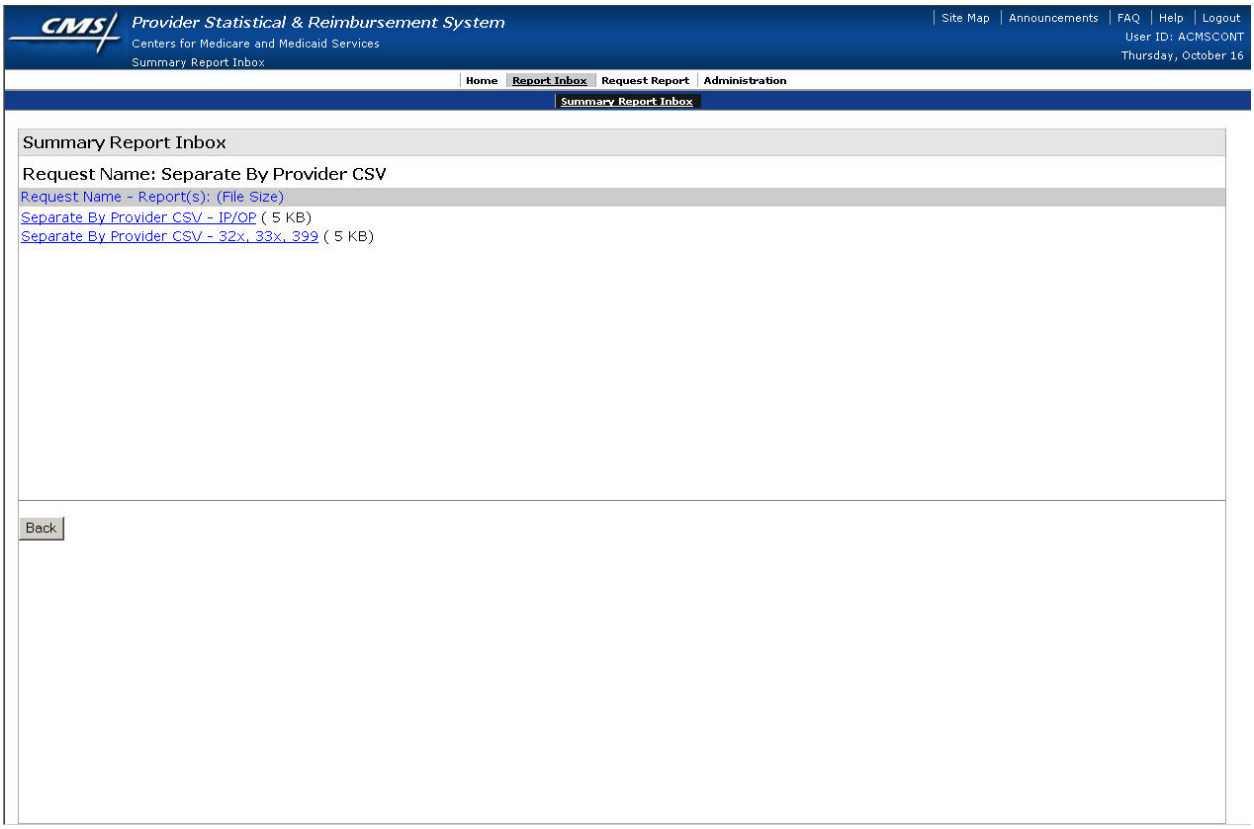
If **Separate Files by Provider** is selected, a ZIP file is created containing a separate file for each provider requested for both CSV and PDF requests. For PDF reports, the ZIP file can be saved or opened when the PDF icon is clicked. For CSV reports, when the user clicks the CSV icon, a secondary page displays, which when clicking on the links, the user can save or open the ZIP file.



The files will be saved as shown in the display below:

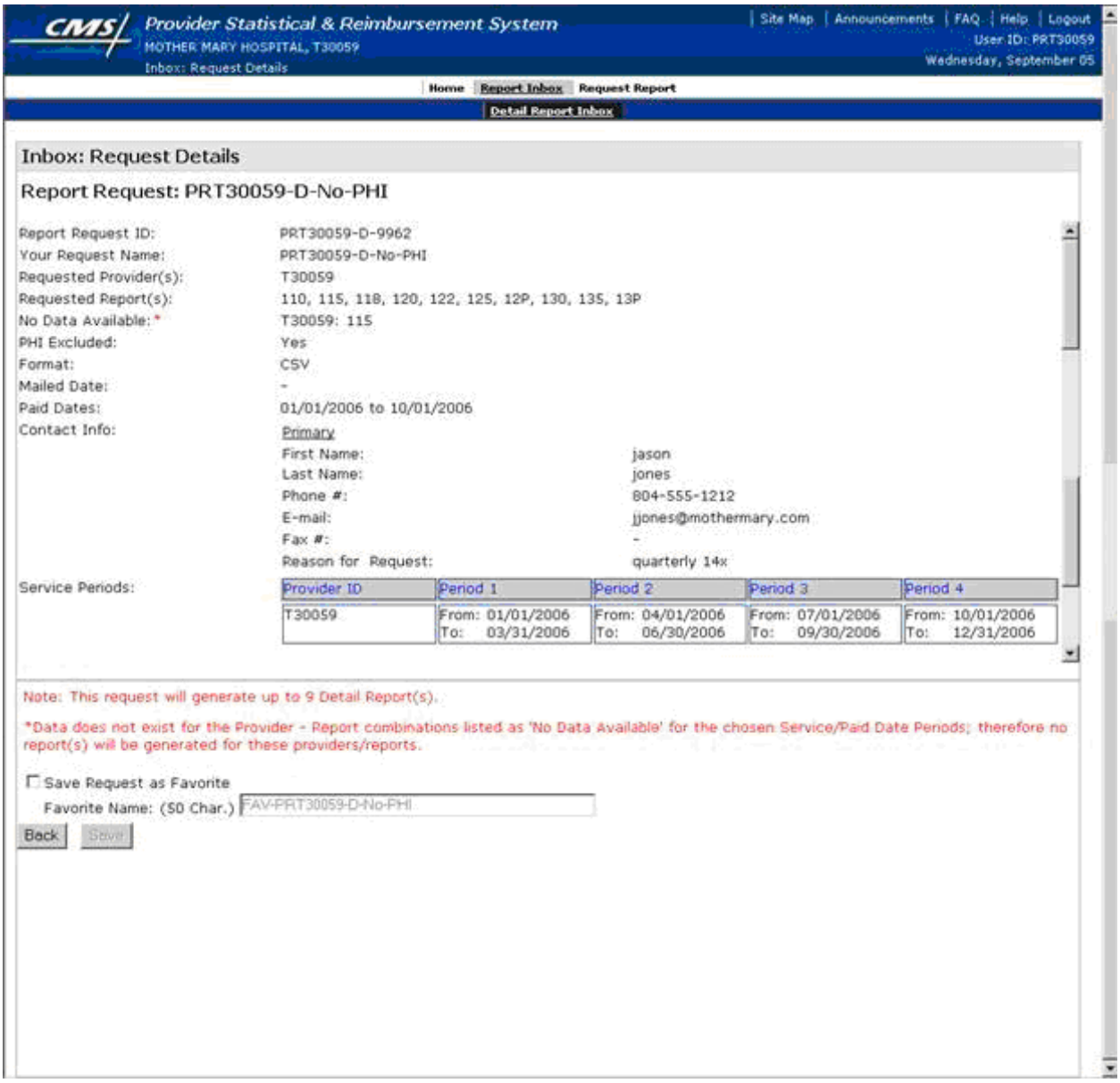


If **Separate Files by Provider** was not selected for CSV report requests, when the user clicks the CSV icon, the secondary page opens, and when the user clicks the links, the user is prompted to either save or open the ZIP file. The ZIP file contains one file that contains all providers included in the request. If **Separate Files by Provider** was not selected for PDF report requests, the report will open in a new window.



A report is automatically deleted from the inbox 21 days after the request status is “Complete” or “Complete/Modified”. You can delete summary reports and summary report requests from the Summary Report Inbox before 21 days has passed or cancel report requests before the report request is completed by clicking the **Delete** check box next to the corresponding reports/report requests to delete and then clicking the **Delete** button at the bottom of the page. Detail report requests cannot be deleted from the Detail Report Inbox prior to the automatic 21-day period.

An example of the report request details page follows. This page contains the details of the report request that displays if the report name hyperlink is selected.



A summary report can be viewed once the report status is “Complete”. To open a report from the Summary Report Inbox, click the **PDF** or **CSV** icon corresponding to the desired report, based on the type of report format that was requested. To refresh the contents of the inbox, click **Refresh**. If a summary report is selected from the Summary Report Inbox, the selected report opens in a new Browser page. The first page of the report provides a “cover page” identifying the total number of pages for each provider number and report. Click the name corresponding to the provider number and report type combination to navigate the contents of the desired report.

An example of the summary report cover page in PDF format follows.

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

REPORT COVER PAGE FOR REQUEST: PRT00007-S-SAMPLE

Provider#-Report Type	Total # of Pages	Provider#-Report Type	Total # of Pages	Provider#-Report Type	Total # of Pages	Provider#-Report Type	Total # of Pages
T00007-110	5	T00007-115	1	T00007-118	1	T00007-11A	1
T00007-122	1	T00007-125	1	T00007-12P	1	T00007-130	1
T00007-135	1	T00007-13A	1	T00007-13P	2	T00007-13Z	1
T00007-140	1	T00007-145	1	T00007-14P	1		

An example of a summary report in PDF format follows.

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/03 THRU 10/01/06
Report Run Date: 01/29/07
Provider FYE: 12/31
Provider Number: 100007 FLORIDA HOSPITAL

PROVIDER SUMMARY REPORT
INPATIENT - PART A

Page: 1
Report #: OD44203
Report Type: 110

	SERVICES FOR PERIOD 01/01/03 - 12/31/03	SERVICES FOR PERIOD 01/01/04 - 12/31/04	SERVICES FOR PERIOD 01/01/05 - 12/31/05	SERVICES FOR PERIOD 01/01/06 - 12/31/06
STATISTIC SECTION				
DISCHARGES	0	7	0	67
MEDICARE DAYS	0	15	0	369
CLAIMS	0	7	0	67

CHARGE SECTION

*** ACCOMMODATION CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0121	MED-SUR-GY/2BED	0	$0.00	11	$9,823.00	0	$0.00	138	$155,304.00
0122	OB/2BED	0	$0.00	0	$0.00	0	$0.00	5	$9,109.00
0200	INTENSIVE CARE or (ICU)	0	$0.00	1	$1,786.00	0	$0.00	29	$65,609.00
0201	ICU/SURGICAL	0	$0.00	0	$0.00	0	$0.00	12	$37,833.00
0206	ICU/INTERMEDIATE	0	$0.00	0	$0.00	0	$0.00	149	$252,467.00
0210	CORONARY CARE or (CCU)	0	$0.00	0	$0.00	0	$0.00	8	$21,008.00
0214	CCU/INTERMEDIATE	0	$0.00	3	$3,435.00	0	$0.00	28	$40,436.00
TOTAL ACCOMMODATIONS		0	$0.00	15	$15,044.00	0	$0.00	369	$581,766.00

*** ANCILLARY CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0250	PHARMACY	0	$0.00	0	$0.00	0	$0.00	3	$2,873.21
0251	DRUGS/GENERIC	0	$0.00	58	$1,109.62	0	$0.00	2,568	$26,846.74
0252	DRUGS/NONGENERIC	0	$0.00	133	$3,741.01	0	$0.00	14,809	$488,865.54
0254	DRUGS/INCIDENT ODX	0	$0.00	0	$0.00	0	$0.00	2,255	$4,726.56
0255	DRUGS/INCIDENT RAD	0	$0.00	2	$169.76	0	$0.00	1,880	$2,407.95
0258	IV SOLUTIONS	0	$0.00	36	$2,748.01	0	$0.00	1,125	$88,424.88
0260	IV THERAPY	0	$0.00	1	$257.00	0	$0.00	0	$999.00
0270	MED-SUR SUPPLIES	0	$0.00	0	$0.00	0	$0.00	8	$2,014.40
0272	STERILE SUPPLY	0	$0.00	7	$3,883.42	0	$0.00	411	$172,789.52
0274	PROSTH/ORTH DEV	0	$0.00	0	$0.00	0	$0.00	1	$151.32
0278	SUPPLY/IMPLANTS	0	$0.00	0	$0.00	0	$0.00	72	$329,704.30

Jan 29, 2007 - 1 - 1:25:37 PM

Note that report examples in this manual do not contain actual PS&R data. The data in the examples is fictional data.

An example of a detail report in PDF format follows.

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 02/29/04
Report Run Date: 01/31/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
INPATIENT - PART A

Page: 1
Report #: OD44202
Report Type: 110
Paid Dates: 01/01/80 to 10/01/06

Claim Information

Patnt Nm:	BALD H	Bill Freq:	7
DCN:	20408627757804	Trans Type:	D
Ptnt Cntrl #:	001000000000	Dschrg Patnt Cd:	1
Med Rcrd #:	181000000000	Dschrg Patnt Stat:	Yes
HIC Num:	196042304A	DRG/CMG Cd:	397
Recpt Dt:	04/27/04	PIP Claim:	No
Paid Dt:	05/03/04	Pricer Rtn Cd:	14
Service From:	01/31/04	Bnfits Exhstd Ind.:	No
Service Thru:	02/04/04	Processor ID:	14000
Med. Days:	4		

Rev Code	Units	Charges
0121	1	$893.00
0214	3	$3,435.00
0251	1	$1.12
0252	28	$92.60
0258	5	$389.36
0260	1	$257.00
0301	9	$661.00
0302	12	$900.00
0305	12	$1,177.00
0324	1	$195.00
0351	3	$3,137.00
0390	4	$3,591.00
0450	1	$952.00
TOTAL:	81	$15,681.08

Reimbursements

Operating		Capital		Payment	
HSP:	$0.00	HSP:	$0.00	Gross Reimb.:	$6,470.02
FSP:	$5,442.08	FSP:	$526.73	LESS:	
Outlier:	$0.00	Outlier:	$0.00	Cash Deduct.:	$876.00
DSH/UP:	$342.85	Hold Harm:	$0.00	Blood Deduct.:	$0.00
IME/Teach Adj:	$124.60	DSH:	$22.54	Coins.:	$0.00
New Tech.:	$0.00	IME:	$11.22	MSP:	$0.00
IPF ECT:	$0.00	Excptns:	$0.00	MSP Pass Thru Recon.:	$0.00
Total:	$5,909.53	Total:	$560.49	Other Adjs:	$0.00
				Net Reimb.:	$5,594.02

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Calc Reimb. PIP:	$0.00
Actual Clm Pymnts PIP:	$0.00
Claim Interest:	$0.00
IRF Penalty:	$0.00
LTCH Short Stay Outlr:	$0.00
Cap Pay Cd:	B
Cap FSP @ 100%:	$526.73
Cap Outlr @ 100%:	$0.00
DRG/CMG Wgt:	1.2648
Dschrg Frctn:	1.0000
DRG Wgt Frctn:	1.2648
Claim Report Splits:	110.115

Patnt Nm:	BALD H	Bill Freq:	8
DCN:	20439959234505	Trans Type:	C
Ptnt Cntrl #:	001000000000	Dschrg Patnt Cd:	1
Med Rcrd #:	181000000000	Dschrg Patnt Stat:	Yes
HIC Num:	196042304A	DRG/CMG Cd:	397
Recpt Dt:	02/10/04	PIP Claim:	No
Paid Dt:	05/03/04	Pricer Rtn Cd:	14
Service From:	01/31/04	Bnfits Exhstd Ind.:	No
Service Thru:	02/04/04	Processor ID:	14000
Med. Days:	-4		

Rev Code	Units	Charges
0121	-1	-$893.00
0214	-3	-$3,435.00
0251	-1	-$1.12
0252	-23	-$66.02
0258	-3	-$231.48
0301	-9	-$661.00
0302	-5	-$357.00
0305	-12	-$1,177.00
0324	-1	-$195.00
0351	-3	-$3,137.00
0390	-3	-$3,157.00
0450	-1	-$952.00
TOTAL:	-65	-$14,262.62

Operating		Capital		Payment	
HSP:	$0.00	HSP:	$0.00	Gross Reimb.:	-$6,470.02
FSP:	-$5,442.08	FSP:	-$526.73	LESS:	
Outlier:	$0.00	Outlier:	$0.00	Cash Deduct.:	-$876.00
DSH/UP:	-$342.85	Hold Harm:	$0.00	Blood Deduct.:	$0.00
IME/Teach Adj:	-$124.60	DSH:	-$22.54	Coins.:	$0.00
New Tech.:	$0.00	IME:	-$11.22	MSP:	$0.00
IPF ECT:	$0.00	Excptns:	$0.00	MSP Pass Thru Recon.:	$0.00
Total:	-$5,909.53	Total:	-$560.49	Other Adjs:	$0.00
				Net Reimb.:	-$5,594.02

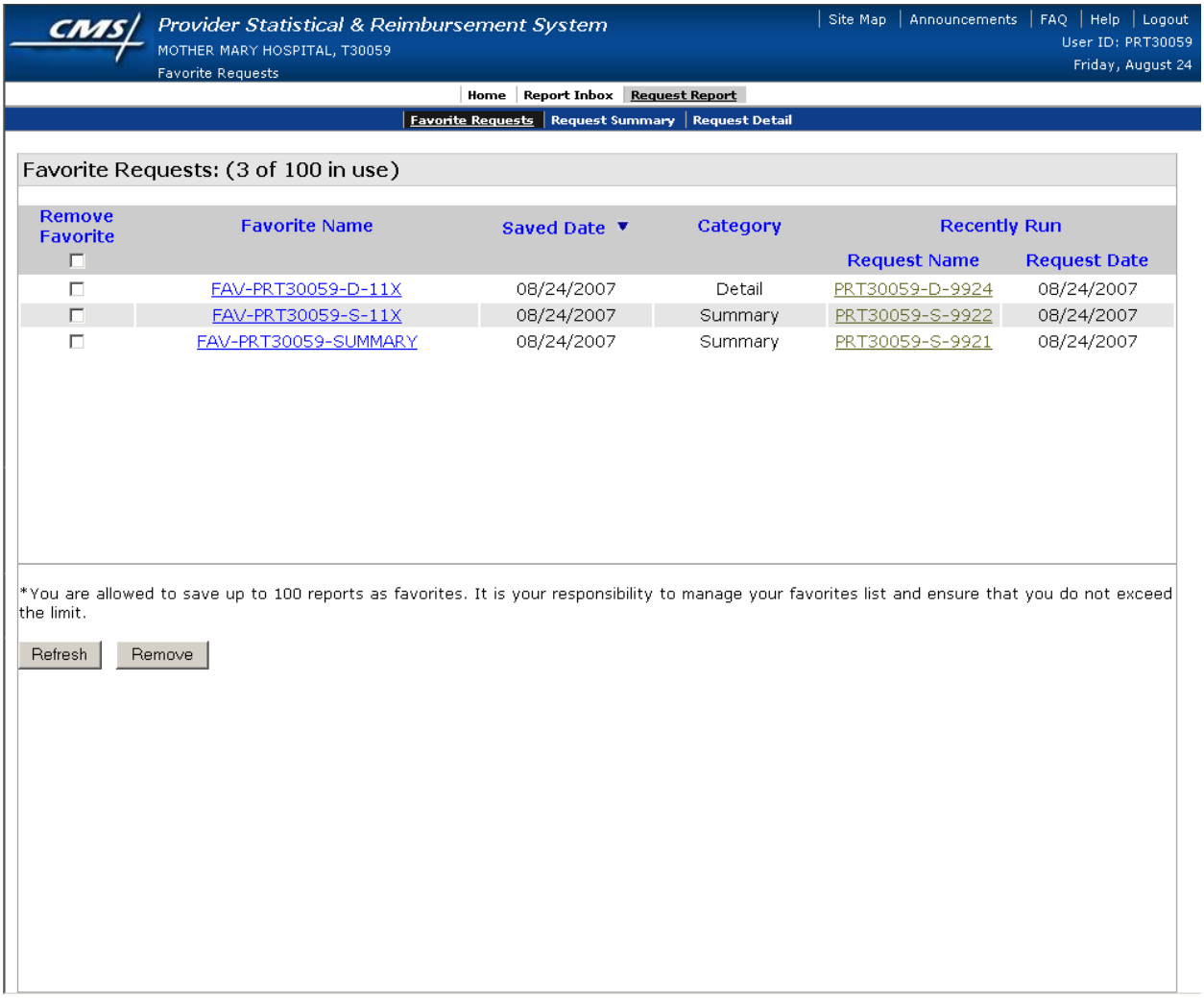
MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Calc Reimb. PIP:	$0.00
Actual Clm Pymnts PIP:	$0.00
Claim Interest:	$0.00
IRF Penalty:	$0.00
LTCH Short Stay Outlr:	$0.00
Cap Pay Cd:	B
Cap FSP @ 100%:	-$526.73
Cap Outlr @ 100%:	$0.00
DRG/CMG Wgt:	-1.2648
Dschrg Frctn:	-1.0000
DRG Wgt Frctn:	-1.2648
Claim Report Splits:	110.115

Jan 31, 2007 - 1 - 2:20:33 PM

Disclaimer: The content of this report is confidential and may be privileged or otherwise protected from disclosure and is solely for the use of the person(s) or entity for whom it is intended.

3.5 Favorite Requests

You can save report requests that you generate frequently as “favorite” report requests. If a favorite report request is saved, you can view the parameters of the request and submit new report requests based on the parameters of the favorite requests. Favorite report requests can be saved for summary reports and detail reports. The Favorite Requests page appears as follows.

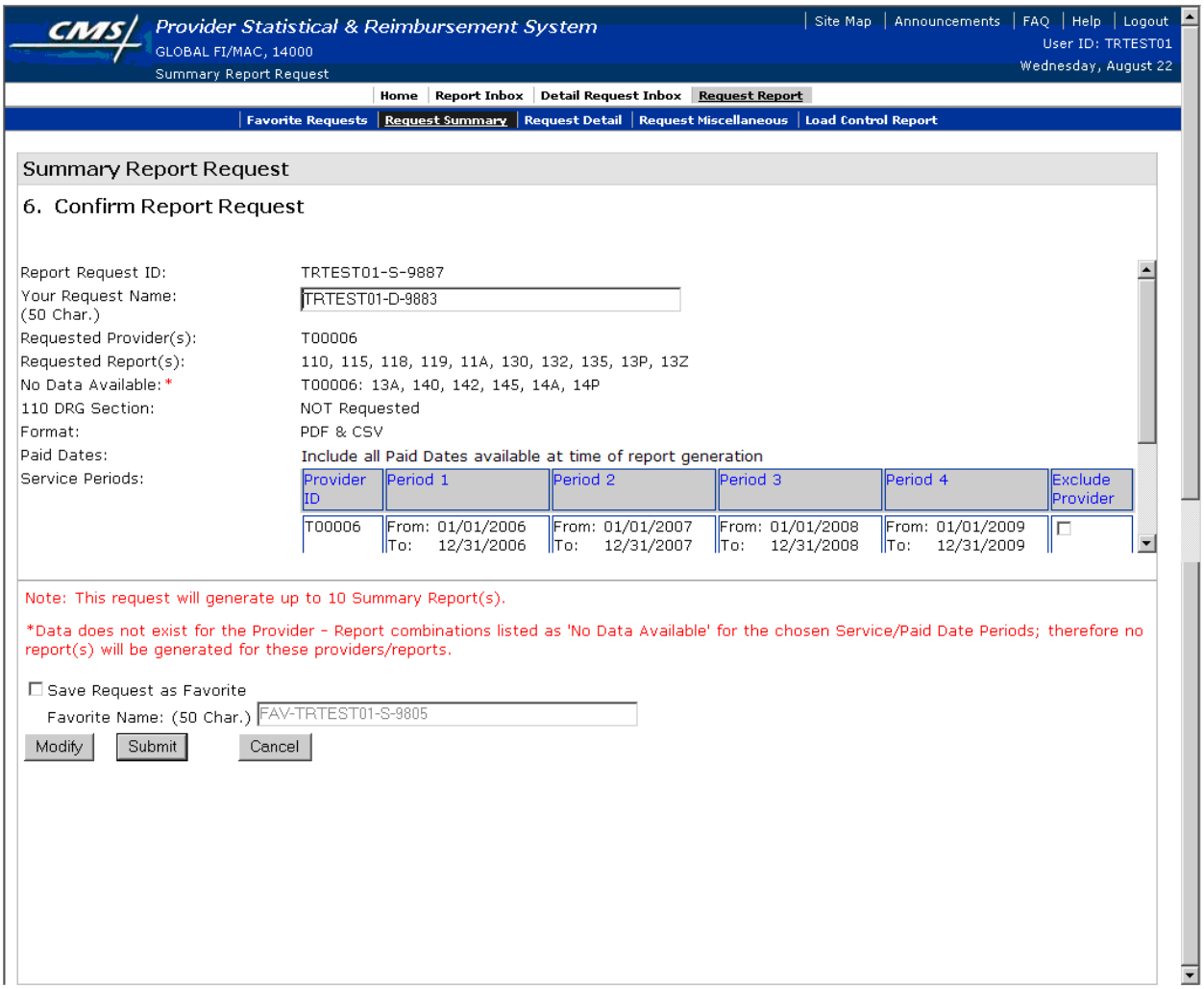


The Favorite Requests page displays the favorite name, the date the favorite request was saved, the type of favorite request, the request name for the most recently generated report based on the favorite request and the last date the favorite request was used to generate a report.

Up to 100 favorite requests can be saved at any given time. To delete a favorite request, select the **Remove Favorite** check box corresponding to the favorite request to delete and then click the **Remove** button at the bottom of the page. To refresh the contents of the page, click **Refresh**.

You can view the details of the favorite request and modify or submit the request by selecting the hyperlink corresponding to the desired favorite request name. The resulting page displays the report request ID, the request name, the provider numbers and reports included in the request, an indicator specifying if the report contains personal health information, the paid dates, the service periods, the

format of the report, and contact information for the report request. Click **Modify** to change the parameters of the report request or **Submit** to process the report using the current report parameters. Click **Cancel** to return to the previous page. An example of a summary report request page follows.



You can navigate to the Summary Report Inbox or the Detail Report Inbox by clicking the request name hyperlink corresponding to the recently run request name. Refer to section 3.4, Report Inbox, for additional information about the Summary Report Inbox and the Detail Report Inbox.

4 Inpatient Reports

The PS&R System consists of a number of inpatient reports that are based on report templates that define a consistent layout for multiple reports. The reports are presented in the order in which the Paid Claims file data is processed. The inpatient template report categories and the corresponding reports based on each report category are:

- 11x
  - Inpatient – Part A (MSP-LCC) (11A)
  - Inpatient Long Term Care – Part A PPS Interim Bills (11T)
  - Inpatient Long Term Care – Part A PPS (11S)
  - Inpatient Rehabilitation – PPS Interim Bills (11K)
  - Inpatient – Part A Managed Care (118)
  - Inpatient Rehabilitation – Part A PPS (11R)
  - Inpatient – PPS Interim Bills (119)
  - Inpatient – Part A (110)
  - Inpatient Psych – Part A PPS (11U)
  - Inpatient Psych – PPS Interim Bills (11V)
- 115
  - Inpatient– Fee Reimbursed (115)
- 18x
  - Swing Bed SNF (MSP-LCC) (18A)
  - Swing Bed SNF (180)
- 21x
  - SNF – Inpatient – Part A (MSP-LCC) (21A)
  - SNF – Inpatient – Part A PPS (210)
- 410
  - Religious Non-Medical – Inpatient – Part A (410)

All inpatient reports display consistent information at the top of the first page of each report. The following provides an example of a report header for the inpatient reports.

Exhibit 4-1 Inpatient Report Header

Program ID: REDESIGN
Paid Dates: 01/01/05 THRU 10/01/06
Report Run Date: 02/05/07
Provider FYE: 06/30
Provider Number: T95425 QUAKER HOME

PROVIDER SUMMARY REPORT
SNF - INPATIENT - PART A PPS

Page: 1
Report #: OD44203
Report Type: 210

The following table contains a list of the fields displayed in the inpatient report header area and a description of these fields.

Exhibit 4-2 Inpatient Report Header Fields

Field	Definition
Program ID	The release number of the PS&R System in effect when the report was generated.
Paid Dates	The range of paid dates for which the report contains data.
Service Month End Date	This field only appears on inpatient and outpatient detail reports. The ending month of service for the current page of the report.
Report Run Date	The date the report was generated in the PS&RSystem.
Provider FYE	The provider's fiscal year end for which the report was generated.
Provider Number	The provider number and corresponding name for which the report was generated.
(Report Name)	The name of the report that was generated.
Page: <#>	The sequential page number of the report page.
Report #	The identification number assigned to the report.
Report Type	The three- or four-character identifier indicating the type of report that was generated.

The report footer displays the date the report was generated, the sequential page number of the report, and the time the report was generated. The following exhibit provides an example of the report footer.

Exhibit 4-3 Inpatient Report Footer

Feb 5, 2007 - 1 - 10:23:57 AM

This chapter provides a description of each inpatient report template and provides a summary of the reports generated using each template. Chapter 5, Outpatient Reports, provides a description of the Outpatient reports available in the PS&R System. See Appendix F, Report Details, for a definition of the data elements available on reports.

4.1 Inpatient Report Type Assignment

Claims data submitted to the PS&R System in the Paid Claims file are processed for assignment to inpatient report groups according to the following sequence:

- 11x
- 18x
- 21x
- 410

A provider's Paid Claims file is processed for inpatient report depending on the claim's bill type and, routes the claim through the appropriate report type assignment logic. All claims that do not satisfy requirements for inpatient reports are automatically processed for outpatient reports and home health agency reports. Once a claim satisfies the requirements for presentation on a report, the claim is not processed further. For example, if a claim's bill category is 21x, the claim is routed through the 21x report type assignment logic. If a claim satisfies requirements for the Inpatient – Fee Reimbursed (115) report, the claim is written to this report. If a claim does not satisfy the Inpatient – Fee Reimbursed (115) report requirements, the claim continues through the subsequent report processing sequence until it matches a report's requirements.

The following sections document the processing requirements for a claim to be presented on the inpatient reports.

4.1.1 11x Claims Processing

If a claim's Bill Type is "11x", the claim or claim lines are assigned to a report in the following sequence:

- A claim is presented on the Inpatient Fee Reimbursed (115) report if any claim line HCPCS code is present and the corresponding Total Fee Schedule Amount is greater than zero (0).
- A claim is presented on the Inpatient – Part A (MSP-LCC) (11A) report if the claim level MSP-LCC Indicator is "M" or the claim level indicator is "FR" (Full Recovery).
- A claim is presented on the Inpatient Long Term Care – Part A PPS Interim Bills (11T) if the claim Service Thru Date is after September 30, 2002, the provider is a long term care hospital, Federal Specific Portion is not zero (0) and the Patient Status Code is "30".
- A claim is presented on the Inpatient Long Term Care – Part A PPS (11S) report if claim Service Thru Date is after September 30, 2002, the provider is a long term care hospital, and Federal Specific Portion is not zero (0).
- A claim is presented on the Inpatient Rehabilitation – PPS Interim Bills (11K) report if the Patient Status Code is "30" and any claim line Revenue Code is "0024".
- A claim is presented on the Inpatient Part A Managed Care (118) report if any Condition Code is "04" or "69".
- A claim is presented on the Inpatient Rehabilitation – Part A PPS (11R) report if any claim line Revenue Code is "0024".
- A claim is presented on the Inpatient Psych – Part A PPS (11V) report the if Provider ID is xx4000 through xx4499 or xxSxxx or xxMxxxx and FSP does not equal zero (0) and Patient Status Code is "30" and benefits are not exhausted (Occurrence Code is not "A3", "B3", "C3", "E3", "F3", or "G3").

- A claim is presented on the Inpatient Psych – PPS Interim Bills (11U) report if the Provider ID is xx4000 through xx4499 or xxSxxx or xxMxxxx and FSP does not equal zero (0).
- A claim is presented on the Inpatient PPS Interim Bills (119) report if the Patient Status Code is “30”, the Diagnostic Related Group (DRG) Code is greater than zero (0), and the Federal Specific Portion is not zero (0).
- A claim is presented on the Inpatient – Part A (110) report for all remaining claims and claim lines.

4.1.2 18x Claims Processing

If a claim’s Bill Type is “18x”, the claim is assigned to a report in the following sequence:

- A claim is presented on the Swing Bed SNF (MSP-LCC) (18A) report if the MSP-LCC indicator is “M” or the claim level indicator is “FR” (Full Recovery).
- A claim is presented on the Swing Bed SNF (180) report for all claims that do not match the criteria for the Swing Bed SNF (MSP-LCC) (18A) report.

4.1.3 21x Claims Processing

If a claim’s Bill Type is “21x”, the claim is assigned to a report in the following sequence:

- A claim is presented on the SNF – Inpatient – Part A (MSP-LCC) (21A) report if the MSP-LCC indicator is “M” or the claim level indicator is “FR” (Full Recovery).
- A claim is presented on the SNF – Inpatient – Part A PPS (210) report for all claims that do not match the criteria for the SNF – Inpatient – Part A (MSP-LCC) (21A) report.

4.1.4 410 Claims Processing

If a claim’s Bill Type is “410”, the claim is assigned to the Religious Non-Medical – Inpatient – Part A (410) report.

4.2 11x Report Template

The 11x template reports are processed at the claim level. There is a summary report and a detail report associated with each report within the 11x report template.

The Inpatient 11x Provider Summary reports display summary statistics, charges, reimbursements, and additional information for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. For example, if the Inpatient Long Term Care – Part A PPS Interim Bills (11T) report is generated, the report contains inpatient long term care Part A services that have been billed on and interim basis data. The statistics section displays the number of discharges, the number of Medicare days, and the number of claims being reported for each of the reporting periods. The charge section displays the number of units and the total dollar amount of the revenue code being reported. The reimbursement section displays operating, capital, and gross reimbursement amounts for the reporting period, such as hospital and federal specific, outlier, DSH/LIP, IME teaching adjustments, new technology, IPF ECT, hold harmless, and exception amounts. This section also provides total operating payments, total capital payments, and net reimbursement totals for each of the reporting periods included in the report. The Payment section displays gross distribution less device credit, cash deductible, blood deductible, coinsurance, net MSP payments, MSP pass thru reconciliation, other adjustments, and the net reimbursement. The Additional Information Section displays the calculated net reimbursement for PIP, actual claim payments for PIP, claim interest payments, IRF penalties, LTCH short stay outlier payments, CAP Federal specific at 100%, CAP outlier at 100%, discharges, DRG/CMG weight, case mix index,

trans-adjusted discharges, trans-adjusted DRG/CMG weight, and trans-adjusted case mix index for each of the reporting periods included in the report.

If the “Include 110 DRG Section” option is selected when the report is generated, the DRG Section is displayed at the end of the report. The DRG section shows information that is grouped by DRG codes. The DRG Section displays data for four service periods and contains information such as Discharges, Medicare Days, Gross Reimbursement, and MSP Payment. The fields in this section are totaled at the bottom of the column.

The Inpatient 11x Payment Reconciliation (Detail) reports display claim, reimbursement, and additional information charges for each individual claim submitted by the provider for the specified reporting period. Each reporting period (for at lease one reporting period up to a maximum of four reporting periods) are presented in chronological order with the earliest reporting period displayed first. All subsequent reporting periods are displayed following the previous reporting period at the end of each reporting period. Each claim displays patient identification information, the period of service associated with the claim, and a list of revenue codes, number of units, and total amount of charges associated with each revenue code included in the claim. In the Additional Information Section in detail reports, the “MSP Cash Deductible”, “MSP Blood Deductible”, “MSP Coinsurance”, “Claim Report Splits”, and “Capital Pay Code” fields display.

An example of the Inpatient 11x Provider Summary report template and the Inpatient 11x Payment Reconciliation (Detail) report template follow.

Exhibit 4-4 Inpatient 11x Provider Summary Report Template (Page 1)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 07/01/04 THRU 11/30/06
Report Run Date: 09/22/08
Provider FYE: 06/30
Provider Number: 100001 SHANDS JACKSONVILLE MEDICAL CENTER

PROVIDER SUMMARY REPORT
INPATIENT - PART A (MSP-LCC)

Page: 1
Report #: OD44203
Report Type: 11A

	SERVICES FOR PERIOD 10/01/04 - 09/30/05	SERVICES FOR PERIOD 10/01/05 - 09/30/06	SERVICES FOR PERIOD 10/01/06 - 09/30/07	SERVICES FOR PERIOD 10/01/07 - 09/30/08
STATISTIC SECTION				
DISCHARGES	0	2	0	0
MEDICARE DAYS	0	3	0	0
CLAIMS	0	2	0	0

CHARGE SECTION

*** ACCOMMODATION CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0110	ROOM-BOARD/PVT	0	$0.00	1	$698.00	0	$0.00	0	$0.00
0120	ROOM-BOARD/SEMI	0	$0.00	2	$1,386.00	0	$0.00	0	$0.00
TOTAL ACCOMMODATIONS		0	$0.00	3	$2,084.00	0	$0.00	0	$0.00

*** ANCILLARY CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0250	PHARMACY	0	$0.00	80	$1,424.70	0	$0.00	0	$0.00
0258	IV SOLUTIONS	0	$0.00	2	$120.00	0	$0.00	0	$0.00
0272	STERILE SUPPLY	0	$0.00	9	$230.00	0	$0.00	0	$0.00
0300	LABORATORY or (LAB)	0	$0.00	5	$232.00	0	$0.00	0	$0.00
0301	LAB/CHEMISTRY	0	$0.00	17	$1,096.50	0	$0.00	0	$0.00
0305	LAB/HEMATOLOGY	0	$0.00	11	$1,150.00	0	$0.00	0	$0.00
0324	DX X-RAY/CHEST	0	$0.00	2	$604.00	0	$0.00	0	$0.00
0390	BLOOD/STOR-PROC	0	$0.00	2	$292.00	0	$0.00	0	$0.00
0450	EMERG ROOM	0	$0.00	2	$1,588.00	0	$0.00	0	$0.00
0730	EKG/ECG	0	$0.00	2	$340.00	0	$0.00	0	$0.00
TOTAL ANCILLARY		0	$0.00	132	$7,077.20	0	$0.00	0	$0.00
TOTAL COVERED CHARGES			$0.00		$9,161.20		$0.00		$0.00

REIMBURSEMENT SECTION

OPERATING				
HOSPITAL SPECIFIC	$0.00	$0.00	$0.00	$0.00

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Exhibit 4-5 Inpatient 11x Provider Summary Report Template (Page 2)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 07/01/04 THRU 11/30/06
Report Run Date: 09/22/08
Provider FYE: 06/30
Provider Number: 100001 SHANDS JACKSONVILLE MEDICAL CENTER

PROVIDER SUMMARY REPORT
INPATIENT - PART A (MSP-LCC)

Page: 2
Report #: OD44203
Report Type: 11A

	SERVICES FOR PERIOD 10/01/04 - 09/30/05	SERVICES FOR PERIOD 10/01/05 - 09/30/06	SERVICES FOR PERIOD 10/01/06 - 09/30/07	SERVICES FOR PERIOD 10/01/07 - 09/30/08
FEDERAL SPECIFIC	$0.00	$8,944.66	$0.00	$0.00
OUTLIER	$0.00	$0.00	$0.00	$0.00
DSH/LIP	$0.00	$3,373.03	$0.00	$0.00
IME/TEACHING ADJ.	$0.00	$2,089.77	$0.00	$0.00
NEW TECHNOLOGY	$0.00	$0.00	$0.00	$0.00
IPF ECT	$0.00	$0.00	$0.00	$0.00
TOTAL OPERATING PAYMENTS	$0.00	$14,407.46	$0.00	$0.00
CAPITAL				
HOSPITAL SPECIFIC	$0.00	$0.00	$0.00	$0.00
FEDERAL SPECIFIC	$0.00	$814.69	$0.00	$0.00
OUTLIER	$0.00	$0.00	$0.00	$0.00
HOLD HARMLESS	$0.00	$0.00	$0.00	$0.00
DSH	$0.00	$102.97	$0.00	$0.00
INDIRECT MEDICAL EDUCATION	$0.00	$183.71	$0.00	$0.00
EXCEPTIONS	$0.00	$0.00	$0.00	$0.00
TOTAL CAPITAL PAYMENTS	$0.00	$1,101.37	$0.00	$0.00
PAYMENT				
GROSS REIMBURSEMENT	$0.00	$15,508.83	$0.00	$0.00
LESS				
DEVICE CREDIT	$0.00	$0.00	$0.00	$0.00
CASH DEDUCTIBLE	$0.00	$1,904.00	$0.00	$0.00
BLOOD DEDUCTIBLE	$0.00	$0.00	$0.00	$0.00
COINSURANCE	$0.00	$0.00	$0.00	$0.00
NET MSP PAYMENTS	$0.00	$2,102.00	$0.00	$0.00
MSP PASS THRU RECONCILIATION	$0.00	$0.00	$0.00	$0.00
OTHER ADJUSTMENTS	$0.00	$6,347.63	$0.00	$0.00

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Exhibit 4-6 Inpatient 11x Provider Summary Report Template (Page 3)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 07/01/04 THRU 11/30/06
Report Run Date: 09/22/08
Provider FYE: 06/30
Provider Number: 100001 SHANDS JACKSONVILLE MEDICAL CENTER

PROVIDER SUMMARY REPORT
INPATIENT - PART A (MSP-LCC)

Page: 3
Report #: OD44203
Report Type: 11A

	SERVICES FOR PERIOD 10/01/04 - 09/30/05	SERVICES FOR PERIOD 10/01/05 - 09/30/06	SERVICES FOR PERIOD 10/01/06 - 09/30/07	SERVICES FOR PERIOD 10/01/07 - 09/30/08
NET REIMBURSEMENT	$0.00	$5,155.20	$0.00	$0.00
ADDITIONAL INFORMATION SECTION				
CALCULATED NET REIMB FOR PIP	$0.00	$0.00	$0.00	$0.00
ACTUAL CLAIM PAYMENTS FOR PIP	$0.00	$0.00	$0.00	$0.00
CLAIM INTEREST PAYMENTS	$0.00	$0.00	$0.00	$0.00
IRF PENALTY AMOUNT	$0.00	$0.00	$0.00	$0.00
LTCH SHORT STAY OUTLIER PAYMENTS	$0.00	$0.00	$0.00	$0.00
CAP FED-SPECIFIC @ 100%	$0.00	$814.69	$0.00	$0.00
CAP OUTLIER @ 100%	$0.00	$0.00	$0.00	$0.00
DISCHARGES	0	2	0	0
DRG/CMG WEIGHT	0.0000	0.0000	0.0000	0.0000
WEIGHT/DISCHARGES	0.0000	0.0000	0.0000	0.0000
DISCHARGE FRACTION	0	0	0	0
DRG WEIGHT FRACTION	0.0000	0.0000	0.0000	0.0000
DRG WEIGHT FRACTION/DISCHARGES	0.0000	0.0000	0.0000	0.0000

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Exhibit 4-7 Inpatient 11x Payment Reconciliation (Detail) Report Template (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 03/31/04
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
INPATIENT - PART A (MSP-LCC)

Page: 1
Report #: OD44202
Report Type: 11A
Paid Dates: 01/01/04 to 10/01/06

Claim Information

Patnt Nm:	FALO S	Bill Freq:	1
DCN:	20448788450204	Trans Type:	
Ptnt Cntrl #:	130000000000	Dschrg Patnt Cd:	20
Med Rcrd #:	293000000000	Dschrg Patnt Stat:	Yes
HIC Num:	481570432A	DRG/CMG Cd:	416
Recpt Dt:	05/03/04	PIP Claim:	No
Paid Dt:	05/17/04	Pricer Rtn Cd:	0
Service From:	03/23/04	Bnfts Exhstd Ind.:	No
Service Thru:	03/23/04	Processor ID:	14000
Med. Days:	1		

Rev Code	Units	Charges
0200	1	$1,786.00
0251	0	$87.47
0252	0	$165.23
0258	0	$462.39
0260	0	$257.00
0301	0	$594.00
0302	0	$83.00
0305	0	$134.00
0320	0	$212.00
0324	0	$195.00
0450	0	$1,937.00
0730	0	$190.00
TOTAL:	1	$6,103.09

Reimbursements

Operating		Capital		Payment	
HSP:	$0.00	HSP:	$0.00	Gross Reimb.:	$8,149.95
FSP:	$6,849.07	FSP:	$662.90	LESS:	
Outlier:	$0.00	Outlier:	$0.00	Cash Deduct.:	$0.00
DSH/UP:	$441.77	Hold Harm:	$0.00	Blood Deduct.:	$0.00
IME/ Teach Adj:	$157.18	DSH:	$28.64	Coins.:	$0.00
New Tech.:	$0.00	IME:	$10.39	MSP:	$5,853.09
IPF ECT:	$0.00	Excptns:	$0.00	MSP Pass Thru Recon.:	$0.00
Total:	$7,448.02	Total:	$701.93	Other Adjs:	$2,046.86
				Net Reimb.:	$250.00

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Calc Reimb. PIP:	$0.00
Actual Clm Pymnts PIP:	
Claim Interest:	$0.00
IRF Penalty:	$0.00
LTCH Short Stay Outlr:	$0.00
Cap Pay Cd:	B
Cap FSP @ 100%:	$662.90
Cap Outlr @ 100%:	$0.00
DRG/CMG Wgt:	
Dschrg Frctn:	
DRG Wgt Frctn:	

Patnt Nm:	PEEK M	Bill Freq:	1
DCN:	20408747550004	Trans Type:	
Ptnt Cntrl #:	131000000000	Dschrg Patnt Cd:	1
Med Rcrd #:	293000000000	Dschrg Patnt Stat:	Yes
HIC Num:	276694090B	DRG/CMG Cd:	331
Recpt Dt:	05/05/04	PIP Claim:	No
Paid Dt:	05/19/04	Pricer Rtn Cd:	0
Service From:	03/30/04	Bnfts Exhstd Ind.:	No
Service Thru:	03/31/04	Processor ID:	14000
Med. Days:	1		

Rev Code	Units	Charges
0121	1	$893.00
0251	0	$7.95
0252	0	$249.82
0258	0	$154.10
0301	0	$922.00
0305	0	$228.00
0306	0	$101.00
0307	0	$72.00
0402	0	$477.00
TOTAL:	1	$3,104.87

Operating		Capital		Payment	
HSP:	$0.00	HSP:	$0.00	Gross Reimb.:	$5,436.38
FSP:	$4,568.63	FSP:	$442.19	LESS:	
Outlier:	$0.00	Outlier:	$0.00	Cash Deduct.:	$876.00
DSH/UP:	$294.68	Hold Harm:	$0.00	Blood Deduct.:	$0.00
IME/ Teach Adj:	$104.85	DSH:	$19.10	Coins.:	$0.00
New Tech.:	$0.00	IME:	$6.93	MSP:	$1,723.16
IPF ECT:	$0.00	Excptns:	$0.00	MSP Pass Thru Recon.:	$0.00
Total:	$4,968.16	Total:	$468.22	Other Adjs:	$2,331.51
				Net Reimb.:	$505.71

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Calc Reimb. PIP:	$0.00
Actual Clm Pymnts PIP:	
Claim Interest:	$0.00
IRF Penalty:	$0.00
LTCH Short Stay Outlr:	$0.00
Cap Pay Cd:	B
Cap FSP @ 100%:	$442.19
Cap Outlr @ 100%:	$0.00
DRG/CMG Wgt:	
Dschrg Frctn:	
DRG Wgt Frctn:	

***** Monthly Totals for PETERBORO GENERAL HOSPITAL for service month end 3/31/04 *****

			Units	Charges
Med. Days: 2	Discharge Count: 2	TOTAL:	2	$9,207.96

Operating		Capital		Payment	
HSP:	$0.00	HSP:	$0.00	Gross Reimb.:	$13,586.33
FSP:	$11,417.70	FSP:	$1,105.09	LESS:	
Outlier:	$0.00	Outlr:	$0.00	Cash Deduct.:	$876.00
DSH/UP:	$736.45	Hold Harm:	$0.00	Blood Deduct.:	$0.00
IME/ Teach Adj:	$262.03	DSH:	$47.74	Coins.:	$0.00
New Tech.:	$0.00	IME:	$17.32	MSP:	$7,576.25
IPF ECT:	$0.00	Excptns:	$0.00	MSP Pass Thru Recon.:	$0.00
Total:	$12,416.18	Total:	$1,170.15	Other Adjs:	$4,378.37
				Net Reimb.:	$755.71

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Calc Reimb. PIP:	$0.00
Actual Clm Pymnts PIP:	
Claim Interest:	$0.00
IRF Penalty:	$0.00
LTCH Short Stay Outlr:	$0.00
Cap FSP @ 100%:	$1,105.09
Cap Outlr @ 100%:	$0.00
DRG/CMG Wgt:	
Wgt/Dschrgs:	
Dschrg Frctn:	
DRG Wgt Frctn:	
DRG Wgt Frctn/Dschrgs:	

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Exhibit 4-8 Inpatient 11x Payment Reconciliation (Detail) Report Template (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: N/A
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
INPATIENT - PART A (MSP-LCC)

Page: 2
Report #: OD44202
Report Type: 11A
Paid Dates: 01/01/04 to 10/01/06

Service Period and Report Type Totals

Service Period		Reimbursements			Additional Information
01/01/2004 - 01/01/2006	Med. Days: 2 Discharge Count: 2 TOTAL: Units 2 Charges $9,207.96	**Operating** HSP: $0.00 FSP: $11,417.70 Outlier: $0.00 DSH/LIP: $736.45 IME/ Teach Adj: $262.03 New Tech.: $0.00 IPF ECT: $0.00 Total: $12,416.18	**Capital** HSP: $0.00 FSP: $1,105.09 Outlr: $0.00 Hold Harmc $0.00 DSH: $47.74 IME: $17.32 Excptns: $0.00 Total: $1,170.15	**Payment** Gross Reimb.: $13,586.33 LESS: Cash Deduct.: $876.00 Blood Deduct.: $0.00 Coins.: $0.00 MSP: $7,576.25 MSP Pass Thru Recon.: $0.00 Other Adjs: $4,378.37 Net Reimb.: $755.71	MSP Cash Deduct.: $0.00 MSP Blood Deduct.: $0.00 MSP Coins.: $0.00 Calc Reimb. PIP: $0.00 Actual Clm Pymnts PIP: Claim Interest: $0.00 IRF Penalty: $0.00 LTCH Short Stay Outlr: $0.00 Cap FSP @ 100%: $1,105.09 Cap Outlr @ 100%: $0.00 DRG/CMG Wgt: Wgt/Dschrgs: Dschrg Frctn: DRG Wgt Frctn: DRG Wgt Frctn/Dschrgs:
*** Report Type 11A Totals for PETERBORO GENERAL HOSPITAL ***	Med. Days: 2 Discharge Count: 2 TOTAL: Units 2 Charges $9,207.96	**Operating** HSP: $0.00 FSP: $11,417.70 Outlier: $0.00 DSH/LIP: $736.45 IME/ Teach Adj: $262.03 New Tech.: $0.00 IPF ECT: $0.00 Total: $12,416.18	**Capital** HSP: $0.00 FSP: $1,105.09 Outlr: $0.00 Hold Harmc $0.00 DSH: $47.74 IME: $17.32 Excptns: $0.00 Total: $1,170.15	**Payment** Gross Reimb.: $13,586.33 LESS: Cash Deduct.: $876.00 Blood Deduct.: $0.00 Coins.: $0.00 MSP: $7,576.25 MSP Pass Thru Recon.: $0.00 Other Adjs: $4,378.37 Net Reimb.: $755.71	**Additional Information** MSP Cash Deduct.: $0.00 MSP Blood Deduct.: $0.00 MSP Coins.: $0.00 Calc Reimb. PIP: $0.00 Actual Clm Pymnts PIP: Claim Interest: $0.00 IRF Penalty: $0.00 LTCH Short Stay Outlr: $0.00 Cap FSP @ 100%: $1,105.09 Cap Outlr @ 100%: $0.00 DRG/CMG Wgt: Wgt/Dschrgs: Dschrg Frctn: DRG Wgt Frctn: DRG Wgt Frctn/Dschrgs:

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The reports that are generated based on the Inpatient 11x report template are:

- Inpatient – Part A (MSP-LCC) (11A)
- Inpatient Long Term Care – Part A PPS Interim Bills (11T)
- Inpatient Long Term Care – Part A PPS (11S)
- Inpatient Rehabilitation – PPS Interim Bills (11K)
- Inpatient – Part A Managed Care (118)
- Inpatient Rehabilitation – Part A PPS (11R)
- Inpatient – PPS Interim Bills (119)
- Inpatient – Part A (110)
- Inpatient Psych – Part A PPS (11U)
- Inpatient Psych – PPS Interim Bills (11V)

- Religious Non-Medical – Inpatient – Part A (410)

The report that is generated based on the Inpatient 115 report template is:

- Inpatient– Fee Reimbursed (115)

A brief description of these reports is provided in the following sections. The reports are presented in the order in which the Paid Claims file is processed.

4.2.1 Inpatient – Fee Reimbursed (115)

The Inpatient – Fee Reimbursed (115) report shows covered charges and reimbursement for fee reimbursed services for inpatient services. The detail report shows reimbursement by revenue code for inpatient services. The items reported on the Inpatient – Fee Reimbursed (115) report are not to be included on the Medicare Cost Report.

The Inpatient Long Term Care – Part A (115) report is generated automatically if the Inpatient – Part A (110) report is requested.

Although the Inpatient – Fee Reimbursed (115) report data processing is performed with the 11x reports, the summary and detail reports have their own format. The following exhibits provide examples of the Inpatient 115 Provider Summary report and the Inpatient 115 Payment Reconciliation detail report.

Exhibit 4-9 Inpatient 115 Provider Summary Report Layout

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 02/01/04 THRU 10/01/06
Report Run Date: 02/01/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PROVIDER SUMMARY REPORT
INPATIENT - FEE REIMBURSED
THESE ITEMS ARE NOT TO BE INCLUDED ON THE MEDICARE COST REPORT

Page: 1
Report #: OD44203
Report Type: 115

	SERVICES FOR PERIOD 01/01/04 - 12/31/04	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
STATISTIC SECTION				
CLAIMS	0			

CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0636	DRUGS/DETAIL CODE	39	$8,002.41						
TOTAL COVERED CHARGES		39	$8,002.41						

REIMBURSEMENT SECTION				
PAYMENT				
GROSS REIMBURSEMENT	$37.05			
LESS				
CASH DEDUCTIBLE	$0.00			
BLOOD DEDUCTIBLE	$0.00			
COINSURANCE	$0.00			
NET MSP PAYMENTS	$0.00			
NET REIMBURSEMENT	$37.05			
ADDITIONAL INFORMATION SECTION				
CLAIM INTEREST PAYMENTS	$0.00			

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Exhibit 4-10 Inpatient 115 Payment Reconciliation (Detail) Report Template (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 02/29/04
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
INPATIENT - FEE REIMBURSED

Page: 1
Report #: OD44202
Report Type: 115
Paid Dates: 01/01/04 to 10/01/06

Claim Information

Patnt Nmc	MADA R	Bill Freq:	7	Rev Code	HCPCS	Units	Charges	HCPCS Reimb.
DCN:	20408527757804	Trans Type:	D	0636	Q2022	195	$40,012.05	$185.25
Ptnt Cntrl #:	001000000000	Processor ID:	14000	TOTAL:		195	$40,012.05	$185.25
Med Rcrd #:	181000000000							
HIC Numc	093761146A							
Recpt Dt:	04/27/04							
Paid Dt:	05/03/04							
Service From:	01/31/04							
Service Thru:	02/04/04							

Reimbursements

Gross Reimb.:	$185.25
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Net Reimb.:	$185.25

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	110,115

Patnt Nmc	MADA R	Bill Freq:	8	Rev Code	HCPCS	Units	Charges	HCPCS Reimb.
DCN:	20439959234505	Trans Type:	C	0636	Q2022	-156	-$32,009.64	-$148.20
Ptnt Cntrl #:	001000000000	Processor ID:	14000	TOTAL:		-156	-$32,009.64	-$148.20
Med Rcrd #:	181000000000							
HIC Numc	093761146A							
Recpt Dt:	02/10/04							
Paid Dt:	05/03/04							
Service From:	01/31/04							
Service Thru:	02/04/04							

Reimbursements

Gross Reimb.:	-$148.20
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Net Reimb.:	-$148.20

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	110,115

***** Monthly Totals for PETERBORO GENERAL HOSPITAL for service month end 2/29/04 *****

	Units	Charges	HCPCS Reimb.
TOTAL:	39	$8,002.41	$37.05

Reimbursements

Gross Reimb.:	$37.05
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Net Reimb.:	$37.05

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00

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Exhibit 4-11 Inpatient 115 Payment Reconciliation (Detail) Report Template (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: N/A
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
INPATIENT - FEE REIMBURSED

Page: 2
Report #: OD44202
Report Type: 115
Paid Dates: 01/01/04 to 10/01/06

Service Period and Report Type Totals

Service Period		Units	Charges	HCPCS Reimb.	Reimbursements		Additional Information	
01/01/2004 - 01/01/2006	TOTAL:	39	$8,002.41	$37.05	Gross Reimb.:	$37.05	MSP Cash Deduct.:	$0.00
					LESS:		MSP Blood Deduct.:	$0.00
					Cash Deduct.:	$0.00	MSP Coins.:	$0.00
					Blood Deduct.:	$0.00	Claim Interest:	$0.00
					Coins.:	$0.00		
					MSP:	$0.00		
					Net Reimb.:	$37.05		
*** Report Type 115 Totals for PETERBORO GENERAL HOSPITAL ***					Reimbursements		Additional Information	
	TOTAL:	39	$8,002.41	$37.05	Gross Reimb.:	$37.05	MSP Cash Deduct.:	$0.00
					LESS:		MSP Blood Deduct.:	$0.00
					Cash Deduct.:	$0.00	MSP Coins.:	$0.00
					Blood Deduct.:	$0.00	Claim Interest:	$0.00
					Coins.:	$0.00		
					MSP:	$0.00		
					Net Reimb.:	$37.05		

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4.2.2 Inpatient – Part A (MSP-LCC) (11A)

The Inpatient – Part A (MSP-LCC) (11A) report is a supplemental report to the Inpatient – Part A (110) report. For providers on PIP (Part A), the interim payments included on the cost report are adjusted by the Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) amounts. The items reported on the Inpatient – Part A (MSP-LCC) (11A) report are included on the Medicare Cost Report.

4.2.3 Inpatient Long Term Care – Part A PPS Interim Bills (11T)

The Inpatient Long Term Care – Part A PPS Interim Bills (11T) report summarizes inpatient long term care Part A services that have been billed on and interim basis (that is, a bill frequency code of 2 or 3). The items reported on the Inpatient Long Term Care – Part A PPS Interim Bills (11T) report are not to be included on the Medicare Cost Report.

4.2.4 Inpatient Long Term Care – Part A PPS (11S)

The Inpatient Long Term Care – Part A PPS (11S) report summarizes Inpatient long term care Part A services. The items reported on the Long Term Care – Part A PPS (11S) report are included on the Medicare Cost Report.

4.2.5 Inpatient Rehabilitation – PPS Interim Bills (11K)

The Inpatient Rehabilitation – PPS Interim Bills (11K) report summarizes Inpatient Part A hospital services reimbursed under the Inpatient Rehabilitation Facility PPS payment system that have been billed on an interim basis (that is, a bill frequency code of 2 or 3). The items reported on the Inpatient Rehabilitation – PPS Interim Bills (11K) report are not to be included on the Medicare Cost Report.

4.2.6 Inpatient – Part A Managed Care (118)

Inpatient – Part A Managed Care (118) report summarizes services billed under Part A for Medicare managed care patients for purposes of receiving reimbursement for direct graduate medical education (DGME) and indirect medical education (IME). The items reported on the Inpatient – Part A Managed Care (118) report are not to be included on the Medicare Cost Report.

4.2.7 Inpatient Rehabilitation – Part A PPS (11R)

The Inpatient Rehabilitation – Part A PPS (11R) report summarizes Inpatient Part A hospital services reimbursed under the Inpatient Rehabilitation Facility Prospective Payment System. The items reported on the Inpatient Rehabilitation– Part A PPS (11R) report are included on the Medicare Cost Report.

4.2.8 Inpatient – PPS Interim Bills (119)

The Inpatient – PPS Interim Bills (119) report summarizes Inpatient Part A. hospital services reimbursed under the Inpatient Prospective Payment System (PPS) that have been billed on an interim basis (that is, bill frequency code of 2 or 3). The items reported on the Inpatient – PPS Interim Bills (119) report are not to be included on the Medicare Cost Report.

4.2.9 Inpatient – Part A (110)

The Inpatient – Part A (110) report summarizes Inpatient Part A hospital services, including services reimbursed under cost, Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), and the Inpatient Prospective Payments System (PPS). The items reported on the Inpatient – Part A (110) report are included on the Medicare Cost Report.

The Inpatient – Fee Reimbursed (115) report is generated automatically when the Inpatient – Part A (110) report is requested.

4.2.10 Inpatient Psych – Part A PPS (11U)

The Inpatient Psych – Part A PPS (11U) report summarizes Inpatient Part A PPS services for Inpatient Psychiatric Facility Hospitals. The items reported on the Inpatient Psych – Part A PPS (11U) report are included on the Medicare Cost Report.

4.2.11 Inpatient Psych – PPS Interim Bills (11V)

The Inpatient Psych – PPS Interim Bills (11V) report summarizes Inpatient Part A hospital services reimbursed under the Inpatient Psychiatric Facility PPS payment system that have been billed on an interim basis (i.e., a bill frequency code of 2 or 3). The items reported on the Inpatient Psych – PPS Interim Bills (11V) report are included on the Medicare Cost Report.

4.2.12 Religious Non-Medical – Inpatient – Part A (410)

The Religious Non-Medical – Inpatient – Part A (410) report summarizes the Medicare days, discharges, charges, deductibles, coinsurance, and net reimbursement for a reporting period. Religious Non-Medical facilities typically have relatively low Medicare utilization and the majority of their charges are for routine inpatient care. The items reported on the Religious Non-Medical – Inpatient – Part A (410) report are included on the Medicare Cost Report.

4.3 18x and 21x Report Template

The 18x and 21x template reports are processed at the claim level. There is a summary report and a detail report associated with each report within the 18x and 21x report templates.

The Inpatient 18x and 21x Provider Summary reports display summary statistics, charges, reimbursements, additional information, for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. For example, if the Swing Bed SNF (MSP-LCC) (18A) report is generated, the report contains claims where the claim level MSP-LCC indicator is “M” or the claim level indicator is “FR” (Full Recovery). The statistics section displays the number of discharges, Medicare days, and number of claims for each of the reporting periods presented on the report. The charge section displays the number of units and the total dollar amount of the revenue code being reported for accommodation charges and ancillary charges (for example, pharmacy, IV solutions, drugs, medical supplies, sterile supplies, and laboratory charges). The Reimbursement Section displays gross reimbursement amounts, cash deductible, blood deductible, coinsurance, net MSP payment, and net reimbursement amounts for each of the reporting periods presented on the report. The Additional Information Section displays calculated net reimbursement for PIP, actual claim payments for PIP, and claim interest payments for each of the reporting periods presented on the report. Additionally, individual resource utilization group (RUG) utilization is displayed by revenue code to assist in the completion of Worksheets 5-7 of the Medicare Cost Report.

The Inpatient 18x and 21x Payment Reconciliation (Detail) reports display detailed claim information, reimbursements, and additional MSP deductible and coinsurance information for each claim included in the reporting period. Additionally, service period and report type totals are provided for each of the service periods included in the report.

An example of the Inpatient 18x and 21x Provider Summary report template and the Inpatient 18x and 21x Payment Reconciliation (Detail) report template follow.

Exhibit 4-12 Inpatient 18x and 21x Provider Summary Report Template (Page 1)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/05/07
Provider FYE: 12/31
Provider Number: T0Z300 SNOW BIRD HOSPITAL

PROVIDER SUMMARY REPORT
SWING BED SNF

Page: 1
Report #: OD44203
Report Type: 180

	SERVICES FOR PERIOD 01/01/04 - 03/31/04	SERVICES FOR PERIOD 04/01/04 - 06/30/04	SERVICES FOR PERIOD 07/01/04 - 09/30/04	SERVICES FOR PERIOD 10/01/04 - 12/31/04
STATISTIC SECTION				
DISCHARGES	20	32	0	0
MEDICARE DAYS	229	301	0	0
CLAIMS	20	32	0	0

CHARGE SECTION

*** ACCOMMODATION CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0121	MED-SUR-GY/2BED	229	$144,499.00	301	$189,931.00	0	$0.00	0	$0.00
TOTAL ACCOMMODATIONS		**229**	**$144,499.00**	**301**	**$189,931.00**	**0**	**$0.00**	**0**	**$0.00**

*** ANCILLARY CHARGES ***

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0250	PHARMACY	744	$42,618.60	1,113	$56,948.00	0	$0.00	0	$0.00
0258	IV SOLUTIONS	62	$5,900.00	269	$27,683.00	0	$0.00	0	$0.00
0259	DRUGS/OTHER	3,911	$26,589.44	4,951	$39,107.74	0	$0.00	0	$0.00
0270	MED-SUR SUPPLIES	0	$0.00	1	$113.00	0	$0.00	0	$0.00
0272	STERILE SUPPLY	0	$0.00	3	$723.00	0	$0.00	0	$0.00
0300	LABORATORY or (LAB)	4	$556.00	20	$1,316.00	0	$0.00	0	$0.00
0301	LAB/CHEMISTRY	96	$11,397.00	134	$16,779.00	0	$0.00	0	$0.00
0302	LAB/IMMUNOLOGY	0	$0.00	1	$87.00	0	$0.00	0	$0.00
0305	LAB/HEMATOLOGY	72	$3,827.00	80	$3,804.00	0	$0.00	0	$0.00
0306	LAB/BACT-MICRO	21	$2,406.00	20	$2,502.00	0	$0.00	0	$0.00
0309	LAB/OTHER	3	$164.00	8	$646.00	0	$0.00	0	$0.00
0320	DX X-RAY	6	$1,940.00	10	$3,908.00	0	$0.00	0	$0.00
0324	DX X-RAY/CHEST	5	$1,171.00	11	$2,653.00	0	$0.00	0	$0.00
0350	CT SCAN	0	$0.00	0	$0.00	0	$0.00	0	$0.00
0351	CT SCAN/HEAD	0	$0.00	1	$1,508.00	0	$0.00	0	$0.00
0352	CT SCAN/BODY	0	$0.00	2	$2,898.00	0	$0.00	0	$0.00
0390	BLOOD/STOR-PROC	0	$0.00	2	$436.00	0	$0.00	0	$0.00

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Exhibit 4-13 Inpatient 18x and 21x Provider Summary Report Template (Page 2)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/05/07
Provider FYE: 12/31
Provider Number: T0Z300 SNOW BIRD HOSPITAL

PROVIDER SUMMARY REPORT
SWING BED SNF

Page: 2
Report #: OD44203
Report Type: 180

		SERVICES FOR PERIOD 01/01/04 - 03/31/04		SERVICES FOR PERIOD 04/01/04 - 06/30/04		SERVICES FOR PERIOD 07/01/04 - 09/30/04		SERVICES FOR PERIOD 10/01/04 - 12/31/04	
REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0402	ULTRASOUND	3	$1,847.00	2	$1,215.00	0	$0.00	0	$0.00
0410	RESPIRATORY SVC	76	$6,504.00	559	$55,071.00	0	$0.00	0	$0.00
0420	PHYSICAL THERP	1,061	$72,009.00	1,437	$98,450.00	0	$0.00	0	$0.00
0430	OCCUPATION THER	762	$52,331.00	1,048	$72,924.00	0	$0.00	0	$0.00
0440	SPEECH PATHOL	1	$357.00	8	$1,733.00	0	$0.00	0	$0.00
0460	PULMONARY FUNC	14	$700.00	12	$600.00	0	$0.00	0	$0.00
0480	CARDIOLOGY	3	$2,014.00	0	$0.00	0	$0.00	0	$0.00
0730	EKG/ECG	4	$988.00	3	$741.00	0	$0.00	0	$0.00
0921	PERI VASCUL LAB	6	$3,330.00	7	$3,946.00	0	$0.00	0	$0.00
0998	BARBER/BEAUTY	0	$0.00	0	$0.00	0	$0.00	0	$0.00
TOTAL ANCILLARY		6,854	$236,649.04	9,702	$395,791.74	0	$0.00	0	$0.00
TOTAL COVERED CHARGES			$381,148.04		$585,722.74		$0.00		$0.00

REIMBURSEMENT SECTION
PAYMENT

GROSS REIMBURSEMENT	$190,570.00	$255,850.00	$0.00	$0.00
CASH DEDUCTIBLE	$0.00	$0.00	$0.00	$0.00
BLOOD DEDUCTIBLE	$0.00	$0.00	$0.00	$0.00
COINSURANCE	$109.50	$0.00	$0.00	$0.00
NET MSP PAYMENTS	$0.00	$0.00	$0.00	$0.00
NET REIMBURSEMENT	$190,460.50	$255,850.00	$0.00	$0.00

ADDITIONAL INFORMATION SECTION

CALCULATED NET REIMB FOR PIP	$0.00	$0.00	$0.00	$0.00
ACTUAL CLAIM PAYMENTS FOR PIP	$0.00	$0.00	$0.00	$0.00
CLAIM INTEREST PAYMENTS	$16.21	$0.00	$0.00	$0.00

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Exhibit 4-14 Inpatient 18x and 21x Payment Reconciliation (Detail) Report Template (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 02/29/04
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T0Z300 SNOW BIRD HOSPITAL

PAYMENT RECONCILIATION REPORT
SWING BED SNF

Page: 1
Report #: OD44202
Report Type: 180
Paid Dates: 01/01/04 to 10/01/06

Claim Information

Patnt Nm:	SICL J	Bill Freq:	1
DCN:	20479589433805	Trans Type:	
Ptnt Cntrl #:	189000000000	Dschrg Patnt Cd:	1
Med Rcrd #:	633000000000	Dschrg Patnt Stat:	Yes
HIC Num:	483582885A	DRG/CMG Cd:	
Recpt Dt:	02/23/04	PIP Claim:	No
Paid Dt:	04/02/04	Bnfits Exhstd Ind.:	No
Service From:	01/21/04	Processor ID:	14000
Service Thru:	02/11/04		
Med. Days:	21		

Rev Code	RUGs	Units	Charges	RUGs Rate
0121		21	$13,251.00	$0.00
0250		19	$1,696.00	$0.00
0258		27	$2,475.00	$0.00
0259		448	$2,924.24	$0.00
0301		22	$2,594.00	$0.00
0305		2	$130.00	$0.00
0306		4	$449.00	$0.00
0320		1	$366.00	$0.00
0324		2	$478.00	$0.00
0402		1	$564.00	$0.00
0410		32	$2,272.00	$0.00
0420		104	$6,939.00	$0.00
0430		82	$5,504.00	$0.00
0921		1	$555.00	$0.00
TOTAL:		766	$40,197.24	

Reimbursements

Gross Reimb.:	$16,590.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$109.50
MSP:	$0.00
Net Reimb.:	$16,480.50

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Calc Reimb. PIP:	$0.00
Actual Clm Pymnts PIP:	$0.00
Claim Interest:	$16.21

Patnt Nm:	HARR D	Bill Freq:	1
DCN:	20449428983905	Trans Type:	
Ptnt Cntrl #:	190000000000	Dschrg Patnt Cd:	6
Med Rcrd #:	905000000000	Dschrg Patnt Stat:	Yes
HIC Num:	288665885A	DRG/CMG Cd:	
Recpt Dt:	04/06/04	PIP Claim:	No
Paid Dt:	04/21/04	Bnfits Exhstd Ind.:	No
Service From:	02/13/04	Processor ID:	14000
Service Thru:	02/27/04		
Med. Days:	14		

Rev Code	RUGs	Units	Charges	RUGs Rate
0121		14	$8,834.00	$0.00
0259		312	$2,617.00	$0.00
0301		2	$355.00	$0.00
0320		1	$328.00	$0.00
0324		1	$263.00	$0.00
0420		36	$2,503.00	$0.00
0430		30	$2,109.00	$0.00
0480		3	$2,014.00	$0.00
TOTAL:		399	$19,023.00	

Gross Reimb.:	$11,060.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Net Reimb.:	$11,060.00

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Calc Reimb. PIP:	$0.00
Actual Clm Pymnts PIP:	$0.00
Claim Interest:	$0.00

***** Monthly Totals for SNOW BIRD HOSPITAL for service month end 2/29/04 *****

Med. Days: 35 Discharge Count: 2

	Units	Charges
TOTAL:	1,165	$59,220.24

Reimbursements

Gross Reimb.:	$27,650.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$109.50
MSP:	$0.00
Net Reimb.:	$27,540.50

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Calc Reimb. PIP:	$0.00
Actual Clm Pymnts PIP:	$0.00
Claim Interest:	$16.21

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Exhibit 4-15 Inpatient 18x and 21x Payment Reconciliation (Detail) Report Template (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: N/A
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T0Z300 SNOW BIRD HOSPITAL

PAYMENT RECONCILIATION REPORT
SWING BED SNF

Page: 30
Report #: OD44202
Report Type: 180
Paid Dates: 01/01/04 to 10/01/06

Service Period and Report Type Totals

Service Period				Units	Charges	Reimbursements		Additional Information	
01/01/2004 - 09/30/2006	Med. Days: 1,053	Discharge Count: 85	TOTAL:	36,887	$2,230,676.97	Gross Reimb.:	$890,970.00	MSP Cash Deduct.:	$0.00
						LESS:		MSP Blood Deduct.:	$0.00
						Cash Deduct.:	$0.00	MSP Coins.:	$0.00
						Blood Deduct.:	$0.00	Calc Reimb. PIP:	$0.00
						Coins.:	$10,343.50	Actual Clm Pymnts PIP:	$0.00
						MSP:	$0.00	Claim Interest:	$16.21
						Net Reimb.:	$880,626.50		
*** Report Type 180 Totals for SNOW BIRD HOSPITAL ***						Reimbursements		Additional Information	
				Units	Charges	Gross Reimb.:	$890,970.00	MSP Cash Deduct.:	$0.00
	Med. Days: 1,053	Discharge Count: 85	TOTAL:	36,887	$2,230,676.97	LESS:		MSP Blood Deduct.:	$0.00
						Cash Deduct.:	$0.00	MSP Coins.:	$0.00
						Blood Deduct.:	$0.00	Calc Reimb. PIP:	$0.00
						Coins.:	$10,343.50	Actual Clm Pymnts PIP:	$0.00
						MSP:	$0.00	Claim Interest:	$16.21
						Net Reimb.:	$880,626.50		

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The reports that are generated based on the Inpatient 18x and 21x report template are:

- Swing Bed SNF (MSP-LCC) (18A)
- Swing Bed SNF (180)
- SNF – Inpatient – Part A (MSP-LCC) (21A)
- SNF – Inpatient – Part A PPS (210)

A brief description of these reports is provided in the following sections.

4.3.1 Swing Bed SNF (MSP-LCC) (18A)

The Swing Bed SNF (MSP-LCC) (18A) report is a supplemental report to the Swing Bed SNF (180) report. The items reported on the Swing Bed SNF (MSP-LCC) (18A) report are included on the Medicare Cost Report.

4.3.2 Swing Bed SNF (180)

The Swing Bed SNF (180) report summarizes swing bed hospital services. The items reported on the Swing Bed SNF (180) report are included on the Medicare Cost Report.

4.3.3 SNF – Inpatient – Part A (MSP-LCC) (21A)

The SNF – Inpatient – Part A (MSP-LCC) (21A) report is a supplemental report to the SNF – Inpatient – Part A PPS (210) report. The items reported on the SNF – Inpatient – Part A (MSP-LCC) (21A) report are included on the Medicare Cost Report.

4.3.4 SNF – Inpatient – Part A PPS (210)

The SNF – Inpatient – Part A PPS (210) report summarizes skilled nursing facility Inpatient – Part B services. The items reported on the SNF – Inpatient – Part A PPS (210) report are included on the Medicare Cost Report.

5 Outpatient Reports

The PS&R System consists of a number of outpatient reports that are based on standardized outpatient report templates. The template categories and the corresponding reports are:

- 72x Hospital Based or Independent Renal Dialysis Center Report Template
  - Hospital Based or Independent Renal Dialysis Center (MSP-LCC) (72A)
  - Hospital Based or Independent Renal Dialysis Center (Composite Rate Services) (720)
  - Hospital Based or Independent Renal Dialysis Center – Fee Reimbursed (725)
- xxA Medicare Secondary Payer - Lower Cost or Charge (MSP-LCC) Report Template
  - Inpatient – Part B (MSP-LCC) (12A)
  - Outpatient – All Other (MSP-LCC) (13A)
  - Outpatient/Other (MSP-LCC) (14A)
  - SNF – Inpatient – Part B (MSP-LCC) (22A)
  - SNF – Outpatient (MSP-LCC) (23A)
  - Home Health – Part B (MSP-LCC) (34A)
  - Clinic – Rural Health (MSP-LCC) (71A)
  - Federally Qualified Health Center (MSP-LCC) (73A)
  - Rehabilitation Facility (MSP-LCC) (74A)
  - Comprehensive Outpatient Rehabilitation Facilities (MSP-LCC) (75A)
  - Community Mental Health Center (MSP-LCC) (76A)
  - ASC and ASC Fee Schedule (MSP-LCC) (83A)
  - Critical Access Hospital (MSP-LCC) (85A)
- xxP Outpatient Prospective Payment System (OPPS) Report Template
  - Inpatient – Part B OPPS (12P)
  - Outpatient – OPPS (13P)
  - Outpatient/Other – OPPS (14P)
  - SNF – Outpatient – OPPS (22P)
  - SNF – Outpatient OPPS (23P)
  - SNF – Outpatient OPPS (24P)
  - Home Health – Outpatient – OPPS (not HHPPS) (34P)
  - Clinic – Rural Health – OPPS (71P)
  - Federally Qualified Health Center – OPPS (73P)
  - Rehabilitation Facility – OPPS (74P)
  - Comprehensive Outpatient Rehabilitation Facilities – OPPS (75P)
  - Community Mental Health Center – OPPS (76P)
  - Hospice – Non-Hospital Based – OPPS (81P)
  - Hospice – Hospital Based – OPPS (82P)
  - ASC and ASC Fee Schedule – OPPS (83P)

- xxZ Ambulance Blend Report Template
  - Inpatient – Ambulance Blend Effective 04/01/02 (12Z)
  - Outpatient – Ambulance Blend Effective 04/01/02 (13Z)
  - SNF – Ambulance Blend Effective 04/01/02 (22Z)
  - SNF – Ambulance Blend Effective 04/01/02 (23Z)
  - ASC and ASC Fee Schedule – Ambulance Blend Effective 04/01/02 (83Z)
  - Critical Access Hospital – Ambulance Blend Effective 04/01/02 (85Z)
- xx2 Vaccines Report Template
  - Inpatient – Part B Vaccine (122)
  - Outpatient – Part B Vaccine (132)
  - Outpatient/Other – Vaccines (142)
  - SNF – Inpatient – Vaccine – Part B 100 % Reasonable Cost (222)
  - SNF – Outpatient – Vaccine – Part B 100 % Reasonable Cost (232)
  - Home Health – Vaccine – Part B 100% Reasonable Cost (342)
  - Clinic – Rural Health – Vaccine – Part B 100% Reasonable Cost (712)
  - Federally Qualified Health Center – Vaccine – Part B 100% Reasonable Cost (732)
  - Rehabilitation Facility – Vaccine – Part B 100% Reasonable Cost (742)
  - Comprehensive Outpatient Rehabilitation Facilities – Vaccine – Part B 100% Reasonable Cost (752)
  - Community Mental Health Center – Vaccine – Part B 100% Reasonable Cost (762)
  - ASC and ASC Fee Schedule – Vaccine – Part B 100% Reasonable Cost (832)
  - Critical Access Hospital – Vaccines – Part B 100% Reasonable Cost (852)
- xx5 Fee Reimbursed Report Template
  - Inpatient – Part B Fee Reimbursed (125)
  - Outpatient – Fee Reimbursed (135)
  - Outpatient/Other – Fee Reimbursed (145)
  - SNF – Inpatient – Fee Reimbursed (225)
  - SNF – Outpatient Fee Reimbursed (235)
  - Home Health – Part B – Fee Reimbursed (345)
  - Federally Qualified Health Center – Fee Reimbursed (735)
  - Rehabilitation Facility – Fee Reimbursed (745)
  - Comprehensive Outpatient Rehabilitation Facilities – Fee Reimbursed (755)
  - Community Mental Health Center – Fee Reimbursed (765)
  - ASC and ASC Fee Schedule – Fee Reimbursed (835)
  - Critical Access Hospital – Fee Reimbursed (855)
- xx0 All Other Cost Reimbursed Report Template
  - Inpatient – Part B Cost Reimbursed (120)
  - Outpatient – Cost Reimbursed (130)
  - Outpatient/Other – All Other Cost Reimbursed (140)
  - SNF – Inpatient – Part B Cost Reimbursed (220)

  - SNF – Outpatient – Cost Reimbursed (230)
  - Home Health – Part B (340)
  - Clinic – Rural Health (710)
  - Federally Qualified Health Center (730)
  - Rehabilitation Facility (740)
  - Comprehensive Outpatient Rehabilitation Facilities (750)
  - Community Mental Health Center (760)
  - Critical Access Hospital (850)
- xxM/xx9 Home Health Agency MSP-LCC / Episodes Report Template
  - Home Health PPS – Part A (MSP-LCC) (32M)
  - Home Health PPS – Part B Episodes (329)
  - Home Health – Part A (MSP-LCC) (33M)
  - Home Health PPS – Part A Episodes (339)
  - Home Health PPS – Part A and Part B Episodes (399)
- 322/332 Home Health Agency RAP Report Template
  - Home Health PPS – Part B RAP (322)
  - Home Health PPS – Part A RAP (332)
- 81x/82x Hospice Report Template
  - Hospice – Non-Hospital Based (MSP-LCC) (81A)
  - Hospice – Non-Hospital Based (810)
  - Hospice – Hospital Based (MSP-LCC) (82A)
  - Hospice – Hospital Based (820)
- 831 ASC and ASC Fee Schedule After 12/90

With the exception of xxA report templates, Outpatient reports display data at the line level for claims received in the Paid Claims files received from the Fiscal Intermediary Standard System (FISS). The xxA Outpatient reports display data at the claim level.

This chapter provides an overview of the sequence of report type assignment for outpatient claims in addition to a description of each of the outpatient reports. Chapter 4, Inpatient Reports, provides a description of the inpatient reports available in the PS&R System. See Appendix B, Report Data, for a definition of the data elements available on reports.

5.1 Outpatient Report Type Assignment

Outpatient claims and claim lines, including 34x home health agency and hospice claims, submitted to the PS&R System in the Paid Claims file are assigned to a report type in the following sequence:

- 72x (Hospital Based or Independent Renal Dialysis Center)
- xxA (Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC))
- xxP (Outpatient Prospective Payment System)
- xxZ (Ambulance Blend)
- xx2 (Vaccine)

- xx5 (Fee Reimbursed)
- 831 (ASC and ASC Fee Schedule After 12/90)
- xx0 (All Other)

For 32x and 33x home health agency (HHA) claims submitted to the PS&R System, the claims are assigned to a report type in the following sequence:

- xxM (Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC))[1]
- xx2 (RAP)
- xx9 (Episodes)[1]

Hospice claims submitted to the PS&R System are assigned to a report type in the following sequence:

- xxA (Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC))
- xxP (Outpatient Prospective Payment System)
- xx0 (All Other)

The following sections document the processing requirements for a claim to be presented on these outpatient reports.

5.1.1 72x (Hospital Based or Independent Renal Dialysis Center)

The 72x claims are assigned to the Hospital Based or Independent Renal Dialysis Center (MSP-LCC) (72A) report, Hospital Based or Independent Renal Dialysis Center (Composite Rate Services) (720) report, Hospital Based or Independent Renal Dialysis Center – Fee Reimbursed (725) report, Outpatient – Part B Vaccine (132) report, and Outpatient Cost Reimbursed (130) report if the type of bill is 72x.

If the MSP-LCC Indicator is “M” or the Full Recovery indicator is “FR”, the claims are displayed on the Hospital Based or Independent Renal Dialysis Center (MSP-LCC) (72A) report. Note that the MSP-LCC and Full Recovery indicators are at the claim level. If either indicator is present, the entire claim is presented on the Hospital Based or Independent Renal Dialysis Center (MSP-LCC) (72A) report.

If the ESRD Revenue Code is “821”, “831”, “841”, or “851”, the claim lines are presented on the Hospital Based or Independent Renal Dialysis Center (Composite Rate Services) (720) report.

If a HCPCS Code is present on a claim line and the corresponding Total Fee Schedule amount is greater than zero (0) or if the Revenue Code is “0634” (EPO), “0635” (EPO), “0825”, “0835”, “0845”, or “0855” (Home Support), the claim line is presented on the Hospital Based or Independent Renal Dialysis Center – Fee Reimbursed (725) report.

If a claim line Revenue Code is “636” or “771”, the corresponding Total Fee Schedule Amount is zero (0) or blank, the claim has a condition code of “A6”, and the line’s corresponding cash deductible and coinsurance amounts are zero (0), the claim line is presented on the Outpatient – Part B Vaccine (132) report.

If a claim line’s cash deductible, coinsurance, or net reimbursement amount is not equal to zero (0), the claim is presented on the Outpatient Cost Reimbursed (130) report.

If none of the previous conditions applies to the claim or claim lines, the claim line is presented on the Hospital Based or Independent Renal Dialysis Center – Fee Reimbursed (725) report.

---

[1] Note that the xxM (Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC)) and xx9 (Episodes) claims are presented on the common xxM/xx9 report template.

5.1.2 xxA (Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC))

Claims that do not satisfy requirements for presentation on 72x reports are presented on the xxA (Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC)) report template if the MSP-LCC Indicator is “M” or the Full Recovery Indicator is “FR”. The specific xxA (Medicare Secondary Payer-Lower Cost or Charge) report on which the claim is presented is determined by the type of data in the claim (for example, inpatient Part B, Outpatient Skilled Nursing Facility, etc.).

5.1.3 xxP (Outpatient Prospective Payment System)

Claim lines that do not satisfy requirements for presentation on xxA reports are presented on the xxP (Outpatient Prospective Payment System) report template if the APC Code is greater than zero (0) and the Service From Date is on or after August 1, 2000.

5.1.4 xxZ (Ambulance Blend)

Claim lines that do not satisfy requirements for presentation on xxP reports are presented on the xxZ (Ambulance Blend) report template if the Revenue Code is 54X, the Service From date is on or after April 1, 2002, and the HCPCS Code is and ambulance code. The valid HCPCS codes for presentation on the xxZ Ambulance Blend report template are:

- A0425-A436
- A0030
- A0040
- A0050
- A0320
- A0322
- A0324
- A0326
- A0328
- A0330
- A0380
- A0390
- Q3019-Q3020

5.1.5 xx2 (Vaccine)

Claim lines that do not satisfy requirements for presentation on xxZ reports are presented on the xx2 (Vaccine) report template if the Revenue Code is “636” or “771”, the Total Fee Schedule Amount is zero (0) or blank, the claim has a condition code of “A6”, and the line’s corresponding cash deductible and coinsurance amounts are zero (0). The xx2 reports only contain those services that are not paid on a fee schedule and are not paid under the Outpatient Prospective Payment System.

5.1.6 xx5 (Fee Reimbursed)

Claim lines that do not satisfy requirements for presentation on xx2 reports are presented on the xx5 (Fee Reimbursed) report template if the claim line has a HCPCS Code and the Total Fee Schedule Amount is greater than zero (0).

5.1.7 Package Services Assignment

Package services claim lines (claim lines with an APC Service Indicator of “N” or APC Package flag of “1” or “2”) are assigned as follows:

- If any claim line goes to the xxP (Outpatient Prospective Payment System) template, the Package(s) goes to the xxP (Outpatient Prospective Payment System) report template
- If any claim line goes to the xx5 (Fee Reimbursed) template, the Package(s) goes to the xx5 (Fee Reimbursed) report template
- If any claim line goes to the xxZ (Ambulance Blend) template, the Package(s) goes to the xxZ (Ambulance Blend) report template
- If the claim line’s bill type is 83x, any unassigned packages go to the 831 (ASC and ASC Fee Schedule After 12/90) report
- Any unassigned Package lines go to the xx0 (All Other) report template

5.1.8 831 (ASC and ASC Fee Schedule After 12/90)

Claim lines with a type of bill of 83x that do not satisfy requirements for presentation on any of the previously processed report templates are presented on the 831 ASC and ASC Fee Schedule After 12/90 (831) report.

5.1.9 xx0 (All Other)

Claim lines that do not satisfy requirements for presentation on any of the previously processed report templates are presented on the xx0 (all Other) report template.

The following sections document the Home Health Agency report type assignments.

5.1.10 xxM (Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC))

Claims with a type of bill of 32x or 33x are presented on the home health agency xxM/xx9 Home Health Agency report template if the MSP-LCC Indicator is “M” or the Full Recovery Indicator is “FR”.

5.1.11 xx2 (RAP)

Claims with a type of bill of 32x or 33x are presented on the home health agency xx2 (RAP) report template if the Home Health Split Indicator is “R”.

5.1.12 xx9 (Episodes)

Claims with a type of bill of 32x or 33x are presented on the home health agency xx9 (Episodes) report template if the claim is not presented on the xx2 (RAP) report template.

5.1.13 xxA (Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC))

Claims with a bill category of “81” or “82” are presented on the hospice xxA (Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC)) report template if the MSP-LCC Indicator is “M” or the Full Recovery Indicator is “FR”.

5.1.14 xxP (Outpatient Prospective Payment System)

Claims with a bill category of “81” or “82” are presented on the hospice xxP (Outpatient Prospective Payment System) report template if the MSP-LCC Indicator is “M” or the Full Recovery Indicator is “FR”.

5.1.15 xx0 (All Other)

Claims with a bill category of “81” or “82” are presented on the hospice xx0 (All Other) report template if the MSP-LCC Indicator is “M” or the Full Recovery Indicator is “FR”.

5.2 72x Hospital Based or Independent Renal Dialysis Center Report Template

The 72x Hospital Based or Independent Renal Dialysis Center Provider Summary report template displays summary statistic, charge, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. The statistic section shows the number of claims for each reporting period. The charge section displays the number of units and the total dollar amount of the revenue code being reported. The reimbursement section displays how Net Reimbursement is calculated. Finally, the additional information section displays the claim interest payments.

The 72x Hospital Based or Independent Renal Dialysis Center Payment Reconciliation (detail) report template is divided into claim information, reimbursements, and additional information sections. The claim information section contains patient information such as the patient name, DCN, HCPCS, and the charges for the revenue codes. The reimbursements section shows how net reimbursement is calculated. The additional information section shows the deductible amounts, coinsurance, and the claim interest. The report template also provides a monthly totals section that sums the information from the sections above.

An example of the 72x Provider Summary report template and the 72x Hospital Based or Independent Renal Dialysis Center Payment Reconciliation (detail) report template follow.

Exhibit 5-1 Outpatient – 72x Provider Summary Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/02/07
Provider FYE: 12/31
Provider Number: T02581 INDIAN BEACH DIALYSIS CENTER

PROVIDER SUMMARY REPORT
HOSP. BASED OR INDEPEND. RENAL DIALYSIS CENTER (COMPOSITE RATE SERVICES)

Page: 1
Report #: OD44203
Report Type: 720

	SERVICES FOR PERIOD 01/01/04 - 03/31/04	SERVICES FOR PERIOD 04/01/04 - 06/30/04	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
STATISTIC SECTION				
CLAIMS	18	38		

CHARGE SECTION

REV CODE	ESRD COND CODE	DESCRIPTION	UNITS	COV CHG/PYMTS	AVG PYMT RATE	UNITS	COV CHG/PYMTS	AVG PYMT RATE	UNITS	COV CHG/PYMTS	AVG PYMT RATE	UNITS	COV CHG/PYMTS	AVG PYMT RATE
0821	71	HEMO/COMPOSITE	20	$2,523.80	$126.19	233	$29,402.27	$126.19			$0.00			$0.00
	76	HEMO/COMPOSITE	0	$0.00	$0.00	10	$1,261.90	$126.19			$0.00			$0.00
0841	73	CAPD/COMPOSITE	11	$1,520.09	$138.19	0	$0.00	$0.00			$0.00			$0.00
	74	CAPD/COMPOSITE	43	$2,325.44	$54.08	126	$6,814.08	$54.08			$0.00			$0.00
0851	73	CCPD/COMPOSITE	0	$0.00	$0.00	3	$438.57	$146.19			$0.00			$0.00
	74	CCPD/COMPOSITE	0	$0.00	$0.00	51	$2,758.08	$54.08			$0.00			$0.00
TOTAL COVERED CHARGES			**74**	**$6,369.33**	**$86.07**	**423**	**$40,674.90**	**$96.16**			**$0.00**			**$0.00**

REIMBURSEMENT SECTION

GROSS REIMBURSEMENT	$6,369.33	$40,674.90		
LESS				
CASH DEDUCTIBLE	$0.00	$0.00		
COINSURANCE	$1,273.90	$8,134.95		
NET MSP PAYMENTS	$0.00	$0.00		
ESRD REDUCTION/NETWORK PAYMENTS	$24.65	$160.80		
NET REIMBURSEMENT	$5,070.78	$32,379.15		

ADDITIONAL INFORMATION SECTION

CLAIM INTEREST PAYMENTS	$0.00	$0.00		

CONDITION CODE KEY:
71 - FULL CARE IN UNIT. 72 - SELF CARE IN UNIT. 73 - SELF CARE TRAINING. 74 - HOME (METHOD 1). 76 - BACK-UP IN FACILITY DIALYSIS.

Feb 2, 2007 - 1 - 7:54:02 AM

Exhibit 5-2 Outpatient – 72x Payment Reconciliation (Detail) Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 01/31/04
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T02581 INDIAN BEACH DIALYSIS CENTER

PAYMENT RECONCILIATION REPORT
HOSP. BASED OR INDEPEND. RENAL DIALYSIS CENTER (COMPOSITE RATE SERVICES)

Page: 1
Report #: OD44202
Report Type: 720
Paid Dates: 01/01/04 to 10/01/06

Claim Information

Patnt Nm:	SNEL R	Bill Freq:	1
DCN:	20408948370304	Trans Type:	
Ptnt Cntrl #:	000000000	Processor ID:	14000
Med Rcrd #:		ESRD Condition Code:	73
HIC Num:	552368600A	Weight (Kg):	
Recpt Dt:	04/12/04	Height (m):	
Paid Dt:	04/26/04	Birth Dt:	11/12/99
Service From:	01/29/04		
Service Thru:	01/29/04		

Rev Code	HCPCS	Units	Cov Chg./ Pymts.	Cash Deduct.	Coins.	MSP	ESRD Rdctn./ Ntwk. Pymts.	Line Item Reimb.
0841	M0986	1	$138.19	$0.00	$27.64	$0.00	$0.50	$110.05
TOTAL:		1	$138.19	$0.00	$27.64	$0.00	$0.50	$110.05

Reimbursements

Gross Reimb.:	$138.19
LESS:	
Cash Deduct.:	$0.00
Coins.:	$27.64
MSP:	$0.00
ESRD Rdctn./Ntwk. Pymts.:	$0.50
Net Reimb.:	$110.05

Additional Information

MSP Cash Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	720

*** Monthly Totals for INDIAN BEACH DIALYSIS CENTER for service month end 1/31/04 ***

	Units	Cov. Chg./ Pymts.	Cash Deduct.	Coins	MSP	ESRD Rdctn./ Ntwk. Pymts.	Line Item Reimb.
TOTAL:	1	$138.19	$0.00	$27.64	$0.00	$0.50	$110.05

Reimbursements

Gross Reimb.:	$138.19
LESS:	
Cash Deduct.:	$0.00
Coins.:	$27.64
MSP:	$0.00
ESRD Rdctn./Ntwk. Pymts.:	$0.50
Net Reimb.:	$110.05

Additional Information

MSP Cash Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00

CONDITION CODE KEY:
71 - FULL CARE IN UNIT. 72 - SELF CARE IN UNIT. 73 - SELF CARE TRAINING. 74 - HOME (METHOD 1). 76 - BACK-UP IN FACILITY DIALYSIS.

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The reports that are generated based on the outpatient 72x Hospital Based or Independent Renal Dialysis Center report template are:

- Hospital Based or Independent Renal Dialysis Center (MSP-LCC) (72A)
- Hospital Based or Independent Renal Dialysis Center (Composite Rate Services) (720)
- Hospital Based or Independent Renal Dialysis Center – Fee Reimbursed (725)

A brief description of these reports is provided in the following sections.

5.2.1 Hospital Based or Independent Renal Dialysis Center (MSP-LCC) (72A)

The Hospital Based or Independent Renal Dialysis Center (MSP-LCC) (72A) report is a supplemental report to the Hospital Based or Independent Renal Dialysis Center (Composite Rate Services) (720) report. The items reported on the Hospital Based or Independent Renal Dialysis Center (MSP-LCC) (72A) report are not to be included on the Medicare Cost Report.

5.2.2 Hospital Based or Independent Renal Dialysis Center (Composite Rate Services) (720)

The Hospital Based or Independent Renal Dialysis Center (Composite Rate Services) (720) report summarizes data for renal dialysis centers (that is, bill type 72x) paid based on an all-inclusive rate. The items reported on the Hospital Based or Independent Renal Dialysis Center (Composite Rate Services) (720) report are included on the Medicare Cost Report.

5.2.3 Hospital Based or Independent Renal Dialysis Center – Fee Reimbursed (725)

The Hospital Based or Independent Renal Dialysis Center – Fee Reimbursed (725) report shows covered charges and reimbursement by revenue code for fee reimbursed services for hospital based or independent renal dialysis center services. The items reported on the Hospital Based or Independent Renal Dialysis Center – Fee Reimbursed (725) report are not to be included on the Medicare Cost Report.

5.3 xxA Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) Report Template

The reports generated based on the Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) contain data at the claim level.

The Outpatient xxA Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) Provider Summary report template displays summary statistic, charge, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. The statistic section shows the number of claims for each reporting period. The charge section displays the number of units and the total dollar amount of the revenue code being reported. The reimbursement section displays how Net Reimbursement is calculated. Finally, the additional information section displays the claim interest payments.

The Outpatient xxA Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) Payment Reconciliation (detail) report template is divided into Claim Information, Reimbursements, and Additional Information sections. The claim information section contains patient information such as the patient name, DCN, HCPCS total, and the charges for the revenue codes. The reimbursements section shows how Net Reimbursement is calculated. The additional information section shows the deductible amounts and the claim interest. The report template provides a monthly totals section that sums the information from the sections above.

An example of the Outpatient – xxA Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) Provider Summary report template and Outpatient – xxA Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) Payment Reconciliation (detail) report template follow.

Exhibit 5-3 Outpatient – xxA Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) Provider Summary Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 02/01/04 THRU 10/01/06
Report Run Date: 02/01/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PROVIDER SUMMARY REPORT
OUTPATIENT - ALL OTHER (MSP-LCC)
THESE ITEMS ARE NOT TO BE INCLUDED ON THE MEDICARE COST REPORT

Page: 1
Report #: OD44203
Report Type: 13A

	SERVICES FOR PERIOD 01/01/04 - 12/31/04	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
STATISTIC SECTION				
CLAIMS	-2			

CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0252	DRUGS/NONGENERIC	-1	-$4.03						
0305	LAB/HEMATOLOGY	-1	-$68.00						
0341	NUC MED/DX	-2	-$2,526.00						
0636	DRUGS/DETAIL CODE	-2	-$886.10						
TOTAL COVERED CHARGES		-6	-$3,484.13						

REIMBURSEMENT SECTION				
GROSS REIMBURSEMENT	-$3,263.29			
LESS				
CASH DEDUCTIBLE	-$200.00			
BLOOD DEDUCTIBLE	$0.00			
COINSURANCE	-$792.04			
NET MSP PAYMENTS	-$2,198.22			
PSYCH REDUCTION	$0.00			
NET REIMBURSEMENT	-$73.03			
ADDITIONAL INFORMATION SECTION				
CLAIM INTEREST PAYMENTS	$0.00			

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Exhibit 5-4 Outpatient – xxA Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) Payment Reconciliation (Detail) Report Template (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 01/31/04
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
OUTPATIENT - ALL OTHER (MSP-LCC)

Page: 1
Report #: OD44202
Report Type: 13A
Paid Dates: 01/01/04 to 10/01/06

Claim Information

Patnt Nm:	CAMP F	Bill Freq:	8
DCN:	20409076128804	Trans Type:	C
Ptnt Cntrl #:	127000000000	Processor ID:	14000
Med Rcrd #:	147000000000		
HIC Num:	054128460A		
Recpt Dt:	02/17/04		
Paid Dt:	05/31/04		
Service From:	01/14/04		
Service Thru:	01/14/04		

Rev Code	HCPCS	Units	Charges
0341	78708	-1	-$1,263.00
0636	Q3005	-1	-$443.05
HCPCS Total:		-2	-$1,706.05
TOTAL:		-2	-$1,706.05

Reimbursements

Gross Reimb.:	-$1,658.06
LESS:	
Cash Deduct.:	-$100.00
Blood Deduct.:	$0.00
Coins.:	-$396.02
MSP:	-$1,145.20
Psyc. Red.:	.
Net Reimb.:	-$16.84

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	13A

Patnt Nm:	COCH H	Bill Freq:	8
DCN:	20419996319104	Trans Type:	C
Ptnt Cntrl #:	128000000000	Processor ID:	14000
Med Rcrd #:	230000000000		
HIC Num:	099773982A		
Recpt Dt:	02/24/04		
Paid Dt:	05/31/04		
Service From:	01/26/04		
Service Thru:	01/27/04		

Rev Code	HCPCS	Units	Charges
0252		-1	-$4.03
0305	85610	-1	-$68.00
0341	78708	-1	-$1,263.00
0636	Q3005	-1	-$443.05
HCPCS Total:		-3	-$1,774.05
TOTAL:		-4	-$1,778.08

Reimbursements

Gross Reimb.:	-$1,605.23
LESS:	
Cash Deduct.:	-$100.00
Blood Deduct.:	$0.00
Coins.:	-$396.02
MSP:	-$1,053.02
Psyc. Red.:	.
Net Reimb.:	-$56.19

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	13A

***** Monthly Totals for PETERBORO GENERAL HOSPITAL for service month end 1/31/04 *****

	Units	Charges
HCPCS Total:	-5	-$3,480.10
TOTAL:	-6	-$3,484.13

Reimbursements

Gross Reimb.:	-$3,263.29
LESS:	
Cash Deduct.:	-$200.00
Blood Deduct.:	$0.00
Coins.:	-$792.04
MSP:	-$2,198.22
Psyc. Red.:	.
Net Reimb.:	-$73.03

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00

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Exhibit 5-5 Outpatient – xxA Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) Payment Reconciliation (Detail) Report Template (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: N/A
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
OUTPATIENT - ALL OTHER (MSP-LCC)

Page: 2
Report #: OD44202
Report Type: 13A
Paid Dates: 01/01/04 to 10/01/06

Service Period and Report Type Totals

Service Period		Units	Charges	Reimbursements		Additional Information	
01/01/2004 - 01/01/2006				Gross Reimb.:	-$3,263.29	MSP Cash Deduct.:	$0.00
				LESS:		MSP Blood Deduct.:	$0.00
	HCPCS Total:	-5	-$3,480.10			MSP Coins.:	$0.00
	TOTAL:	-6	-$3,484.13	Cash Deduct.:	-$200.00	Claim Interest:	$0.00
				Blood Deduct.:	$0.00		
				Coins.:	-$792.04		
				MSP:	-$2,198.22		
				Psyc. Red.:	.		
				Net Reimb.:	-$73.03		

*** Report Type 13A Totals for PETERBORO GENERAL HOSPITAL ***		Units	Charges	Reimbursements		Additional Information	
				Gross Reimb.:	-$3,263.29	MSP Cash Deduct.:	$0.00
				LESS:		MSP Blood Deduct.:	$0.00
	HCPCS Total:	-5	-$3,480.10			MSP Coins.:	$0.00
	TOTAL:	-6	-$3,484.13	Cash Deduct.:	-$200.00	Claim Interest:	$0.00
				Blood Deduct.:	$0.00		
				Coins.:	-$792.04		
				MSP:	-$2,198.22		
				Psyc. Red.:	$0.00		
				Net Reimb.:	-$73.03		

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The reports that are generated based on the outpatient xxA Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) report template are:

- Inpatient – Part B (MSP-LCC) (12A)
- Outpatient – All Other (MSP-LCC) (13A)
- Outpatient/Other (MSP-LCC) (14A)
- SNF – Inpatient – Part B (MSP-LCC) (22A)
- SNF – Outpatient (MSP-LCC) (23A)
- Clinic – Rural Health (MSP-LCC) (71A)
- Federally Qualified Health Center (MSP-LCC) (73A)
- Rehabilitation Facility (MSP-LCC) (74A)
- Comprehensive Outpatient Rehabilitation Facilities (MSP-LCC) (75A)
- Community Mental Health Center (MSP-LCC) (76A)

- Hospice – Non-Hospital Based (MSP-LCC) (81A)
- Hospice – Hospital Based (MSP-LCC) (82A)
- ASC and ASC Fee Schedule (MSP-LCC) (83A)
- Critical Access Hospital (MSP-LCC) (85A)

A brief description of these reports is provided in the following sections.

5.3.1 Inpatient – Part B (MSP-LCC) (12A)

The Inpatient – Part B (MSP-LCC) (12A) report is a supplemental report to the Inpatient – Part B Cost Reimbursed (120) report. For providers on PIP (Part A), the interim payments included on the Medicare Cost Report are adjusted by the Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) amount. The items reported on the Inpatient – Part B (MSP-LCC) (12A) report are not to be included on the Medicare Cost Report.

5.3.2 Outpatient – All Other (MSP-LCC) (13A)

The Outpatient – All Other (MSP-LCC) (13A) report is a supplemental report to the Outpatient – Cost Reimbursed (130) report. The items reported on the Outpatient – All Other (MSP-LCC) (13A) report are not to be included on the Medicare Cost Report.

5.3.3 Outpatient/Other (MSP-LCC) (14A)

The Outpatient/Other (MSP-LCC) (14A) report is a supplemental report to the Outpatient/Other – All Other Cost Reimbursed (140) report. The items reported on the Outpatient/Other (MSP-LCC) (14A) report are not to be included on the Medicare Cost Report.

5.3.4 SNF – Inpatient – Part B (MSP-LCC) (22A)

The SNF – Inpatient – Part B (MSP-LCC) (22A) report is a supplemental report to the SNF – Inpatient – Part B Cost Reimbursed (220) report. The items reported on the SNF – Inpatient – Part B (MSP-LCC) (22A) report are not to be included on the Medicare Cost Report.

5.3.5 SNF – Outpatient (MSP-LCC) (23A)

The SNF – Outpatient (MSP-LCC) (23A) report is a supplemental report to the SNF – Outpatient Cost Reimbursed (230) report. The items reported on the SNF – Outpatient (MSP-LCC) (23A) report are not to be included on the Medicare Cost Report.

5.3.6 Home Health – Part B (MSP-LCC) (34A)

The Home Health Part B (MSP-LCC) (34A) report summarizes the Part B claims not under a plan of treatment that is subject to MSP-LCC limitation. Data in this report are subject to coinsurance and deductible. The items reported on the Home Health Part B (MSP-LCC) (34A) report are not to be included on the Medicare Cost Report.

5.3.7 Clinic – Rural Health (MSP-LCC) (71A)

The Clinic – Rural Health (MSP-LCC) (71A) report is a supplemental report to the Clinic – Rural Health (710) report. The items reported on the Clinic – Rural Health (MSP-LCC) (71A) report are not to be included on the Medicare Cost Report.

5.3.8 Federally Qualified Health Center (MSP-LCC) (73A)

The Federally Qualified Health Center (MSP-LCC) (73A) report is a supplemental report to the Federally Qualified Health Center (730) report. The items reported on the Federally Qualified Health Center (MSP-LCC) (73A) report are not to be included on the Medicare Cost Report.

5.3.9 Rehabilitation Facility (MSP-LCC) (74A)

The Rehabilitation Facility (MSP-LCC) (74A) report is a supplemental report to the Rehabilitation Facility (740) report. The items reported on the Rehabilitation Facility (MSP-LCC) (74A) report are not to be included on the Medicare Cost Report.

5.3.10 Comprehensive Outpatient Rehabilitation Facilities (MSP-LCC) (75A)

The Comprehensive Outpatient Rehabilitation Facilities (MSP-LCC) (75A) report is a supplemental report to the Comprehensive Outpatient Rehabilitation Facilities (750) report. The items reported on the Comprehensive Outpatient Rehabilitation Facilities (MSP-LCC) (75A) report are not to be included on the Medicare Cost Report.

5.3.11 Community Mental Health Center (MSP-LCC) (76A)

The Community Mental Health Center (MSP-LCC) (76A) report is a supplemental report to the Community Mental Health Center (760) report. The items reported on the Community Mental Health Center (MSP-LCC) (76A) report are not to be included on the Medicare Cost Report.

5.3.12 ASC and ASC Fee Schedule (MSP-LCC) (83A)

The ASC and ASC Fee Schedule (MSP-LCC) (83A) report is a supplemental report to the ASC and ASC Fee Schedule After 12/90 (831) report. The items reported on the ASC and ASC Fee Schedule (MSP-LCC) (83A) report are not to be included on the Medicare Cost Report.

5.3.13 Critical Access Hospital (MSP-LCC) (85A)

The Critical Access Hospital (MSP-LCC) (85A) report is a supplemental report to the Critical Access Hospital (850) report. The items reported on the Critical Access Hospital (MSP-LCC) (85A) report are not to be included on the Medicare Cost Report.

5.4 xxP Outpatient Prospective Payment System (OPPS) Report Template

The xxP Outpatient Prospective Payment System (OPPS) provider summary report template displays summary statistic, charge, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. The statistic section shows the number of claims for each reporting period. The charge section displays the number of units and the total dollar amount of the revenue code being reported. The reimbursement section displays how Net Reimbursement is calculated. Finally, the additional information section displays the claim interest payments and the elected coinsurance.

The xxP Outpatient Prospective Payment System (OPPS) Payment Reconciliation (detail) report template is divided into Claim Information, Reimbursements, and Additional Information sections. The claim information section contains patient information such as the patient name, DCN, HCPCS total, and the charges for the revenue codes. The reimbursements section shows how Net Reimbursement is calculated. The additional information section shows the deductible amounts, claim interest, and coinsurance. The report template also provides a monthly totals section that sums the information from the sections above.

An example of the xxP Outpatient Prospective Payment System (OPPS) Provider Summary report template and the xxP Outpatient Prospective Payment System (OPPS) Payment Reconciliation (Detail) Report template follow.

Exhibit 5-6 Outpatient – xxP Outpatient Prospective Payment System (OPPS) Provider Summary Report Template (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 02/01/04 THRU 10/01/06
Report Run Date: 02/01/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PROVIDER SUMMARY REPORT
OUTPATIENT - OPPS

Page: 1
Report #: OD44203
Report Type: 13P

	SERVICES FOR PERIOD 01/01/04 - 12/31/04	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested

STATISTIC SECTION

CLAIMS	10			

CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0251	DRUGS/GENERIC	3	$26.77						
0252	DRUGS/NONGENERIC	15	$245.36						
0254	DRUGS/INCIDENT ODX	0	$0.00						
0255	DRUGS/INCIDENT RAD	0	$0.00						
0258	IV SOLUTIONS	0	$0.00						
0260	IV THERAPY	1	$257.00						
0272	STERILE SUPPLY	0	$0.00						
0320	DX X-RAY	1	$207.00						
0324	DX X-RAY/CHEST	3	$585.00						
0351	CT SCAN/HEAD	1	$1,054.00						
0352	CT SCAN/BODY	0	$0.00						
0402	ULTRASOUND	0	$0.00						
0410	RESPIRATORY SVC	0	$0.00						
0450	EMERG ROOM	10	$4,039.00						
0610	MRT	0	$0.00						
0636	DRUGS/DETAIL CODE	24	$23,893.50						
0710	RECOVERY ROOM	1	$167.00						
0730	EKG/ECG	3	$570.00						
0761	TREATMENT RM	16	$1,519.00						
0762	OBSERVATION RM	21	$1,806.00						
0921	PERI VASCUL LAB	0	$0.00						
TOTAL COVERED CHARGES		**99**	**$34,369.63**						

REIMBURSEMENT SECTION

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Exhibit 5-7 Outpatient – xxP Outpatient Prospective Payment System (OPPS) Provider Summary Report Template (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 02/01/04 THRU 10/01/06
Report Run Date: 02/01/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PROVIDER SUMMARY REPORT
OUTPATIENT - OPPS

Page: 2
Report #: OD44203
Report Type: 13P

	SERVICES FOR PERIOD 01/01/04 - 12/31/04	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
GROSS AFC PAYMENT	$8,144.57			
PLUS:				
OUTLIER	$20.52			
GROSS REIMBURSEMENT	$8,165.09			
LESS				
CASH DEDUCTIBLE	$100.00			
BLOOD DEDUCTIBLE	$0.00			
COINSURANCE	$1,829.57			
NET MSP PAYMENTS	$0.00			
MSP RECONCILIATION	$0.00			
OTHER ADJUSTMENTS	$0.00			
PSYCH REDUCTION	$0.00			
NET REIMBURSEMENT	$6,235.52			

ADDITIONAL INFORMATION SECTION

CLAIM INTEREST PAYMENTS	$0.00			
ELECTED COINSURANCE	$0.00			

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Exhibit 5-8 Outpatient – xxP Outpatient Prospective Payment System (OPPS) Payment Reconciliation (Detail) Report Template (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 04/30/04
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
OUTPATIENT - OPPS

Page: 1
Report #: OD44202
Report Type: 13P
Paid Dates: 01/01/04 to 10/01/06

Claim Information

Patnt Nm: BOSS K
DCN: 20428010354705
Ptnt Cntrl #: 001000000000
Med Rcrd #: 083000000000
HIC Num: 186390410A
Recpt Dt: 04/29/04
Paid Dt: 05/14/04
Service From: 04/18/04
Service Thru: 04/18/04
Bill Freq: 1
Trans Type:
Processor ID: 14000

Rev Code	HCPCS	Units	Charges	GAPC	Cash Deduct.	Blood Deduct.	Coins.	MSP	MSP Recon.	Psyc. Red.	Line Item Reimb.	Elected Coins.	MODS	Serv Ind.	Pymt Ind.	Dscnt Fct.	TOB Incl.	APC
0450	99281	1	$81.00	$73.15	$0.00	$0.00	$19.16	$0.00	$0.00		$53.99	$0.00		V	1	1	0	610
TOTAL:		1	$81.00	$73.15	$0.00	$0.00	$19.16	$0.00	$0.00		$53.99	$0.00						

Reimbursements

GAPC: $73.15
PLUS:
Outlier: $0.00
Gross Reimb.: $73.15
LESS:
Cash Deduct.: $0.00
Blood Deduct.: $0.00
Coins.: $19.16
MSP: $0.00
MSP Recon.: $0.00
Other Adjs.: $0.00
Psyc. Red.: -
Net Reimb.: $53.99

Additional Information

MSP Cash Deduct.: $0.00
MSP Blood Deduct.: $0.00
MSP Coins.: $0.00
Claim Interest: $0.00
Elected Coins.: $0.00
Claim Report Splits: 13P

Patnt Nm: EOFF M
DCN: 20438079845605
Ptnt Cntrl #: 001000000000
Med Rcrd #: 210000000000
HIC Num: 00000000077
Recpt Dt: 04/30/04
Paid Dt: 05/14/04
Service From: 04/18/04
Service Thru: 04/18/04
Bill Freq: 1
Trans Type:
Processor ID: 14000

Rev Code	HCPCS	Units	Charges	GAPC	Cash Deduct.	Blood Deduct.	Coins.	MSP	MSP Recon.	Psyc. Red.	Line Item Reimb.	Elected Coins.	MODS	Serv Ind.	Pymt Ind.	Dscnt Fct.	TOB Incl.	APC
0450	99281	1	$81.00	$73.15	$0.00	$0.00	$19.16	$0.00	$0.00		$53.99	$0.00		V	1	1	0	610
TOTAL:		1	$81.00	$73.15	$0.00	$0.00	$19.16	$0.00	$0.00		$53.99	$0.00						

GAPC: $73.15
PLUS:
Outlier: $0.00
Gross Reimb.: $73.15
LESS:
Cash Deduct.: $0.00
Blood Deduct.: $0.00
Coins.: $19.16
MSP: $0.00
MSP Recon.: $0.00
Other Adjs.: $0.00
Psyc. Red.: -
Net Reimb.: $53.99

MSP Cash Deduct.: $0.00
MSP Blood Deduct.: $0.00
MSP Coins.: $0.00
Claim Interest: $0.00
Elected Coins.: $0.00
Claim Report Splits: 135,13P

Patnt Nm: WINK D
DCN: 20428030045605
Ptnt Cntrl #: 001000000000
Med Rcrd #: 152000000000
HIC Num: 177055622A
Recpt Dt: 04/30/04
Paid Dt: 05/14/04
Service From: 04/18/04
Service Thru: 04/18/04
Bill Freq: 1
Trans Type:
Processor ID: 14000

Rev Code	HCPCS	Units	Charges	GAPC	Cash Deduct.	Blood Deduct.	Coins.	MSP	MSP Recon.	Psyc. Red.	Line Item Reimb.	Elected Coins.	MODS	Serv Ind.	Pymt Ind.	Dscnt Fct.	TOB Incl.	APC
0324	71010	1	$195.00	$41.69	$0.00	$0.00	$20.84	$0.00	$0.00		$20.85	$0.00		X	1	1	0	260
0450	99284	1	$952.00	$221.60	$0.00	$0.00	$53.00	$0.00	$0.00		$168.60	$0.00	25	V	1	1	0	612
0730	93005	1	$190.00	$19.78	$0.00	$0.00	$3.96	$0.00	$0.00		$15.82	$0.00		S	1	1	0	99
TOTAL:		3	$1,337.00	$283.07	$0.00	$0.00	$77.80	$0.00	$0.00		$205.27	$0.00						

GAPC: $283.07
PLUS:
Outlier: $0.00
Gross Reimb.: $283.07
LESS:
Cash Deduct.: $0.00
Blood Deduct.: $0.00
Coins.: $77.80
MSP: $0.00
MSP Recon.: $0.00
Other Adjs.: $0.00
Psyc. Red.: -
Net Reimb.: $205.27

MSP Cash Deduct.: $0.00
MSP Blood Deduct.: $0.00
MSP Coins.: $0.00
Claim Interest: $0.00
Elected Coins.: $0.00
Claim Report Splits: 135,13P

Patnt Nm: GUID D
DCN: 20478139554905
Ptnt Cntrl #: 001000000000
Med Rcrd #: 326000000000

Rev Code	HCPCS	Units	Charges	GAPC	Cash Deduct.	Blood Deduct.	Coins.	MSP	MSP Recon.	Psyc. Red.	Line Item Reimb.	Elected Coins.	MODS	Serv Ind.	Pymt Ind.	Dscnt Fct.	TOB Incl.	APC
0251		1	$18.37	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00		N	9	1	0	0
0324	71010	1	$195.00	$41.69	$0.00	$0.00	$20.84	$0.00	$0.00		$20.85	$0.00		X	1	1	0	260

GAPC: $549.87
PLUS:
Outlier: $0.00

MSP Cash Deduct.: $0.00
MSP Blood Deduct.: $0.00
MSP Coins.: $0.00
Claim Interest: $0.00

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Exhibit 5-9 Outpatient – xxP Outpatient Prospective Payment System (OPPS) Payment Reconciliation (Detail) Report Template (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: N/A
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
OUTPATIENT - OPPS

Page: 5
Report #: OD44202
Report Type: 13P
Paid Dates: 01/01/04 to 10/01/06

Service Period and Report Type Totals

Service Period		Units	Charges	GAPC	Cash Deduct.	Blood Deduct.	Coins.	MSP	MSP Recon.	Psyc. Red.	Line Item Reimb.	Elected Coins.
01/01/2004 - 01/01/2006	TOTAL:	99	$34,369.63	$8,144.57	$100.00	$0.00	$1,829.57	$0.00	$0.00		$6,215.00	$0.00

Reimbursements	
GAPC:	$8,144.57
PLUS:	
Outlier:	$20.52
Gross Reimb.:	$8,165.09
LESS:	
Cash Deduct.:	$100.00
Blood Deduct.:	$0.00
Coins.:	$1,829.57
MSP:	$0.00
MSP Recon.:	$0.00
Other Adjs.:	$0.00
Psyc. Red.:	-
Net Reimb.:	$6,235.52

Additional Info	
MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Elected Coins.:	$0.00

*** Report Type 13P Totals for PETERBORO GENERAL HOSPITAL ***

	Units	Charges	GAPC	Cash Deduct.	Blood Deduct.	Coins.	MSP	MSP Recon.	Psyc. Red.	Line Item Reimb.	Elected Coins.
TOTAL:	99	$34,369.63	$8,144.57	$100.00	$0.00	$1,829.57	$0.00	$0.00	$0.00	$6,215.00	$0.00

Reimbursements	
GAPC:	$8,144.57
PLUS:	
Outlier:	$20.52
Gross Reimb.:	$8,165.09
LESS:	
Cash Deduct.:	$100.00
Blood Deduct.:	$0.00
Coins.:	$1,829.57
MSP:	$0.00
MSP Recon.:	$0.00
Other Adjs.:	$0.00
Psyc. Red.:	$0.00
Net Reimb.:	$6,235.52

Additional Info	
MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Elected Coins.:	$0.00

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The reports that are generated based on the outpatient xxP Outpatient Prospective Payment System (OPPS) report template are:

- Inpatient Part B OPPS (12P)
- Outpatient – OPPS (13P)
- Outpatient/Other – OPPS (14P)
- SNF – Outpatient – OPPS (22P)
- SNF – Outpatient OPPS (23P)
- SNF – Outpatient OPPS (24P)
- Home Health Outpatient – OPPS (not HHPPS) (34P)
- Clinic – Rural Health – OPPS (71P)
- Federally Qualified Health Center – OPPS (73P)
- Rehabilitation Facility – OPPS (74P)

- Comprehensive Outpatient Rehabilitation Facilities – OPPS (75P)
- Community Mental Health Center – OPPS (76P)
- Hospice – Non-Hospital Based – OPPS (81P)
- Hospice – Hospital Based (OPPS) (82P)
- ASC and ASC Fee Schedule – OPPS (83P)

A brief description of these reports is provided in the following sections.

5.4.1 Inpatient – Part B OPPS (12P)

The Inpatient – Part B OPPS (12P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Inpatient – Part B OPPS (12P) report are included on the Medicare Cost Report.

5.4.2 Outpatient – OPPS (13P)

The Outpatient – OPPS (13P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Outpatient – OPPS (13P) report are included on the Medicare Cost Report.

5.4.3 Outpatient/Other – OPPS (14P)

The Outpatient/Other – OPPS (14P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Outpatient/Other – OPPS (14P) report are included on the Medicare Cost Report.

5.4.4 SNF – Outpatient – OPPS (22P)

The SNF – Outpatient – OPPS (22P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the SNF – Outpatient – OPPS (22P) report are included on the Medicare Cost Report.

5.4.5 SNF – Outpatient OPPS (23P)

The SNF – Outpatient OPPS (23P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the SNF – Outpatient OPPS (23P) report are included on the Medicare Cost Report.

5.4.6 SNF – Outpatient OPPS (24P)

The SNF – Outpatient OPPS (24P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the SNF – Outpatient OPPS (24P) report are included on the Medicare Cost Report.

5.4.7 Home Health Outpatient – OPPS (not HHPPS) (34P)

The Home Health Outpatient – OPPS (not HHPPS) (34P) report summarizes the Part B claims data not under a signed plan of care that are reimbursed under Outpatient Prospective Payment System. This report is used in cost reports prior to October 1, 2000. The items reported on the Home Health Outpatient – OPPS (not HHPPS) (34P) report are included on the Medicare Cost Report.

5.4.8 Clinic – Rural Health – OPPS (71P)

The Clinic – Rural Health – OPPS (71P) report captures data from all lines that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Clinic – Rural Health – OPPS (71P) report are included on the Medicare Cost Report.

5.4.9 Federally Qualified Health Center – OPPS (73P)

The Federally Qualified Health Center – OPPS (73P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Federally Qualified Health Center – OPPS (73P) report are included on the Medicare Cost Report.

5.4.10 Rehabilitation Facility – OPPS (74P)

The Rehabilitation Facility – OPPS (74P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Rehabilitation Facility – OPPS (74P) report are included on the Medicare Cost Report.

5.4.11 Comprehensive Outpatient Rehabilitation Facilities – OPPS (75P)

The Comprehensive Outpatient Rehabilitation Facilities – OPPS (75P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Comprehensive Outpatient Rehabilitation Facilities – OPPS (75P) report are included on the Medicare Cost Report.

5.4.12 Community Mental Health Center – OPPS (76P)

The Community Mental Health Center – OPPS (76P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Community Mental Health Center – OPPS (76P) report are included on the Medicare Cost Report.

5.4.13 Hospice – Non-Hospital Based – OPPS (81P)

The Hospice – Non-Hospital Based – OPPS (81P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Hospice – Non-Hospital Based – OPPS (81P) report are included on the Medicare Cost Report.

5.4.14 Hospice – Hospital Based (OPPS) (82P)

The Hospice – Hospital Based (OPPS) (82P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the Hospice – Hospital Based (OPPS) (82P) report are included on the Medicare Cost Report.

5.4.15 ASC and ASC Fee Schedule – OPPS (83P)

The ASC and ASC Fee Schedule – OPPS (83P) report captures data from all lines of a claim that were paid under Outpatient Prospective Payment System including lines paid as APC services packaged with them. This report contains claim lines for services on or after August 1, 2000. The items reported on the ASC and ASC Fee Schedule – OPPS (83P) report are included on the Medicare Cost Report.

5.5 xxZ Ambulance Blend Report Template

The xxZ Outpatient – Ambulance Blend Provider Summary report template displays summary statistic, charge, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. The statistic section shows the number of claims for each reporting period. This section also shows Total Ambulance Trips and Total Ambulance Miles, which are unique to the xxZ report. The charge section displays the number of units and the total dollar amount of the revenue code being reported. The reimbursement section displays how Net Reimbursement is calculated. Finally, the additional information section displays the claim interest payments and the Total Gross Fee Schedule Amount.

The xxZ Outpatient – Ambulance Blend Payment Reconciliation (detail) report template is divided into Claim Information, Reimbursements, and Additional Information sections. The claim information section displays patient information such as the patient name, DCN, Line Item Reimbursement, Total Ambulance Trips, Total Ambulance Miles, and the charges for the revenue codes. The reimbursements section shows how Net Reimbursement is calculated. The additional information section shows the deductible amounts, claim interest, and Total Gross Fee Schedule. The template also provides a monthly totals section that sums the information from the sections above.

An example of the xxZ Outpatient – Ambulance Blend Provider Summary report template and the xxZ Outpatient – Ambulance Blend Payment Reconciliation (detail) report template follow.

Exhibit 5-10 Outpatient – xxZ Ambulance Blend Provider Summary Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 02/01/04 THRU 10/01/06
Report Run Date: 02/01/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PROVIDER SUMMARY REPORT
OUTPATIENT - AMBULANCE BLEND EFFECTIVE 04/01/02

Page: 1
Report #: OD44203
Report Type: 13Z

	SERVICES FOR PERIOD 01/01/04 - 12/31/04			SERVICES FOR PERIOD No Data Requested			SERVICES FOR PERIOD No Data Requested			SERVICES FOR PERIOD No Data Requested		
STATISTIC SECTION												
CLAIMS			9									
	UNITS	CHARGES	GROSS FEE AMT	UNITS	CHARGES	GROSS FEE AMT	UNITS	CHARGES	GROSS FEE AMT	UNITS	CHARGES	GROSS FEE AMT
TOTAL AMBULANCE TRIPS	9	$30,142.00	$1,557.63									
TOTAL AMBULANCE MILES	103	$2,461.00	$211.46									
TOTAL GROSS FEE SCHEDULE AMT			$1,769.09									

CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0540	AMBULANCE		$32,603.00						
TOTAL COVERED CHARGES		112	**$32,603.00**						

REIMBURSEMENT SECTION

GROSS REIMBURSEMENT	**$14,005.11**			
LESS				
CASH DEDUCTIBLE	$0.00			
BLOOD DEDUCTIBLE	$0.00			
COINSURANCE	$4,731.12			
NET MSP PAYMENTS	$0.00			
PSYCH REDUCTION	$0.00			
NET REIMBURSEMENT	**$9,273.99**			

ADDITIONAL INFORMATION SECTION

CLAIM INTEREST PAYMENTS	$0.00			

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Exhibit 5-11 Outpatient – xxZ Ambulance Blend Payment Reconciliation (Detail) Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 02/29/04
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
OUTPATIENT - AMBULANCE BLEND EFFECTIVE 04/01/02

Page: 1
Report #: OD44202
Report Type: 13Z
Paid Dates: 01/01/04 to 10/01/06

Claim Information

Patnt Nm:	SCHM A	Bill Freq:	1
DCN:	20448159246204	Trans Type:	
Ptnt Cntrl #:	129000000000	Processor ID:	14000
Med Rcrd #:	161000000000	Zip Code:	32701
HIC Num:	262667937A		
Recpt Dt:	05/03/04		
Paid Dt:	05/17/04		
Service From:	02/20/04		
Service Thru:	02/20/04		

Rev Code	HCPCS	Units	Charges	Gross Fee Amt.	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
0540	A0431	1	$6,585.00	$270.27	$2,306.45	$0.00	$0.00	$851.12	$0.00		$1,455.33
0540	A0436	6	$162.00	$10.84	$81.90	$0.00	$0.00	$25.97	$0.00		$55.93
Total Amb. Trips:		1	$6,585.00	$270.27	$2,306.45	$0.00	$0.00	$851.12	$0.00		$1,455.33
Total Amb. Miles:		6	$162.00	$10.84	$81.90	$0.00	$0.00	$25.97	$0.00		$55.93
TOTAL:		7	$6,747.00	$281.11	$2,388.35	$0.00	$0.00	$877.09	$0.00		$1,511.26

Reimbursements

Gross Reimb.:	$2,388.35
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$877.09
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$1,511.26

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	13Z

Patnt Nm:	WEIL H	Bill Freq:	1
DCN:	20428778846504	Trans Type:	
Ptnt Cntrl #:	132000000000	Processor ID:	14000
Med Rcrd #:		Zip Code:	32822
HIC Num:	173779777D		
Recpt Dt:	04/30/04		
Paid Dt:	05/14/04		
Service From:	02/27/04		
Service Thru:	02/27/04		

Rev Code	HCPCS	Units	Charges	Gross Fee Amt.	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
0540	A0425	9	$63.00	$5.09	$37.06	$0.00	$0.00	$11.14	$0.00		$25.92
0540	A0426	1	$325.00	$20.33	$155.76	$0.00	$0.00	$50.39	$0.00		$105.37
Total Amb. Trips:		1	$325.00	$20.33	$155.76	$0.00	$0.00	$50.39	$0.00		$105.37
Total Amb. Miles:		9	$63.00	$5.09	$37.06	$0.00	$0.00	$11.14	$0.00		$25.92
TOTAL:		10	$388.00	$25.42	$192.82	$0.00	$0.00	$61.53	$0.00		$131.29

Reimbursements

Gross Reimb.:	$192.82
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$61.53
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$131.29

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	13Z

*** Monthly Totals for PETERBORO GENERAL HOSPITAL for service month end 2/29/04 ***

	Units	Charges	Gross Reimb.	Gross Fee Amt.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
Total Amb. Trips:	2	$6,910.00	$2,462.21	$290.60	$0.00	$0.00	$901.51	$0.00		$1,560.70
Total Amb. Miles:	15	$225.00	$118.96	$15.93	$0.00	$0.00	$37.11	$0.00		$81.85
TOTAL:	17	$7,135.00	$2,581.17	$306.53	$0.00	$0.00	$938.62	$0.00		$1,642.55

Reimbursements

Gross Reimb.:	$2,581.17
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$938.62
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$1,642.55

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00

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The reports that are generated based on the outpatient xxZ Ambulance Blend report template are:

- Inpatient – Ambulance Blend Effective 04/01/02 (12Z)
- Outpatient – Ambulance Blend Effective 04/01/02 (13Z)
- SNF – Ambulance Blend Effective 04/01/02 (22Z)
- SNF – Ambulance Blend Effective 04/01/02 (23Z)
- ASC and ASC Fee Schedule – Ambulance Blend Effective 04/01/02 (83Z)
- Critical Access Hospital – Ambulance Blend Effective 04/01/02 (85Z)

A brief description of these reports is provided in the following sections.

5.5.1 Inpatient – Ambulance Blend Effective 04/01/02 (12Z)

The Inpatient – Ambulance Blend Effective 04/01/02 (12Z) report summarizes hospital inpatient ambulance services reimbursed under the ambulance fee schedule blended payment, which is effective for services provided on or after April 1, 2002. The items reported on the Inpatient – Ambulance Blend Effective 04/01/02 (12Z) report are included on the Medicare Cost Report.

5.5.2 Outpatient – Ambulance Blend Effective 04/01/02 (13Z)

The Outpatient – Ambulance Blend Effective 04/01/02 (13Z) report summarizes hospital outpatient ambulance services reimbursed under the ambulance fee schedule blended payment, which is effective for services provided on or after April 1, 2002. The items reported on the Outpatient – Ambulance Blend Effective 04/01/02 (13Z) report are included on the Medicare Cost Report.

5.5.3 SNF – Ambulance Blend Effective 04/01/02 (22Z)

The SNF – Ambulance Blend Effective 04/01/02 (22Z) report summarizes skilled nursing facility, outpatient ambulance services reimbursed under the ambulance fee schedule blended payment, which is effective for services provided on or after April 1, 2002. The items reported on the SNF – Ambulance Blend Effective 04/01/02 (22Z) report are included on the Medicare Cost Report.

5.5.4 SNF – Ambulance Blend Effective 04/01/02 (23Z)

The SNF – Ambulance Blend Effective 04/01/02 (23Z) report summarizes skilled nursing facility, outpatient ambulance services reimbursed under the ambulance fee schedule blended payment, which is effective for services provided on or after April 1, 2002. The items reported on the SNF – Ambulance Blend Effective 04/01/02 (23Z) report are included on the Medicare Cost Report.

5.5.5 ASC and ASC Fee Schedule – Ambulance Blend Effective 04/01/02 (83Z)

The ASC and ASC Fee Schedule – Ambulance Blend Effective 04/01/02 (83Z) report summarizes skilled nursing facility, outpatient ambulance services reimbursed under the ambulance fee schedule blended payment, which is effective for services provided on or after April 1, 2002. The items reported on the ASC and ASC Fee Schedule – Ambulance Blend Effective 04/01/02 (83Z) report are included on the Medicare Cost Report.

5.5.6 Critical Access Hospital Ambulance Blend Effective 04/01/02 (85Z)

The Critical Access Hospital Ambulance Blend Effective 04/01/02 (85Z) report summarizes critical access hospital, outpatient ambulance services reimbursed under the fee schedule blended payment, which is effective for services provided on or after April 1, 2002. The items reported on the Critical Access Hospital Ambulance Blend Effective 04/01/02 (85Z) report are included on the Medicare Cost Report.

5.6 xx2 Vaccines Report Template

The xx2 Outpatient – Vaccines Provider Summary report template displays summary statistic, charge, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. The statistic section shows the number of claims for each reporting period. The charge section displays the number of units and the total dollar amount of the revenue code being reported. The reimbursement section displays how Net Reimbursement is calculated. Finally, the additional information section displays the claim interest payments.

The xx2 Outpatient – Vaccines Payment Reconciliation (detail) report template is divided into claim information, reimbursements, and additional information sections. The claim information section contains patient information such as the patient name, DCN, Line Item Reimbursement, and the charges for the revenue codes. The reimbursements section shows how Net Reimbursement is calculated. The additional information section shows the deductible amounts, claim interest, and MSP Coinsurance. The report template also displays a monthly totals section that sums the information from the sections above.

An example of the xx2 Outpatient – Vaccines Provider Summary report template and xx2 Outpatient – Vaccines Payment Reconciliation (detail) report template follow.

Exhibit 5-12 Outpatient – xx2 Vaccines Provider Summary Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/05/07
Provider FYE: 12/31
Provider Number: T92305 MOTHER MARY ESRD

PROVIDER SUMMARY REPORT
OUTPATIENT - PART B VACCINE

Page: 1
Report #: OD44203
Report Type: 132

	SERVICES FOR PERIOD 01/01/04 - 12/31/04	SERVICES FOR PERIOD 01/01/05 - 12/31/05	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
STATISTIC SECTION				
CLAIMS	1	2		

CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0636	DRUGS/DETAIL CODE	1	$18.00	2	$98.00				
0771	VACCINE ADMIN	1	$15.00	2	$30.00				
TOTAL COVERED CHARGES		2	$33.00	4	$128.00				

REIMBURSEMENT SECTION				
GROSS REIMBURSEMENT	$33.00	$128.00		
LESS				
CASH DEDUCTIBLE	$0.00	$0.00		
BLOOD DEDUCTIBLE	$0.00	$0.00		
COINSURANCE	$0.00	$0.00		
NET MSP PAYMENTS	$0.00	$0.00		
PSYCH REDUCTION	$0.00	$0.00		
NET REIMBURSEMENT	$33.00	$128.00		
ADDITIONAL INFORMATION SECTION				
CLAIM INTEREST PAYMENTS	$0.00	$0.00		

Feb 5, 2007 - 1 - 10:21:53 AM

Exhibit 5-13 Outpatient – xx2 Vaccines Payment Reconciliation (Detail) Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 01/31/05
Report Run Date: 02/19/07
Provider FYE: 12/31
Provider Number: T92305 MOTHER MARY ESRD

PAYMENT RECONCILIATION REPORT
OUTPATIENT - PART B VACCINE

Page: 2
Report #: OD44202
Report Type: 132
Paid Dates: 01/01/80 to 10/01/06

Claim Information

Patnt Nm:	EDGI I	Bill Freq:	1
DCN:	20599769236704	Trans Type:	
Ptnt Cntrl #:	378000000000	Processor ID:	14000
Med Rcrd #:			
HIC Num:	155367884A		
Recpt Dt:	02/10/05		
Paid Dt:	02/24/05		
Service From:	01/03/05		
Service Thru:	01/31/05		

Rev Code	HCPCS	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
0636	90732	1	$80.00	$80.00	$0.00	$0.00	$0.00	$0.00		$80.00
0771	G0009	1	$15.00	$15.00	$0.00	$0.00	$0.00	$0.00		$15.00
TOTAL:		2	$95.00	$95.00	$0.00	$0.00	$0.00	$0.00		$95.00

Reimbursements

Gross Reimb.:	$95.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$95.00

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	720,725

Patnt Nm:	JENK K	Bill Freq:	1
DCN:	20549988933601	Trans Type:	
Ptnt Cntrl #:	LUG000000000	Processor ID:	14000
Med Rcrd #:	LUG000000000		
HIC Num:	240321813A		
Recpt Dt:	02/09/05		
Paid Dt:	02/23/05		
Service From:	01/17/05		
Service Thru:	01/31/05		

Rev Code	HCPCS	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
0636	90658	1	$18.00	$18.00	$0.00	$0.00	$0.00	$0.00		$18.00
0771	G0008	1	$15.00	$15.00	$0.00	$0.00	$0.00	$0.00		$15.00
TOTAL:		2	$33.00	$33.00	$0.00	$0.00	$0.00	$0.00		$33.00

Reimbursements

Gross Reimb.:	$33.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$33.00

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	130,720,725

*** Monthly Totals for MOTHER MARY ESRD for service month end 1/31/05 ***

	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
TOTAL:	4	$128.00	$128.00	$0.00	$0.00	$0.00	$0.00		$128.00

Reimbursements

Gross Reimb.:	$128.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$128.00

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest Amount:	$0.00

Feb 19, 2007 - 2 - 8:47:25 AM

The reports that are generated based on the outpatient xx2 Vaccines report template are:

- Inpatient – Part B Vaccine (122)
- Outpatient – Part B Vaccine (132)
- Outpatient/Other – Vaccines (142)
- SNF – Inpatient – Vaccine – Part B 100 % Reasonable Cost (222)
- SNF – Outpatient – Vaccine – Part B 100 % Reasonable Cost (232)
- Home Health – Vaccine – Part B 100% Reasonable Cost (342)
- Clinic – Rural Health – Vaccine – Part B 100% Reasonable Cost (712)
- Federally Qualified Health Center – Vaccine – Part B 100% Reasonable Cost (732)
- Rehabilitation Facility – Vaccine – Part B 100% Reasonable Cost (742)
- Comprehensive Outpatient Rehabilitation Facilities – Vaccine – Part B 100% Reasonable Cost (752)
- Community Mental Health Center – Vaccine – Part B 100% Reasonable Cost (762)

- ASC and ASC Fee Schedule – Vaccine – Part B 100% Reasonable Cost (832)
- Critical Access Hospital – Vaccines – Part B 100% Reasonable Cost (852)

A brief description of these reports is provided in the following sections.

5.6.1 Inpatient – Part B Vaccine (122)

The Inpatient – Part B Vaccine (122) report accumulates data applicable to vaccine services reimbursed based on 100 % of reasonable cost. The items reported on the Inpatient – Part B Vaccine (122) report are included on the Medicare Cost Report.

5.6.2 Outpatient – Part B Vaccine (132)

The Outpatient – Part B (132) report accumulates data applicable to vaccine services reimbursed based on 100 % of reasonable cost. The items reported on the Outpatient – Part B (132) report are included on the Medicare Cost Report.

5.6.3 Outpatient/Other Vaccines (142)

The Outpatient/Other Vaccines (142) report accumulates data applicable to vaccine services reimbursed based on 100 percent of reasonable cost. The items reported on the Outpatient/Other Vaccines (142) report are included on the Medicare Cost Report.

5.6.4 SNF – Inpatient – Vaccine – Part B 100% Reasonable Cost (222)

The SNF – Inpatient – Vaccine – Part B 100% Reasonable Cost (222) report accumulates data applicable to vaccine services reimbursed based on 100 percent of reasonable cost. The items reported on the SNF – Inpatient – Vaccine – Part B 100% Reasonable Cost (222) report are included on the Medicare Cost Report.

5.6.5 SNF – Outpatient – Vaccine – Part B 100% Reasonable Cost (232)

The SNF – Outpatient – Vaccine – Part B 100% Reasonable Cost (232) report accumulates data applicable to vaccine services reimbursed based on 100 percent of reasonable cost. The items reported on the SNF – Outpatient – Vaccine – Part B 100% Reasonable Cost (232) report are included on the Medicare Cost Report.

5.6.6 Home Health – Vaccine – Part B 100% Reasonable Cost (342)

The Home Health – Vaccine – Part B 100% Reasonable Cost (342) report summarizes vaccine services provided by rural health clinics. The items reported on the Home Health – Vaccine – Part B 100% Reasonable Cost (342) report are included on the Medicare Cost Report.

5.6.7 Clinic – Rural Health – Vaccine – Part B 100% Reasonable Cost (712)

The Clinic – Rural Health – Vaccine – Part B 100% Reasonable Cost (712) report summarizes vaccine services provided by rural health clinics. The items reported on the Clinic – Rural Health – Vaccine – Part B 100% Reasonable Cost (712) report are included on the Medicare Cost Report.

5.6.8 Federally Qualified Health Center – Vaccine – Part B 100% Reasonable Cost (732)

The Federally Qualified Health Center – Vaccine – Part B 100% Reasonable Cost (732) report summarizes vaccine services provided by Federally Qualified Health Centers. The items reported on the Federally Qualified Health Center – Vaccine – Part B 100% Reasonable Cost (732) report are included on the Medicare Cost Report.

5.6.9 Rehabilitation Facility – Vaccine – Part B 100% Reasonable Cost (742)

The Rehabilitation Facility – Vaccine – Part B 100% Reasonable Cost (742) report summarizes vaccine services provided by rehabilitation facilities. The items reported on the Rehabilitation Facility – Vaccine – Part B 100% Reasonable Cost (742) report are included on the Medicare Cost Report.

5.6.10 Comprehensive Outpatient Rehabilitation Facilities – Vaccine – Part B 100% Reasonable Cost (752)

The Comprehensive Outpatient Rehabilitation Facilities – Vaccine – Part B 100% Reasonable Cost (752) report summarizes vaccine services provided by Comprehensive Outpatient Rehabilitation facilities. The items reported on the Comprehensive Outpatient Rehabilitation Facilities – Vaccine – Part B 100% Reasonable Cost (752) report are included on the Medicare Cost Report.

5.6.11 Community Mental Health Center – Vaccine – Part B 100% Reasonable Cost (762)

The Community Mental Health Center – Vaccine – Part B 100% Reasonable Cost (762) report summarizes vaccine services provided by Community Health Centers. The items reported on the Community Mental Health Center – Vaccine – Part B 100% Reasonable Cost (762) report are included on the Medicare Cost Report.

5.6.12 ASC and ASC Fee Schedule – Vaccine – Part B 100% Reasonable Cost (832)

The ASC and ASC Fee Schedule – Vaccine – Part B 100% Reasonable Cost (832) report summarizes vaccine services provided by Ambulatory Surgical/Surgery Centers reimbursed on a reasonable cost basis. The items reported on the ASC and ASC Fee Schedule – Vaccine – Part B 100% Reasonable Cost (832) report are included on the Medicare Cost Report.

5.6.13 Critical Access Hospital – Vaccines – Part B 100% Reasonable Cost (852)

The Critical Access Hospital – Vaccines – Part B 100% Reasonable Cost (852) report summarizes vaccine services provided by critical access hospitals reimbursed on a reasonable cost basis. The items reported on the Critical Access Hospital – Vaccines – Part B 100% Reasonable Cost (852) report are included on the Medicare Cost Report.

5.7 xx5 Fee Reimbursed Report Template

The xx5 Fee Reimbursed Provider Summary report template displays summary statistic, charge, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. The statistic section shows the number of claims for each reporting period. The charge section displays the number of units and the total dollar amount of the revenue code being reported. The reimbursement section displays how net reimbursement is calculated. Finally, the additional information section displays the claim interest payments.

The xx5 Fee Reimbursed Payment Reconciliation (detail) report template is divided into claim information, reimbursements, and additional information sections. The claim information section displays patient information such as the patient name, DCN, Line Item Reimbursement, and the charges for the revenue codes. The reimbursements section shows how net reimbursement is calculated. The additional information section shows the deductible amounts, claim interest, and MSP Coinsurance. The report template also displays a monthly totals section that sums the information from the sections above.

An example of the xx5 Fee Reimbursed Provider Summary report template and the xx5 Fee Reimbursed Payment Reconciliation (detail) report template follow.

Exhibit 5-14 Outpatient – xx5 Fee Reimbursed Provider Summary Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/03 THRU 10/01/06
Report Run Date: 02/01/07
Provider FYE: 06/30
Provider Number: T00113 SHATTERED HEART TEACHING HOSPITAL

PROVIDER SUMMARY REPORT
OUTPATIENT - FEE REIMBURSED
THESE ITEMS ARE NOT TO BE INCLUDED ON THE MEDICARE COST REPORT

Page: 1
Report #: OD44203
Report Type: 135

	SERVICES FOR PERIOD 01/01/03 - 12/31/03	SERVICES FOR PERIOD 01/01/04 - 12/31/04	SERVICES FOR PERIOD No Data Requested	SERVICES FOR PERIOD No Data Requested
STATISTIC SECTION				
CLAIMS	0	10		

CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0300	LABORATORY or (LAB)	0	$0.00	6	$44.40				
0301	LAB/CHEMISTRY	0	$0.00	21	$1,102.80				
0305	LAB/HEMATOLOGY	0	$0.00	4	$136.00				
0306	LAB/BACT-MICRO	0	$0.00	3	$82.00				
0307	LAB/UROLOGY	0	$0.00	1	$33.00				
0420	PHYSICAL THERP	0	$0.00	0	$0.00				
0430	OCCUPATION THER	0	$0.00	0	$0.00				
TOTAL COVERED CHARGES		0	$0.00	35	$1,398.20				

REIMBURSEMENT SECTION				
GROSS REIMBURSEMENT	$0.00	$435.95		
LESS				
CASH DEDUCTIBLE	$0.00	$0.00		
BLOOD DEDUCTIBLE	$0.00	$0.00		
COINSURANCE	$0.00	$0.00		
NET MSP PAYMENTS	$0.00	$0.00		
PSYCH REDUCTION	$0.00	$0.00		
NET REIMBURSEMENT	$0.00	$435.95		
ADDITIONAL INFORMATION SECTION				
CLAIM INTEREST PAYMENTS	$0.00	$0.00		

Feb 1, 2007 - 1 - 8:20:03 PM

Exhibit 5-15 Outpatient – xx5 Fee Reimbursed Payment Reconciliation (Detail) Report Template (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 03/31/04
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00073 CROSS YOUR HEART HOSPITAL

PAYMENT RECONCILIATION REPORT
OUTPATIENT - FEE REIMBURSED

Page: 1
Report #: OD44202
Report Type: 135
Paid Dates: 01/01/04 to 10/01/06

Claim Information

Patnt Nm:	BOGG R	Bill Freq:	1
DCN:	20498088151504	Trans Type:	
Ptnt Cntrl #:	002000000000	Processor ID:	14000
Med Rcrd #:	000000000000		
HIC Num:	373325946A		
Recpt Dt:	04/30/04		
Paid Dt:	05/14/04		
Service From:	03/24/04		
Service Thru:	03/25/04		

Rev Code	HCPCS	Panel Code	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
0300	G0001		1	$45.00	$3.00	$0.00	$0.00	$0.00	$0.00		$3.00
0301	80048	80048	1	$306.84	$11.83	$0.00	$0.00	$0.00	$0.00		$11.83
0301	82565	ATP02	1	$15.90	$4.11	$0.00	$0.00	$0.00	$0.00		$4.11
0301	84520	ATP02	1	$15.90	$3.17	$0.00	$0.00	$0.00	$0.00		$3.17
0305	85049		1	$21.00	$6.25	$0.00	$0.00	$0.00	$0.00		$6.25
0305	85610		1	$20.70	$5.49	$0.00	$0.00	$0.00	$0.00		$5.49
TOTAL:			6	$425.34	$33.85	$0.00	$0.00	$0.00	$0.00		$33.85

Reimbursements

Gross Reimb.:	$33.85
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$33.85

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	130,135,13P

Patnt Nm:	CURR B	Bill Freq:	1
DCN:	20498077752504	Trans Type:	
Ptnt Cntrl #:	002000000000	Processor ID:	14000
Med Rcrd #:	000000000000		
HIC Num:	464266141D		
Recpt Dt:	04/30/04		
Paid Dt:	05/14/04		
Service From:	03/11/04		
Service Thru:	03/25/04		

Rev Code	HCPCS	Panel Code	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
0305	85025		1	$45.15	$10.86	$0.00	$0.00	$0.00	$0.00		$10.86
TOTAL:			1	$45.15	$10.86	$0.00	$0.00	$0.00	$0.00		$10.86

Reimbursements

Gross Reimb.:	$10.86
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$10.86

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	130,135,13P

***** Monthly Totals for CROSS YOUR HEART HOSPITAL for service month end 3/31/04 *****

	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
TOTAL:	7	$470.49	$44.71	$0.00	$0.00	$0.00	$0.00		$44.71

Reimbursements

Gross Reimb.:	$44.71
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$44.71

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00

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Exhibit 5-16 Outpatient – xx5 Fee Reimbursed Payment Reconciliation (Detail) Report Template (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: N/A
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T00073 CROSS YOUR HEART HOSPITAL

PAYMENT RECONCILIATION REPORT
OUTPATIENT - FEE REIMBURSED

Page: 3
Report #: OD44202
Report Type: 135
Paid Dates: 01/01/04 to 10/01/06

Service Period and Report Type Totals

Service Period		Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
01/01/2004 - 01/01/2006	TOTAL:	12	$701.64	$122.55	$0.00	$0.00	$0.00	$0.00		$122.55

Reimbursements		Additional Information	
Gross Reimb.:	$122.55	MSP Cash Deduct.:	$0.00
LESS:		MSP Blood Deduct.:	$0.00
Cash Deduct.:	$0.00	MSP Coins.:	$0.00
Blood Deduct.:	$0.00	Claim Interest:	$0.00
Coins.:	$0.00		
MSP:	$0.00		
Psyc. Red.:	.		
Net Reimb.:	$122.55		

*** Report Type 135 Totals for CROSS YOUR HEART HOSPITAL ***

	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
TOTAL:	12	$701.64	$122.55	$0.00	$0.00	$0.00	$0.00	$0.00	$122.55

Reimbursements		Additional Information	
Gross Reimb.:	$122.55	MSP Cash Deduct.:	$0.00
LESS:		MSP Blood Deduct.:	$0.00
Cash Deduct.:	$0.00	MSP Coins.:	$0.00
Blood Deduct.:	$0.00	Claim Interest:	$0.00
Coins.:	$0.00		
MSP:	$0.00		
Psyc. Red.:	$0.00		
Net Reimb.:	$122.55		

Feb 7, 2007 - 3 - 12:39:54 PM

The reports that are generated based on the outpatient xx5 Fee Reimbursed report template are:

- Inpatient – Part B Fee Reimbursed (125)
- Outpatient – Fee Reimbursed (135)
- Outpatient/Other – Fee Reimbursed (145)
- SNF – Inpatient – Fee Reimbursed (225)
- SNF – Outpatient Fee Reimbursed (235)
- Home Health – Part B – Fee Reimbursed (345)
- Federally Qualified Health Center – Fee Reimbursed (735)
- Rehabilitation Facility – Fee Reimbursed (745)
- Comprehensive Outpatient Rehabilitation Facilities – Fee Reimbursed (755)
- Community Mental Health Center – Fee Reimbursed (765)
- ASC and ASC Fee Schedule – Fee Reimbursed (835)
- Critical Access Hospital – Fee Reimbursed (855)

A brief description of these reports is provided in the following sections.

5.7.1 Inpatient – Part B Fee Reimbursed (125)

The Inpatient – Part B Fee Reimbursed (125) report shows covered charges and reimbursement by revenue code for fee reimbursed services for patients who have exhausted Part A benefits. The items reported on the Inpatient – Part B Fee Reimbursed (125) report are not to be included on the Medicare Cost Report.

5.7.2 Outpatient – Fee Reimbursed (135)

The Outpatient – Fee Reimbursed (135) report shows covered charges and reimbursement by revenue code for fee reimbursed services for hospital outpatient services. The items reported on the Outpatient – Fee Reimbursed (135) report are not to be included on the Medicare Cost Report.

5.7.3 Outpatient/Other – Fee Reimbursed (145)

The Outpatient/Other – Fee Reimbursed (145) report shows covered charges and reimbursement by revenue code for fee reimbursed services for other outpatient services. The items reported on the Outpatient/Other – Fee Reimbursed (145) report are not to be included on the Medicare Cost Report.

5.7.4 SNF – Inpatient – Fee Reimbursed (225)

The SNF – Inpatient – Fee Reimbursed (225) report shows covered charges and reimbursement by revenue code for fee reimbursed services for inpatient skilled nursing facility services. The items reported on the SNF – Inpatient – Fee Reimbursed (225) report are not to be included on the Medicare Cost Report.

5.7.5 SNF – Outpatient Fee Reimbursed (235)

The SNF – Outpatient Fee Reimbursed (235) report shows covered charges and reimbursement by revenue code for fee reimbursed services for outpatient skilled nursing facility services. The items reported on the SNF – Outpatient Fee Reimbursed (235) report are not to be included on the Medicare Cost Report.

5.7.6 Home Health – Part B – Fee Reimbursed (345)

The Home Health – Part B – Fee Reimbursed (345) report shows covered charges and reimbursement by revenue code for fee reimbursed services. The items reported on the Home Health – Part B – Fee Reimbursed (345) report are not to be included on the Medicare Cost Report.

5.7.7 Federally Qualified Health Center – Fee Reimbursed (735)

The Federally Qualified Health Center – Fee Reimbursed (735) report shows covered charges and reimbursement by revenue code for fee reimbursed services. The items reported on the Federally Qualified Health Center – Fee Reimbursed (735) report are not to be included on the Medicare Cost Report.

5.7.8 Rehabilitation Facility – Fee Reimbursed (745)

The Rehabilitation Facility – Fee Reimbursed (745) report shows covered charges and reimbursement by revenue code for fee reimbursed services. The items reported on the Rehabilitation Facility – Fee Reimbursed (745) report are not to be included on the Medicare Cost Report.

5.7.9 Comprehensive Outpatient Rehabilitation Facilities – Fee Reimbursed (755)

The Comprehensive Outpatient Rehabilitation Facilities – Fee Reimbursed (755) report shows covered charges and reimbursement by revenue code for fee reimbursed services. The items reported on the

Comprehensive Outpatient Rehabilitation Facilities – Fee Reimbursed (755) report are not to be included on the Medicare Cost Report.

5.7.10 Community Mental Health Center – Fee Reimbursed (765)

The Community Mental Health Center – Fee Reimbursed (765) report shows covered charges and reimbursement by revenue code for fee reimbursed services. The items reported on the Community Mental Health Center – Fee Reimbursed (765) report are included on the Medicare Cost Report.

5.7.11 ASC and ASC Fee Schedule – Fee Reimbursed (835)

The ASC and ASC Fee Schedule – Fee Reimbursed (835) report shows covered charges and reimbursements by revenue code for fee reimbursed services. The items reported on the ASC and ASC Fee Schedule – Fee Reimbursed (835) report are included on the Medicare Cost Report.

5.7.12 Critical Access Hospital – Fee Reimbursed (855)

The Critical Access Hospital – Fee Reimbursed (855) report shows covered charges and reimbursements by revenue code for fee reimbursed services. The items reported on the Critical Access Hospital – Fee Reimbursed (855) report are included on the Medicare Cost Report.

5.8 xx0 All Other Report Template

The Outpatient – xx0 All Other Provider Summary report template displays summary statistic, charge, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. The statistic section shows the number of claims for each reporting period. The charge section displays the number of units and the total dollar amount of the revenue code being reported. The reimbursement section displays how Net Reimbursement is calculated. Finally, the additional information section displays the claim interest payments.

The Outpatient – xx0 All Other Payment Reconciliation (detail) report template is divided into Claim Information, Reimbursements, and Additional Information sections. The claim information section contains patient information such as the patient name, DCN, Line Item Reimbursement, and the charges for the revenue codes. The reimbursements section shows how Net Reimbursement is calculated. The additional information section shows the deductible amounts, claim interest, and MSP coinsurance amount. The report template also provides a monthly totals section that sums the information from the sections above.

An example of the outpatient xx0 All Other report template and outpatient xx0 All Other Payment Reconciliation report template follow.

Exhibit 5-17 Outpatient – xx0 All Other Provider Summary Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/05/07
Provider FYE: 09/30
Provider Number: T50100 CHARITY HOUSE MEMORIAL HOSPITAL

PROVIDER SUMMARY REPORT
OUTPATIENT - COST REIMBURSED

Page: 1
Report #: OD44203
Report Type: 130

	SERVICES FOR PERIOD 01/01/04 - 12/31/04	SERVICES FOR PERIOD 01/01/05 - 12/31/05	SERVICES FOR PERIOD 01/01/06 - 12/31/06	SERVICES FOR PERIOD No Data Requested
STATISTIC SECTION				
CLAIMS	0	2	43	

CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0260	IV THERAPY	0	$0.00	0	$0.00	0	$0.00		
0278	SUPPLY/IMPLANTS	0	$0.00	0	$0.00	1	$7,050.00		
0300	LABORATORY or (LAB)	0	$0.00	2	$0.00	52	$0.00		
0301	LAB/CHEMISTRY	0	$0.00	0	$0.00	5	$0.00		
0420	PHYSICAL THERP	0	$0.00	0	$0.00	0	$0.00		
0480	CARDIOLOGY	0	$0.00	0	$0.00	0	$0.00		
TOTAL COVERED CHARGES		0	$0.00	2	$0.00	58	$7,050.00		

REIMBURSEMENT SECTION				
GROSS REIMBURSEMENT	$0.00	$0.00	$2,467.50	
LESS				
CASH DEDUCTIBLE	$0.00	$0.00	$0.00	
BLOOD DEDUCTIBLE	$0.00	$0.00	$0.00	
COINSURANCE	$0.00	$0.00	$1,410.00	
NET MSP PAYMENTS	$0.00	$0.00	$0.00	
PSYCH REDUCTION	$0.00	$0.00	$0.00	
NET REIMBURSEMENT	$0.00	$0.00	$1,057.50	
ADDITIONAL INFORMATION SECTION				
CLAIM INTEREST PAYMENTS	$0.00	$0.00	$0.00	

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Exhibit 5-18 Outpatient – xx0 All Other Payment Reconciliation Report Template (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 05/31/04
Report Run Date: 02/07/07
Provider FYE: 09/30
Provider Number: T00044 SACRED SISTERS MEDICAL CENTER

PAYMENT RECONCILIATION REPORT
OUTPATIENT - COST REIMBURSED

Page: 5
Report #: OD44202
Report Type: 130
Paid Dates: 01/01/00 to 10/01/06

Claim Information

Patnt Nm:	COHE A	Bill Freq:	1
DCN:	20468549043805	Trans Type:	
Ptnt Cntrl #:	M25000000000	Processor ID:	14000
Med Rcrd #:	M16000000000		
HIC Num:	199178966A		
Recpt Dt:	05/17/04		
Paid Dt:	05/31/04		
Service From:	05/11/04		
Service Thru:	05/11/04		

Rev Code	HCPCS	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
0301	83880	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
0301	84484	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
TOTAL:		0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00

Reimbursements

Gross Reimb.:	$0.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$0.00

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	130,135,13P

Patnt Nm:	EPPS J	Bill Freq:	1
DCN:	20448509043805	Trans Type:	
Ptnt Cntrl #:	M25000000000	Processor ID:	14000
Med Rcrd #:	M34000000000		
HIC Num:	078581079A		
Recpt Dt:	05/17/04		
Paid Dt:	05/31/04		
Service From:	05/11/04		
Service Thru:	05/11/04		

Rev Code	HCPCS	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Psyc. Red.	Line Item Reimb.
0301	84484	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
TOTAL:		0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00

Reimbursements

Gross Reimb.:	$0.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$0.00

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Claim Report Splits:	130,135,13P

***** Monthly Totals for SACRED SISTERS MEDICAL CENTER for service month end 5/31/04 *****

	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins	MSP	Psyc. Red.	Line Item Reimb.
TOTAL:	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00

Reimbursements

Gross Reimb.:	$0.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$0.00

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00

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Exhibit 5-19 Outpatient – xx0 All Other Payment Reconciliation Report Template (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: N/A
Report Run Date: 02/07/07
Provider FYE: 09/30
Provider Number: T00044 SACRED SISTERS MEDICAL CENTER

PAYMENT RECONCILIATION REPORT
OUTPATIENT - COST REIMBURSED

Page: 6
Report #: OD44202
Report Type: 130
Paid Dates: 01/01/00 to 10/01/06

Service Period and Report Type Totals

Service Period		Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins	MSP	Psyc. Red.	Line Item Reimb.
01/01/2000 - 01/01/2006	TOTAL:	9	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00

Reimbursements	
Gross Reimb.:	$0.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	-
Net Reimb.:	$0.00

Additional Information	
MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00

*** Report Type 130 Totals for SACRED SISTERS MEDICAL CENTER ***

	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins	MSP	Psyc. Red.	Line Item Reimb.
TOTAL:	9	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Reimbursements	
Gross Reimb.:	$0.00
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	$0.00
MSP:	$0.00
Psyc. Red.:	$0.00
Net Reimb.:	$0.00

Additional Information	
MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00

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The reports that are generated based on the outpatient xx0 All Other Cost Reimbursed report template are:

- Inpatient – Part B Cost Reimbursed (120)
- Outpatient – Cost Reimbursed (130)
- Outpatient/Other – All Other Cost Reimbursed (140)
- SNF – Inpatient – Part B Cost Reimbursed (220)
- SNF – Outpatient – Cost Reimbursed (230)
- Home Health – Part B (340)
- Clinic – Rural Health (710)
- Federally Qualified Health Center (730)
- Rehabilitation Facility (740)
- Comprehensive Outpatient Rehabilitation Facilities (750)
- Community Mental Health Center (760)
- Critical Access Hospital (850)

A brief description of these reports is provided in the following sections.

5.8.1 Inpatient – Part B Cost Reimbursed (120)

The Inpatient – Part B Cost Reimbursed (120) report accumulates data for services normally covered under Part A that have become covered under Part B. For reimbursement purposes, Inpatient Part B and Outpatient Part B are combined on the Medicare Cost Report. The items reported on the Inpatient – Part B Cost Reimbursed (120) report are included on the Medicare Cost Report.

5.8.2 Outpatient – Cost Reimbursed (130)

The Outpatient – Cost Reimbursed (130) report summarizes hospital outpatient data reimbursed on a reasonable cost basis, for all services other than diagnostic services. This report also summarizes laboratory services reimbursed on a fee schedule in a supplemental report. The items reported on the Outpatient – Cost Reimbursed (130) report are included on the Medicare Cost Report.

5.8.3 Outpatient/Other – All Other Cost Reimbursed (140)

The Outpatient/Other – All Other Cost Reimbursed (140) report summarizes hospital other Part B data (for bill type 14x) reimbursed on a reasonable cost basis. The items reported on the Outpatient/Other – All Other Cost Reimbursed (140) report are included on the Medicare Cost Report.

5.8.4 SNF – Inpatient – Part B Cost Reimbursed (220)

The SNF – Inpatient – Part B Cost Reimbursed (220) report summarizes SNF Inpatient – Part B services. The items reported on the SNF – Inpatient – Part B Cost Reimbursed (220) report are included on the Medicare Cost Report.

5.8.5 SNF – Outpatient – Cost Reimbursed (230)

The SNF – Outpatient – Cost Reimbursed (230) report summarizes skilled nursing facility outpatient services. The items reported on the SNF – Outpatient – Cost Reimbursed (230) report are included on the Medicare Cost Report.

5.8.6 Home Health – Part B (340)

The Home Health – Part B (340) report summarizes home health agency outpatient services. The items reported on the Home Health – Part B (340) report are included on the Medicare Cost Report.

5.8.7 Clinic – Rural Health (710)

The Clinic – Rural Health (710) report summarizes data for rural health clinic services (bill type 71x) paid based on an all-inclusive rate. The items reported on the Clinic – Rural Health (710) report are included on the Medicare Cost Report.

5.8.8 Federally Qualified Health Center (730)

The Federally Qualified Health Center (730) report summarizes data for Federally Qualified Health Clinic services (bill type 73x) paid based on an all-inclusive rate. The items reported on the Federally Qualified Health Center (730) report are included on the Medicare Cost Report.

5.8.9 Rehabilitation Facility (740)

The Rehabilitation Facility (740) report shows cost reimbursed data, if any, by accommodation and ancillary service revenue codes. This report captures lines of claims paid under the cost-reimbursed method for Outpatient Rehabilitation facilities-mainly services prior to January 1, 1999. This report is used to determine if a provider has low utilization or no Medicare business for cost reporting. The items reported on the Rehabilitation Facility (740) report are included on the Medicare Cost Report.

5.8.10 Comprehensive Outpatient Rehabilitation Facilities (750)

The Comprehensive Outpatient Rehabilitation Facilities (750) report shows cost reimbursement data, if any, by accommodation and ancillary service revenue codes. This report captures lines of claims paid under the cost-reimbursed method for Comprehensive Rehabilitation facilities-mainly services prior to January 1, 1999. This report is used to determine if a provider has low utilization or no Medicare business for cost reporting. The items reported on the Comprehensive Outpatient Rehabilitation Facilities (750) report are included on the Medicare Cost Report.

5.8.11 Community Mental Health Center (760)

The Community Mental Health Center (760) report captures lines of claims paid under the cost-reimbursed method for Community Health Centers for services prior to August 1, 2000. The items reported on the Community Mental Health Center (760) report are included on the Medicare Cost Report.

5.8.12 Critical Access Hospital (850)

The Critical Access Hospital (850) report summarizes data for critical access hospital services (bill type 85x) reimbursed on a cost basis. The items reported on the Critical Access Hospital (850) report are included on the Medicare Cost Report.

5.9 xxM/xx9 Home Health Agency Report Template

The xxM/xx9 Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) and Episodes summary reports display summary services, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The services section is divided into “Services without Outlier”, “Services with Outlier”, and “Total Services.” Payment types such as “Full Episodes”, “Lupa”, etc. categorize the services section. The reimbursement section shows how Gross Reimbursement and Net Reimbursement are calculated. Finally, the additional information section shows claim interest payments. In addition, the MSA supplemental report is generated for the Home Health PPS – Part B Episodes (329) and Home Health PPS – Part A Episodes (339) reports. The user can choose to exclude this section.

The xxM/xx9 Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) and Episodes detail reports display detail claim information, reimbursements, and additional information sections. The claim information section contains data such as Part A/Part B visits, Fee Type, HCPCS, and charges for each revenue code. The reimbursements section shows how Net Reimbursement is calculated. The additional information section contains data such as deductibles, HIPPS code, HIPPS weight, and payment type. A monthly totals section is displayed at the bottom of the report, which sums the information from the sections above.

Exhibit 5-20 Outpatient – xxM/xx9 Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) and Episodes Summary Report Template (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/05/07
Provider FYE: 12/31
Provider Number: T37008 MOBILE NURSE SERVICES

PROVIDER SUMMARY REPORT
HOME HEALTH PPS - PART A EPISODES

Page: 1
Report #: OD44228
Report Type: 339

SERVICES APPLIED FOR THE PERIODS: 01/01/2004 - 12/31/2004

CHARGE SECTION

*** SERVICES WITHOUT OUTLIER ***		FULL EPISODES		LUPA EPISODES		PEP ONLY EPISODES		SCIC ONLY EPISODES		SCIC WITHIN A PEP		*TOTAL*	
REV CODE	DESCRIPTION	VISITS	CHARGES	VISITS	CHARGES	VISITS	CHARGES	VISITS	CHARGES	VISITS	CHARGES	VISITS	CHARGES
027X	MEDICAL/SURGICAL SUPPLIES AND DEVICES	0	$100.62	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$100.62
042X	PHYSICAL THERAPY	55	$6,875.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	55	$6,875.00
043X	OCCUPATIONAL THERAPY	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00
055X	SKILLED NURSING	39	$4,875.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	39	$4,875.00
056X	MEDICAL SOCIAL SERVICES	2	$250.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	2	$250.00
057X	HOME HEALTH AIDE	15	$725.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	15	$725.00
0623	SURGICAL DRESSINGS	0	$69.12	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$69.12
*** TOT SERVICES WITHOUT OUTLIER ***		111	$12,894.74	0	$0.00	0	$0.00	0	$0.00	0	$0.00	111	$12,894.74

*** SERVICES WITH OUTLIER ***													
REV CODE	DESCRIPTION												
*** TOT SERVICES WITH OUTLIER ***		0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00

*** TOTAL SERVICES ***													
REV CODE	DESCRIPTION												
027X	MEDICAL/SURGICAL SUPPLIES AND DEVICES	0	$100.62	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$100.62
042X	PHYSICAL THERAPY	55	$6,875.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	55	$6,875.00
043X	OCCUPATIONAL THERAPY	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00
055X	SKILLED NURSING	39	$4,875.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	39	$4,875.00
056X	MEDICAL SOCIAL SERVICES	2	$250.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	2	$250.00

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Exhibit 5-21 Outpatient – xxM/xx9 Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) and Episodes Summary Report Template (Second Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/05/07
Provider FYE: 12/31
Provider Number: T37008 MOBILE NURSE SERVICES

PROVIDER SUMMARY REPORT
HOME HEALTH PPS - PART B EPISODES

Page: 2
Report #: OD44228
Report Type: 329

SERVICES APPLIED FOR THE PERIODS: 01/01/2004 - 12/31/2004

*** TOTAL SERVICES ***

REV CODE	DESCRIPTION												
057X	HOME HEALTH AIDE	12	$600.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	12	$600.00
0623	SURGICAL DRESSINGS	0	$552.86	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$552.86
*** TOTAL COVERED SERVICES ***		27	$2,951.42	0	$0.00	0	$0.00	0	$0.00	0	$0.00	27	$2,951.42

REIMBURSEMENT SECTION

	FULL EPISODES	LUPA EPISODES	PEP ONLY EPISODES	SCIC ONLY EPISODES	SCIC WITHIN A PEP	*TOTAL*
# EPISODES WITHOUT OUTLIER	4	0	0	0	0	4
HIPPS REIMBURSEMENT WITHOUT OUTLIER	$14,884.25	$0.00	$1,661.47	$0.00	$0.00	$16,545.72
# EPISODES WITH OUTLIER	0	0	0	0	0	0
HIPPS REIMBURSEMENT WITH OUTLIER	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OUTLIER REIMBURSEMENTS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PROSTHETIC/ORTHOTIC DEVICES	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
DME	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OXYGEN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OTHER FEE REIMBURSEMENTS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
GROSS REIMBURSEMENT	$14,884.25	$0.00	$1,661.47	$0.00	$0.00	$16,545.72
LESS						
DEDUCTIBLES	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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Exhibit 5-22 Outpatient – xxM/xx9 Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) and Episodes Summary Report Template (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/05/07
Provider FYE: 12/31
Provider Number: T37008 MOBILE NURSE SERVICES

PROVIDER SUMMARY REPORT
HOME HEALTH PPS - PART B EPISODES

Page: 3
Report #: OD44228
Report Type: 329

SERVICES APPLIED FOR THE PERIODS: 01/01/2004 - 12/31/2004

	FULL EPISODES	LUPA EPISODES	PEP ONLY EPISODES	SCIC ONLY EPISODES	SCIC WITHIN A PEP	*TOTAL*
COINSURANCE	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**
NET MSP PAYMENTS	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**
MSP RECONCILIATION	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**
OTHER ADJUSTMENTS	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**
NET REIMBURSEMENT	$14,884.25	$0.00	$1,661.47	$0.00	$0.00	$16,545.72
ADDITIONAL INFORMATION SECTION						
CLAIM INTEREST PAYMENTS	$0.03	$0.00	$0.00	$0.00	$0.00	**$0.03**

SERVICES APPLIED FOR THE PERIODS: 01/01/2005 - 12/31/2005

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Exhibit 5-23 Outpatient – xxM/xx9 Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) and Episodes Payment Reconciliation (Detail) Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 09/30/04
Report Run Date: 02/19/07
Provider FYE: 12/31
Provider Number: T37008 MOBILE NURSE SERVICES

PAYMENT RECONCILIATION REPORT
HOME HEALTH PPS - PART A EPISODES

Page: 1
Report #: OD44202
Report Type: 339
Paid Dates: 01/01/80 to 10/01/06

Claim Information

Patnt Nm:	HEIL C	Bill Freq:	8
DCN:	20436939312102	Trans Type:	C
Ptnt Cntrl #:	240000000000865E WAY	Pricer Rtn Cd.:	5
Med Rcrd #:		Processor ID:	14000
HIC Num:	182878977A	Part A Visits:	11
Recpt Dt:	12/30/04	Part B Visits:	0
Paid Dt:	01/28/05		
Service From:	12/24/04		
Service Thru:	12/24/04		

Rev Code	HCPCS	Fee Type	Units / Visits	Charges	Gross Fee Reimb.
0420	G0151		4	$500.00	$0.00
0551	G0154		7	$875.00	$0.00
TOTAL:				$1,375.00	$0.00

Reimbursements

HIPPS Reimb.:	$3,049.75
PLUS:	
Outlier:	$0.00
Gross Fee Reimb.:	$0.00
Gross Reimb.:	$3,049.75
LESS:	
Deductibles:	$0.00
Coins.:	$0.00
MSP:	$0.00
MSP Recon.:	$0.00
Other Adjs.:	$0.00
Net Reimb.:	$3,049.75

Additional Information

MSP Deductibles:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Patient CBSA:	6840
HIPPS CODE:	
HIPPS WGHT:	
PAYMENT TYPE:	FULL EPISODE

*** Monthly Totals for MOBILE NURSE SERVICES for service month end 9/30/04 ***

*** BY TYPE OF EPISODE ***

	Full Episodes	LUPA	PEP	SCIC/PEP	SCIC	Total
Visits	11	0	0	0	0	11
Covered Charges	$1,375.00	$0.00	$0.00	$0.00	$0.00	$1,375.00
HIPPS Reimb.	$3,049.75	$0.00	$0.00	$0.00	$0.00	$3,049.75
Outlier	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

*** FEE-REIMBURSED SERVICES ***

	DME	P&O	Oxygen	Other Fee	Total
Covered Charges	$0.00	$0.00	$0.00	$0.00	$1,375.00
Gross Fee Reimb.	$0.00	$0.00	$0.00	$0.00	$0.00

*** TOTAL ***

Total Covered Charges:	$1,375.00
Total Gross Reimb.:	$3,049.75
LESS:	
Deductibles:	$0.00
Coinsurance	$0.00
MSP:	$0.00
MSP Reconciliation:	$0.00
Other Adjustments:	$0.00
Net Reimbursement:	$3,049.75

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The reports that are generated based on the outpatient xxM/xx9 Home Health Agency report template are:

- Home Health PPS – Part A (MSP-LCC) (32M)
- Home Health PPS – Part B Episodes (329)
- Home Health – Part A (MSP-LCC) (33M)
- Home Health PPS – Part A Episodes (339)
- Home Health PPS – Part A and Part B Episodes (399)

A brief description of these reports is provided in the following sections.

5.9.1 Home Health PPS (MSP-LCC) (32M)

The Home Health PPS (MSP-LCC) (32M) report is a supplemental report to the Home Health PPS – Part B Episodes (329) report. The items reported on the Home Health PPS (MSP-LCC) (32M) report are included on the Medicare Cost Report.

5.9.2 Home Health PPS – Part B Episodes (329)

The Home Health PPS – Part B Episodes (329) report summarizes data included on Part B home health prospective payments episodes covered under a signed plan of treatment. Part B home health data is broken out into different episodic units. Services included on this report are typically not subject to deductibles or coinsurance. The items reported on the Home Health PPS – Part B Episodes (329) report are included on the Medicare Cost Report.

5.9.3 Home Health – Part A (MSP-LCC) (33M)

The Home Health – Part A (MSP-LCC) (33M) report is a supplemental report to the Home Health – Part A Episodes (339) report. The items reported on the Home Health – Part A (MSP-LCC) (33M) report are included on the Medicare Cost Report.

5.9.4 Home Health PPS – Part A Episodes (339)

The Home Health PPS – Part A Episodes (339) report summarizes data included on Part A home health prospective payment episodes. Part A home health data is separated into different episode units. The items reported on the Home Health PPS – Part A Episodes (339) report are included on the Medicare Cost Report.

5.9.5 Home Health PPS – Part A and Part B Episodes (399)

The Home Health PPS – Part A and Part B Episodes (399) report summarizes home health episode data from the Home Health PPS – Part B Episodes (329) report and the Home Health PPS – Part A Episodes (339) report. The items reported on the Home Health PPS – Part A and Part B Episodes (399) report are included on the Medicare Cost Report.

5.10 322/332 Home Health Agency Report Template

The 322/332 Home Health Agency Provider Summary report template displays a RAP and a reimbursement section for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The RAP section shows the total initial RAPs, total cancelled RAPs, and the total RAPs outstanding for the different service periods. The reimbursement section shows gross reimbursement and net reimbursement.

The 322/332 Home Health Agency Payment Reconciliation (detail) report template displays detail claim information, reimbursements, and additional information sections. The claim information section contains data such as the number of Part A/Part B visits, fee type, HCPCS, and charges for each revenue code. The reimbursements section shows how net reimbursement is calculated. The additional information section contains data such as deductibles, HIPPS code, HIPPS weight, payment type, and cancel method. There is a monthly totals section at the bottom of the report, which sums the information from the sections above.

An example of the outpatient 322/332 Home Health Agency Summary report template and the outpatient 322/332 Home Health Agency Payment Reconciliation (detail) report template follow.

Exhibit 5-24 Outpatient – 322/332 Home Health Agency Summary Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/05/07
Provider FYE: 12/31
Provider Number: T37008 MOBILE NURSE SERVICES

PROVIDER SUMMARY REPORT
HOME HEALTH PPS - PART B RAP
THESE ITEMS ARE NOT TO BE INCLUDED ON THE MEDICARE COST REPORT

Page: 1
Report #: OD44228
Report Type: 322

	SERVICES FOR PERIOD 01/01/04 - 12/31/04		SERVICES FOR PERIOD 01/01/05 - 12/31/05		SERVICES FOR PERIOD No Data Requested		SERVICES FOR PERIOD No Data Requested	
	COUNT	REIMB	COUNT	REIMB	COUNT	REIMB	COUNT	REIMB
TOTAL INITIAL RAP	27	$52,489.27	403	$914,075.99				
RAP CANCELLED BY CLAIM	0	$0.00	0	$0.00				
RAP AUTO CANCELLED	-1	-$2,816.90	0	$0.00				
RAP PROVIDER CANCELLED	0	$0.00	0	$0.00				
RAP FI CANCELLED	0	$0.00	0	$0.00				
TOTAL CANCELLED RAPS	-1	-$2,816.90	0	$0.00				
TOT RAPS OUTSTANDING	403	$914,075.99			26	$49,672.37		
GROSS REIMBURSEMENT		$914,075.99				$49,672.37		
NET REIMBURSEMENT		$914,075.99				$49,672.37		

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Exhibit 5-25 Outpatient – 322/332 Home Health Agency Payment Reconciliation (Detail) Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 06/30/04
Report Run Date: 02/19/07
Provider FYE: 12/31
Provider Number: T37008 MOBILE NURSE SERVICES

PAYMENT RECONCILIATION REPORT
HOME HEALTH PPS - PART B RAP

Page: 1
Report #: OD44202
Report Type: 322
Paid Dates: 01/01/80 to 10/01/06

Claim Information

Patnt Nm:	BARO H	Bill Freq:	2
DCN:	20509709145904	Trans Type:	
Ptnt Cntrl #:	000000000000	Pricer Rtn Cd.:	5
Med Rcrd #:		Processor ID:	14000
HIC Num:	289273102A	Part A Visits:	
Recpt Dt:	01/27/05	Part B Visits:	
Paid Dt:	01/31/05		
Service From:	09/24/04		
Service Thru:	09/24/04		

Rev Code	HCPCS	Fee Type	Units	Charges	Gross Fee Reimb.
TOTAL:					

Reimbursements

HIPPS Reimb.:	$2,816.90
PLUS:	
Outlier:	$0.00
Gross Fee Reimb.:	$0.00
Gross Reimb.:	$2,816.90
LESS:	
Deductibles:	$0.00
Coins.:	$0.00
MSP:	$0.00
MSP Recon.:	$0.00
Other Adjs.:	$0.00
Net Reimb.:	$2,816.90

Additional Information

MSP Deductibles:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Patient CBSA:	5600
HIPPS CODE:	
HIPPS WGHT:	
PAYMENT TYPE:	RAP
CANCEL METHOD:	N/A

*** Monthly Totals for MOBILE NURSE SERVICES for service month end 6/30/04 ***

	Count	Reimbursement
TOTAL INITIAL RAP:	1	$2,816.90
RAP CANCELLED BY CLAIM:	0	$0.00
RAP AUTO CANCELLED:	0	$0.00
RAP PROVIDER CANCELLED:	0	$0.00
RAP FI CANCELLED:	0	$0.00
TOTAL CANCELLED RAPS:	0	$0.00
*** TOTAL RAPS OUTSTANDING ***	1	$2,816.90

GROSS REIMBURSEMENT:	$2,816.90
NET REIMBURSEMENT:	$2,816.90

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The reports that are generated based on the outpatient 322/332 Home Health Agency report template are:

- Home Health PPS – Part B RAP (322)
- Home Health PPS – Part A RAP (332)

A brief description of these reports is provided in the following sections.

5.10.1 Home Health PPS – Part B RAP (322)

The Home Health PPS – Part B RAP (322) report summarizes Medicare Part B Requests for Anticipated Payments (RAP) activity. The items reported on the Home Health PPS – Part B RAP (322) report are not to be included on the Medicare Cost Report.

5.10.2 Home Health PPS – Part A RAP (332)

The Home Health PPS – Part A RAP (332) report summarizes Medicare Part A Requests for Anticipated Payments (RAPs) activity. The items reported on the Home Health PPS – Part A RAP (332) report are not to be included on the Medicare Cost Report.

5.11 81x/82x Hospice Report Template

The 81x/82x Hospice Provider Summary report template displays summary statistic, charge, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. The statistic section shows the Medicare days, Claims, and Total unduplicated census count for each reporting period. The charge section displays the number of units, Unduplicated days, and the total dollar amount of the revenue code being reported. The reimbursement section displays how Net Reimbursement is calculated. Finally, the additional information section displays the claim interest payments.

The 81x/82x Hospice Payment Reconciliation (detail) report template is divided into Claim Information, Reimbursements, and Additional Information sections. The claim information section contains patient information such as the patient name, DCN, description, Unduplicated days, Line Item Reimbursement, and the charges for the revenue codes. The reimbursements section shows how Net Reimbursement is calculated. The additional information section shows claim interest, MSA/E/CBSA, and claim report splits. The report template also provides a monthly totals section that sums the information from the sections above.

An example of the outpatient 81x/82x Hospice Summary report template and the outpatient 81x/82x Hospice Payment Reconciliation (detail) report template follow.

Exhibit 5-26 Outpatient – 81x/82x Hospice Summary Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/01/07
Provider FYE: 12/31
Provider Number: T01515 BIRD SONG HOSPICE

PROVIDER SUMMARY REPORT
HOSPICE - NON-HOSPITAL BASED

Page: 1
Report #: OD44203
Report Type: 810

	SERVICES FOR PERIOD 01/01/04 - 03/31/04	SERVICES FOR PERIOD 04/01/04 - 06/30/04	SERVICES FOR PERIOD 07/01/04 - 09/30/04	SERVICES FOR PERIOD 10/01/04 - 12/31/04
STATISTIC SECTION				
MEDICARE DAYS	0	0	0	0
CLAIMS	0	591	5	0
TOTAL UNDUPLICATED CENSUS COUNT	0	5	561	0

CHARGE SECTION

REV CODE	DESCRIPTION	UNDUP DAYS	HOURS	UNITS	CHARGES	UNDUP DAYS	HOURS	UNITS	CHARGES	UNDUP DAYS	HOURS	UNITS	CHARGES	UNDUP DAYS	HOURS	UNITS	CHARGES
0651	HOSPICE/RTN HOME	0			-$107.14	54			$6,222.24	13,039			$1,526,538.96	0	0	0	$0.00
0652	HOSPICE/CTNS HOME						-11		-$301.84		757		$21,690.56	0	0	0	$0.00
0655	HOSPICE/IP RESPITE					0			$0.00	67			$8,394.43	0	0	0	$0.00
0656	HOSPICE/IP NON RESPITE					3			$1,623.75	776			$420,010.00	0	0	0	$0.00
0657	HOSPICE/PHYSICIAN	0			$0.00	1			$160.49	256			$14,820.60	0	0	0	$0.00
TOTAL COVERED CHARGES		0			-$107.14	58	-11		$7,704.64	14,138	757		$1,991,454.55	0	0	0	$0.00

REIMBURSEMENT SECTION				
GROSS REIMBURSEMENT	-$151.15	$1,992,233.14	$7,222.61	$0.00
LESS				
DEDUCTIBLES	$0.00	$0.00	$0.00	$0.00
COINSURANCE	$0.00	$0.00	$0.00	$0.00
NET MSP PAYMENTS	$0.00	$0.00	$0.00	$0.00
MSP RECONCILIATION	$0.00	$0.00	$0.00	$0.00
OTHER ADJUSTMENTS	$0.00	$0.00	$0.00	$0.00
NET REIMBURSEMENT	-$151.15	$1,992,233.14	$7,222.61	$0.00
ADDITIONAL INFORMATION SECTION				
CLAIM INTEREST PAYMENTS	$0.00	$0.00	$0.00	$0.00

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Exhibit 5-27 Outpatient – 81x/82x Hospice Payment Reconciliation (Detail) Report Template

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 03/31/04
Report Run Date: 02/07/07
Provider FYE: 12/31
Provider Number: T01515 BIRD SONG HOSPICE

PAYMENT RECONCILIATION REPORT
HOSPICE - NON-HOSPITAL BASED

Page: 1
Report #: OD44202
Report Type: 810
Paid Dates: 01/01/04 to 10/01/06

Claim Information

Patnt Nm:	ERIC D	Bill Freq:	8
DCN:	20419418481705 01	Trans Type:	C
Ptnt Cntrl #:	100000000000	Pricer Rtn Cd:	0
Med Rcrd #:	449000000000	Processor ID:	14000
HIC Num:	161568768D		
Recpt Dt:	04/07/04		
Paid Dt:	11/03/04		
Service From:	03/01/04		
Service Thru:	03/31/04		
Med Days:			

Rev Code	Description	Undup Days	Hours	Units	Charges	HCPCS	Gross Fee Reimb.	Gross Reimb.
0651	HOSPICE/RTN HOME	-31			-$3,649.01		$0.00	-$3,649.16
0657	HOSPICE/PHYSICIAN	-1			-$102.03	99303	-$102.03	-$102.03
0657	HOSPICE/PHYSICIAN	-4			-$121.64	99311	-$121.64	-$121.64
TOTAL:		-36			-$3,872.68		-$223.67	-$3,872.83

Reimbursements

Gross Reimb.:	-$3,872.83
LESS:	
Deductibles:	$0.00
Coins.:	$0.00
MSP:	$0.00
MSP Recon.:	$0.00
Other Adjs.:	$0.00
Net Reimb.:	-$3,872.83

Additional Information

Claim Interest:	$0.00
Patient CBSA:	3600
Claim Report Splits:	810

Patnt Nm:	ERIC D	Bill Freq:	7
DCN:	20446628170304 01	Trans Type:	D
Ptnt Cntrl #:	100000000000	Pricer Rtn Cd:	0
Med Rcrd #:	449000000000	Processor ID:	14000
HIC Num:	161568768D		
Recpt Dt:	10/29/04		
Paid Dt:	11/03/04		
Service From:	03/01/04		
Service Thru:	03/31/04		
Med Days:			

Rev Code	Description	Undup Days	Hours	Units	Charges	HCPCS	Gross Fee Reimb.	Gross Reimb.
0651	HOSPICE/RTN HOME	31			$3,541.87		$0.00	$3,498.01
0657	HOSPICE/PHYSICIAN	1			$102.03	99303	$102.03	$102.03
0657	HOSPICE/PHYSICIAN	4			$121.64	99311	$121.64	$121.64
TOTAL:		36			$3,765.54		$223.67	$3,721.68

Reimbursements

Gross Reimb.:	$3,721.68
LESS:	
Deductibles:	$0.00
Coins.:	$0.00
MSP:	$0.00
MSP Recon.:	$0.00
Other Adjs.:	$0.00
Net Reimb.:	$3,721.68

Additional Information

Claim Interest:	$0.00
Patient CBSA:	9910
Claim Report Splits:	810

*** Monthly Totals for BIRD SONG HOSPICE for service month end 3/31/04 ***

	Undup Days	Hours	Units	Charges	Gross Fee Reimb.	Gross Reimb.
Med. Days: TOTAL:	0			-$107.14	$0.00	-$151.15

Reimbursements

Gross Reimb.:	-$151.15
LESS:	
Deductibles:	$0.00
Coins.:	$0.00
MSP:	$0.00
MSP Recon.:	$0.00
Other Adjs.:	$0.00
Net Reimb.:	-$151.15

Additional Information

Claim Interest:	$0.00

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The reports that are generated based on the outpatient 81x/82x Hospice report template are:

- Hospice – Non-Hospital Based (MSP-LCC) (81A)
- Hospice – Non-Hospital Based (810)
- Hospice – Hospital Based (MSP-LCC) (82A)
- Hospice – Hospital Based (820)

A brief description of these reports is provided in the following sections.

5.11.1 Hospice – Non-Hospital Based (MSP-LCC) (81A)

The Hospice – Non-Hospital Based (MSP-LCC) (81A) report summarizes the non-hospital based (free-standing) hospice claims that are subject to Medicare Secondary Payer-Lower Cost or Charge (MSP-LCC) limitation. The items reported on the Hospice – Non-Hospital Based (MSP-LCC) (81A) report are not to be included on the Medicare Cost Report.

5.11.2 Hospice – Non-Hospital Based (810)

The Hospice – Non-Hospital Based (810) report summarizes the non-hospital based (freestanding) hospice claim data. The items reported on the Hospice – Non-Hospital Based (810) report are included on the Medicare Cost Report.

5.11.3 Hospice – Hospital Based (MSP-LCC) (82A)

The Hospice – Hospital Based (MSP-LCC) (82A) report summarizes hospital based (provider) hospice claims that are subject to the (MSP-LCC) limitation. The items reported on the Hospice – Hospital Based (MSP-LCC) (82A) report are not to be included on the Medicare Cost Report.

5.11.4 Hospice – Hospital Based (820)

The Hospice – Hospital Based (820) report summarizes the hospital (provider) based Hospice claim data. The items reported on the Hospice – Hospital Based (820) report are included on the Medicare Cost Report.

5.12 831 ASC and ASC Fee Schedule After 12/90

The 831 ASC and ASC Fee Schedule After 12/90 Provider Summary report displays summary statistic, charge, reimbursement, and additional information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The data displayed in each section is determined by the report selected for generation. The statistic section shows the claims for each reporting period. The charge section displays the number of units and the total dollar amount of the revenue code being reported. The reimbursement section displays how Net Reimbursement is calculated. Finally, the additional information section displays the claim interest payments and the standard overhead amount.

The 831 ASC and ASC Fee Schedule After 12/90 Payment Reconciliation (detail) report is divided into Claim Information, Reimbursements, and Additional Information sections. The claim information section displays patient information such as the patient name, DCN, Standard Overhead Amount, Blood Deductible, Line Item Reimbursement, and the charges for the revenue codes. The reimbursements section shows how Net Reimbursement is calculated. The additional information section shows Claim Interest, MSP Cash Deductible, MSP Blood Deductible, MSP Coinsurance, Standard Overhead Amount, and Claim Report Splits. The report also provides a monthly totals section that sums the information from the sections above.

An example of the 831 ASC and ASC Fee Schedule After 12/90 Provider Summary report and the 831 ASC and ASC Fee Schedule After 12/90 Payment Reconciliation (detail) report follow.

Exhibit 5-28 Outpatient – 831 ASC and ASC Fee Schedule After 12/90 Provider Summary Report (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 11/30/99
Report Run Date: 02/19/07
Provider FYE: 09/30
Provider Number: T00028 PARROTHEAD MEDICAL CENTER

PAYMENT RECONCILIATION REPORT
ASC AND ASC FEE SCHEDULE AFTER 12/90

Page: 1
Report #: OD44202
Report Type: 831
Paid Dates: 01/01/80 to 10/01/06

Claim Information

Patnt Nm:	WOOD M	Bill Freq:	8
DCN:	20449979184608	Trans Type:	C
Ptnt Cntrl #:	097000000000	Processor ID:	14000
Med Rcrd #:	145000000000		
HIC Num:	186488514C1		
Recpt Dt:	03/29/04		
Paid Dt:	05/03/04		
Service From:	06/19/00		
Service Thru:	06/19/00		

Rev Code	HCPCS	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Line Item Reimb.	Stndrd. Ovrhd. Amt.
0250		-1	-$34.90	-$11.87	$0.00	$0.00	-$6.98	$0.00	-$4.89	$0.00
0258		-1	-$63.55	-$21.61	$0.00	$0.00	-$12.71	$0.00	-$8.90	$0.00
0272		-2	-$58.80	-$19.99	$0.00	$0.00	-$11.76	$0.00	-$8.23	$0.00
0320	76000	-1	-$313.05	-$106.44	$0.00	$0.00	-$62.61	$0.00	-$43.83	-$55.65
0370		-1	-$71.20	-$24.21	$0.00	$0.00	-$14.24	$0.00	-$9.97	$0.00
0490	62289	-1	-$686.55	-$233.43	$0.00	$0.00	-$137.31	$0.00	-$96.12	-$309.31
TOTAL:		-7	-$1,228.05	-$417.55	$0.00	$0.00	-$245.61	$0.00	-$171.94	-$364.96

Reimbursements

Gross Reimb.:	-$417.55
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	-$245.61
MSP:	$0.00
Net Reimb.:	-$171.94

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Stndrd. Ovrhd. Amt.:	-$364.96
Claim Report Splits:	831

***** Monthly Totals for PARROTHEAD MEDICAL CENTER for service month end 11/30/99 *****

	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins	MSP	Line Item Reimb.	Stndrd. Ovrhd. Amt.:
TOTAL:	-7	-$1,228.05	-$417.55	$0.00	$0.00	-$245.61	$0.00	-$171.94	-$364.96

Reimbursements

Gross Reimb.:	-$417.55
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	-$245.61
MSP:	$0.00
Net Reimb.:	-$171.94

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Stndrd. Ovrhd. Amt.:	-$364.96

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Exhibit 5-29 Outpatient – 831 ASC and ASC Fee Schedule After 12/90 Provider Summary Report (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: N/A
Report Run Date: 02/19/07
Provider FYE: 09/30
Provider Number: T00028 PARROTHEAD MEDICAL CENTER

PAYMENT RECONCILIATION REPORT
ASC AND ASC FEE SCHEDULE AFTER 12/90

Page: 3
Report #: OD44202
Report Type: 831
Paid Dates: 01/01/80 to 10/01/06

Service Period and Report Type Totals

Service Period		Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins	MSP	Line Item Reimb.	Stndrd. Ovrhd. Amt.:
01/01/1999 - 12/31/1999	TOTAL:	-7	-$1,228.05	-$417.55	$0.00	$0.00	-$245.61	$0.00	-$171.94	-$364.96
01/01/2000 - 12/31/2000	TOTAL:	-16	-$1,153.40	-$415.22	$0.00	$0.00	-$230.68	$0.00	-$184.54	-$1,082.59
01/01/2004 - 12/31/2004	TOTAL:	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
*** Report Type 831 Totals for PARROTHEAD MEDICAL CENTER ***	TOTAL:	-23	-$2,381.45	-$832.77	$0.00	$0.00	-$476.29	$0.00	-$356.48	-$1,447.55

Reimbursements

01/01/1999 - 12/31/1999	Gross Reimb.:	-$417.55	Cash Deduct.:	$0.00	
	LESS:		Blood Deduct.:	$0.00	
			Coins.:	-$245.61	
			MSP:	$0.00	
			Net Reimb.:	-$171.94	
01/01/2000 - 12/31/2000	Gross Reimb.:	-$415.22	Cash Deduct.:	$0.00	
	LESS:		Blood Deduct.:	$0.00	
			Coins.:	-$230.68	
			MSP:	$0.00	
			Net Reimb.:	-$184.54	
01/01/2004 - 12/31/2004	Gross Reimb.:	$0.00	Cash Deduct.:	$0.00	
	LESS:		Blood Deduct.:	$0.00	
			Coins.:	$0.00	
			MSP:	$0.00	
			Net Reimb.:	$0.00	
*** Report Type 831 Totals for PARROTHEAD MEDICAL CENTER ***	Gross Reimb.:	-$832.77	Cash Deduct.:	$0.00	
	LESS:		Blood Deduct.:	$0.00	
			Coins.:	-$476.29	
			MSP:	$0.00	
			Net Reimb.:	-$356.48	

Additional Information

01/01/1999 - 12/31/1999	MSP Cash Deduct.:	$0.00
	MSP Blood Deduct.:	$0.00
	MSP Coins.:	$0.00
	Claim Interest:	$0.00
	Stndrd. Ovrhd. Amt.:	-$364.96
01/01/2000 - 12/31/2000	MSP Cash Deduct.:	$0.00
	MSP Blood Deduct.:	$0.00
	MSP Coins.:	$0.00
	Claim Interest:	$0.00
	Stndrd. Ovrhd. Amt.:	-$1,082.59
01/01/2004 - 12/31/2004	MSP Cash Deduct.:	$0.00
	MSP Blood Deduct.:	$0.00
	MSP Coins.:	$0.00
	Claim Interest:	$0.00
	Stndrd. Ovrhd. Amt.:	$0.00
*** Report Type 831 Totals for PARROTHEAD MEDICAL CENTER ***	MSP Cash Deduct.:	$0.00
	MSP Blood Deduct.:	$0.00
	MSP Coins.:	$0.00
	Claim Interest:	$0.00
	Stndrd. Ovrhd. Amt.:	-$1,447.55

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Exhibit 5-30 Outpatient – 831 ASC and ASC Fee Schedule After 12/90 Payment Reconciliation (Detail) Report (First Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 11/30/99
Report Run Date: 02/19/07
Provider FYE: 09/30
Provider Number: T00028 PARROTHEAD MEDICAL CENTER

PAYMENT RECONCILIATION REPORT
ASC AND ASC FEE SCHEDULE AFTER 12/90

Page: 1
Report #: OD44202
Report Type: 831
Paid Dates: 01/01/80 to 10/01/06

Claim Information

Patnt Nm:	WOOD M	Bill Freq:	8
DCN:	20449979184608	Trans Type:	C
Ptnt Cntrl #:	097000000000	Processor ID:	14000
Med Rcrd #:	145000000000		
HIC Num:	186488514C1		
Recpt Dt:	03/29/04		
Paid Dt:	05/03/04		
Service From:	06/19/00		
Service Thru:	06/19/00		

Rev Code	HCPCS	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Line Item Reimb.	Stndrd. Ovrhd. Amt.
0250		-1	-$34.90	-$11.87	$0.00	$0.00	-$6.98	$0.00	-$4.89	$0.00
0258		-1	-$63.55	-$21.61	$0.00	$0.00	-$12.71	$0.00	-$8.90	$0.00
0272		-2	-$58.80	-$19.99	$0.00	$0.00	-$11.76	$0.00	-$8.23	$0.00
0320	76000	-1	-$313.05	-$106.44	$0.00	$0.00	-$62.61	$0.00	-$43.83	-$55.65
0370		-1	-$71.20	-$24.21	$0.00	$0.00	-$14.24	$0.00	-$9.97	$0.00
0490	62289	-1	-$686.55	-$233.43	$0.00	$0.00	-$137.31	$0.00	-$96.12	-$309.31
TOTAL:		-7	-$1,228.05	-$417.55	$0.00	$0.00	-$245.61	$0.00	-$171.94	-$364.96

Reimbursements

Gross Reimb.:	-$417.55
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	-$245.61
MSP:	$0.00
Net Reimb.:	-$171.94

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Stndrd. Ovrhd. Amt.:	-$364.96
Claim Report Splits:	831

***** Monthly Totals for PARROTHEAD MEDICAL CENTER for service month end 11/30/99 *****

	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins	MSP	Line Item Reimb.	Stndrd. Ovrhd. Amt.:
TOTAL:	-7	-$1,228.05	-$417.55	$0.00	$0.00	-$245.61	$0.00	-$171.94	-$364.96

Reimbursements

Gross Reimb.:	-$417.55
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	-$245.61
MSP:	$0.00
Net Reimb.:	-$171.94

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Stndrd. Ovrhd. Amt.:	-$364.96

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Exhibit 5-31 Outpatient – 831 ASC and ASC Fee Schedule After 12/90 Payment Reconciliation (Detail) Report (Last Page)

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 06/30/00
Report Run Date: 02/19/07
Provider FYE: 09/30
Provider Number: T00028 PARROTHEAD MEDICAL CENTER

PAYMENT RECONCILIATION REPORT
ASC AND ASC FEE SCHEDULE AFTER 12/90

Page: 2
Report #: OD44202
Report Type: 831
Paid Dates: 01/01/80 to 10/01/06

Claim Information

Patnt Nm:	COOP B	Bill Freq:	1
DCN:	20438139042805	Trans Type:	
Ptnt Cntrl #:	559000000000	Processor ID:	14000
Med Rcrd #:			
HIC Num:	147067179D		
Recpt Dt:	05/17/04		
Paid Dt:	04/30/04		
Service From:	05/08/04		
Service Thru:	05/14/04		

Rev Code	HCPCS	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins.	MSP	Line Item Reimb.	Stndrd. Ovrhd. Amt.
0250		-3	-$67.15	-$24.17	$0.00	$0.00	-$13.43	$0.00	-$10.74	$0.00
0258		-1	-$63.55	-$22.88	$0.00	$0.00	-$12.71	$0.00	-$10.17	$0.00
0271		-1	-$0.90	-$0.32	$0.00	$0.00	-$0.18	$0.00	-$0.14	$0.00
0272		-8	-$232.80	-$83.81	$0.00	$0.00	-$46.56	$0.00	-$37.25	$0.00
0272		0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0360	64475	-1	-$429.00	-$154.44	$0.00	$0.00	-$85.80	$0.00	-$68.64	-$463.97
0360	64476	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$309.31
0360	64476	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$309.31
0370		-1	-$72.00	-$25.92	$0.00	$0.00	-$14.40	$0.00	-$11.52	$0.00
0490		-1	-$288.00	-$103.68	$0.00	$0.00	-$57.60	$0.00	-$46.08	$0.00
TOTAL:		-16	-$1,153.40	-$415.22	$0.00	$0.00	-$230.68	$0.00	-$184.54	-$1,082.59

Reimbursements

Gross Reimb.:	-$415.22
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	-$230.68
MSP:	$0.00
Net Reimb.:	-$184.54

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Stndrd. Ovrhd. Amt.:	-$1,082.59
Claim Report Splits:	76P

*** Monthly Totals for PARROTHEAD MEDICAL CENTER for service month end 6/30/00 ***

	Units	Charges	Gross Reimb.	Cash Deduct.	Blood Deduct.	Coins	MSP	Line Item Reimb.	Stndrd. Ovrhd. Amt.:
TOTAL:	-16	-$1,153.40	-$415.22	$0.00	$0.00	-$230.68	$0.00	-$184.54	-$1,082.59

Reimbursements

Gross Reimb.:	-$415.22
LESS:	
Cash Deduct.:	$0.00
Blood Deduct.:	$0.00
Coins.:	-$230.68
MSP:	$0.00
Net Reimb.:	-$184.54

Additional Information

MSP Cash Deduct.:	$0.00
MSP Blood Deduct.:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Stndrd. Ovrhd. Amt.:	-$1,082.59

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6 Consolidation Reports

The PS&R System consists of consolidation reports that are based on standardized inpatient and outpatient report templates. The consolidation reports are:

- 998 Consolidation of Outpatient Claims (Excluding MSP-LCC)
- 1000 Consolidated Summary of All Report Types

This chapter provides an overview of the consolidation reports available in the PS&R System. Chapter 4, Inpatient Reports, provides a description of the inpatient reports available in the PS&R System. Chapter 5, Outpatient Reports, provides a description of the outpatient reports available in the PS&R System. See Appendix B, Report Data, for a definition of the data elements available on reports.

6.1 998 Consolidation of Outpatient Claims (Excluding MSP-LCC)

The 998 Consolidation of Outpatient Claims (Excluding MSP-LCC) report can be produced for any provider to consolidate all outpatient claims that have the potential to be presented on different report types except MSP-LCC claims. This report is generated in detail format only. No summary format is available. This report is divided into Claim Information, Reimbursements, and Additional Information sections for one reporting period up to a maximum of four reporting periods. (Note that the report always contains column headings for each of the four possible reporting periods even if the report contains fewer than four reporting periods.) The 998 Consolidation of Outpatient Claims (Excluding MSP-LCC) report claim information section contains patient information such as the patient name, DCN, Gross Reimbursement, Deductibles, Line Item Reimbursement, subtotals for the reports, and the charges for the revenue codes. The reimbursements section shows how Net Reimbursement is calculated. The additional information section shows claim interest, total gross fee schedule, deductibles, and coinsurance. The report also provides a monthly totals section that sums the information from the sections above.

An example of the 998 Consolidation of Outpatient Claims (Excluding MSP-LCC) report follows.

Exhibit 6-1 998 Consolidation of Outpatient Claims (Excluding MSP-LCC) Report

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Service Month End: 02/29/04
Report Run Date: 02/21/07
Provider FYE: 12/31
Provider Number: T00007 PETERBORO GENERAL HOSPITAL

PAYMENT RECONCILIATION REPORT
CONSOLIDATION OF OUTPATIENT CLAIMS (EXCLUDING MSP - LCC)

Page: 1
Report #: OD44202
Report Type: 998
Paid Dates: 01/01/80 to 10/01/06

Claim Information

Patnt Nm:	WILL R	Bill Freq:	1
DCN:	20438699452205	Trans Type:	
Ptnt Cntrl #:	000000000000	Processor ID:	14000
Med Rcrd #:	000791948726	Zip Code:	32701
HIC Num:	193572220A	ESRD Condition Code:	
Recpt Dt:	05/03/04		
Paid Dt:	05/17/04		
Service From:	03/31/04		
Service Thru:	03/31/04		

Rev Code	HCPCS	Units	Charges	Gross Reimb.	Deductibles	Coins.	MSP	MSP Recon.	ESRD Rdctn./ Ntwk. Pymts.	Psyc. Red.	Line Item Reimb.	APC	PS&R Report
0540	A0431	1	$6,585.00	$2,306.45	$0.00	$851.12	$0.00	$0.00	$0.00		$1,455.33	0	13Z
0540	A0436	6	$162.00	$81.90	$0.00	$25.97	$0.00	$0.00	$0.00		$55.93	0	13Z

	Units	Charges	Gross Reimb.	Deductibles	Coins.	MSP	MSP Recon.	ESRD Rdctn./ Ntwk. Pymts.	Psyc. Red.	Line Item Reimb.
Subtotal Report: 13Z	7	$6,747.00	$2,388.35	$0.00	$877.09	$0.00	$0.00	$0.00		$1,511.26
TOTAL:	7	$6,747.00	$2,388.35	$0.00	$877.09	$0.00	$0.00	$0.00		$1,511.26

Reimbursements

Gross Reimb.:	$2,388.35
Outlier	$0.00
LESS:	
Deductibles:	$0.00
Coins.:	$877.09
MSP:	$0.00
Other Adjs.:	$0.00
MSP Recon.:	$0.00
ESRD Rdctn./ Ntwk. Pymts.:	$0.00
Psyc. Red.:	-
Net Reimb.:	$1,511.26

Additional Information

MSP Deductibles:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Tot. Gross Fee Sched.:	$281.11

Patnt Nm:	COX S	Bill Freq:	1
DCN:	20488388753505	Trans Type:	
Ptnt Cntrl #:	041000000000	Processor ID:	14000
Med Rcrd #:	591000000000	Zip Code:	32822
HIC Num:	163005764A	ESRD Condition Code:	
Recpt Dt:	04/30/04		
Paid Dt:	05/14/04		
Service From:	04/23/04		
Service Thru:	04/23/04		

Rev Code	HCPCS	Units	Charges	Gross Reimb.	Deductibles	Coins.	MSP	MSP Recon.	ESRD Rdctn./ Ntwk. Pymts.	Psyc. Red.	Line Item Reimb.	APC	PS&R Report
0540	A0425	9	$63.00	$37.06	$0.00	$11.14	$0.00	$0.00	$0.00		$25.92	0	13Z
0540	A0426	1	$325.00	$155.76	$0.00	$50.39	$0.00	$0.00	$0.00		$105.37	0	13Z

	Units	Charges	Gross Reimb.	Deductibles	Coins.	MSP	MSP Recon.	ESRD Rdctn./ Ntwk. Pymts.	Psyc. Red.	Line Item Reimb.
Subtotal Report: 13Z	10	$388.00	$192.82	$0.00	$61.53	$0.00	$0.00	$0.00		$131.29
TOTAL:	10	$388.00	$192.82	$0.00	$61.53	$0.00	$0.00	$0.00		$131.29

Reimbursements

Gross Reimb.:	$192.82
Outlier	$0.00
LESS:	
Deductibles:	$0.00
Coins.:	$61.53
MSP:	$0.00
Other Adjs.:	$0.00
MSP Recon.:	$0.00
ESRD Rdctn./ Ntwk. Pymts.:	$0.00
Psyc. Red.:	-
Net Reimb.:	$131.29

Additional Information

MSP Deductibles:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Tot. Gross Fee Sched.:	$25.42

*** Monthly Totals for PETERBORO GENERAL HOSPITAL for service month end 2/29/04 ***

	Units	Charges	Gross Reimb.	Deductibles	Coins.	MSP	MSP Recon.	ESRD Rdctn./ Ntwk. Pymts.	Psyc. Red.	Line Item Reimb.
Subtotal Report: 13Z	17	$7,135.00	$2,581.17	$0.00	$938.62	$0.00	$0.00	$0.00		$1,642.55
TOTAL:	17	$7,135.00	$2,581.17	$0.00	$938.62	$0.00	$0.00	$0.00		$1,642.55

Reimbursements

Gross Reimb.:	$2,581.17
Outlier	$0.00
LESS:	
Deductibles:	$0.00
Coins.:	$938.62
MSP:	$0.00
Other Adjs.:	$0.00
MSP Recon.:	$0.00
ESRD Rdctn./ Ntwk. Pymts.:	$0.00
Psyc. Red.:	-
Net Reimb.:	$1,642.55

Additional Information

MSP Deductibles:	$0.00
MSP Coins.:	$0.00
Claim Interest:	$0.00
Tot. Gross Fee Sched.:	$306.53

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6.2 1000 Consolidated Summary of All Report Types

The Consolidated Summary of All Report Types (1000) report can be generated for any provider to consolidate a summary of all report types. The report types are grouped according to the following categories:

- Inpatient reports
- Outpatient reports (excluding MSP-LCC)
- Outpatient MSP-LCC reports
- Home Health Agency reports

Not all items reported on the Consolidated Summary of All Report Types (1000) report are included on the Medicare Cost Report.

An example of the 1000 Consolidated Summary of All Report Types report follows.

Exhibit 6-2 1000 Consolidated Summary of All Report Types Report

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 01/01/04 THRU 10/01/06
Report Run Date: 02/01/07
Provider FYE: 09/30
Provider Number: T00028 PARROTHEAD MEDICAL CENTER

PROVIDER SUMMARY REPORT
CONSOLIDATED SUMMARY OF ALL REPORT TYPES
THIS DATA IS INFORMATIONAL ONLY - NOT ALL ITEMS ARE USED FOR COST REPORTS

Page: 1
Report #: OD44203
Report Type: 1000

SERVICES APPLIED FOR THE PERIODS: 01/01/2004 - 12/31/2004

REPORT TYPE		CHARGES	GROSS REIMBURSEMENT	DEDUCTIBLES	COINSURANCE	MSP	ESRD RDCTN/NTWK PYMTS	MSP OTHER	OTHER ADJUSTMENTS	PSYCH REDUCTION	NET REIMBURSEMENT
INPATIENT REPORTS	110	$83,797.15	$23,678.99	$1,752.00	$657.00	$0.00	$0.00	$0.00	$0.00	$0.00	$21,269.99
	11A	$2,682.18	$5,058.98	$876.00	$0.00	$1,359.85	$0.00	$0.00	$2,376.80	$0.00	$446.33
TOTAL		**$86,479.33**	**$28,737.97**	**$2,628.00**	**$657.00**	**$1,359.85**	**$0.00**	**$0.00**	**$2,376.80**	**$0.00**	**$21,716.32**
OUTPATIENT REPORTS (excluding MSP-LCC)	130	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	135	$2,351.52	$638.90	$0.00	$0.00	$145.01	$0.00	$0.00	$0.00	$0.00	$493.89
	13P	$13,183.12	$2,474.59	$0.00	$829.22	$0.00	$0.00	$0.00	$0.00	$0.00	$1,645.37
TOTAL		**$15,534.64**	**$3,113.49**	**$0.00**	**$829.22**	**$145.01**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$2,139.26**
TOTAL		**$102,013.97**	**$31,851.46**	**$2,628.00**	**$1,486.22**	**$1,504.86**	**$0.00**	**$0.00**	**$2,376.80**	**$0.00**	**$23,855.58**

SERVICES APPLIED FOR THE PERIODS: 01/01/2005 - 12/31/2005

REPORT TYPE	CHARGES	GROSS REIMBURSEMENT	DEDUCTIBLES	COINSURANCE	MSP	ESRD RDCTN/NTWK PYMTS	MSP OTHER	OTHER ADJUSTMENTS	PSYCH REDUCTION	NET REIMBURSEMENT

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A Report Details

The table below contains report details for the reports that can be generated in the PS&R System.

- **Report Type**: This is the identification number assigned to the report.
- **Report Name**: This is the name/description of the report as it will appear in the report header.
- **Service Category**: This is the service type category – "Inpatient" or "Outpatient" - of the report. Users of the redesigned system have the option to request reports by Service Category.
- **Provider Type(s)**: This is the type(s) of provider applicable to the report. Users of the redesigned system have the option to request reports for providers by Provider Type.
- **Provider Number Range**: This is the range of provider numbers applicable to the report. This defines the Provider Type(s).
- **Cost Report: Yes/No**: This column indicates whether the report is needed to complete a Medicare cost report. If the report is needed to complete a cost report, "Yes" appears in the column; if the report is not needed to complete a cost report, "No" appears in the column. If a report is not needed for a cost report, the following statement appears in the report header: "These items are not to be included on the Medicare Cost Reports." Note that "Yes" appears in this column if the report is used for the Cost Report in some instances but not all instances.

Exhibit A-1 Report Details

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
11A	Inpatient - Part A (MSP-LCC)	Inpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
11K	Inpatient Rehabilitation - PPS Interim Bills	Inpatient	IRF Hospital	3025-3099 T001-T999 R300-R399	No
11R	Inpatient Rehabilitation - Part A PPS	Inpatient	IRF Hospital	3025-3099 T001-T999 R300-R399	Yes
11S	Inpatient Long Term Care - Part A PPS	Inpatient	LTCH Hospital	2000-2299	Yes
11T	Inpatient Long Term Care - Part A PPS Interim Bills	Inpatient	LTCH Hospital	2000-2299	No

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
11U	Inpatient Psych - Part A PPS	Inpatient	IPF Group	4000-4499 S001-S999 M300-M399	Yes
11V	Inpatient Psych - PPS Interim Bills	Inpatient	IPF Group	4000-4499 S001-S999 M300-M399	No
110	Inpatient - Part A	Inpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
115	Inpatient - Fee Reimbursed	Inpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	No
118	Inpatient - Part A Managed Care	Inpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
119	Inpatient - PPS Interim Bills	Inpatient	Acute Hospital	0001-0999	No
12A	Inpatient - Part B (MSP-LCC)	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	No

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
12P	Inpatient - Part B OPPS	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
12Z	Inpatient - Ambulance Blend Effective 04/01/02	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
120	Inpatient - Part B Cost Reimbursed	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
122	Inpatient - Part B Vaccine	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
125	Inpatient - Part B Fee Reimbursed	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	No
13A	Outpatient - All Other (MSP-LCC)	Outpatient	Either Hospital or ESRD	0001-0999 1200-1399 2000-2299 2300-2899 2900-2999 3025-3099 3300-3399 3500-3799 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	No
13P	Outpatient - OPPS	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
13Z	Outpatient - Ambulance Blend Effective 04/01/02	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
130	Outpatient - Cost Reimbursed	Outpatient	Either Hospital or ESRD	0001-0999 1200-1399 2000-2299 2300-2899 2900-2999 3025-3099 3300-3399 3500-3799 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
132	Outpatient - Part B Vaccine	Outpatient	Either Hospital or ESRD	0001-0999 1200-1399 2000-2299 2300-2899 2900-2999 3025-3099 3300-3399 3500-3799 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
135	Outpatient - Fee Reimbursed	Outpatient	Either Hospital or ESRD	0001-0999 1200-1399 2000-2299 2300-2899 2900-2999 3025-3099 3300-3399 3500-3799 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	No
14A	Outpatient/Other (MSP-LCC)	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	No

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
14P	Outpatient/Other - OPPS	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
140	Outpatient/Other - All Other Cost Reimbursed	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
142	Outpatient/Other - Vaccines	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
145	Outpatient/Other - Fee Reimbursed	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	No
18A	Swing Bed SNF (MSP-LCC)	Inpatient	Swing Bed SNF or CAH Hospital Group	U001-U999 W001-W999 Y001-Y999 Z300-Z399 1300-1399	Yes

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
180	Swing Bed SNF	Inpatient	Swing Bed SNF or CAH Hospital	U001-U999 W001-W999 Y001-Y999 Z300-Z399 1300-1399	Yes
21A	SNF - Inpatient - Part A (MSP-LCC)	Inpatient	SNF	5000-6499	Yes
210	SNF - Inpatient - Part A PPS	Inpatient	SNF	5000-6499	Yes
22A	SNF - Inpatient - Part B (MSP-LCC)	Outpatient	SNF	5000-6499	No
22P	SNF - Outpatient - OPPS	Outpatient	SNF	5000-6499	Yes
22Z	SNF - Ambulance Blend Effective 04/01/02	Outpatient	SNF	5000-6499	Yes
220	SNF - Inpatient - Part B Cost Reimbursed	Outpatient	SNF	5000-6499	Yes
222	SNF - Inpatient – Vaccine - Part B 100% Reasonable Cost	Outpatient	SNF	5000-6499	Yes
225	SNF - Inpatient - Fee Reimbursed	Outpatient	SNF	5000-6499	No
23A	SNF - Outpatient (MSP-LCC)	Outpatient	SNF	5000-6499	No
23P	SNF - Outpatient - OPPS	Outpatient	SNF	5000-6499	Yes
23Z	SNF - Ambulance Blend Effective 04/01/02	Outpatient	SNF	5000-6499	Yes
230	SNF - Outpatient - Cost Reimbursed	Outpatient	SNF	5000-6499	Yes
232	SNF - Outpatient - Vaccine- Part B 100% Reasonable Cost	Outpatient	SNF	5000-6499	Yes
235	SNF - Outpatient - Fee Reimbursed	Outpatient	SNF	5000-6499	No
24P	SNF - Outpatient - OPPS	Outpatient	SNF	5000-6499	Yes
32M	Home Health PPS (MSP-LCC)	Outpatient	HHA	3100-3199 7000-8499 9000-9799	Yes
322	Home Health PPS - Part B RAP	Outpatient	HHA	3100-3199 7000-8499 9000-9799	No
329	Home Health PPS - Part B Episodes	Outpatient	HHA	3100-3199 7000-8499 9000-9799	Yes
33M	Home Health PPS - Part A (MSP-LCC)	Outpatient	HHA	3100-3199 7000-8499 9000-9799	Yes

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
332	Home Health PPS - Part A RAP	Outpatient	HHA	3100-3199 7000-8499 9000-9799	No
339	Home Health PPS - Part A Episodes	Outpatient	HHA	3100-3199 7000-8499 9000-9799	Yes
34A	Home Health - Part B (MSP-LCC)	Outpatient	HHA	3100-3199 7000-8499 9000-9799	No
34P	Home Health – Outpatient - OPPS (Not HHPPS)	Outpatient	HHA	3100-3199 7000-8499 9000-9799	Yes
340	Home Health - Part B	Outpatient	HHA	3100-3199 7000-8499 9000-9799	Yes
342	Home Health – Vaccine – Part B 100% Reasonable Cost	Outpatient	HHA	3100-3199 7000-8499 9000-9799	Yes
345	Home Health - Part B - Fee Reimbursed	Outpatient	HHA	3100-3199 7000-8499 9000-9799	No
399	Home Health PPS - Part A and Part B Episodes	Outpatient	HHA	3100-3199 7000-8499 9000-9799	Yes
410	Religious Non-Medical - Inpatient - Part A	Inpatient	Religious Nonmedical Inst	1990-1999 6990-6999	Yes
71A	Clinic - Rural Health (MSP-LCC)	Outpatient	Rural Health Clinic	3400-3499 3800-3999 8500-8899 8900-8999	No
71P	Clinic - Rural Health - OPPS	Outpatient	Rural Health Clinic	3400-3499 3800-3999 8500-8899 8900-8999	Yes
710	Clinic - Rural Health	Outpatient	Rural Health Clinic	3400-3499 3800-3999 8500-8899 8900-8999	Yes
712	Clinic - Rural Health – Vaccine - Part B 100% Reasonable Cost	Outpatient	Rural Health Clinic	3400-3499 3800-3999 8500-8899 8900-8999	Yes

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
72A	Hospital Based or Independent Renal Dialysis Center (MSP-LCC)	Outpatient	ESRD/Hospital	0001-0999 2300-2899 2900-2999 3300-3399 3500-3799	No
720	Hospital Based or Independent Renal Dialysis Center (Composite Rate Services)	Outpatient	ESRD/Hospital	0001-0999 2300-2899 2900-2999 3300-3399 3500-3799	Yes
725	Hospital Based or Independent Renal Dialysis Center - Fee Reimbursed	Outpatient	ESRD/Hospital	0001-0999 2300-2899 2900-2999 3300-3399 3500-3799	No
73A	Federally Qualified Health Center (MSP-LCC)	Outpatient	FQHC	1000-1199 1800-1989	No
73P	Federally Qualified Health Center - OPPS	Outpatient	FQHC	1000-1199 1800-1989	Yes
730	Federally Qualified Health Center	Outpatient	FQHC	1000-1199 1800-1989	Yes
732	Federally Qualified Health Center - Vaccine - Part B 100% Reasonable Cost	Outpatient	FQHC	1000-1199 1800-1989	Yes
735	Federally Qualified Health Center - Fee Reimbursed	Outpatient	FQHC	1000-1199 1800-1989	No
74A	Rehabilitation Facility (MSP-LCC)	Outpatient	OPT	6500-6989	No
74P	Rehabilitation Facility - OPPS	Outpatient	OPT	6500-6989	Yes
740	Rehabilitation Facility	Outpatient	OPT	6500-6989	Yes
742	Rehabilitation Facility – Vaccine - Part B 100% Reasonable Cost	Outpatient	OPT	6500-6989	Yes
745	Rehabilitation Facility - Fee Reimbursed	Outpatient	OPT	6500-6989	No
75A	Comprehensive Outpatient Rehabilitation Facilities (MSP-LCC)	Outpatient	CORF	3200-3299 4500-4599 4800-4899	No
75P	Comprehensive Outpatient Rehabilitation Facilities - OPPS	Outpatient	CORF	3200-3299 4500-4599 4800-4899	Yes
750	Comprehensive Outpatient Rehabilitation Facilities	Outpatient	CORF	3200-3299 4500-4599 4800-4899	Yes

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
752	Comprehensive Outpatient Rehabilitation Facilities - Vaccine - Part B 100% Reasonable Cost	Outpatient	CORF	3200-3299 4500-4599 4800-4899	Yes
755	Comprehensive Outpatient Rehabilitation Facilities - Fee Reimbursed	Outpatient	CORF	3200-3299 4500-4599 4800-4899	No
76A	Community Mental Health Center (MSP-LCC)	Outpatient	CMHC	1400-1499 4600-4799 4900-4999	No
76P	Community Mental Health Center – OPPS	Outpatient	CMHC	1400-1499 4600-4799 4900-4999	Yes
760	Community Mental Health Center	Outpatient	CMHC	1400-1499 4600-4799 4900-4999	Yes
762	Community Mental Health Center - Vaccine - Part B 100% Reasonable Cost	Outpatient	CMHC	1400-1499 4600-4799 4900-4999	Yes
765	Community Mental Health Center - Fee Reimbursed	Outpatient	CMHC	1400-1499 4600-4799 4900-4999	No
81A	Hospice - Non-Hospital Based (MSP-LCC)	Outpatient	Hospice	1500-1799	Yes
81P	Hospice - Non-Hospital Based - OPPS	Outpatient	Hospice	1500-1799	Yes
810	HOSPICE - Non-Hospital Based	Outpatient	Hospice	1500-1799	Yes
82A	Hospice - Hospital Based (MSP-LCC)	Outpatient	Hospice	1500-1799	Yes
82P	Hospice - Hospital Based - OPPS	Outpatient	Hospice	1500-1799	Yes
820	Hospice - Hospital Based	Outpatient	Hospice	1500-1799	Yes
83A	ASC and ASC Fee Schedule (MSP-LCC)	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	No

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
83P	ASC and ASC Fee Schedule – OPPS	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
83Z	ASC and ASC Fee Schedule – Ambulance Blend Effective 04/01/02	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
832	ASC and ASC Fee Schedule – Vaccine – Part B 100% Reasonable Cost	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes
831	ASC and ASC Fee Schedule After 12/90	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	Yes

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
835	ASC and ASC Fee Schedule – Fee Reimbursed	Outpatient	Hospital Group	0001-0999 1200-1399 2000-2299 3025-3099 3300-3399 4000-4499 S001-S999 T000-T999 M300-M399 R300-R399	No
85A	Critical Access Hospital (MSP-LCC)	Outpatient	CAH Hospital	1300-1399	Yes
85Z	Critical Access Hospital - Ambulance Blend Effective 04/01/02	Outpatient	CAH Hospital	1300-1399	Yes
850	Critical Access Hospital	Outpatient	CAH Hospital	1300-1399	Yes
852	Critical Access Hospital - Vaccines - Part B 100% Reasonable Cost	Outpatient	CAH Hospital	1300-1399	Yes
855	Critical Access Hospital - Fee Reimbursed	Outpatient	CAH Hospital	1300-1399	Yes

Report Type	Report Name	Service Category	Provider Type(s)	Provider Number Range	Cost Report: Yes / No
998	Consolidation of Outpatient Claims (Excluding MSP-LCC)	Outpatient	Hospital Group	0001-0999 1000-1199 1200-1399 1400-1499 1500-1799 1800-1989 2000-2299 2300-2899 2900-2999 3025-3099 3100-3199 3200-3299 3300-3399 3400-3499 3500-3799 3800-3999 4000-4499 4500-4599 4600-4799 4800-4899 4900-4999 5000-6499 6500-6989 7000-8499 8500-8899 8900-8999 9000-9799 S001-S999 T000-T999 M300-M399 R300-R399	Yes
1000	Consolidated Summary of All Report Groups	Inpatient/ Outpatient	All	All	No

B Report Data

The following table contains a list of all the data elements that appear on inpatient or outpatient reports in the PS&R System. The table provides a description of each field along with the report type on which the data element is located.

Exhibit B-1 Report Data

Report Type	Data Element	Description
110	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
110	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.)
110	CLAIMS	Currently this field has no cost report usage.
110	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
110	CHARGES	The charges applicable to each revenue code.
110	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
110	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
110	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the “Medicare Days” field for cost reporting purposes.
110	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
110	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.
110	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
110	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.
110	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.
110	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.

Report Type	Data Element	Description
110	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS pricer program. For cost reporting purposes the amount must be recomputed.
110	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
110	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.
110	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.
110	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
110	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
110	OUTLIER	This field will show the outlier portion of the PPS payment for capital.
110	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
110	DSH	This is the disproportionate share portion of the PPS capital payment.
110	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
110	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
110	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.
110	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.
110	DEVICE CREDIT	This amount represents the credit that a provider received to replace a medical device that may have been defective or under warranty. This amount can be identified with a value code of “FD” on the claim.
110	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
110	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.

Report Type	Data Element	Description
110	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
110	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
110	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.
110	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
110	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.) Ensure the amounts from report 118 are also transferred to the cost report.
110	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
110	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
110	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
110	IRF PENALTY AMOUNT	The 25% penalty assessed for failure to submit IRF PAI data timely.
110	LTCH SHORT STAY OUTLIER PAYMENTS	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.
110	CAP FED-SPECIFIC @ 100%	Note: This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only.
110	CAP OUTLIER @ 100%	Note: This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period.

Report Type	Data Element	Description
110	DRG/CMG WEIGHT	This is the actual weight of the DRG/CMG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
110	WEIGHT / DISCHARGES	This is the actual weight (non-transfer adjusted) of the DRG, determined by the PPS Pricer program, divided by the discharges.
110	DISCHARGE FRACTION	For transfer cases, the billed days are divided by the average length of stay for the DRG and the result is entered in this field. The amounts in this field cannot exceed 1.0000. For non-transfer cases, the amount 1.0000 will always appear in this field.
110	DRG WEIGHT FRACTION	This is the actual weight of the DRG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
110	DRG WEIGHT FRACTION / DISCHARGES	This field reflects the DRG weight times the discharge fraction divided by the discharges. This amount can be used to calculate a transfer adjusted case mix.
11A	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
118	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
118	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.) Note: For Report Type 118 the Medicare Days are HMO days.
118	CLAIMS	Currently this field has no cost report usage.
118	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
118	CHARGES	The charges applicable to each revenue code.
118	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)

Report Type	Data Element	Description
118	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
118	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the "Medicare Days" field for cost reporting purposes.
118	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
118	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.
118	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
118	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.
118	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.
118	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS Pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.
118	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS Pricer program. For cost reporting purposes the amount must be recomputed.
118	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
118	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.
118	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.
118	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
118	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
118	OUTLIER	This field will show the outlier portion of the PPS payment for capital.

Report Type	Data Element	Description
118	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
118	DSH	This is the disproportionate share portion of the PPS capital payment.
118	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
118	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
118	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.
118	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.
118	DEVICE CREDIT	This amount represents the credit that a provider received to replace a medical device that may have been defective or under warranty. This amount can be identified with a value code of “FD” on the claim.
118	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
118	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.
118	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
118	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
118	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.
118	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
118	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
118	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.

Report Type	Data Element	Description
118	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
118	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
118	IRF PENALTY AMOUNT	The 25% penalty assessed for failure to submit IRF PAI data timely.
118	LTCH SHORT STAY OUTLIER PAYMENTS	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.
118	CAP FED-SPECIFIC @ 100%	Note: This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only.
118	CAP OUTLIER @ 100%	Note: This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period.
118	DRG/CMG WEIGHT	This is the actual weight of the DRG/CMG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
118	WEIGHT / DISCHARGES	This is the actual weight (non-transfer adjusted) of the DRG, determined by the PPS Pricer program, divided by the discharges.
118	DISCHARGE FRACTION	For transfer cases, the billed days are divided by the average length of stay for the DRG and the result is entered in this field. The amounts in this field cannot exceed 1.0000. For non-transfer cases, the amount 1.0000 will always appear in this field.
118	DRG WEIGHT FRACTION	This is the actual weight of the DRG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
118	DRG WEIGHT FRACTION / DISCHARGES	This field reflects the DRG weight times the discharge fraction divided by the discharges. This amount can be used to calculate a transfer adjusted case mix.

Report Type	Data Element	Description
119	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
119	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.)
119	CLAIMS	Currently this field has no cost report usage.
119	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
119	CHARGES	The charges applicable to each revenue code.
119	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
119	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
119	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the “Medicare Days” field for cost reporting purposes.
119	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
119	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.
119	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
119	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.
119	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.
119	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS Pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.
119	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS Pricer program. For cost reporting purposes the amount must be recomputed.
119	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
119	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.

Report Type	Data Element	Description
119	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.
119	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
119	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
119	OUTLIER	This field will show the outlier portion of the PPS payment for capital.
119	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
119	DSH	This is the disproportionate share portion of the PPS capital payment.
119	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
119	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
119	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.
119	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.
119	DEVICE CREDIT	This amount represents the credit that a provider received to replace a medical device that may have been defective or under warranty. This amount can be identified with a value code of “FD” on the claim.
119	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
119	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.
119	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
119	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.

Report Type	Data Element	Description
119	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.
119	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
119	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
119	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
119	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
119	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
119	IRF PENALTY AMOUNT	The 25% penalty assessed for failure to submit IRF PAI data timely.
119	LTCH SHORT STAY OUTLIER PAYMENTS	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.
119	CAP FED-SPECIFIC @ 100%	Note: This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only.
119	CAP OUTLIER @ 100%	Note: This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period.
119	DRG/CMG WEIGHT	This is the actual weight of the DRG/CMG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.

Report Type	Data Element	Description
119	WEIGHT / DISCHARGES	This is the actual weight (non-transfer adjusted) of the DRG, determined by the PPS Pricer program, divided by the discharges.
119	DISCHARGE FRACTION	For transfer cases, the billed days are divided by the average length of stay for the DRG and the result is entered in this field. The amounts in this field cannot exceed 1.0000. For non-transfer cases, the amount 1.0000 will always appear in this field.
119	DRG WEIGHT FRACTION	This is the actual weight of the DRG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
119	DRG WEIGHT FRACTION / DISCHARGES	This field reflects the DRG weight times the discharge fraction divided by the discharges. This amount can be used to calculate a transfer adjusted case mix.
11K	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
11K	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.)
11K	CLAIMS	Currently this field has no cost report usage.
11K	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
11K	CHARGES	The charges applicable to each revenue code.
11K	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
11K	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
11K	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the "Medicare Days" field for cost reporting purposes.
11K	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
11K	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.
11K	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
11K	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.

Report Type	Data Element	Description
11K	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.
11K	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS Pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.
11K	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS Pricer program. For cost reporting purposes the amount must be recomputed.
11K	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
11K	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.
11K	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.
11K	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
11K	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
11K	OUTLIER	This field will show the outlier portion of the PPS payment for capital.
11K	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
11K	DSH	This is the disproportionate share portion of the PPS capital payment.
11K	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
11K	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
11K	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.
11K	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.

Report Type	Data Element	Description
11K	DEVICE CREDIT	This amount represents the credit that a provider received to replace a medical device that may have been defective or under warranty. This amount can be identified with a value code of “FD” on the claim.
11K	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
11K	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.
11K	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
11K	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
11K	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.
11K	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
11K	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
11K	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
11K	ACTUAL CLAIM PAYMENTS FOR PIP	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
11K	CLAIM INTEREST PAYMENTS	The 25% penalty assessed for failure to submit IRF PAI data timely.
11K	IRF PENALTY AMOUNT	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.

Report Type	Data Element	Description
11K	LTCH SHORT STAY OUTLIER PAYMENTS	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
11K	CAP FED-SPECIFIC @ 100%	This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only. Note: This field is populated for IPPS Hospitals only.
11K	CAP OUTLIER @ 100%	This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. Note: This field is populated for IPPS Hospitals only.
11K	DRG/CMG WEIGHT	This is the actual weight of the DRG/CMG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
11K	WEIGHT / DISCHARGES	This is the actual weight (non-transfer adjusted) of the DRG, determined by the PPS Pricer program, divided by the discharges.
11K	DISCHARGE FRACTION	For transfer cases, the billed days are divided by the average length of stay for the DRG and the result is entered in this field. The amounts in this field cannot exceed 1.0000. For non-transfer cases, the amount 1.0000 will always appear in this field.
11K	DRG WEIGHT FRACTION	This is the actual weight of the DRG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
11K	DRG WEIGHT FRACTION / DISCHARGES	This field reflects the DRG weight times the discharge fraction divided by the discharges. This amount can be used to calculate a transfer adjusted case mix.
11R	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
11R	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.)
11R	CLAIMS	Currently this field has no cost report usage.

Report Type	Data Element	Description
11R	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
11R	CHARGES	The charges applicable to each revenue code.
11R	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
11R	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
11R	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the "Medicare Days" field for cost reporting purposes.
11R	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
11R	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.
11R	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
11R	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.
11R	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.
11R	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS Pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.
11R	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS Pricer program. For cost reporting purposes the amount must be recomputed.
11R	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
11R	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.
11R	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.

Report Type	Data Element	Description
11R	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
11R	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
11R	OUTLIER	This field will show the outlier portion of the PPS payment for capital.
11R	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
11R	DSH	This is the disproportionate share portion of the PPS capital payment.
11R	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
11R	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
11R	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.
11R	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.
11R	DEVICE CREDIT	This amount represents the credit that a provider received to replace a medical device that may have been defective or under warranty. This amount can be identified with a value code of “FD” on the claim.
11R	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
11R	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.
11R	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
11R	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
11R	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.

Report Type	Data Element	Description
11R	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
11R	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
11R	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
11R	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
11R	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
11R	IRF PENALTY AMOUNT	The 25% penalty assessed for failure to submit IRF PAI data timely.
11R	LTCH SHORT STAY OUTLIER PAYMENTS	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.
11R	CAP FED-SPECIFIC @ 100%	Note: This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only.
11R	CAP OUTLIER @ 100%	Note: This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period.
11R	DRG/CMG WEIGHT	This is the actual weight of the DRG/CMG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
11R	WEIGHT / DISCHARGES	This is the actual weight (non-transfer adjusted) of the DRG, determined by the PPS Pricer program, divided by the discharges.
11R	DISCHARGE FRACTION	For transfer cases, the billed days are divided by the average length of stay for the DRG and the result is entered in this field. The amounts in this field cannot exceed 1.0000. For non-transfer cases, the amount 1.0000 will always appear in this field.

Report Type	Data Element	Description
11R	DRG WEIGHT FRACTION	This is the actual weight of the DRG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
11R	DRG WEIGHT FRACTION / DISCHARGES	This field reflects the DRG weight times the discharge fraction divided by the discharges. This amount can be used to calculate a transfer adjusted case mix.
11S	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
11S	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.)
11S	CLAIMS	Currently this field has no cost report usage.
11S	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
11S	CHARGES	The charges applicable to each revenue code.
11S	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
11S	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
11S	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the "Medicare Days" field for cost reporting purposes.
11S	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
11S	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.
11S	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
11S	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.
11S	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.
11S	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS Pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.

Report Type	Data Element	Description
11S	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS Pricer program. For cost reporting purposes the amount must be recomputed.
11S	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
11S	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.
11S	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.
11S	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
11S	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
11S	OUTLIER	This field will show the outlier portion of the PPS payment for capital.
11S	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
11S	DSH	This is the disproportionate share portion of the PPS capital payment.
11S	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
11S	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
11S	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.
11S	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.
11S	DEVICE CREDIT	This amount represents the credit that a provider received to replace a medical device that may have been defective or under warranty. This amount can be identified with a value code of “FD” on the claim.
11S	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
11S	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.

Report Type	Data Element	Description
11S	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
11S	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
11S	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.
11S	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
11S	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
11S	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
11S	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
11S	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
11S	IRF PENALTY AMOUNT	The 25% penalty assessed for failure to submit IRF PAI data timely.
11S	LTCH SHORT STAY OUTLIER PAYMENTS	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.
11S	CAP FED-SPECIFIC @ 100%	Note: This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only.
11S	CAP OUTLIER @ 100%	Note: This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period.

Report Type	Data Element	Description
11S	DRG/CMG WEIGHT	This is the actual weight of the DRG/CMG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
11S	WEIGHT / DISCHARGES	This is the actual weight (non-transfer adjusted) of the DRG, determined by the PPS Pricer program, divided by the discharges.
11S	DISCHARGE FRACTION	This field does not apply and will be zero.
11S	DRG WEIGHT FRACTION	This field does not apply and will be zero.
11S	DRG WEIGHT FRACTION / DISCHARGES	This field does not apply and will be zero.
11T	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
11T	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.)
11T	CLAIMS	Currently this field has no cost report usage.
11T	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
11T	CHARGES	The charges applicable to each revenue code.
11T	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
11T	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
11T	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the "Medicare Days" field for cost reporting purposes.
11T	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
11T	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.
11T	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
11T	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.
11T	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.

Report Type	Data Element	Description
11T	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS Pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.
11T	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS Pricer program. For cost reporting purposes the amount must be recomputed.
11T	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
11T	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.
11T	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.
11T	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
11T	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
11T	OUTLIER	This field will show the outlier portion of the PPS payment for capital.
11T	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
11T	DSH	This is the disproportionate share portion of the PPS capital payment.
11T	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
11T	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
11T	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.
11T	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.
11T	DEVICE CREDIT	This amount represents the credit that a provider received to replace a medical device that may have been defective or under warranty. This amount can be identified with a value code of “FD” on the claim.

Report Type	Data Element	Description
11T	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
11T	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.
11T	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
11T	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
11T	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.
11T	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
11T	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
11T	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
11T	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
11T	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
11T	IRF PENALTY AMOUNT	The 25% penalty assessed for failure to submit IRF PAI data timely.
11T	LTCH SHORT STAY OUTLIER PAYMENTS	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.

Report Type	Data Element	Description
11T	CAP FED-SPECIFIC @ 100%	Note: This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only.
11T	CAP OUTLIER @ 100%	Note: This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period.
11T	DRG/CMG WEIGHT	This is the actual weight of the DRG/CMG determined by the PPS Pricer program. The aggregate amount in this field, for a provider's fiscal year, may be used to calculate a case mix index (CMI) for PPS operating payments made to a specific provider.
11T	WEIGHT / DISCHARGES	This is the actual weight (non-transfer adjusted) of the DRG, determined by the PPS Pricer program, divided by the discharges.
11T	DISCHARGE FRACTION	This field does not apply and will be zero.
11T	DRG WEIGHT FRACTION	This field does not apply and will be zero.
11T	DRG WEIGHT FRACTION / DISCHARGES	This field does not apply and will be zero.
410	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
410	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.)
410	CLAIMS	Currently this field has no cost report usage.
410	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
410	CHARGES	The charges applicable to each revenue code.
410	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
410	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
410	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the "Medicare Days" field for cost reporting purposes.
410	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
410	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.

Report Type	Data Element	Description
410	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
410	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.
410	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.
410	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS Pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.
410	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS Pricer program. For cost reporting purposes the amount must be recomputed.
410	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
410	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.
410	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.
410	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
410	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
410	OUTLIER	This field will show the outlier portion of the PPS payment for capital.
410	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
410	DSH	This is the disproportionate share portion of the PPS capital payment.
410	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
410	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
410	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.

Report Type	Data Element	Description
410	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.
410	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
410	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.
410	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
410	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
410	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.
410	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
410	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
410	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
410	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
410	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
410	IRF PENALTY AMOUNT	The 25% penalty assessed for failure to submit IRF PAI data timely.
410	LTCH SHORT STAY OUTLIER PAYMENTS	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.

Report Type	Data Element	Description
410	CAP FED-SPECIFIC @ 100%	Note: This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only.
410	CAP OUTLIER @ 100%	Note: This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period.
410	DRG/CMG WEIGHT	This field does not apply and will be zero.
410	WEIGHT / DISCHARGES	This field does not apply and will be zero.
410	DISCHARGE FRACTION	This field does not apply and will be zero.
410	DRG WEIGHT FRACTION	This field does not apply and will be zero.
410	DRG WEIGHT FRACTION / DISCHARGES	This field does not apply and will be zero.
11U	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
11U	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.)
11U	CLAIMS	Currently this field has no cost report usage.
11U	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
11U	CHARGES	The charges applicable to each revenue code.
11U	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
11U	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
11U	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the “Medicare Days” field for cost reporting purposes.
11U	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
11U	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.
11U	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
11U	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.
11U	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.

Report Type	Data Element	Description
11U	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS Pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.
11U	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS Pricer program. For cost reporting purposes the amount must be recomputed.
11U	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
11U	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.
11U	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.
11U	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
11U	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
11U	OUTLIER	This field will show the outlier portion of the PPS payment for capital.
11U	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
11U	DSH	This is the disproportionate share portion of the PPS capital payment.
11U	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
11U	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
11U	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.
11U	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.
11U	DEVICE CREDIT	This amount represents the credit that a provider received to replace a medical device that may have been defective or under warranty. This amount can be identified with a value code of “FD” on the claim.

Report Type	Data Element	Description
11U	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
11U	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.
11U	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
11U	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
11U	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.
11U	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
11U	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
11U	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
11U	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
11U	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
11U	IRF PENALTY AMOUNT	The 25% penalty assessed for failure to submit IRF PAI data timely.
11U	LTCH SHORT STAY OUTLIER PAYMENTS	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.

Report Type	Data Element	Description
11U	CAP FED-SPECIFIC @ 100%	Note: This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only.
11U	CAP OUTLIER @ 100%	Note: This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period.
11U	DRG/CMG WEIGHT	This field does not apply and will be zero.
11U	WEIGHT / DISCHARGES	This field does not apply and will be zero.
11U	DISCHARGE FRACTION	This field does not apply and will be zero.
11U	DRG WEIGHT FRACTION	This field does not apply and will be zero.
11U	DRG WEIGHT FRACTION / DISCHARGES	This field does not apply and will be zero.
11V	DISCHARGES	This field is only valid for inpatient claims. This indicates the number of patients discharged.
11V	MEDICARE DAYS	The provider's hospital routine (adults and peds) days. (Note: The provider's crosswalk may be used to allocate days for cost reporting purposes.)
11V	CLAIMS	Currently this field has no cost report usage.
11V	UNITS	The number of units applicable to each revenue code. Note: for accommodations revenue codes this may include non-covered days.
11V	CHARGES	The charges applicable to each revenue code.
11V	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
11V	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
11V	TOTAL ACCOMODATIONS	This category may include provider liable days that are non-covered days. This category may be used to prorate the “Medicare Days” field for cost reporting purposes.
11V	TOTAL ANCILLARY	All Medicare covered charges associated with revenue codes designated as ancillary.
11V	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as routine and ancillary.
11V	HOSPITAL SPECIFIC	This line plus any federal specific amounts are the total DRG amounts other than outlier.
11V	FEDERAL SPECIFIC	This line plus any hospital specific amounts are the total DRG amounts other than outlier.
11V	OUTLIER	Summarizes cost outlier payments (Value code 17) made under the Prospective Payment System.

Report Type	Data Element	Description
11V	DSH/LIP	The DSH/LIP amount (value code 18) shown on the PS&R report represents interim payments calculated by the PPS Pricer program. For cost reporting purposes the DSH/LIP amount must be recomputed for qualifying hospitals.
11V	IME/ TEACHING ADJ.	Indirect medical education/Teaching adjustment (Value Code 19) amount shown on the PS&R are estimated payments made on a bill-by-bill basis by the PPS Pricer program. For cost reporting purposes the amount must be recomputed.
11V	NEW TECHNOLOGY	Summarizes new technology payments (Value code 77) made under the Prospective Payment System.
11V	IPF ECT	Summarizes IPF ECT (Inpatient Psych Facility Electro Convulsive Therapy) payments made under the Prospective Payment System.
11V	TOTAL OPERATING PAYMENTS	This is the sum of the operating amounts for HSP, FSP, outlier, DSH/LIP, IME/teaching adjustment, new technology, IPF ECT and exception payments.
11V	HOSPITAL SPECIFIC	This is the hospital-specific portion of the PPS payment for capital. The field will be zero for providers paid based on the hold-harmless old capital or the hold-harmless 100 percent federal method and for new hospitals during their first two years of operation.
11V	FEDERAL SPECIFIC	This field includes the federal portion of the PPS payment for capital. This field will also include the new capital amount for hospitals paid under the hold-harmless old capital method.
11V	OUTLIER	This field will show the outlier portion of the PPS payment for capital.
11V	HOLD HARMLESS	This field shows the hold harmless amount paid for old capital based on the hold-harmless old capital method.
11V	DSH	This is the disproportionate share portion of the PPS capital payment.
11V	INDIRECT MEDICAL EDUCATION	This is the indirect medical education adjustment payment to PPS teaching hospitals applicable to PPS capital payments.
11V	EXCEPTIONS	This is the per discharge exception interim payment for capital-related costs that qualifying hospitals are entitled to receive in accordance with Medicare payment policy.
11V	TOTAL CAPITAL PAYMENTS	This is the sum of the capital amounts for HSP, FSP, outlier, hold harmless, disproportionate share adjustment, indirect medical education, and exception payments.
11V	GROSS REIMBURSEMENT	This amount is the sum of total operating and total capital payments.
11V	DEVICE CREDIT	This amount represents the credit that a provider received to replace a medical device that may have been defective or under warranty. This amount can be identified with a value code of “FD” on the claim.

Report Type	Data Element	Description
11V	CASH DEDUCTIBLE	The sum of actual cash deductible amount from the paid claim records.
11V	BLOOD DEDUCTIBLE	The sum of actual blood deductible amount from the paid claim records.
11V	COINSURANCE	The sum of actual coinsurance amount from the paid claim records.
11V	NET MSP PAYMENTS	The sum of net payments made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
11V	MSP PASS THRU RECONCILIATION	This field is informational only and should not be included in the cost report. This amount occurs in cases where Medicare has made no payment on the claim yet classifies it as PR (Partial Recovery) because of the estimated pass through payments. The actual pass through amounts will be determined in the cost report. The MSP Pass Thru Reconciliation amount must be ignored for cost reporting.
11V	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
11V	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
11V	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
11V	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, such as operating Outlier and ECT (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 11A, 18A, 21A, 118, and all other inpatient reports are transferred to the cost report.
11V	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
11V	IRF PENALTY AMOUNT	The 25% penalty assessed for failure to submit IRF PAI data timely.
11V	LTCH SHORT STAY OUTLIER PAYMENTS	The per diem payments made under PPS to the provider for a patient's stay in the facility prior to being transferred to another facility. These payments are included in the net reimbursement field. This field is shown for informational purposes only.

Report Type	Data Element	Description
11V	CAP FED-SPECIFIC @ 100%	Note: This field equals the federal specific field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period. This field should be used by hold-harmless providers only.
11V	CAP OUTLIER @ 100%	Note: This field equals the outlier field for providers that were paid based on the hold-harmless 100 percent federal method (method B) for the entire reporting period.
11V	DRG/CMG WEIGHT	This field does not apply and will be zero.
11V	WEIGHT / DISCHARGES	This field does not apply and will be zero.
11V	DISCHARGE FRACTION	This field does not apply and will be zero.
11V	DRG WEIGHT FRACTION	This field does not apply and will be zero.
11V	DRG WEIGHT FRACTION / DISCHARGES	This field does not apply and will be zero.
115	CLAIMS	Currently this field has no cost report usage.
115	UNITS	The number of units applicable to each revenue code.
115	CHARGES	The charges applicable to each revenue code.
115	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
115	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
115	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
115	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
115	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
115	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
115	COINSURANCE	The actual coinsurance amount from the paid claim record.
115	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
115	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
115	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.

Report Type	Data Element	Description
210	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
210	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
210	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
210	COINSURANCE	The actual coinsurance amount from the paid claim record.
210	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
210	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
210	CALCULATED NET REIMB FOR PIP CLAIMS	For intermediary use. Indicates that provider received PIP payments. May be used to identify duplicate payments.
210	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 18A and 21A are transferred to the cost report.
210	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
21A	ACTUAL CLAIM PAYMENTS FOR PIP	This field reflects the actual payments made on a claim basis on PIP claims, (the MSP LCC net reimbursement is not paid on a PIP claim so is reflected in this field as a negative amount). Transfer all amounts in this field directly to the cost report worksheet E-1 in addition to the PIP payments. Ensure the amounts from reports 18A and 21A are transferred to the cost report.
180	RUC	This field reflects the units paid per RUG category.
180	RUB	This field reflects the units paid per RUG category.
180	RUA	This field reflects the units paid per RUG category.
180	RUX	This field reflects the units paid per RUG category.
180	RUL	This field reflects the units paid per RUG category.
180	RVC	This field reflects the units paid per RUG category.
180	RVB	This field reflects the units paid per RUG category.
180	RVA	This field reflects the units paid per RUG category.
180	RVX	This field reflects the units paid per RUG category.
180	RVL	This field reflects the units paid per RUG category.

Report Type	Data Element	Description
180	RHC	This field reflects the units paid per RUG category.
180	RHB	This field reflects the units paid per RUG category.
180	RHA	This field reflects the units paid per RUG category.
180	RHX	This field reflects the units paid per RUG category.
180	RHL	This field reflects the units paid per RUG category.
180	RMC	This field reflects the units paid per RUG category.
180	RMB	This field reflects the units paid per RUG category.
180	RMA	This field reflects the units paid per RUG category.
180	RMX	This field reflects the units paid per RUG category.
180	RML	This field reflects the units paid per RUG category.
180	RLB	This field reflects the units paid per RUG category.
180	RLA	This field reflects the units paid per RUG category.
180	RLX	This field reflects the units paid per RUG category.
180	SE3	This field reflects the units paid per RUG category.
180	SE2	This field reflects the units paid per RUG category.
180	SE1	This field reflects the units paid per RUG category.
180	SSC	This field reflects the units paid per RUG category.
180	SSB	This field reflects the units paid per RUG category.
180	SSA	This field reflects the units paid per RUG category.
180	CC2	This field reflects the units paid per RUG category.
180	CC1	This field reflects the units paid per RUG category.
180	CB2	This field reflects the units paid per RUG category.
180	CB1	This field reflects the units paid per RUG category.
180	CA2	This field reflects the units paid per RUG category.
180	CA1	This field reflects the units paid per RUG category.
180	IB2	This field reflects the units paid per RUG category.
180	IB1	This field reflects the units paid per RUG category.
180	IA2	This field reflects the units paid per RUG category.
180	IA1	This field reflects the units paid per RUG category.
180	BB2	This field reflects the units paid per RUG category.
180	BB1	This field reflects the units paid per RUG category.
180	BA2	This field reflects the units paid per RUG category.
180	BA1	This field reflects the units paid per RUG category.
180	PE2	This field reflects the units paid per RUG category.
180	PE1	This field reflects the units paid per RUG category.
180	PD2	This field reflects the units paid per RUG category.

Report Type	Data Element	Description
180	PD1	This field reflects the units paid per RUG category.
180	PC2	This field reflects the units paid per RUG category.
180	PC1	This field reflects the units paid per RUG category.
180	PB2	This field reflects the units paid per RUG category.
180	PB1	This field reflects the units paid per RUG category.
180	PA2	This field reflects the units paid per RUG category.
180	PA1	This field reflects the units paid per RUG category.
180	AAA	This field reflects the units paid per RUG category.
12A	CLAIMS	Currently this field has no cost report usage.
12A	UNITS	The number of units applicable to each revenue code.
12A	CHARGES	The charges applicable to each revenue code.
12A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
12A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
12A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
12A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
12A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
12A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
12A	COINSURANCE	The actual coinsurance amount from the paid claim record.
12A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
12A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
12A	CLAIM INTEREST PAYMENTS	Sum of interest paid on claims due to untimely claims processing. Currently this field has no cost report usage.
13A	CLAIMS	Currently this field has no cost report usage.
13A	UNITS	The number of units applicable to each revenue code.
13A	CHARGES	The charges applicable to each revenue code.

Report Type	Data Element	Description
13A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
13A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
13A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
13A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
13A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
13A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
13A	COINSURANCE	The actual coinsurance amount from the paid claim record.
13A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
13A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
13A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
14A	CLAIMS	Currently this field has no cost report usage.
14A	UNITS	The number of units applicable to each revenue code.
14A	CHARGES	The charges applicable to each revenue code.
14A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
14A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
14A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
14A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
14A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
14A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.

Report Type	Data Element	Description
14A	COINSURANCE	The actual coinsurance amount from the paid claim record.
14A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
14A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
14A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
22A	CLAIMS	Currently this field has no cost report usage.
22A	UNITS	The number of units applicable to each revenue code.
22A	CHARGES	The charges applicable to each revenue code.
22A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
22A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
22A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
22A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
22A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
22A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
22A	COINSURANCE	The actual coinsurance amount from the paid claim record.
22A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
22A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
22A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
23A	CLAIMS	Currently this field has no cost report usage.
23A	UNITS	The number of units applicable to each revenue code.

Report Type	Data Element	Description
23A	CHARGES	The charges applicable to each revenue code.
23A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
23A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
23A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
23A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
23A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
23A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
23A	COINSURANCE	The actual coinsurance amount from the paid claim record.
23A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
23A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
23A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
34A	CLAIMS	Currently this field has no cost report usage.
34A	UNITS	The number of units applicable to each revenue code.
34A	CHARGES	The charges applicable to each revenue code.
34A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
34A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
34A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
34A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
34A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.

Report Type	Data Element	Description
34A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
34A	COINSURANCE	The actual coinsurance amount from the paid claim record.
34A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
34A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
34A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
71A	CLAIMS	Currently this field has no cost report usage.
71A	UNITS	The number of units applicable to each revenue code.
71A	CHARGES	The charges applicable to each revenue code.
71A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
71A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
71A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
71A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
71A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
71A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
71A	COINSURANCE	The actual coinsurance amount from the paid claim record.
71A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
71A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
71A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.

Report Type	Data Element	Description
73A	CLAIMS	Currently this field has no cost report usage.
73A	UNITS	The number of units applicable to each revenue code.
73A	CHARGES	The charges applicable to each revenue code.
73A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
73A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
73A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
73A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
73A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
73A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
73A	COINSURANCE	The actual coinsurance amount from the paid claim record.
73A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
73A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
73A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
74A	CLAIMS	Currently this field has no cost report usage.
74A	UNITS	The number of units applicable to each revenue code.
74A	CHARGES	The charges applicable to each revenue code.
74A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
74A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
74A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
74A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.

Report Type	Data Element	Description
74A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
74A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
74A	COINSURANCE	The actual coinsurance amount from the paid claim record.
74A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
74A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
74A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
75A	CLAIMS	Currently this field has no cost report usage.
75A	UNITS	The number of units applicable to each revenue code.
75A	CHARGES	The charges applicable to each revenue code.
75A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
75A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
75A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
75A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
75A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
75A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
75A	COINSURANCE	The actual coinsurance amount from the paid claim record.
75A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
75A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)

Report Type	Data Element	Description
75A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
76A	CLAIMS	Currently this field has no cost report usage.
76A	UNITS	The number of units applicable to each revenue code.
76A	CHARGES	The charges applicable to each revenue code.
76A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
76A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
76A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
76A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
76A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
76A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
76A	COINSURANCE	The actual coinsurance amount from the paid claim record.
76A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
76A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
76A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
83A	CLAIMS	Currently this field has no cost report usage.
83A	UNITS	The number of units applicable to each revenue code.
83A	CHARGES	The charges applicable to each revenue code.
83A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
83A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)

Report Type	Data Element	Description
83A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
83A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
83A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
83A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
83A	COINSURANCE	The actual coinsurance amount from the paid claim record.
83A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
83A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
83A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
85A	CLAIMS	Currently this field has no cost report usage.
85A	UNITS	The number of units applicable to each revenue code.
85A	CHARGES	The charges applicable to each revenue code.
85A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
85A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
85A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
85A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
85A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
85A	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
85A	COINSURANCE	The actual coinsurance amount from the paid claim record.
85A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.

Report Type	Data Element	Description
85A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
85A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
12P	CLAIMS	Currently this field has no cost report usage.
12P	UNITS	The number of units applicable to each revenue code.
12P	CHARGES	The charges applicable to each revenue code.
12P	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
12P	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
12P	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
12P	GROSS APC PAYMENT	The gross APC amount paid to the provider on a claim-by-claim basis as determined by the OPPS Pricer.
12P	OUTLIER	The outlier portion of the OPPS payment for the APC.
12P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
12P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
12P	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
12P	COINSURANCE	The actual coinsurance amount from the paid claim record.
12P	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
12P	MSP RECONCILIATION	This field is the accumulation of the difference between the Medicare allowable amount and the actual Medicare reimbursement. This occurs in situations where there is OTAF or MSP-LCC.
12P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
12P	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)

Report Type	Data Element	Description
12P	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
12P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
13P	CLAIMS	Currently this field has no cost report usage.
13P	UNITS	The number of units applicable to each revenue code.
13P	CHARGES	The charges applicable to each revenue code.
13P	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
13P	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
13P	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
13P	GROSS APC PAYMENT	The gross APC amount paid to the provider on a claim-by-claim basis as determined by the OPPS Pricer.
13P	OUTLIER	The outlier portion of the OPPS payment for the APC.
13P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
13P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
13P	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
13P	COINSURANCE	The actual coinsurance amount from the paid claim record.
13P	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
13P	MSP RECONCILIATION	This field is the accumulation of the difference between the Medicare allowable amount and the actual Medicare reimbursement. This occurs in situations where there is OTAF or MSP-LCC.
13P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
13P	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)

Report Type	Data Element	Description
13P	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
13P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
14P	CLAIMS	Currently this field has no cost report usage.
14P	UNITS	The number of units applicable to each revenue code.
14P	CHARGES	The charges applicable to each revenue code.
14P	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
14P	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
14P	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
14P	GROSS APC PAYMENT	The gross APC amount paid to the provider on a claim-by-claim basis as determined by the OPPS Pricer.
14P	OUTLIER	The outlier portion of the OPPS payment for the APC.
14P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
14P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
14P	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
14P	COINSURANCE	The actual coinsurance amount from the paid claim record.
14P	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
14P	MSP RECONCILIATION	This field is the accumulation of the difference between the Medicare allowable amount and the actual Medicare reimbursement. This occurs in situations where there is OTAF or MSP-LCC.
14P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
14P	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)

Report Type	Data Element	Description
14P	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
14P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
22P	CLAIMS	Currently this field has no cost report usage.
22P	UNITS	The number of units applicable to each revenue code.
22P	CHARGES	The charges applicable to each revenue code.
22P	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
22P	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
22P	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
22P	GROSS APC PAYMENT	The gross APC amount paid to the provider on a claim-by-claim basis as determined by the OPPS Pricer.
22P	OUTLIER	The outlier portion of the OPPS payment for the APC.
22P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
22P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
22P	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
22P	COINSURANCE	The actual coinsurance amount from the paid claim record.
22P	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
22P	MSP RECONCILIATION	This field is the accumulation of the difference between the Medicare allowable amount and the actual Medicare reimbursement. This occurs in situations where there is OTAF or MSP-LCC.
22P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
22P	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)

Report Type	Data Element	Description
22P	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
22P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
23P	CLAIMS	Currently this field has no cost report usage.
23P	UNITS	The number of units applicable to each revenue code.
23P	CHARGES	The charges applicable to each revenue code.
23P	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
23P	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
23P	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
23P	GROSS APC PAYMENT	The gross APC amount paid to the provider on a claim-by-claim basis as determined by the OPPS Pricer.
23P	OUTLIER	The outlier portion of the OPPS payment for the APC.
23P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
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71P	CLAIMS	Currently this field has no cost report usage.
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83P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
12Z	CLAIMS	Currently this field has no cost report usage.
12Z	UNITS	The number of units applicable to each revenue code.
12Z	CHARGES	The charges applicable to each revenue code.
12Z	GROSS FEE AMT	This is an accumulation of 100% fee reimbursed ambulance services. Sorted by trips and mileage.
12Z	TOTAL AMBULANCE TRIPS	Accumulated number of trips from paid claims.
12Z	TOTAL AMBULANCE MILES	Accumulated number of miles from paid claims.
12Z	TOTAL GROSS FEE SCHEDULE AMT	This is an accumulation of 100% fee reimbursed ambulance services.
12Z	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4or a complete listing of revenue codes.)
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13Z	TOTAL AMBULANCE TRIPS	Accumulated number of trips from paid claims.
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22Z	CHARGES	The charges applicable to each revenue code.
22Z	GROSS FEE AMT	This is an accumulation of 100% fee reimbursed ambulance services. Sorted by trips and mileage.
22Z	TOTAL AMBULANCE TRIPS	Accumulated number of trips from paid claims.
22Z	TOTAL AMBULANCE MILES	Accumulated number of miles from paid claims.

Report Type	Data Element	Description
22Z	TOTAL GROSS FEE SCHEDULE AMT	This is an accumulation of 100% fee reimbursed ambulance services.
22Z	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
22Z	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
22Z	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
22Z	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
22Z	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
22Z	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
22Z	COINSURANCE	The actual coinsurance amount from the paid claim record.
22Z	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
22Z	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
22Z	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
23Z	CLAIMS	Currently this field has no cost report usage.
23Z	UNITS	The number of units applicable to each revenue code.
23Z	CHARGES	The charges applicable to each revenue code.
23Z	GROSS FEE AMT	This is an accumulation of 100% fee reimbursed ambulance services. Sorted by trips and mileage.
23Z	TOTAL AMBULANCE TRIPS	Accumulated number of trips from paid claims.
23Z	TOTAL AMBULANCE MILES	Accumulated number of miles from paid claims.
23Z	TOTAL GROSS FEE SCHEDULE AMT	This is an accumulation of 100% fee reimbursed ambulance services.
23Z	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)

Report Type	Data Element	Description
23Z	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
23Z	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
23Z	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
23Z	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
23Z	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
23Z	COINSURANCE	The actual coinsurance amount from the paid claim record.
23Z	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
23Z	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
23Z	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
83Z	CLAIMS	Currently this field has no cost report usage.
83Z	UNITS	The number of units applicable to each revenue code.
83Z	CHARGES	The charges applicable to each revenue code.
83Z	GROSS FEE AMT	This is an accumulation of 100% fee reimbursed ambulance services. Sorted by trips and mileage.
83Z	TOTAL AMBULANCE TRIPS	Accumulated number of trips from paid claims.
83Z	TOTAL AMBULANCE MILES	Accumulated number of miles from paid claims.
83Z	TOTAL GROSS FEE SCHEDULE AMT	This is an accumulation of 100% fee reimbursed ambulance services.
83Z	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
83Z	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
83Z	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
83Z	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.

Report Type	Data Element	Description
83Z	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
83Z	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
83Z	COINSURANCE	The actual coinsurance amount from the paid claim record.
83Z	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
83Z	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
83Z	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
85Z	CLAIMS	Currently this field has no cost report usage.
85Z	UNITS	The number of units applicable to each revenue code.
85Z	CHARGES	The charges applicable to each revenue code.
85Z	GROSS FEE AMT	This is an accumulation of 100% fee reimbursed ambulance services. Sorted by trips and mileage. Not applicable for CAH ambulance services paid at cost.
85Z	TOTAL AMBULANCE TRIPS	Accumulated number of trips from paid claims.
85Z	TOTAL AMBULANCE MILES	Accumulated number of miles from paid claims.
85Z	TOTAL GROSS FEE SCHEDULE AMT	This is an accumulation of 100% fee reimbursed ambulance services. Not applicable for CAH ambulance services paid at cost.
85Z	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
85Z	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
85Z	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
85Z	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
85Z	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
85Z	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
85Z	COINSURANCE	The actual coinsurance amount from the paid claim record.

Report Type	Data Element	Description
85Z	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
85Z	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
85Z	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
122	CLAIMS	Currently this field has no cost report usage.
122	UNITS	The number of units applicable to each revenue code.
122	CHARGES	The charges applicable to each revenue code.
122	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
122	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
122	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
122	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
122	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
122	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
122	COINSURANCE	The actual coinsurance amount from the paid claim record.
122	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
122	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
122	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
132	CLAIMS	Currently this field has no cost report usage.
132	UNITS	The number of units applicable to each revenue code.
132	CHARGES	The charges applicable to each revenue code.

Report Type	Data Element	Description
132	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
132	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
132	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
132	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
132	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
132	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
132	COINSURANCE	The actual coinsurance amount from the paid claim record.
132	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
132	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
132	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
142	CLAIMS	Currently this field has no cost report usage.
142	UNITS	The number of units applicable to each revenue code.
142	CHARGES	The charges applicable to each revenue code.
142	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
142	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
142	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
142	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
142	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
142	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.

Report Type	Data Element	Description
142	COINSURANCE	The actual coinsurance amount from the paid claim record.
142	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
142	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
142	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
222	CLAIMS	Currently this field has no cost report usage.
222	UNITS	The number of units applicable to each revenue code.
222	CHARGES	The charges applicable to each revenue code.
222	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
222	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
222	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
222	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
222	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
222	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
222	COINSURANCE	The actual coinsurance amount from the paid claim record.
222	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
222	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
222	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
232	CLAIMS	Currently this field has no cost report usage.
232	UNITS	The number of units applicable to each revenue code.

Report Type	Data Element	Description
232	CHARGES	The charges applicable to each revenue code.
232	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
232	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
232	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
232	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
232	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
232	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
232	COINSURANCE	The actual coinsurance amount from the paid claim record.
232	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
232	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
232	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
342	CLAIMS	Currently this field has no cost report usage.
342	UNITS	The number of units applicable to each revenue code.
342	CHARGES	The charges applicable to each revenue code.
342	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
342	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
342	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
342	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
342	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.

Report Type	Data Element	Description
342	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
342	COINSURANCE	The actual coinsurance amount from the paid claim record.
342	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
342	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
342	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
712	CLAIMS	Currently this field has no cost report usage.
712	UNITS	The number of units applicable to each revenue code.
712	CHARGES	The charges applicable to each revenue code.
712	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
712	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
712	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
712	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
712	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
712	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
712	COINSURANCE	The actual coinsurance amount from the paid claim record.
712	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
712	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
712	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.

Report Type	Data Element	Description
732	CLAIMS	Currently this field has no cost report usage.
732	UNITS	The number of units applicable to each revenue code.
732	CHARGES	The charges applicable to each revenue code.
732	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
732	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
732	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
732	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
732	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
732	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
732	COINSURANCE	The actual coinsurance amount from the paid claim record.
732	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
732	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
732	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
742	CLAIMS	Currently this field has no cost report usage.
742	UNITS	The number of units applicable to each revenue code.
742	CHARGES	The charges applicable to each revenue code.
742	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
742	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
742	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
742	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.

Report Type	Data Element	Description
742	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
742	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
742	COINSURANCE	The actual coinsurance amount from the paid claim record.
742	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
742	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
742	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
752	CLAIMS	Currently this field has no cost report usage.
752	UNITS	The number of units applicable to each revenue code.
752	CHARGES	The charges applicable to each revenue code.
752	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
752	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
752	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
752	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
752	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
752	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
752	COINSURANCE	The actual coinsurance amount from the paid claim record.
752	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
752	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)

Report Type	Data Element	Description
752	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
762	CLAIMS	Currently this field has no cost report usage.
762	UNITS	The number of units applicable to each revenue code.
762	CHARGES	The charges applicable to each revenue code.
762	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
762	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
762	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
762	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
762	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
762	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
762	COINSURANCE	The actual coinsurance amount from the paid claim record.
762	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
762	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
762	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
832	CLAIMS	Currently this field has no cost report usage.
832	UNITS	The number of units applicable to each revenue code.
832	CHARGES	The charges applicable to each revenue code.
832	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
832	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)

Report Type	Data Element	Description
832	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
832	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
832	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
832	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
832	COINSURANCE	The actual coinsurance amount from the paid claim record.
832	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
832	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
832	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
852	CLAIMS	Currently this field has no cost report usage.
852	UNITS	The number of units applicable to each revenue code.
852	CHARGES	The charges applicable to each revenue code.
852	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
852	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
852	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
852	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
852	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
852	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
852	COINSURANCE	The actual coinsurance amount from the paid claim record.
852	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.

Report Type	Data Element	Description
852	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
852	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
230	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
340	CLAIMS	Currently this field has no cost report usage.
340	UNITS	The number of units applicable to each revenue code.
340	CHARGES	The charges applicable to each revenue code.
340	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
340	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
340	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
340	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
340	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
340	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
340	COINSURANCE	The actual coinsurance amount from the paid claim record.
340	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
340	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
340	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
710	CLAIMS	Currently this field has no cost report usage.
710	UNITS-Revenue Code 520	The number of units applicable to each revenue code.
710	UNITS-Revenue Code 521	The number of units applicable to each revenue code.
710	UNITS-Revenue Code 522	The number of units applicable to each revenue code.

Report Type	Data Element	Description
710	UNITS-Revenue Code 524	The number of units applicable to each revenue code.
710	UNITS-Revenue Code 525	The number of units applicable to each revenue code.
710	UNITS-Revenue Code 527	The number of units applicable to each revenue code.
710	UNITS-Revenue Code 528	The number of units applicable to each revenue code.
710	UNITS-Revenue Code 770	The number of units applicable to each revenue code.
710	UNITS-Revenue Code 900	The number of units applicable to each revenue code.
710	UNITS-Revenue Code 910	The number of units applicable to each revenue code.
710	UNITS-Revenue Code 949	The number of units applicable to each revenue code.
710	CHARGES	The charges applicable to each revenue code.
710	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
710	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
710	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
710	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
710	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
710	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
710	COINSURANCE	The actual coinsurance amount from the paid claim record.
710	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
710	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
710	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
730	CLAIMS	Currently this field has no cost report usage.
730	UNITS-Revenue Code 520	The number of units applicable to each revenue code.
730	UNITS-Revenue Code 521	The number of units applicable to each revenue code.
730	UNITS-Revenue Code 522	The number of units applicable to each revenue code.
730	UNITS-Revenue Code 524	The number of units applicable to each revenue code.
730	UNITS-Revenue Code 525	The number of units applicable to each revenue code.

Report Type	Data Element	Description
730	UNITS-Revenue Code 527	The number of units applicable to each revenue code.
730	UNITS-Revenue Code 528	The number of units applicable to each revenue code.
730	UNITS-Revenue Code 770	The number of units applicable to each revenue code.
730	UNITS-Revenue Code 900	The number of units applicable to each revenue code.
730	UNITS-Revenue Code 910	The number of units applicable to each revenue code.
730	UNITS-Revenue Code 949	The number of units applicable to each revenue code.
730	CHARGES	The charges applicable to each revenue code.
730	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
730	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
730	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
730	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
730	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
730	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
730	COINSURANCE	The actual coinsurance amount from the paid claim record.
730	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
730	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
730	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
740	CLAIMS	Currently this field has no cost report usage.
740	UNITS	The number of units applicable to each revenue code.
740	CHARGES	The charges applicable to each revenue code.
740	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)

Report Type	Data Element	Description
740	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
740	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
740	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
740	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
740	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
740	COINSURANCE	The actual coinsurance amount from the paid claim record.
740	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
740	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
740	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
750	CLAIMS	Currently this field has no cost report usage.
750	UNITS	The number of units applicable to each revenue code.
750	CHARGES	The charges applicable to each revenue code.
750	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
750	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
750	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
750	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
750	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
750	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
750	COINSURANCE	The actual coinsurance amount from the paid claim record.

Report Type	Data Element	Description
750	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
750	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
750	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
760	CLAIMS	Currently this field has no cost report usage.
760	UNITS	The number of units applicable to each revenue code.
760	CHARGES	The charges applicable to each revenue code.
760	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
760	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
760	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
760	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
760	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
760	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
760	COINSURANCE	The actual coinsurance amount from the paid claim record.
760	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
760	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
760	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
850	CLAIMS	Currently this field has no cost report usage.
850	UNITS	The number of units applicable to each revenue code.
850	CHARGES	The charges applicable to each revenue code.

Report Type	Data Element	Description
850	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
850	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
850	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
850	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
850	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
850	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
850	COINSURANCE	The actual coinsurance amount from the paid claim record.
850	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
850	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
850	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
125	CLAIMS	Currently this field has no cost report usage.
125	UNITS	The number of units applicable to each revenue code.
125	CHARGES	The charges applicable to each revenue code.
125	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
125	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
125	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
125	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
125	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
125	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.

Report Type	Data Element	Description
125	COINSURANCE	The actual coinsurance amount from the paid claim record.
125	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
125	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
125	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
135	CLAIMS	Currently this field has no cost report usage.
135	UNITS	The number of units applicable to each revenue code.
135	CHARGES	The charges applicable to each revenue code.
135	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
135	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
135	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
135	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
135	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
135	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
135	COINSURANCE	The actual coinsurance amount from the paid claim record.
135	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
135	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
135	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
145	CLAIMS	Currently this field has no cost report usage.
145	UNITS	The number of units applicable to each revenue code.

Report Type	Data Element	Description
145	CHARGES	The charges applicable to each revenue code.
145	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
145	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
145	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
145	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
145	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
145	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
145	COINSURANCE	The actual coinsurance amount from the paid claim record.
145	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
145	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
145	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
225	CLAIMS	Currently this field has no cost report usage.
225	UNITS	The number of units applicable to each revenue code.
225	CHARGES	The charges applicable to each revenue code.
225	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
225	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
225	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
225	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
225	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.

Report Type	Data Element	Description
225	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
225	COINSURANCE	The actual coinsurance amount from the paid claim record.
225	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
225	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
225	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
235	CLAIMS	Currently this field has no cost report usage.
235	UNITS	The number of units applicable to each revenue code.
235	CHARGES	The charges applicable to each revenue code.
235	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
235	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
235	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
235	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
235	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
235	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
235	COINSURANCE	The actual coinsurance amount from the paid claim record.
235	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
235	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
235	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.

Report Type	Data Element	Description
345	CLAIMS	Currently this field has no cost report usage.
345	UNITS	The number of units applicable to each revenue code.
345	CHARGES	The charges applicable to each revenue code.
345	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
345	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
345	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
345	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
345	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
345	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
345	COINSURANCE	The actual coinsurance amount from the paid claim record.
345	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
345	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
345	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
745	CLAIMS	Currently this field has no cost report usage.
745	UNITS	The number of units applicable to each revenue code.
745	CHARGES	The charges applicable to each revenue code.
745	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
745	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
745	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
745	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.

Report Type	Data Element	Description
745	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
745	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
745	COINSURANCE	The actual coinsurance amount from the paid claim record.
745	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
745	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
745	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
755	CLAIMS	Currently this field has no cost report usage.
755	UNITS	The number of units applicable to each revenue code.
755	CHARGES	The charges applicable to each revenue code.
755	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
755	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
755	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
755	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
755	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
755	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
755	COINSURANCE	The actual coinsurance amount from the paid claim record.
755	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
755	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)

Report Type	Data Element	Description
755	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
765	CLAIMS	Currently this field has no cost report usage.
765	UNITS	The number of units applicable to each revenue code.
765	CHARGES	The charges applicable to each revenue code.
765	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
765	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
765	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
765	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
765	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
765	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
765	COINSURANCE	The actual coinsurance amount from the paid claim record.
765	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
765	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
765	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
835	CLAIMS	Currently this field has no cost report usage.
835	UNITS	The number of units applicable to each revenue code.
835	CHARGES	The charges applicable to each revenue code.
835	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
835	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)

Report Type	Data Element	Description
835	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
835	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
835	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
835	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
835	COINSURANCE	The actual coinsurance amount from the paid claim record.
835	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
835	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
835	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
855	CLAIMS	Currently this field has no cost report usage.
855	UNITS	The number of units applicable to each revenue code.
855	CHARGES	The charges applicable to each revenue code.
855	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
855	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
855	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
855	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
855	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
855	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
855	COINSURANCE	The actual coinsurance amount from the paid claim record.
855	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.

Report Type	Data Element	Description
855	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
855	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
720	CLAIMS	Currently this field has no cost report usage.
720	UNITS - Rev Code 821 - Cond Code 71	The number of units applicable to each revenue code.
720	UNITS - Rev Code 821 - Cond Code 72	The number of units applicable to each revenue code.
720	UNITS - Rev Code 821 - Cond Code 73	The number of units applicable to each revenue code.
720	UNITS - Rev Code 821 - Cond Code 74	The number of units applicable to each revenue code.
720	UNITS - Rev Code 821 - Cond Code 76	The number of units applicable to each revenue code.
720	UNITS - Rev Code 831 - Cond Code 71	The number of units applicable to each revenue code.
720	UNITS - Rev Code 831 - Cond Code 72	The number of units applicable to each revenue code.
720	UNITS - Rev Code 831 - Cond Code 73	The number of units applicable to each revenue code.
720	UNITS - Rev Code 831 - Cond Code 74	The number of units applicable to each revenue code.
720	UNITS - Rev Code 831 - Cond Code 76	The number of units applicable to each revenue code.
720	UNITS - Rev Code 841 - Cond Code 73	The number of units applicable to each revenue code.
720	UNITS - Rev Code 841 - Cond Code 74	The number of units applicable to each revenue code.
720	UNITS - Rev Code 851 - Cond Code 73	The number of units applicable to each revenue code.
720	UNITS - Rev Code 851 - Cond Code 74	The number of units applicable to each revenue code.
720	COV CHG/PYMTS	The charges applicable to each revenue code.
720	AVG PYMT RATE - Rev Code 821 - Cond Code 71	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 821 - Cond Code 72	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 821 - Cond Code 73	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 821 - Cond Code 74	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 821 - Cond Code 76	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 831 - Cond Code 71	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 831 - Cond Code 72	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 831 - Cond Code 73	The average composite rate reimbursement by treatment type.

Report Type	Data Element	Description
720	AVG PYMT RATE - Rev Code 831 - Cond Code 74	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 831 - Cond Code 76	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 841 - Cond Code 73	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 841 - Cond Code 74	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 851 - Cond Code 73	The average composite rate reimbursement by treatment type.
720	AVG PYMT RATE - Rev Code 851 - Cond Code 74	The average composite rate reimbursement by treatment type.
720	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
720	ESRD COND CODE	The condition code tells the type of treatment furnished.
720	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
720	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
720	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
720	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
720	COINSURANCE	The actual coinsurance amount from the paid claim record.
720	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
720	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
720	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
725	CLAIMS	Currently this field has no cost report usage.
725	UNITS	The number of units applicable to each revenue code.
725	COV CHG/PYMTS	The charges applicable to each revenue code.
725	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)

Report Type	Data Element	Description
725	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
725	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
725	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
725	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
725	COINSURANCE	The actual coinsurance amount from the paid claim record.
725	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
725	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
725	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
72A	CLAIMS	Currently this field has no cost report usage.
72A	UNITS	The number of units applicable to each revenue code.
72A	CHARGES	The charges applicable to each revenue code.
72A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
72A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
72A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
72A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
72A	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
72A	COINSURANCE	The actual coinsurance amount from the paid claim record.
72A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.

Report Type	Data Element	Description
72A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
72A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
810	MEDICARE DAYS	Currently this field has no cost report usage.
810	CLAIMS	Currently this field has no cost report usage.
810	TOTAL UNDUPLICATED CENSUS COUNT	The unduplicated census count of the hospice for all patients initially admitted and filing an election within the reporting period.
810	UNDUP DAYS	Currently this field has no cost report usage.
810	HOURS - REV CODE 0652	The number of hours applicable to this revenue code.
810	UNITS - REV CODE 0651	The number of units applicable to each revenue code.
810	UNITS - REV CODE 0652	The number of hours applicable to this revenue code.
810	UNITS - REV CODE 0655	The number of units applicable to each revenue code.
810	UNITS - REV CODE 0656	The number of units applicable to each revenue code.
810	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
810	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
810	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
810	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
810	DEDUCTIBLES	The actual deductible amount from the paid claim record.
810	COINSURANCE	The actual coinsurance amount from the paid claim record.
810	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
810	MSP RECONCILIATION	This field is the accumulation of the difference between the Medicare allowable amount and the actual Medicare reimbursement. This occurs in situations where there is OTAF or MSP-LCC.
810	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.

Report Type	Data Element	Description
810	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
810	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
81A	MEDICARE DAYS	Currently this field has no cost report usage.
81A	CLAIMS	Currently this field has no cost report usage.
81A	TOTAL UNDUPLICATED CENSUS COUNT	The unduplicated census count of the hospice for all patients initially admitted and filing an election within the reporting period.
81A	UNDUP DAYS	Currently this field has no cost report usage.
81A	HOURS	The number of hours applicable to this revenue code.
81A	UNITS - REV CODE 0651	The number of units applicable to each revenue code.
81A	UNITS - REV CODE 0652	The number of hours applicable to this revenue code.
81A	UNITS - REV CODE 0655	The number of units applicable to each revenue code.
81A	UNITS - REV CODE 0656	The number of units applicable to each revenue code.
81A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
81A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
81A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
81A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
81A	DEDUCTIBLES	The actual deductible amount from the paid claim record.
81A	COINSURANCE	The actual coinsurance amount from the paid claim record.
81A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
81A	MSP RECONCILIATION	This field is the accumulation of the difference between the Medicare allowable amount and the actual Medicare reimbursement. This occurs in situations where there is OTAF or MSP-LCC.
81A	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.

Report Type	Data Element	Description
81A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
81A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
820	MEDICARE DAYS	Currently this field has no cost report usage.
820	CLAIMS	Currently this field has no cost report usage.
820	TOTAL UNDUPLICATED CENSUS COUNT	The unduplicated census count of the hospice for all patients initially admitted and filing an election within the reporting period.
820	UNDUP DAYS	Currently this field has no cost report usage.
820	HOURS	The number of hours applicable to this revenue code.
820	UNITS - REV CODE 0651	The number of units applicable to each revenue code.
820	UNITS - REV CODE 0652	The number of hours applicable to this revenue code.
820	UNITS - REV CODE 0655	The number of units applicable to each revenue code.
820	UNITS - REV CODE 0656	The number of units applicable to each revenue code.
820	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
820	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
820	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
820	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
820	DEDUCTIBLES	The actual deductible amount from the paid claim record.
820	COINSURANCE	The actual coinsurance amount from the paid claim record.
820	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
820	MSP RECONCILIATION	This field is the accumulation of the difference between the Medicare allowable amount and the actual Medicare reimbursement. This occurs in situations where there is OTAF or MSP-LCC.
820	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.

Report Type	Data Element	Description
820	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
820	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
82A	MEDICARE DAYS	Currently this field has no cost report usage.
82A	CLAIMS	Currently this field has no cost report usage.
82A	TOTAL UNDUPLICATED CENSUS COUNT	The unduplicated census count of the hospice for all patients initially admitted and filing an election within the reporting period.
82A	UNDUP DAYS	Currently this field has no cost report usage.
82A	HOURS	The number of hours applicable to this revenue code.
82A	UNITS - REV CODE 0651	The number of units applicable to each revenue code.
82A	UNITS - REV CODE 0652	The number of hours applicable to this revenue code.
82A	UNITS - REV CODE 0655	The number of units applicable to each revenue code.
82A	UNITS - REV CODE 0656	The number of units applicable to each revenue code.
82A	REV CODE	Each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing of revenue codes.)
82A	DESCRIPTION	The description of each revenue code and its associated covered units and charges. (See IOM 100-04, Chapter 25, Section 60.4 for a complete listing and a description of all revenue codes.)
82A	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
82A	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
82A	DEDUCTIBLES	The actual deductible amount from the paid claim record.
82A	COINSURANCE	The actual coinsurance amount from the paid claim record.
82A	NET MSP PAYMENTS	The net payment made by a higher priority payer under the MSP provisions is shown in this field. Note: Primary payments are first allocated to the extent of any deductibles or coinsurance.
82A	MSP RECONCILIATION	This field is the accumulation of the difference between the Medicare allowable amount and the actual Medicare reimbursement. This occurs in situations where there is OTAF or MSP-LCC.
82A	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.

Report Type	Data Element	Description
82A	NET REIMBURSEMENT	This amount represents an accumulation of interim payments made on the claims. (This does not include payments such as bi-weekly pass-through payments, lump sums and financial adjustments, etc.)
82A	CLAIM INTEREST PAYMENTS	Interest payments are accumulated primarily for the IRS Form-1099 reporting requirements. The amounts shown are related to the claims payment timeliness (CPT) provisions.
322	COUNT	This is the total number of Requests for Advance Payment (RAP) for Part B.
322	REIMB	This is the total RAP payment amount for Part B.
322	TOTAL INITIAL RAP	This is the initial Request for Advance Payment (RAP) submitted by the HHA for Part B.
322	RAP CANCELLED BY CLAIM	This is a claim cancel normally part of a claim adjustment for Part B.
322	RAP AUTO CANCELLED	This is the (initial) RAP cancel which is made when the final RAP is processed for Part B.
322	RAP PROVIDER CANCELLED	This is a RAP cancel initiated by the HHA for Part B.
322	RAP FI CANCELLED	This is the RAP cancel by the FI since the HHA did not submit the final RAP within the required timeline for Part B.
322	TOTAL CANCELLED RAPS	This is the total of all RAP cancel types for Part B.
322	TOT RAPS OUTSTANDING	This indicates the difference between the initial and final RAP payments for Part B.
322	GROSS REIMBURSEMENT	This is the gross RAP payment for Part B.
322	NET REIMBURSEMENT	This is the net RAP payment for Part B.
332	COUNT	This is the total number of Requests for Advance Payment (RAP) for PART A.
332	REIMB	This is the total RAP payment amount for PART A.
332	TOTAL INITIAL RAP	this is the initial Request for Advance (RAP) submitted by the HHA for Part A.
332	RAP CANCELLED BY CLAIM	This is a claim cancel normally part of a claim adjustment for Part A.
332	RAP AUTO CANCELLED	This is the (initial) RAP cancel which is made when the final RAP is processed for Part A.
332	RAP PROVIDER CANCELLED	This is a RAP cancel initiated by the HHA for Part A.
332	RAP FI CANCELLED	This is the RAP cancel by the FI since the HHA did not submit the final RAP within required timeline for Part A.
332	TOTAL CANCELLED RAPS	This is the total of all RAP cancel types for Part A.
332	TOT RAPS OUTSTANDING	This indicates the difference between the initial and final RAP payments for Part A.
332	GROSS REIMBURSEMENT	This is the gross RAP payment for Part A
332	NET REIMBURSEMENT	This is the net RAP payment for Part A.

Report Type	Data Element	Description
329	FULL 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	FULL 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	FULL 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	FULL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	FULL 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	FULL 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	FULL 0623 - Displays by itself	These fields are not populated on this report.
329	FULL All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	LUPA 0023 - Does not display	These fields are not populated on this report.
329	LUPA 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	LUPA 0274 - Displays by itself	These fields are not populated on this report.
329	LUPA 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	LUPA 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	LUPA 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	LUPA 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	LUPA 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	LUPA 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	LUPA 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	LUPA 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	LUPA 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	LUPA 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	LUPA 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	LUPA 0623 - Displays by itself	These fields are not populated on this report.
329	LUPA All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	PEP 0023 - Does not display	These fields are not populated on this report.
329	PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	PEP 0274 - Displays by itself	These fields are not populated on this report.
329	PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	PEP 0623 - Displays by itself	These fields are not populated on this report.
329	PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	SCIC/PEP 0023 - Does not display	These fields are not populated on this report.
329	SCIC/PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	SCIC/PEP 0274 - Displays by itself	These fields are not populated on this report.
329	SCIC/PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	SCIC/PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 0623 - Displays by itself	These fields are not populated on this report.
329	SCIC/PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	SCIC 0023 - Does not display	These fields are not populated on this report.
329	SCIC 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	SCIC 0274 - Displays by itself	These fields are not populated on this report.
329	SCIC 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	SCIC 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	SCIC 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	SCIC 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	SCIC 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	SCIC 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	SCIC 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	SCIC 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	SCIC 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	SCIC 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	SCIC 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	SCIC 0623 - Displays by itself	These fields are not populated on this report.
329	SCIC All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	TOTAL 0023 - Does not display	These fields are not populated on this report.
329	TOTAL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	TOTAL 0274 - Displays by itself	These fields are not populated on this report.
329	TOTAL 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	TOTAL 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	TOTAL 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	TOTAL 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	TOTAL 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	TOTAL 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	TOTAL 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	TOTAL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	TOTAL 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	TOTAL 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	TOTAL 0623 - Displays by itself	These fields are not populated on this report.
329	TOTAL All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	FULL 0023 - Does not display	These fields are not populated on this report.
329	FULL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	FULL 0274 - Displays by itself	These fields are not populated on this report.
329	FULL 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	FULL 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	FULL 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	FULL 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	FULL 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	FULL 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	FULL 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	FULL 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	FULL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	FULL 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	FULL 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	FULL 0623 - Displays by itself	These fields are not populated on this report.
329	FULL All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	LUPA 0023 - Does not display	These fields are not populated on this report.
329	LUPA 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	LUPA 0274 - Displays by itself	These fields are not populated on this report.
329	LUPA 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	LUPA 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	LUPA 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	LUPA 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	LUPA 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	LUPA 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	LUPA 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	LUPA 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	LUPA 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	LUPA 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	LUPA 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	LUPA 0623 - Displays by itself	These fields are not populated on this report.
329	LUPA All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	PEP 0023 - Does not display	These fields are not populated on this report.
329	PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	PEP 0274 - Displays by itself	These fields are not populated on this report.
329	PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	PEP 0623 - Displays by itself	These fields are not populated on this report.
329	PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	SCIC/PEP 0023 - Does not display	These fields are not populated on this report.
329	SCIC/PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	SCIC/PEP 0274 - Displays by itself	These fields are not populated on this report.
329	SCIC/PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	SCIC/PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 0623 - Displays by itself	These fields are not populated on this report.
329	SCIC/PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	SCIC 0023 - Does not display	These fields are not populated on this report.
329	SCIC 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	SCIC 0274 - Displays by itself	These fields are not populated on this report.
329	SCIC 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	SCIC 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	SCIC 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	SCIC 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	SCIC 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	SCIC 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	SCIC 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	SCIC 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	SCIC 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	SCIC 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	SCIC 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	SCIC 0623 - Displays by itself	These fields are not populated on this report.
329	SCIC All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	TOTAL 0023 - Does not display	These fields are not populated on this report.
329	TOTAL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	TOTAL 0274 - Displays by itself	These fields are not populated on this report.
329	TOTAL 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	TOTAL 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	TOTAL 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	TOTAL 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	TOTAL 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	TOTAL 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	TOTAL 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	TOTAL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	TOTAL 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	TOTAL 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	TOTAL 0623 - Displays by itself	These fields are not populated on this report.
329	TOTAL All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	FULL 0023 - Does not display	These fields are not populated on this report.
329	FULL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	FULL 0274 - Displays by itself	These fields are not populated on this report.
329	FULL 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	FULL 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	FULL 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	FULL 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	FULL 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	FULL 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	FULL 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	FULL 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	FULL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	FULL 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	FULL 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	FULL 0623 - Displays by itself	These fields are not populated on this report.
329	FULL All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	LUPA 0023 - Does not display	These fields are not populated on this report.
329	LUPA 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	LUPA 0274 - Displays by itself	These fields are not populated on this report.
329	LUPA 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	LUPA 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	LUPA 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	LUPA 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	LUPA 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	LUPA 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	LUPA 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	LUPA 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	LUPA 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	LUPA 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	LUPA 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	LUPA 0623 - Displays by itself	These fields are not populated on this report.
329	LUPA All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	PEP 0023 - Does not display	These fields are not populated on this report.
329	PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	PEP 0274 - Displays by itself	These fields are not populated on this report.
329	PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	PEP 0623 - Displays by itself	These fields are not populated on this report.
329	PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	SCIC/PEP 0023 - Does not display	These fields are not populated on this report.
329	SCIC/PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	SCIC/PEP 0274 - Displays by itself	These fields are not populated on this report.
329	SCIC/PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	SCIC/PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	SCIC/PEP 0623 - Displays by itself	These fields are not populated on this report.
329	SCIC/PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	SCIC 0023 - Does not display	These fields are not populated on this report.
329	SCIC 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
329	SCIC 0274 - Displays by itself	These fields are not populated on this report.
329	SCIC 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.
329	SCIC 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
329	SCIC 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
329	SCIC 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
329	SCIC 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
329	SCIC 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
329	SCIC 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
329	SCIC 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
329	SCIC 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
329	SCIC 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
329	SCIC 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
329	SCIC 0623 - Displays by itself	These fields are not populated on this report.
329	SCIC All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
329	TOTAL 0023 - Does not display	These fields are not populated on this report.
329	TOTAL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B durable medical equipment payments without outlier.
329	TOTAL 0274 - Displays by itself	Total Part B Prosthetics & Orthotics charges without outlier.
329	TOTAL 029X - All revenue codes lines where the first three positions = '029' are rolled up	Total Part B Durable Med Equip charges without outlier.
329	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	Part B physical therapy count for full episodes without outlier.
329	TOTAL 043X - All revenue code lines where the first three positions = '043' are rolled up	Part B occupational therapy count without outlier.
329	TOTAL 044X - All revenue code lines where the first three positions = '044' are rolled up	Part B speech count without outlier.
329	TOTAL 055X - All revenue code lines where the first three positions = '055' are rolled up	Part B nursing count without outlier.

Report Type	Data Element	Description
329	TOTAL 056X - All revenue code lines where the first three positions = '056' are rolled up	Part B med soc serv without outlier.
329	TOTAL 057X - All revenue code lines where the first three positions = '057' are rolled up	Part B home health aide count without outlier.
329	TOTAL 058X - All revenue code lines where the first three positions = '058' are rolled up	Total Part B visits without outlier.
329	TOTAL 059X - All revenue code lines where the first three positions = '059' are rolled up	Total Part B visits without outlier.
329	TOTAL 060X - All revenue code lines where the first three positions = '060' are rolled up	Total Part B Oxygen charges without outlier.
329	TOTAL 062X - All revenue code lines where the first three positions = '062' are rolled up	Total Part B Med Supplies charges without outlier.
329	TOTAL 0623 - Displays by itself	Total Part B Surgical Dressings charges without outlier.
329	TOTAL All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B Revenue Code Charges.
329	FULL # EPISODES WITHOUT OUTLIER	Part B number of Episodes without outlier for full episodes.
329	FULL HIPPS REIMBURSEMENT WITHOUT OUTLIER	Part B HIPPS Reimbursement without outlier for full episodes.
329	FULL # EPISODES WITH OUTLIER	Part B number of Episodes with outlier for full episodes.
329	FULL HIPPS REIMBURSEMENT WITH OUTLIER	Part B HIPPS Reimbursement with outlier for full episodes.
329	FULL OUTLIER REIMBURSEMENTS	Part B outlier reimbursement for full episodes.
329	FULL PROSTHETIC/ORTHOTIC DEVICES	This is prosthetics and orthotics for full episodes.
329	FULL DME	This is DME for full episodes.
329	FULL OXYGEN	This is oxygen for full episodes.
329	FULL OTHER FEE REIMBURSEMENTS	Part B Other Fee for full episodes.
329	FULL GROSS REIMBURSEMENT	Part B gross reimbursement for full episodes.
329	FULL DEDUCTIBLES	This is deductibles for Part B.
329	FULL COINSURANCE	This is coinsurance for Part B.
329	FULL NET MSP PAYMENTS	This is MSP for Part B.
329	FULL MSP RECONCILIATION	Net MSP for Part B.
329	FULL OTHER ADJUSTMENTS	Other adjustments for Part B.
329	FULL NET REIMBURSEMENT	Net reimbursement for Part B.

Report Type	Data Element	Description
329	FULL CLAIM INTEREST PAYMENTS	Part B claim interest payment for full episode.
329	LUPA # EPISODES WITHOUT OUTLIER	This is Part B number episodes without outlier for LUPA.
329	LUPA HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is Part B HHPPS reimbursement without outlier for LUPA.
329	LUPA # EPISODES WITH OUTLIER	This is Part B number episodes with outlier for LUPA.
329	LUPA HIPPS REIMBURSEMENT WITH OUTLIER	This is Part B HHPPS reimbursement with outlier for LUPA.
329	LUPA OUTLIER REIMBURSEMENTS	This is Part B outlier reimbursement for LUPA.
329	LUPA PROSTHETIC/ORTHOTIC DEVICES	This is Part B P&O for LUPA.
329	LUPA DME	This is Part B DME for LUPA.
329	LUPA OXYGEN	This is Part B oxygen for LUPA.
329	LUPA OTHER FEE REIMBURSEMENTS	This is Part B - other fee, LUPA.
329	LUPA GROSS REIMBURSEMENT	Part B Gross Reimbursement for LUPA.
329	LUPA DEDUCTIBLES	This is Part B deductibles for LUPA.
329	LUPA COINSURANCE	This is Part B coinsurance for LUPA.
329	LUPA NET MSP PAYMENTS	This is Part B MSP recon for LUPA.
329	LUPA MSP RECONCILIATION	This is Part B net MSP payment for LUPA.
329	LUPA OTHER ADJUSTMENTS	This is Part B other adjustments for LUPA.
329	LUPA NET REIMBURSEMENT	This is Part B net reimbursement for LUPA.
329	LUPA CLAIM INTEREST PAYMENTS	Part B Claim Interest Payments for LUPA.
329	PEP # EPISODES WITHOUT OUTLIER	This is Part B number of episodes without outlier for PEP.
329	PEP HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is Part B HHPPS reimbursement without outlier for PEP.
329	PEP # EPISODES WITH OUTLIER	This is Part B number of episodes with outlier for PEP.
329	PEP HIPPS REIMBURSEMENT WITH OUTLIER	This is Part B HHPPS reimbursement with outlier for PEP.
329	PEP OUTLIER REIMBURSEMENTS	This is Part B outlier reimbursement for PEP.
329	PEP PROSTHETIC/ORTHOTIC DEVICES	This is Part B P&O for PEP.
329	PEP DME	This is Part B DME for PEP.
329	PEP OXYGEN	This is Part B oxygen for PEP.
329	PEP OTHER FEE REIMBURSEMENTS	This is Part B - other fee PEP.
329	PEP GROSS REIMBURSEMENT	Part B Gross Reimbursement for PEP.
329	PEP DEDUCTIBLES	This is Part B deductibles for PEP.
329	PEP COINSURANCE	This is Part B coinsurance for PEP.
329	PEP NET MSP PAYMENTS	This is Part B MSP recon for PEP.
329	PEP MSP RECONCILIATION	This is Part B net MSP payment for PEP.
329	PEP OTHER ADJUSTMENTS	This is Part B other adjustments for PEP.

Report Type	Data Element	Description
329	PEP NET REIMBURSEMENT	This is Part B net reimbursement for PEP.
329	PEP CLAIM INTEREST PAYMENTS	Part B Claim Interest Payments for PEP.
329	SCIC/PEP # EPISODES WITHOUT OUTLIER	This is Part B number of episodes without outlier for PEP.
329	SCIC/PEP HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is Part B HHPPS reimbursement without outlier for SCIS/PEP.
329	SCIC/PEP # EPISODES WITH OUTLIER	This is Part B number of episodes with outlier for SCIC/PEP.
329	SCIC/PEP HIPPS REIMBURSEMENT WITH OUTLIER	This is Part B HHPPS reimbursement with outlier for SCIC/PEP.
329	SCIC/PEP OUTLIER REIMBURSEMENTS	This is Part B OUTLIER reimbursement for SCIC/PEP.
329	SCIC/PEP PROSTHETIC/ORTHOTIC DEVICES	This is Part B P&O for SCIC/PEP.
329	SCIC/PEP DME	This is Part B DME for SCIS/PEP.
329	SCIC/PEP OXYGEN	This is Part B oxygen for SCIC/PEP.
329	SCIC/PEP OTHER FEE REIMBURSEMENTS	This is Part B - other fee SCIC/PEP.
329	SCIC/PEP GROSS REIMBURSEMENT	Part B Gross Reimbursement for SCIC/PEP.
329	SCIC/PEP DEDUCTIBLES	This is Part B deduct for SCIC/PEP.
329	SCIC/PEP COINSURANCE	This is Part B coinsurance for SCIC/PEP.
329	SCIC/PEP NET MSP PAYMENTS	This is Part B MSP recon for SCIC/PEP.
329	SCIC/PEP MSP RECONCILIATION	This is Part B net MSP payment for SCIC/PEP.
329	SCIC/PEP OTHER ADJUSTMENTS	This is Part B other adjustment for SCIC/ PEP.
329	SCIC/PEP NET REIMBURSEMENT	This is Part B NET reimbursement for SCIC/PEP.
329	SCIC/PEP CLAIM INTEREST PAYMENTS	Part B Claim Interest Payments for SCIC/PEP.
329	SCIC # EPISODES WITHOUT OUTLIER	Part B number of episodes without outlier for SCIC.
329	SCIC HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is Part B number of episodes without outlier for SCIC only.
329	SCIC # EPISODES WITH OUTLIER	This is Part B HHPPS reimbursement without outlier for SCIC only.
329	SCIC HIPPS REIMBURSEMENT WITH OUTLIER	This is Part B number of episodes with outlier for SCIC only.
329	SCIC OUTLIER REIMBURSEMENTS	This is Part B HHPPS reimbursement with outlier for SCIC only.
329	SCIC PROSTHETIC/ORTHOTIC DEVICES	This is Part B outlier reimbursement for SCIC only.
329	SCIC DME	This is Part B P&O for SCIC only.
329	SCIC OXYGEN	This is Part B DME for SCIC only.
329	SCIC OTHER FEE REIMBURSEMENTS	This is Part B oxygen for SCIC only.
329	SCIC GROSS REIMBURSEMENT	This is Part B - other fee SCIC only.

Report Type	Data Element	Description
329	SCIC DEDUCTIBLES	Part B deductibles for SCIC.
329	SCIC COINSURANCE	This is Part B deductibles for SCIC only.
329	SCIC NET MSP PAYMENTS	This is Part B coinsurance for SCIC only.
329	SCIC MSP RECONCILIATION	This is Part B MSP reconciliation for SCIC only.
329	SCIC OTHER ADJUSTMENTS	This is Part B net MSP payment for SCIC only.
329	SCIC NET REIMBURSEMENT	This is Part B other adjustments for SCIC only.
329	SCIC CLAIM INTEREST PAYMENTS	This is Part B NET reimbursement for SCIC only.
329	TOTAL HIPPS REIMBURSEMENT WITHOUT OUTLIER	Total Part B HIPPS reimbursement without outlier.
329	TOTAL # EPISODES WITH OUTLIER	
329	TOTAL HIPPS REIMBURSEMENT WITH OUTLIER	This is the total Part B number of episodes without outlier.
329	TOTAL OUTLIER REIMBURSEMENTS	This is the total Part B HHPPS reimbursement without outlier.
329	TOTAL PROSTHETIC/ORTHOTIC DEVICES	This is the total Part B number of episodes with outlier.
329	TOTAL DME	This is Part B HHPPS reimbursement with outlier for SCIC only.
329	TOTAL OXYGEN	This is Part B oxygen.
329	TOTAL OTHER FEE REIMBURSEMENTS	This is Part B other fee.
329	TOTAL GROSS REIMBURSEMENT	This is TOTAL Part B DME.
329	TOTAL DEDUCTIBLES	This is Part B deductibles.
329	TOTAL COINSURANCE	This is Part B coinsurance.
329	TOTAL NET MSP PAYMENTS	This is Part B MSP payments.
329	TOTAL MSP RECONCILIATION	This is Part B MSP reconciliation.
329	TOTAL OTHER ADJUSTMENTS	This is Part B other adjustments.
329	TOTAL NET REIMBURSEMENT	This is Part B net reimbursement.
329	TOTAL CLAIM INTEREST PAYMENTS	Total Part B claim interest payments.
339	"Rev Code"(PDF)/ "Revenue Code"(CSV) Column)	These fields are not populated on this report.
339	FULL 0023 - Does not display	These fields are not populated on this report.
339	FULL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	FULL 0274 - Displays by itself	These fields are not populated on this report.
339	FULL 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
339	FULL 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
339	FULL 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
339	FULL 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
339	FULL 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.
339	FULL 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
339	FULL 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
339	FULL 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
339	FULL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	FULL 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
339	FULL 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	FULL 0623 - Displays by itself	These fields are not populated on this report.
339	FULL All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	LUPA 0023 - Does not display	These fields are not populated on this report.
339	LUPA 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	LUPA 0274 - Displays by itself	These fields are not populated on this report.
339	LUPA 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
339	LUPA 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
339	LUPA 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
339	LUPA 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
339	LUPA 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.
339	LUPA 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
339	LUPA 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
339	LUPA 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
339	LUPA 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	LUPA 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
339	LUPA 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	LUPA 0623 - Displays by itself	These fields are not populated on this report.
339	LUPA All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	PEP 0023 - Does not display	These fields are not populated on this report.
339	PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	PEP 0274 - Displays by itself	These fields are not populated on this report.
339	PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

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339	PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
339	PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
339	PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
339	PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.
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339	PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
339	PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
339	PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
339	PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	PEP 0623 - Displays by itself	These fields are not populated on this report.
339	PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	SCIC/PEP 0023 - Does not display	These fields are not populated on this report.
339	SCIC/PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	SCIC/PEP 0274 - Displays by itself	These fields are not populated on this report.
339	SCIC/PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

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339	SCIC/PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
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339	SCIC/PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 0623 - Displays by itself	These fields are not populated on this report.
339	SCIC/PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	SCIC 0023 - Does not display	These fields are not populated on this report.
339	SCIC 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	SCIC 0274 - Displays by itself	These fields are not populated on this report.
339	SCIC 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

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339	SCIC 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
339	SCIC 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
339	SCIC 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	SCIC 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
339	SCIC 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	SCIC 0623 - Displays by itself	These fields are not populated on this report.
339	SCIC All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	TOTAL 0023 - Does not display	These fields are not populated on this report.
339	TOTAL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	TOTAL 0274 - Displays by itself	These fields are not populated on this report.
339	TOTAL 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

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339	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
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339	TOTAL 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
339	TOTAL 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
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339	TOTAL 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	TOTAL 0623 - Displays by itself	These fields are not populated on this report.
339	TOTAL All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	SERVICES WITH OUTLIER	These fields are not populated on this report.
339	FULL 0023 - Does not display	These fields are not populated on this report.
339	FULL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	FULL 0274 - Displays by itself	These fields are not populated on this report.
339	FULL 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

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339	FULL 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	FULL 0623 - Displays by itself	These fields are not populated on this report.
339	FULL All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	LUPA 0023 - Does not display	These fields are not populated on this report.
339	LUPA 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	LUPA 0274 - Displays by itself	These fields are not populated on this report.
339	LUPA 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

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339	LUPA 0623 - Displays by itself	These fields are not populated on this report.
339	LUPA All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	PEP 0023 - Does not display	These fields are not populated on this report.
339	PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	PEP 0274 - Displays by itself	These fields are not populated on this report.
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339	PEP 0623 - Displays by itself	These fields are not populated on this report.
339	PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	SCIC/PEP 0023 - Does not display	These fields are not populated on this report.
339	SCIC/PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
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339	SCIC/PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
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339	SCIC/PEP 0623 - Displays by itself	These fields are not populated on this report.
339	SCIC/PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	SCIC 0023 - Does not display	These fields are not populated on this report.
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339	SCIC 0623 - Displays by itself	These fields are not populated on this report.
339	SCIC All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	TOTAL 0023 - Does not display	These fields are not populated on this report.
339	TOTAL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
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339	FULL 0623 - Displays by itself	These fields are not populated on this report.
339	FULL All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	LUPA 0023 - Does not display	These fields are not populated on this report.
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339	LUPA 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	LUPA 0623 - Displays by itself	These fields are not populated on this report.
339	LUPA All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	PEP 0023 - Does not display	These fields are not populated on this report.
339	PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	PEP 0274 - Displays by itself	These fields are not populated on this report.
339	PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
339	PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
339	PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
339	PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
339	PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.
339	PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
339	PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
339	PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
339	PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
339	PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	PEP 0623 - Displays by itself	These fields are not populated on this report.
339	PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	SCIC/PEP 0023 - Does not display	These fields are not populated on this report.
339	SCIC/PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	SCIC/PEP 0274 - Displays by itself	These fields are not populated on this report.
339	SCIC/PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
339	SCIC/PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	SCIC/PEP 0623 - Displays by itself	These fields are not populated on this report.
339	SCIC/PEP All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	SCIC 0023 - Does not display	These fields are not populated on this report.
339	SCIC 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	These fields are not populated on this report.
339	SCIC 0274 - Displays by itself	These fields are not populated on this report.
339	SCIC 029X - All revenue codes lines where the first three positions = '029' are rolled up	These fields are not populated on this report.

Report Type	Data Element	Description
339	SCIC 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
339	SCIC 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
339	SCIC 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
339	SCIC 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.
339	SCIC 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
339	SCIC 057X - All revenue code lines where the first three positions = '057' are rolled up	These fields are not populated on this report.
339	SCIC 058X - All revenue code lines where the first three positions = '058' are rolled up	These fields are not populated on this report.
339	SCIC 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	SCIC 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
339	SCIC 062X - All revenue code lines where the first three positions = '062' are rolled up	These fields are not populated on this report.
339	SCIC 0623 - Displays by itself	These fields are not populated on this report.
339	SCIC All other Rev Codes display as they come in on the claim (they do not roll up)	These fields are not populated on this report.
339	TOTAL 0023 - Does not display	These fields are not populated on this report.
339	TOTAL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Total Part B Med Supplies charges.
339	TOTAL 0274 - Displays by itself	Total Part B Prosthetics and Orthotics charges without outlier.
339	TOTAL 029X - All revenue codes lines where the first three positions = '029' are rolled up	Total Part B Durable Medical Equipment charges without outlier.

Report Type	Data Element	Description
339	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	Total Part B physical therapy count without outlier.
339	TOTAL 043X - All revenue code lines where the first three positions = '043' are rolled up	Total Part B occupational therapy count without outlier.
339	TOTAL 044X - All revenue code lines where the first three positions = '044' are rolled up	Total Part B speech count without outlier.
339	TOTAL 055X - All revenue code lines where the first three positions = '055' are rolled up	Total Part B nursing count without outlier.
339	TOTAL 056X - All revenue code lines where the first three positions = '056' are rolled up	Total Part B Med Soc Serv without outlier
339	TOTAL 057X - All revenue code lines where the first three positions = '057' are rolled up	Total Part B home health aide count without outlier.
339	TOTAL 058X - All revenue code lines where the first three positions = '058' are rolled up	Total Part B Other Visits without outlier.
339	TOTAL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not normally used.
339	TOTAL 060X - All revenue code lines where the first three positions = '060' are rolled up	Total Part B Oxygen charges without outlier
339	TOTAL 062X - All revenue code lines where the first three positions = '062' are rolled up	Total Part B Med Supplies charges without outlier.
339	TOTAL 0623 - Displays by itself	Total Part B Surgical Dressings charges without outlier.
339	TOTAL All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B Revenue Code Charges.
339	FULL # EPISODES WITHOUT OUTLIER	Part B Medical Supplies charges with outlier.
339	FULL HIPPS REIMBURSEMENT WITHOUT OUTLIER	Part B HIPPS Reimbursement without outlier for full episodes.
339	FULL # EPISODES WITH OUTLIER	Part B number of episodes with outlier for full episodes.
339	FULL HIPPS REIMBURSEMENT WITH OUTLIER	Part B HIPPS Reimbursement with outlier for full episodes.
339	FULL OUTLIER REIMBURSEMENTS	Part B outlier reimbursement for full episodes.
339	FULL PROSTHETIC/ORTHOTIC DEVICES	This is P&O for full episodes.

Report Type	Data Element	Description
339	FULL DME	This is DME for full episodes.
339	FULL OXYGEN	This is oxygen for full episodes.
339	FULL OTHER FEE REIMBURSEMENTS	Part B other fee for full episodes.
339	FULL GROSS REIMBURSEMENT	Part B gross reimbursement for full episodes.
339	FULL DEDUCTIBLES	This is DED for Part B.
339	FULL COINSURANCE	This is coinsurance for Part B.
339	FULL NET MSP PAYMENTS	This is MSP for Part B.
339	FULL MSP RECONCILIATION	Net MSP for Part B.
339	FULL OTHER ADJUSTMENTS	Other adjustments for Part B.
339	FULL NET REIMBURSEMENT	Net reimbursement for Part B.
339	FULL CLAIM INTEREST PAYMENTS	This is the Part A information.
339	LUPA # EPISODES WITHOUT OUTLIER	This is the Part A information.
339	LUPA HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is the Part A information.
339	LUPA # EPISODES WITH OUTLIER	This is the Part A information.
339	LUPA HIPPS REIMBURSEMENT WITH OUTLIER	This is the Part A information.
339	LUPA OUTLIER REIMBURSEMENTS	This is the Part A information.
339	LUPA PROSTHETIC/ORTHOTIC DEVICES	This is the Part A information.
339	LUPA DME	This is the Part A information.
339	LUPA OXYGEN	This is the Part A information.
339	LUPA OTHER FEE REIMBURSEMENTS	This is the Part A information.
339	LUPA GROSS REIMBURSEMENT	This is the Part A information.
339	LUPA DEDUCTIBLES	This is the Part A information.
339	LUPA COINSURANCE	This is the Part A information.
339	LUPA NET MSP PAYMENTS	This is the Part A information.
339	LUPA MSP RECONCILIATION	This is the Part A information.
339	LUPA OTHER ADJUSTMENTS	This is the Part A information.
339	LUPA NET REIMBURSEMENT	This is the Part A information.
339	LUPA CLAIM INTEREST PAYMENTS	This is the Part A information.
339	PEP # EPISODES WITHOUT OUTLIER	This is the Part A information.
339	PEP HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is the Part A information.
339	PEP # EPISODES WITH OUTLIER	This is the Part A information.
339	PEP HIPPS REIMBURSEMENT WITH OUTLIER	This is the Part A information.
339	PEP OUTLIER REIMBURSEMENTS	This is THE Part A information.

Report Type	Data Element	Description
339	PEP PROSTHETIC/ORTHOTIC DEVICES	This is the Part A information.
339	PEP DME	This is the Part A information.
339	PEP OXYGEN	This is the Part A information.
339	PEP OTHER FEE REIMBURSEMENTS	This is the Part A information.
339	PEP GROSS REIMBURSEMENT	This is the Part A information.
339	PEP DEDUCTIBLES	This is the Part A information.
339	PEP COINSURANCE	This is the Part A information.
339	PEP NET MSP PAYMENTS	This is the Part A information.
339	PEP MSP RECONCILIATION	This is the Part A information.
339	PEP OTHER ADJUSTMENTS	This is the Part A information.
339	PEP NET REIMBURSEMENT	This is the Part A information.
339	PEP CLAIM INTEREST PAYMENTS	This is the Part A information.
339	SCIC/PEP # EPISODES WITHOUT OUTLIER	This is the Part A information.
339	SCIC/PEP HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is the Part A information.
339	SCIC/PEP # EPISODES WITH OUTLIER	This is the Part A information.
339	SCIC/PEP HIPPS REIMBURSEMENT WITH OUTLIER	This is the Part A information.
339	SCIC/PEP OUTLIER REIMBURSEMENTS	This is the Part A information.
339	SCIC/PEP PROSTHETIC/ORTHOTIC DEVICES	This is the Part A information.
339	SCIC/PEP DME	This is the Part A information.
339	SCIC/PEP OXYGEN	This is the Part A information.
339	SCIC/PEP OTHER FEE REIMBURSEMENTS	This is the Part A information.
339	SCIC/PEP GROSS REIMBURSEMENT	This is the Part A information.
339	SCIC/PEP DEDUCTIBLES	This is the Part A information.
339	SCIC/PEP COINSURANCE	This is the Part A information.
339	SCIC/PEP NET MSP PAYMENTS	This is the Part A information.
339	SCIC/PEP MSP RECONCILIATION	This is the Part A information.
339	SCIC/PEP OTHER ADJUSTMENTS	This is the Part A information.
339	SCIC/PEP NET REIMBURSEMENT	This is the Part A information.
339	SCIC/PEP CLAIM INTEREST PAYMENTS	This is the Part A information.
339	SCIC # EPISODES WITHOUT OUTLIER	This is the Part A information.
339	SCIC HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is the Part A information.
339	SCIC # EPISODES WITH OUTLIER	This is the Part A information.

Report Type	Data Element	Description
339	SCIC HIPPS REIMBURSEMENT WITH OUTLIER	This is the Part A information.
339	SCIC OUTLIER REIMBURSEMENTS	This is the Part A information.
339	SCIC PROSTHETIC/ORTHOTIC DEVICES	This is the Part A information.
339	SCIC DME	This is the Part A information.
339	SCIC OXYGEN	This is the Part A information.
339	SCIC OTHER FEE REIMBURSEMENTS	This is the Part A information.
339	SCIC GROSS REIMBURSEMENT	This is the Part A information.
339	SCIC DEDUCTIBLES	This is the Part A information.
339	SCIC COINSURANCE	This is the Part A information.
339	SCIC NET MSP PAYMENTS	This is the Part A information.
339	SCIC MSP RECONCILIATION	This is the Part A information.
339	SCIC OTHER ADJUSTMENTS	This is the Part A information.
339	SCIC NET REIMBURSEMENT	This is the Part A information.
339	SCIC CLAIM INTEREST PAYMENTS	This is the Part A information.
339	TOTAL HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is the Part A information.
339	TOTAL # EPISODES WITH OUTLIER	This is the Part A information.
339	TOTAL HIPPS REIMBURSEMENT WITH OUTLIER	This is the Part A information.
339	TOTAL OUTLIER REIMBURSEMENTS	This is the Part A information.
339	TOTAL PROSTHETIC/ORTHOTIC DEVICES	This is the Part A information.
339	TOTAL DME	This is the Part A information.
339	TOTAL OXYGEN	This is the Part A information.
339	TOTAL OTHER FEE REIMBURSEMENTS	This is the Part A information.
339	TOTAL GROSS REIMBURSEMENT	This is the Part A information.
339	TOTAL DEDUCTIBLES	This is the Part A information.
339	TOTAL COINSURANCE	This is the Part A information.
339	TOTAL NET MSP PAYMENTS	This is the Part A information.
339	TOTAL MSP RECONCILIATION	This is the Part A information.
339	TOTAL OTHER ADJUSTMENTS	This is the Part A information.
339	TOTAL NET REIMBURSEMENT	This is the Part A information.
339	TOTAL CLAIM INTEREST PAYMENTS	This is the Part A information.
32M	FULL EPISODES	This is the Part B MSP-LCC information.
32M	LUPA EPISODES	This is the Part B MSP-LCC information.
32M	PEP ONLY EPISODES	This is the Part B MSP-LCC information.

Report Type	Data Element	Description
32M	SCIC ONLY EPISODES	This is the Part B MSP-LCC information.
32M	SCIC WITHIN A PEP	This is the Part B MSP-LCC information.
32M	TOTAL	This is the Part B MSP-LCC information.
32M	VISITS	This is the Part B MSP-LCC information.
32M	CHARGES	This is the Part B MSP-LCC information.
32M	REV CODE	This is the Part B MSP-LCC information.
32M	DESCRIPTION	This is the Part B MSP-LCC information.
32M	TOT SERVICES WITHOUT OUTLIER	This is the Part B MSP-LCC information.
32M	TOT SERVICES WITH OUTLIER	This is the Part B MSP-LCC information.
32M	TOT COVERED SERVICES	This is the Part B MSP-LCC information.
32M	# EPISODES WITHOUT OUTLIER	This is the Part B MSP-LCC information.
32M	HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is the Part B MSP-LCC information.
32M	# EPISODES WITH OUTLIER	This is the Part B MSP-LCC information.
32M	HIPPS REIMBURSEMENT WITH OUTLIER	This is the Part B MSP-LCC information.
32M	OUTLIER REIMBURSEMENTS	This is the Part B MSP-LCC information.
32M	PROSTHETIC/ORTHOTIC DEVICES	This is the Part B MSP-LCC information.
32M	DME	This is the Part B MSP-LCC information.
32M	OXYGEN	This is the Part B MSP-LCC information.
32M	OTHER FEE REIMBURSEMENTS	This is the Part B MSP-LCC information.
32M	GROSS REIMBURSEMENT	This is the Part B MSP-LCC information.
32M	DEDUCTIBLES	This is the Part B MSP-LCC information.
32M	COINSURANCE	This is the Part B MSP-LCC information.
32M	NET MSP PAYMENTS	This is the Part B MSP-LCC information.
32M	MSP RECONCILIATION	This is the Part B MSP-LCC information.
32M	OTHER ADJUSTMENTS	This is the Part B MSP-LCC information.
32M	NET REIMBURSEMENT	This is the Part B MSP-LCC information.
32M	CLAIM INTEREST PAYMENTS	This is the Part B MSP-LCC information.
	"Rev Code"(PDF)/ "Revenue Code"(CSV) Column)	This is the Part B MSP-LCC information.

Report Type	Data Element	Description
32M	0023 - Does not display 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up 0274 - Displays by itself 029X - All revenue code lines where the first three positions = '029' are rolled up 042X - All revenue code lines where the first three positions = '042' are rolled up 043X - All revenue code lines where the first three positions = '043' are rolled up 044X - All revenue code lines where the first three positions = '044' are rolled up 055X - All revenue code lines where the first three positions = '055' are rolled up 056X - All revenue code lines where the first three positions = '056' are rolled up 057X - All revenue code lines where the first three positions = '057' are rolled up 058X - All revenue code lines where the first three positions = '058' are rolled up 059X - All revenue code lines where the first three positions = '059' are rolled up 060X - All revenue code lines where the first three positions = '060' are rolled up 062X - All revenue code lines where the first three positions = '062' (excluding 0623) are rolled up 0623 - Displays by itself All other Rev Codes display as they come in on the claim (they do not roll up)	This is the Part B MSP-LCC information.
33M	FULL EPISODES	This is the Part B MSP-LCC information.
33M	LUPA EPISODES	This is the Part B MSP-LCC information.
33M	PEP ONLY EPISODES	This is the Part B MSP-LCC information.
33M	SCIC ONLY EPISODES	This is the Part B MSP-LCC information.
33M	SCIC WITHIN A PEP	This is the Part B MSP-LCC information.
33M	TOTAL	This is the Part B MSP-LCC information.

Report Type	Data Element	Description
33M	VISITS	This is the Part B MSP-LCC information.
33M	CHARGES	This is the Part B MSP-LCC information.
33M	REV CODE	This is the Part B MSP-LCC information.
33M	DESCRIPTION	This is the Part B MSP-LCC information.
33M	TOT SERVICES WITHOUT OUTLIER	This is the Part B MSP-LCC information.
33M	TOT SERVICES WITH OUTLIER	This is the Part B MSP-LCC information.
33M	TOT COVERED SERVICES	This is the Part B MSP-LCC information.
33M	# EPISODES WITHOUT OUTLIER	This is the Part B MSP-LCC information.
33M	HIPPS REIMBURSEMENT WITHOUT OUTLIER	This is the Part B MSP-LCC information.
33M	# EPISODES WITH OUTLIER	This is the Part B MSP-LCC information.
33M	HIPPS REIMBURSEMENT WITH OUTLIER	This is the Part B MSP-LCC information.
33M	OUTLIER REIMBURSEMENTS	This is the Part B MSP-LCC information.
33M	PROSTHETIC/ORTHOTIC DEVICES	This is the Part B MSP-LCC information.
33M	DME	This is the Part B MSP-LCC information.
33M	OXYGEN	This is the Part B MSP-LCC information.
33M	OTHER FEE REIMBURSEMENTS	This is the Part B MSP-LCC information.
33M	GROSS REIMBURSEMENT	This is the Part B MSP-LCC information.
33M	DEDUCTIBLES	This is the Part B MSP-LCC information.
33M	COINSURANCE	This is the Part B MSP-LCC information.
33M	NET MSP PAYMENTS	This is the Part B MSP-LCC information.
33M	MSP RECONCILIATION	This is the Part B MSP-LCC information.
33M	OTHER ADJUSTMENTS	This is the Part B MSP-LCC information.
33M	NET REIMBURSEMENT	This is the Part B MSP-LCC information.
33M	CLAIM INTEREST PAYMENTS	This is the Part B MSP-LCC information.
	"Rev Code"(PDF)/ "Revenue Code"(CSV) Column)	This is the Part B MSP-LCC information.

Report Type	Data Element	Description
33M	0023 - Does not display 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up 0274 - Displays by itself 029X - All revenue code lines where the first three positions = '029' are rolled up 042X - All revenue code lines where the first three positions = '042' are rolled up 043X - All revenue code lines where the first three positions = '043' are rolled up 044X - All revenue code lines where the first three positions = '044' are rolled up 055X - All revenue code lines where the first three positions = '055' are rolled up 056X - All revenue code lines where the first three positions = '056' are rolled up 057X - All revenue code lines where the first three positions = '057' are rolled up 058X - All revenue code lines where the first three positions = '058' are rolled up 059X - All revenue code lines where the first three positions = '059' are rolled up 060X - All revenue code lines where the first three positions = '060' are rolled up 062X - All revenue code lines where the first three positions = '062' (excluding 0623) are rolled up 0623 - Displays by itself All other Rev Codes display as they come in on the claim (they do not roll up)	This is the Part A MSP-LCC information.
399	TOTAL UNDUPLICATED CENSUS COUNT	
399	FULL EPISODES	Total Part A and Part B undup census count for 60 day (full) episodes.
399	LUPA EPISODES	Total Part A and Part B undup census count for 4 or fewer visits during 60 day episode period.

Report Type	Data Element	Description
399	PEP ONLY EPISODES	Total Part A and Part B undup census count for transfer or discharge and return within 60 days.
399	SCIC ONLY EPISODES	Total Part A and Part B undup census count for significant chg in condition (revised diagnosis).
399	SCIC WITHIN A PEP	Total Part A and Part B undup census count for SCIC within PEP definition.
399	TOTAL	Total Part A and Part B undup census counts for all episode types.
399	VISITS	Total Part A and Part B visits.
399	CHARGES	Total Part A and Part B covered charges.
399	REV CODE	
399	DESCRIPTION	
399	TOT SERVICES WITHOUT OUTLIER	
399	TOT SERVICES WITH OUTLIER	
399	TOT COVERED SERVICES	
399	"Rev Code"(PDF)/ "Revenue Code"(CSV) Column)	
399	SERVICES WITHOUT OUTLIER	
399	FULL 0023 - Does not display	
399	FULL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	This is the total (Part A and Part B) med supplies payments.
399	FULL 0274 - Displays by itself	Part B Prosthetic/Orthotic Device charges without outlier.
399	FULL 029X - All revenue codes lines where the first three positions = '029' are rolled up	This is the total (Part A and Part B) durable medical equipment payments.
399	FULL 042X - All revenue code lines where the first three positions = '042' are rolled up	Total Part A and Part B physical therapy visit count during full episode without outlier.
399	FULL 043X - All revenue code lines where the first three positions = '043' are rolled up	Total Part A and Part B occupational therapy visit count during full episode without outlier.
399	FULL 044X - All revenue code lines where the first three positions = '044' are rolled up	Total Part A and Part B occupational therapy visit count during full episode without outlier.
399	FULL 055X - All revenue code lines where the first three positions = '055' are rolled up	Total Part A and Part B visit count related to nursing services during full episode without outlier.
399	FULL 056X - All revenue code lines where the first three positions = '056' are rolled up	Total Part A and Part B visit count related to med soc serv during full episode without outlier.

Report Type	Data Element	Description
399	FULL 057X - All revenue code lines where the first three positions = '057' are rolled up	Total Part A and Part B visit count related to home health aide service during full episode without outlier.
399	FULL 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits without outlier.
399	FULL 059X - All revenue code lines where the first three positions = '059' are rolled up	Total Part A and Part B visit count for various disciplines for full episode without outlier.
399	FULL 060X - All revenue code lines where the first three positions = '060' are rolled up	This is the total oxygen for full episode.
399	FULL 062X - All revenue code lines where the first three positions = '062' are rolled up	This is the total med suppl for full episode.
399	FULL 0623 - Displays by itself	This is the total surg dress for full episode.
399	FULL All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	LUPA 0023 - Does not display	These fields are not populated on this report.
399	LUPA 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	This is the total medical supplies for full episode.
399	LUPA 0274 - Displays by itself	Part B Prosthetic/Orthotic Device charges without outlier.
399	LUPA 029X - All revenue codes lines where the first three positions = '029' are rolled up	This is the total durable medical equipment for LUPA.
399	LUPA 042X - All revenue code lines where the first three positions = '042' are rolled up	Total Part A and Part B physical therapy visit count during LUPA episode.
399	LUPA 043X - All revenue code lines where the first three positions = '043' are rolled up	Total Part A and Part B occupational therapy visit count during LUPA episode.
399	LUPA 044X - All revenue code lines where the first three positions = '044' are rolled up	Total Part A and Part B speech therapy visit count during LUPA episode.
399	LUPA 055X - All revenue code lines where the first three positions = '055' are rolled up	Total Part A and Part B visit count related to nursing services during PEP episode.
399	LUPA 056X - All revenue code lines where the first three positions = '056' are rolled up	Total Part A and Part B visit count related to med soc serv during LUPA episode.

Report Type	Data Element	Description
399	LUPA 057X - All revenue code lines where the first three positions = '057' are rolled up	Total Part A and Part B visit count related to home health aide serv during LUPA episode.
399	LUPA 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B Other Visits without outlier.
399	LUPA 059X - All revenue code lines where the first three positions = '059' are rolled up	Total Part A and Part B visit count for all disciplines for LUPA episodes.
399	LUPA 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B Oxygen charges without outlier.
399	LUPA 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B Med Supplies charges without outlier.
399	LUPA 0623 - Displays by itself	Total Part B Surgical Dressings charges without outlier.
399	LUPA All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B Revenue Code Charges.
399	PEP 0023 - Does not display	These fields are not populated on this report.
399	PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B Med Supplies charges with outlier.
399	PEP 0274 - Displays by itself	Part B Prosthetics and Orthotics charges with outlier.
399	PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B Durable Med Equip charges with outlier.
399	PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	Total Part A and Part B physical therapy visit count during PEP episode.
399	PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	Total Part A and Part B occupational therapy visit count during PEP episode.
399	PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	Total Part A and Part B speech therapy visit count during PEP episode.
399	PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	Total Part A and Part B visit count related to nursing services during PEP episode.
399	PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	Total Part A and Part B visit count related to med soc serv during PEP episode.

Report Type	Data Element	Description
399	PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	Total Part A and Part B visit count related to home health aide serv during PEP episode.
399	PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B Other Visits with outlier.
399	PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	Total Part A and Part B visit count for all disciplines for PEP episodes.
399	PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B Oxygen charges with outlier
399	PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B Med Supplies charges with outlier.
399	PEP 0623 - Displays by itself	Part B Surgical Dressings charges with outlier.
399	PEP All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B Revenue Code Charges.
399	SCIC/PEP 0023 - Does not display	These fields are not populated on this report.
399	SCIC/PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B Med Supplies charges with outlier.
399	SCIC/PEP 0274 - Displays by itself	Part B Prosthetics and Orthotics charges with outlier.
399	SCIC/PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B Durable Med Equip charges with outlier.
399	SCIC/PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	Total Part A and Part B occupational therapy visit count during SCIC/ PEP episode.
399	SCIC/PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	Total Part A and Part B occupational therapy visit count during SCIC/PEP episode.
399	SCIC/PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	Total Part A and Part B speech therapy visit count during SCIC/PEP episode.
399	SCIC/PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	Total Part A and Part B visit count related to nursing services during SCIC/PEP episode.
399	SCIC/PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	Total Part A and Part B visit count related to med soc serv during SCIC/PEP episode.

Report Type	Data Element	Description
399	SCIC/PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	Total Part A and Part B visit count related to home health aide serv during SCIC/PEP episode.
399	SCIC/PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B Other Visits with outlier.
399	SCIC/PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	Total Part A and Part B visit count for all disciplines for SCIC/PEP episodes.
399	SCIC/PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges with outlier.
399	SCIC/PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges with outlier.
399	SCIC/PEP 0623 - Displays by itself	Part B surgical dressings charges with outlier.
399	SCIC/PEP All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	SCIC 0023 - Does not display	These fields are not populated on this report.
399	SCIC 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B medical supplies charges with outlier.
399	SCIC 0274 - Displays by itself	Part B prosthetics and orthotics charges with outlier.
399	SCIC 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges with outlier.
399	SCIC 042X - All revenue code lines where the first three positions = '042' are rolled up	Total Part A and Part B occupational therapy visit count during SCIC only episode.
399	SCIC 043X - All revenue code lines where the first three positions = '043' are rolled up	Total Part A and Part B occupational therapy visit count during SCIC only episode.
399	SCIC 044X - All revenue code lines where the first three positions = '044' are rolled up	Total Part A and Part B speech therapy visit count during SCIC only episode.
399	SCIC 055X - All revenue code lines where the first three positions = '055' are rolled up	Total Part A and Part B visit count related to nursing services during SCIC only episode.
399	SCIC 056X - All revenue code lines where the first three positions = '056' are rolled up	Total Part A and Part B visit count related to med soc serv during SCIC only episode.

Report Type	Data Element	Description
399	SCIC 057X - All revenue code lines where the first three positions = '057' are rolled up	Total Part A and Part B visit count related to home health aide serv during SCIC only episode.
399	SCIC 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits with outlier.
399	SCIC 059X - All revenue code lines where the first three positions = '059' are rolled up	Total Part A and Part B visit count for all disciplines for SCIC only episodes.
399	SCIC 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges with outlier.
399	SCIC 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges with outlier.
399	SCIC 0623 - Displays by itself	Part B surgical dressings charges with outlier.
399	SCIC All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	TOTAL 0023 - Does not display	These fields are not populated on this report.
399	TOTAL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B medical supplies charges with outlier.
399	TOTAL 0274 - Displays by itself	Part B prosthetics and orthotics charges with outlier.
399	TOTAL 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges with outlier.
399	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	Total Part A and Part B occupational therapy visit count for all disciplines.
399	TOTAL 043X - All revenue code lines where the first three positions = '043' are rolled up	Total Part A and Part B occupational therapy visit count for all disciplines.
399	TOTAL 044X - All revenue code lines where the first three positions = '044' are rolled up	Total Part A and Part B speech therapy visit count for all disciplines.
399	TOTAL 055X - All revenue code lines where the first three positions = '055' are rolled up	Total Part A and Part B visit count related to nursing services for all disciplines.
399	TOTAL 056X - All revenue code lines where the first three positions = '056' are rolled up	Total Part A and Part B visit count related to med soc serv for all disciplines.

Report Type	Data Element	Description
399	TOTAL 057X - All revenue code lines where the first three positions = '057' are rolled up	Total Part A and Part B visit count related to home health aide serv for all disciplines.
399	TOTAL 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits with outlier.
399	TOTAL 059X - All revenue code lines where the first three positions = '059' are rolled up	Total Part A and Part B visit count for all disciplines for all disciplines.
399	TOTAL 060X - All revenue code lines where the first three positions = '060' are rolled up	Total Part B oxygen charges without outlier.
399	TOTAL 062X - All revenue code lines where the first three positions = '062' are rolled up	Total Part B Med Supplies charges without outlier.
399	TOTAL 0623 - Displays by itself	Total Part B Surgical Dressings charges without outlier.
399	TOTAL All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B Revenue Code Charges.
399	SERVICES WITH OUTLIER	
399	FULL 0023 - Does not display	These fields are not populated on this report.
399	FULL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Total (Part A and Part B) med supplies payments.
399	FULL 0274 - Displays by itself	Part B Prosthetics and Orthotics charges with outlier.
399	FULL 029X - All revenue codes lines where the first three positions = '029' are rolled up	Total (Part A and Part B) durable medical equipment payments.
399	FULL 042X - All revenue code lines where the first three positions = '042' are rolled up	Physical therapy visit count during full episode with outlier.
399	FULL 043X - All revenue code lines where the first three positions = '043' are rolled up	Occupational therapy visit count during full episode with outlier.
399	FULL 044X - All revenue code lines where the first three positions = '044' are rolled up	Occupational therapy visit count during full episode with outlier.
399	FULL 055X - All revenue code lines where the first three positions = '055' are rolled up	Visit count related to nursing services during full episode with outlier.
399	FULL 056X - All revenue code lines where the first three positions = '056' are rolled up	Visit count related to med soc serv during full episode without outlier.

Report Type	Data Element	Description
399	FULL 057X - All revenue code lines where the first three positions = '057' are rolled up	Visit count related to home health aide serv during full episode with outlier.
399	FULL 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits.
399	FULL 059X - All revenue code lines where the first three positions = '059' are rolled up	Total visit count for various disciplines for full episode with outlier.
399	FULL 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges with outlier.
399	FULL 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges with outlier.
399	FULL 0623 - Displays by itself	Part B surgical dressings charges with outlier.
399	FULL All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	LUPA 0023 - Does not display	These fields are not populated on this report.
399	LUPA 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B medical supplies charges with outlier.
399	LUPA 0274 - Displays by itself	Part B prosthetics and orthotics charges with outlier.
399	LUPA 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges with outlier.
399	LUPA 042X - All revenue code lines where the first three positions = '042' are rolled up	Total physical therapy covered charges during LUPA episode.
399	LUPA 043X - All revenue code lines where the first three positions = '043' are rolled up	Total occupational therapy covered charges during LUPA episode.
399	LUPA 044X - All revenue code lines where the first three positions = '044' are rolled up	Total speech therapy covered charges during LUPA episode.
399	LUPA 055X - All revenue code lines where the first three positions = '055' are rolled up	Total covered charges related to nursing services during PEP episode.
399	LUPA 056X - All revenue code lines where the first three positions = '056' are rolled up	Total covered charges related to med soc serv during LUPA episode.

Report Type	Data Element	Description
399	LUPA 057X - All revenue code lines where the first three positions = '057' are rolled up	Total covered charges related to home health aide serv during LUPA episode.
399	LUPA 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits.
399	LUPA 059X - All revenue code lines where the first three positions = '059' are rolled up	Total visit covered charges for various disciplines for LUPA episode.
399	LUPA 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges with outlier.
399	LUPA 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges with outlier.
399	LUPA 0623 - Displays by itself	Part B surgical dressings charges with outlier.
399	LUPA All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	PEP 0023 - Does not display	These fields are not populated on this report.
399	PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B medical supplies charges with outlier.
399	PEP 0274 - Displays by itself	Part B prosthetics and orthotics charges with outlier.
399	PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges with outlier.
399	PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	Total physical therapy covered charges during PEP episode.
399	PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	Total occupational therapy covered charges during PEP episode.
399	PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	Total speech therapy covered charges during PEP episode.
399	PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	Total covered charges related to nursing services during PEP episode.
399	PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	Total covered charges related to med soc serv during PEP episode.

Report Type	Data Element	Description
399	PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	Total covered charges related to home health aide serv during PEP episode.
399	PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits.
399	PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	Total visit covered charges for various disciplines for PEP episode.
399	PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges with outlier.
399	PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges with outlier.
399	PEP 0623 - Displays by itself	Part B surgical dressings charges with outlier.
399	PEP All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	SCIC/PEP 0023 - Does not display	These fields are not populated on this report.
399	SCIC/PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B medical supplies charges with outlier.
399	SCIC/PEP 0274 - Displays by itself	Part B prosthetics and orthotics charges with outlier.
399	SCIC/PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges with outlier.
399	SCIC/PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	Total physical therapy covered charges during SCIC/PEP episode.
399	SCIC/PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	Total occupational therapy covered charges during SCIC/PEP episode.
399	SCIC/PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	Total speech therapy covered charges during SCIC/PEP episode.
399	SCIC/PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	Total covered charges related to nursing services during SCIC/PEP episode.
399	SCIC/PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	Total covered charges related to med soc serv during SCIC/ PEP episode.

Report Type	Data Element	Description
399	SCIC/PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	Total covered charges related to home health aide serv during SCIC/PEP episode.
399	SCIC/PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits.
399	SCIC/PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	Total visit covered charges for various disciplines for SCIC/PEP episode.
399	SCIC/PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges with outlier.
399	SCIC/PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges with outlier.
399	SCIC/PEP 0623 - Displays by itself	Part B surgical dressings charges with outlier.
399	SCIC/PEP All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	SCIC 0023 - Does not display	These fields are not populated on this report.
399	SCIC 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B medical supplies charges with outlier.
399	SCIC 0274 - Displays by itself	Part B prosthetics and orthotics charges with outlier.
399	SCIC 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges with outlier.
399	SCIC 042X - All revenue code lines where the first three positions = '042' are rolled up	Total physical therapy covered charges during SCIC only episode.
399	SCIC 043X - All revenue code lines where the first three positions = '043' are rolled up	Total occupational therapy covered charges during SCIC only episode.
399	SCIC 044X - All revenue code lines where the first three positions = '044' are rolled up	Total speech therapy covered charges during SCIC only episode.
399	SCIC 055X - All revenue code lines where the first three positions = '055' are rolled up	Total covered charges related to nursing services during SCIC only episode.
399	SCIC 056X - All revenue code lines where the first three positions = '056' are rolled up	Total covered charges related to med soc serv during SCIC only episode.

Report Type	Data Element	Description
399	SCIC 057X - All revenue code lines where the first three positions = '057' are rolled up	Total covered charges related to home health aide services during SCIC only episode.
399	SCIC 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits.
399	SCIC 059X - All revenue code lines where the first three positions = '059' are rolled up	Total visit covered charges for various disciplines for SCIC only episode.
399	SCIC 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B Oxygen charges with outlier.
399	SCIC 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B Med Supplies charges with outlier.
399	SCIC 0623 - Displays by itself	Part B Surgical Dressings charges with outlier.
399	SCIC All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B Revenue Code Charges.
399	TOTAL 0023 - Does not display	These fields are not populated on this report.
399	TOTAL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B medical supplies charges with outlier.
399	TOTAL 0274 - Displays by itself	Part B prosthetics and orthotics charges with outlier.
399	TOTAL 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges with outlier.
399	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	Part B physical therapy count with outlier.
399	TOTAL 043X - All revenue code lines where the first three positions = '043' are rolled up	Part B occupational therapy count with outlier.
399	TOTAL 044X - All revenue code lines where the first three positions = '044' are rolled up	Part B speech count with outlier.
399	TOTAL 055X - All revenue code lines where the first three positions = '055' are rolled up	Part B nursing count with outlier.
399	TOTAL 056X - All revenue code lines where the first three positions = '056' are rolled up	Part B Med Soc Serv with outlier.

Report Type	Data Element	Description
399	TOTAL 057X - All revenue code lines where the first three positions = '057' are rolled up	Part B home health aide count with outlier.
399	TOTAL 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits.
399	TOTAL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not normally used.
399	TOTAL 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges with outlier.
399	TOTAL 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges with outlier.
399	TOTAL 0623 - Displays by itself	Part B surgical dressings charges with outlier.
399	TOTAL All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	TOTAL SERVICES	
399	FULL 0023 - Does not display	These fields are not populated on this report.
399	FULL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B medical supplies charges.
399	FULL 0274 - Displays by itself	Part B prosthetics and orthotics charges.
399	FULL 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges.
399	FULL 042X - All revenue code lines where the first three positions = '042' are rolled up	Part B physical therapy count.
399	FULL 043X - All revenue code lines where the first three positions = '043' are rolled up	Part B occupational therapy count.
399	FULL 044X - All revenue code lines where the first three positions = '044' are rolled up	Part B speech count.
399	FULL 055X - All revenue code lines where the first three positions = '055' are rolled up	Part B nursing count.
399	FULL 056X - All revenue code lines where the first three positions = '056' are rolled up	Part B Med Soc Serv.

Report Type	Data Element	Description
399	FULL 057X - All revenue code lines where the first three positions = '057' are rolled up	Part B Home Health Aide count.
399	FULL 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits without outlier.
399	FULL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not normally used.
399	FULL 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B Oxygen charges.
399	FULL 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B Med Supplies charges.
399	FULL 0623 - Displays by itself	Part B Surgical Dressings charges.
399	FULL All other Rev Codes display as they come in on the claim (they do not roll up)	All other
399	LUPA 0023 - Does not display	These fields are not populated on this report.
399	LUPA 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B Med Supplies charges.
399	LUPA 0274 - Displays by itself	Part B Prosthetics and Orthotics charges.
399	LUPA 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B Durable Med Equip charges.
399	LUPA 042X - All revenue code lines where the first three positions = '042' are rolled up	Total physical therapy covered charges during LUPA episode.
399	LUPA 043X - All revenue code lines where the first three positions = '043' are rolled up	Total occupational therapy covered charges during LUPA episode.
399	LUPA 044X - All revenue code lines where the first three positions = '044' are rolled up	Total speech therapy covered charges during LUPA episode.
399	LUPA 055X - All revenue code lines where the first three positions = '055' are rolled up	Total covered charges related to nursing services during PEP episode.
399	LUPA 056X - All revenue code lines where the first three positions = '056' are rolled up	Total covered charges related to med soc serv during LUPA episode.

Report Type	Data Element	Description
399	LUPA 057X - All revenue code lines where the first three positions = '057' are rolled up	Total covered charges related to home health aide serv during LUPA episode.
399	LUPA 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits without outlier.
399	LUPA 059X - All revenue code lines where the first three positions = '059' are rolled up	Total visit covered charges for various disciplines for LUPA episode.
399	LUPA 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges.
399	LUPA 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges.
399	LUPA 0623 - Displays by itself	Part B surgical dressings charges.
399	LUPA All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	PEP 0023 - Does not display	These fields are not populated on this report.
399	PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B Med Supplies charges.
399	PEP 0274 - Displays by itself	Part B prosthetics and orthotics charges.
399	PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges.
399	PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	Total physical therapy covered charges during PEP episode.
399	PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	Total occupational therapy covered charges during PEP episode.
399	PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	Total speech therapy covered charges during PEP episode.
399	PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	Total covered charges related to nursing services during PEP episode.
399	PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	Total covered charges related to med soc serv during PEP episode.

Report Type	Data Element	Description
399	PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	Total covered charges related to home health aide serv during PEP episode.
399	PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits without outlier.
399	PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	Total visit covered charges for various disciplines for PEP episode.
399	PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges.
399	PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges.
399	PEP 0623 - Displays by itself	Part B surgical dressings charges.
399	PEP All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	SCIC/PEP 0023 - Does not display	These fields are not populated on this report.
399	SCIC/PEP 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B medical supplies charges.
399	SCIC/PEP 0274 - Displays by itself	Part B prosthetics and orthotics charges.
399	SCIC/PEP 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges.
399	SCIC/PEP 042X - All revenue code lines where the first three positions = '042' are rolled up	Total physical therapy covered charges during SCIC/PEP episode.
399	SCIC/PEP 043X - All revenue code lines where the first three positions = '043' are rolled up	Total occupational therapy covered charges during SCIC/PEP episode.
399	SCIC/PEP 044X - All revenue code lines where the first three positions = '044' are rolled up	Total speech therapy covered charges during SCIC/PEP episode.
399	SCIC/PEP 055X - All revenue code lines where the first three positions = '055' are rolled up	Total covered charges related to nursing services during SCIC/PEP episode.
399	SCIC/PEP 056X - All revenue code lines where the first three positions = '056' are rolled up	Total covered charges related to med soc serv during SCIC/ PEP episode.

Report Type	Data Element	Description
399	SCIC/PEP 057X - All revenue code lines where the first three positions = '057' are rolled up	Total covered charges related to home health aide serv during SCIC/PEP episode.
399	SCIC/PEP 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits without outlier.
399	SCIC/PEP 059X - All revenue code lines where the first three positions = '059' are rolled up	Total visit covered charges for various disciplines for SCIC/PEP episode.
399	SCIC/PEP 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B oxygen charges.
399	SCIC/PEP 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B medical supplies charges.
399	SCIC/PEP 0623 - Displays by itself	Part B surgical dressings charges.
399	SCIC/PEP All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	SCIC 0023 - Does not display	These fields are not populated on this report.
399	SCIC 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Part B med supplies charges.
399	SCIC 0274 - Displays by itself	Part B prosthetics and orthotics charges.
399	SCIC 029X - All revenue codes lines where the first three positions = '029' are rolled up	Part B durable medical equipment charges.
399	SCIC 042X - All revenue code lines where the first three positions = '042' are rolled up	Total physical therapy covered charges during SCIC only episode.
399	SCIC 043X - All revenue code lines where the first three positions = '043' are rolled up	Total occupational therapy covered charges during SCIC only episode.
399	SCIC 044X - All revenue code lines where the first three positions = '044' are rolled up	Total speech therapy covered charges during SCIC only episode.
399	SCIC 055X - All revenue code lines where the first three positions = '055' are rolled up	Total covered charges related to nursing services during SCIC only episode.
399	SCIC 056X - All revenue code lines where the first three positions = '056' are rolled up	Total covered charges related to medical social services during SCIC only episode.

Report Type	Data Element	Description
399	SCIC 057X - All revenue code lines where the first three positions = '057' are rolled up	Total covered charges related to home health aide services during SCIC only episode.
399	SCIC 058X - All revenue code lines where the first three positions = '058' are rolled up	Part B other visits without outlier.
399	SCIC 059X - All revenue code lines where the first three positions = '059' are rolled up	Total visit covered charges for various disciplines for SCIC only episode.
399	SCIC 060X - All revenue code lines where the first three positions = '060' are rolled up	Part B Oxygen charges.
399	SCIC 062X - All revenue code lines where the first three positions = '062' are rolled up	Part B Med Supplies charges.
399	SCIC 0623 - Displays by itself	Part B Surgical Dressings charges.
399	SCIC All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B Revenue Code Charges.
399	TOTAL 0023 - Does not display	These fields are not populated on this report.
399	TOTAL 027X - All revenue code lines where the first three positions = '027' (excluding 0274) are rolled up	Total Part B medical supplies charges.
399	TOTAL 0274 - Displays by itself	Total Part B prosthetic and orthotic device charges.
399	TOTAL 029X - All revenue codes lines where the first three positions = '029' are rolled up	Total Part B durable medical equipment charges.
399	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	Total Part B physical therapy count.
399	TOTAL 043X - All revenue code lines where the first three positions = '043' are rolled up	Total Part B occupational therapy count.
399	TOTAL 044X - All revenue code lines where the first three positions = '044' are rolled up	Total Part B speech count.
399	TOTAL 055X - All revenue code lines where the first three positions = '055' are rolled up	Total Part B nursing count.
399	TOTAL 056X - All revenue code lines where the first three positions = '056' are rolled up	Total Part B medical social services.

Report Type	Data Element	Description
399	TOTAL 057X - All revenue code lines where the first three positions = '057' are rolled up	Total Part B home health aide count.
399	TOTAL 058X - All revenue code lines where the first three positions = '058' are rolled up	Total Part B other visits.
399	TOTAL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not normally used.
399	TOTAL 060X - All revenue code lines where the first three positions = '060' are rolled up	Total Part B oxygen charges.
399	TOTAL 062X - All revenue code lines where the first three positions = '062' are rolled up	Total Part B medical supplies charges.
399	TOTAL 0623 - Displays by itself	Total Part B surgical dressings charges.
399	TOTAL All other Rev Codes display as they come in on the claim (they do not roll up)	All other Part B revenue code charges.
399	FULL # EPISODES WITHOUT OUTLIER	Part B number of episodes without outlier for full episodes.
399	FULL HIPPS REIMBURSEMENT WITHOUT OUTLIER	Part B HIPPS reimbursement without outlier for full episodes.
399	FULL # EPISODES WITH OUTLIER	Part B number of episodes with outlier for full episodes.
399	FULL HIPPS REIMBURSEMENT WITH OUTLIER	Part B HIPPS reimbursement with outlier for full episodes.
399	FULL OUTLIER REIMBURSEMENTS	Part B outlier reimbursement for full episodes.
399	FULL PROSTHETIC/ORTHOTIC DEVICES	Total prosthetics and orthotics for full episodes.
399	FULL DME	Total durable medical equipment for full episodes.
399	FULL OXYGEN	Oxygen for full episodes.
399	FULL OTHER FEE REIMBURSEMENTS	Total other fee reimbursement.
399	FULL GROSS REIMBURSEMENT	Part B gross reimbursement for full episodes.
399	FULL DEDUCTIBLES	Total Part B deductibles.
399	FULL COINSURANCE	Total coinsurance.
399	FULL NET MSP PAYMENTS	Total MSP.
399	FULL MSP RECONCILIATION	Net MSP for Part B.
399	FULL OTHER ADJUSTMENTS	Total other adjustment.
399	FULL NET REIMBURSEMENT	Total net reimbursement.
399	FULL CLAIM INTEREST PAYMENTS	Part B claim interest payments for full episodes.
399	LUPA # EPISODES WITHOUT OUTLIER	Part B # of Episodes w/o outlier for LUPA.

Report Type	Data Element	Description
399	LUPA HIPPS REIMBURSEMENT WITHOUT OUTLIER	Part B HIPPS reimbursement without outlier for LUPA.
399	LUPA # EPISODES WITH OUTLIER	Part B # of Episodes with outlier for LUPA.
399	LUPA HIPPS REIMBURSEMENT WITH OUTLIER	Part B HIPPS reimbursement with outlier for LUPA.
399	LUPA OUTLIER REIMBURSEMENTS	Part B outlier reimbursement for LUPA.
399	LUPA PROSTHETIC/ORTHOTIC DEVICES	Part B P&O for LUPA.
399	LUPA DME	Part B DME for LUPA.
399	LUPA OXYGEN	Part B Oxygen for LUPA.
399	LUPA OTHER FEE REIMBURSEMENTS	Part B Other Fee for LUPA.
399	LUPA GROSS REIMBURSEMENT	Part B gross reimbursement for LUPA.
399	LUPA DEDUCTIBLES	Part B deductible for LUPA.
399	LUPA COINSURANCE	Part B coinsurance for LUPA.
399	LUPA NET MSP PAYMENTS	Part B MSP Recon for LUPA.
399	LUPA MSP RECONCILIATION	Part B Net MSP Payment for LUPA.
399	LUPA OTHER ADJUSTMENTS	Part B Other Adjust for LUPA.
399	LUPA NET REIMBURSEMENT	Part B net reimbursement for LUPA.
399	LUPA CLAIM INTEREST PAYMENTS	Part B claim interest payments for LUPA.
399	PEP # EPISODES WITHOUT OUTLIER	Part B # of Episodes w/o outlier for PEP.
399	PEP HIPPS REIMBURSEMENT WITHOUT OUTLIER	Part B HIPPS reimbursement without outlier for PEP.
399	PEP # EPISODES WITH OUTLIER	Part B # of Episodes with outlier for PEP.
399	PEP HIPPS REIMBURSEMENT WITH OUTLIER	Part B HIPPS reimbursement with outlier for PEP.
399	PEP OUTLIER REIMBURSEMENTS	Part B outlier reimbursement for PEP.
399	PEP PROSTHETIC/ORTHOTIC DEVICES	Part B P&O for PEP.
399	PEP DME	Part B DME for PEP.
399	PEP OXYGEN	Part B Oxygen for PEP.
399	PEP OTHER FEE REIMBURSEMENTS	Part B Other Fee for PEP.
399	PEP GROSS REIMBURSEMENT	Part B gross reimbursement for PEP.
399	PEP DEDUCTIBLES	Part B Deduct for PEP.
399	PEP COINSURANCE	Part B Coins for PEP.
399	PEP NET MSP PAYMENTS	Part B MSP Recon for PEP.
399	PEP MSP RECONCILIATION	Part B Net MSP Payment for PEP.
399	PEP OTHER ADJUSTMENTS	Part B Other Adjust for PEP.
399	PEP NET REIMBURSEMENT	Part B net reimbursement for PEP.
399	PEP CLAIM INTEREST PAYMENTS	Part B Claim Interest Payments for PEP.

Report Type	Data Element	Description
399	SCIC/PEP # EPISODES WITHOUT OUTLIER	Part B # of Episodes w/o outlier for SCIC/PEP.
399	SCIC/PEP HIPPS REIMBURSEMENT WITHOUT OUTLIER	Part B HIPPS reimbursement without outlier for SCIC/PEP.
399	SCIC/PEP # EPISODES WITH OUTLIER	Part B # of Episodes with outlier for SCIC/PEP.
399	SCIC/PEP HIPPS REIMBURSEMENT WITH OUTLIER	Part B HIPPS Reimb with outlier for SCIC/PEP.
399	SCIC/PEP OUTLIER REIMBURSEMENTS	Part B outlier reimb for SCIC/PEP.
399	SCIC/PEP PROSTHETIC/ORTHOTIC DEVICES	Part B P&O for SCIC/PEP.
399	SCIC/PEP DME	Part B DME for SCIC/PEP.
399	SCIC/PEP OXYGEN	Part B Oxygen for SCIC/PEP.
399	SCIC/PEP OTHER FEE REIMBURSEMENTS	Part B Other Fee for SCIC/PEP.
399	SCIC/PEP GROSS REIMBURSEMENT	Part B Gross Reimb for SCIC/PEP.
399	SCIC/PEP DEDUCTIBLES	Part B Deduct for SCIC/PEP.
399	SCIC/PEP COINSURANCE	Part B Coins for SCIC/PEP.
399	SCIC/PEP NET MSP PAYMENTS	Part B MSP Recon for SCIC/PEP.
399	SCIC/PEP MSP RECONCILIATION	Part B Net MSP Payment for SCIC/PEP.
399	SCIC/PEP OTHER ADJUSTMENTS	Part B Other Adjust for SCIC/PEP.
399	SCIC/PEP NET REIMBURSEMENT	Part B Net Reimb for SCIC/PEP.
399	SCIC/PEP CLAIM INTEREST PAYMENTS	Part B Claim Interest Payments for SCIC/PEP.
399	SCIC # EPISODES WITHOUT OUTLIER	Part B # of Episodes w/o outlier for SCIC.
399	SCIC HIPPS REIMBURSEMENT WITHOUT OUTLIER	Part B HIPPS Reimb w/o outlier for SCIC.
399	SCIC # EPISODES WITH OUTLIER	Part B # of Episodes with outlier for SCIC.
399	SCIC HIPPS REIMBURSEMENT WITH OUTLIER	Part B HIPPS Reimb with outlier for SCIC.
399	SCIC OUTLIER REIMBURSEMENTS	Part B outlier reimb for SCIC.
399	SCIC PROSTHETIC/ORTHOTIC DEVICES	Part B P&O for SCIC.
399	SCIC DME	Part B DME for SCIC.
399	SCIC OXYGEN	Part B Oxygen for SCIC.
399	SCIC OTHER FEE REIMBURSEMENTS	Part B Other Fee for SCIC.
399	SCIC GROSS REIMBURSEMENT	Part B Gross Reimb for SCIC.
399	SCIC DEDUCTIBLES	Part B Deduct for SCIC.
399	SCIC COINSURANCE	Part B Coins for SCIC.
399	SCIC NET MSP PAYMENTS	Part B MSP Recon for SCIC.
399	SCIC MSP RECONCILIATION	Part B Net MSP Payment for SCIC.

Report Type	Data Element	Description
399	SCIC OTHER ADJUSTMENTS	Part B Other Adjust for SCIC.
399	SCIC NET REIMBURSEMENT	Part B Net Reimb for SCIC.
399	SCIC CLAIM INTEREST PAYMENTS	Part B Claim Interest Payments for SCIC.
399	TOTAL HIPPS REIMBURSEMENT WITHOUT OUTLIER	Total Part B # of Episodes w/o outlier.
399	TOTAL # EPISODES WITH OUTLIER	Total Part B HIPPS Reimb w/o outlier.
399	TOTAL HIPPS REIMBURSEMENT WITH OUTLIER	Total Part B # of Episodes with outlier.
399	TOTAL OUTLIER REIMBURSEMENTS	Total Part B HIPPS Reimb with outlier.
399	TOTAL PROSTHETIC/ORTHOTIC DEVICES	Total P&O for full episodes.
399	TOTAL DME	Total DME for full episodes.
399	TOTAL OXYGEN	Oxygen for full episodes.
399	TOTAL OTHER FEE REIMBURSEMENTS	Total other fee reimbursements.
399	TOTAL GROSS REIMBURSEMENT	Total Part B gross reimbursement.
399	TOTAL DEDUCTIBLES	Total Part B deductible.
399	TOTAL COINSURANCE	Total coinsurance.
399	TOTAL NET MSP PAYMENTS	Total MSP.
399	TOTAL MSP RECONCILIATION	Net MSP for Part B.
399	TOTAL OTHER ADJUSTMENTS	Total other adjustments.
399	TOTAL NET REIMBURSEMENT	Total net reimbursement.
399	TOTAL CLAIM INTEREST PAYMENTS	Total Part B claim interest payments.

C Error Messages

This appendix documents the error messages used throughout the PS&R System. This appendix is organized according to the following sections:

- Home Page
- Summary Report Request, Select Provider(s)
- Summary Report Request, Select Report(s)
- Summary Report Request, Select Service Period(s)
- Summary Report Request, Select Report Format
- Summary Report Request, Report Request Confirmation
- Detail Report Request, Select Provider(s)
- Detail Report Request, Select Report(s)
- Detail Report Request, Select Service Period(s)
- Detail Report Request, Select Report Format
- Detail Report Request, Report Request Confirmation
- Detail Report Request, Load Control
- Detail Report Request, FI/MAC Provider Requests
- Miscellaneous Report Request, Select Reports
- Detail Report Request, Miscellaneous
- Miscellaneous System Error Messages
- Error Codes in Numeric Order

Each section provides the form on which the error or warning message results, the type of user, validation, the error message, and where relevant, the error ID.

C.1 Home Page

The Home page error messages are presented in the following table.

Exhibit C-1 Home Page Error Messages

Form/Field	User Type	Validation	Error Message	ID
No Claims loaded	PS&R	There must be claims loaded for a given provider. No reports will be generated with 0 claims loaded.	"Error E318: No claims have been loaded for provider <ID #>."	E318

C.2 Summary Report Request, Select Provider(s)

The Summary Report Request, Select Provider(s) page error messages are presented in the following table.

Exhibit C-2 Summary Report Request, Select Provider(s) Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
"By Provider Number"	CMS, FI/MAC Non-Admin	If no provider is selected from the "By Provider Number" list box	"Error E025: No provider number(s) were chosen."	E025
"By Provider Type Within Contractor" Radio Button	CMS	If "By Provider Number" radio button is not clicked, this radio button must be clicked.	"Error E024: Please select provider(s)."	E024
"By Provider Type" Radio Button	FI/MAC, Parent Provider	If radio button is clicked, at least one provider type must be selected.	"Error E026: "By Provider Type" option selected, but no provider type(s) chosen."	E026
		If "By Provider Number" radio button or "All Providers" (Parent Provider users only) is not clicked, this radio button must be clicked.	"Error E024: Please select provider(s)."	E024
"By Provider Type" Drop Down Menu	CMS, FI/MAC, Parent Provider	Provider type selected must apply to at least one provider applicable to the FI/PP.	"Error E101: No providers of the selected Provider Type(s) are applicable."	E101
"All Providers" (Parent Provider users only) or "By Provider Type" and "Filter by FYE Date" Checkbox	CMS, FI/MAC, Parent Provider	Provider type(s) and FYE date selected must have at least one applicable provider.	"Error E101: No providers of the selected Provider Type(s) are applicable."	E101
"Filter by FYE Date" Checkbox	FI/MAC, Parent Provider	If box is checked, a month must be selected from the "Month" drop-down menu.	"Error E081: "Filter by FYE Date" chosen, but month not selected."	E081
"Filter by FYE Date" Checkbox – "Day" Drop-Down Menu	FI/MAC, Parent Provider	The day selected must be in the month selected.	"Error E310: <date> is not a valid date."	E310

Form / Field	User Type	Validation	Error Message	ID
"By Provider Number" Radio Button	CMS, FI/MAC, Parent Provider	If radio button is clicked, at least one provider number must be selected.	"Error E025: No provider number(s) were chosen."	E025
		If "By Provider Type within Contractor" (CMS users only) or "By Provider Type" or "All Providers" (Parent Provider users only) radio button is not clicked, this radio button must be clicked.	"Error E024: Please select provider(s)."	E024
"All Providers"	Parent Provider	If "By Provider Type" or "By Provider Number" radio button is not clicked, this radio button must be clicked.	"Error E024: Please select provider(s)."	E024

C.3 Summary Report Request, Select Report(s)

The Summary Report Request, Select Report(s) page error messages are presented in the following table.

Exhibit C-3 Summary Report Request, Select Report(s) Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
"By Service Type" Radio Button	All	If "By Report Type" radio button or "By Report Number" radio button is not clicked, this radio button must be clicked.	"Error E034: No reports were selected."	E034
"By Report Group" Radio Button	All	If radio button is clicked, at least one report group must be selected.	"Error E036: "By Report group" option selected, but no report group(s) chosen."	E036
		If "By Service Type" radio button or "By Report Type" radio button is not clicked, this radio button must be clicked.	"Error E034: No reports were selected."	E034
"By Report Type" Radio Button	All	If radio button is clicked, at least one report type must be selected.	"Error E037: "By Report Type" option selected, but no report type(s) chosen."	E037
		If "By Service Type" radio button or "By Report Group" radio button is not clicked, this radio button must be clicked.	"Error E034: No reports were selected."	E034

Form / Field	User Type	Validation	Error Message	ID
"Include 110 DRG Section"	All	If the box is checked, service type selected must be "All" or "Inpatient", Report Group must be 11x, or Report Type must be 110.	"Error E066: The DRG Section is only valid with selections of "All", "Inpatient", "11x", or "110"."	E066
"The 329 and 339 Patient CBSA Visit Section"		Box checked: None of the providers in the request is an HHA Provider (two ways to determine if there is an HHA provider in the request: a) in the report type box a 32x, 33x, or 34x report is included, or b) HHA Provider is in the xx3100-xx3199,xx7000-xx8499,xx9000-xx9799 range.)	"The 329 and 339 Patient CBSA Visit Section is only applicable to HHA Providers and reports 329 and 339."	E320
"The 329 and 339 Patient CBSA Visit Section"		Box Checked: At least one provider is an HHA Provider, but the request is not "Outpatient", or "All" (By Service Type), OR "32x", "33x", "xx9" (By Report Group), OR "329", "339" (By Report Type).	"The 329 and 339 Patient CBSA Visit Section is only applicable to HHA Providers and reports 329 and 339."	E321

C.4 Summary Report Request, Select Service Period(s)

The Summary Report Request, Select Service Period(s) page error and warning messages are presented in the following table.

Exhibit C-4 Summary Report Request, Select Service Period(s) Page Error and Warning Messages

Form / Field	User Type	Validation	Error / Warning Message	ID
Update Service Dates by Interval	All	Date field must not be null.	"Error E322: Period 1 Start Date contains a non-numeric character or is not in MM/DD/YYYY format."	E322
	All	Date field must contain only numeric characters.	"Error E322: Period 1 Start Date contains a non-numeric character or is not in MM/DD/YYYY format."	E322
	All	Date field entry must be in MM/DD/YYYY format.	"Error E322: Period 1 Start Date contains a non-numeric character or is not in MM/DD/YYYY format."	E322

Form / Field	User Type	Validation	Error / Warning Message	ID
	All	The date field's Month, Day, and Year values must be valid.	"Error E001: Period 1 Start Date contains an invalid month, day, and/or year."	E001
Update Service Dates by Period	All	All date field entries must contain only numeric characters.	"Error E069: Service Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E069
	All	All date field entries must be in MM/DD/YYYY format.	"Error E069: Service Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E069
	All	All date fields' Month, Day, and Year values must be valid.	"Error E001: Service Date(s) entry contains an invalid month, day, and/or year."	E001
	All	If one service period's "To" date is populated, it must be greater than or equal to its corresponding "From" date.	"Error E312: Period (#) service dates do not have a valid date range. From: (from date), To: (to date)"	E312
	All	If multiple service period date ranges are provided, service periods 2, 3, and 4's "From" date entry must be greater than the previous service period's "To" Date (note: "previous service period" refers to any prior service period that has an entry – this may require ignoring service periods without entries. This validation assures chronological service periods and that there are no overlapping service periods).	"Error E312: Period (#) service dates do not have a valid date range. From: (from date). To: (to date)"	E312
"Exclude" Checkbox		For each provider, at least one service period's "Exclude" checkbox must not be selected.	"Error E102: All service periods excluded for Provider <ID #>"	E102
Service Period From Dates (in "Selected Service Periods Table")	All	Fields must not be null.	"Error E008: Service start date must be on or after (2006 FYE Date plus 1 day)."	E008

Form / Field	User Type	Validation	Error / Warning Message	ID
Service Period From Dates (in "Selected Service Periods Table")	All	Fields must not be null.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."	E038
Service Period From Dates (in "Selected Service Periods Table")	All	Only numeric characters.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."	E038
	All	Entry must be in MM/DD/YYYY format.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."	E038
	All	Month, Day, and Year values must be valid.	"Error E001: Service Date entry for Provider <ID #> contains an invalid month, day, and/or year."	E001
	All	Entry must be less than or equal to its corresponding Service Period To Date.	"Error E312: Service date(s) for Provider (ID #) do not have a valid date range. From: (from date), To: (to date)"	E312
	All	Entry must be greater than the previous Service Period To Date (this assures chronological service periods and that there are no overlapping service periods).	"Error E092: Service Periods overlap and/or are not chronological for Provider ID: <ID #>."	E092
	All user types except Freestanding Providers	Entry is one day greater than previous Service Period To Date (this checks to see if the service periods are consecutive).	"Warning W004: You have selected non-consecutive service periods for Provider <ID #>. This will exclude cost report data from the results. Do you wish to continue?"	W004
	Freestanding Providers Only	Entry is one day greater than previous Service Period To Date (this checks to see if the service periods are consecutive).	"Warning W004: You have selected non-consecutive service periods. This will exclude cost report data from the results. Do you wish to continue?"	W004

Form / Field	User Type	Validation	Error / Warning Message	ID
	All	Field must not be null.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."	E038
Service Period To Dates (in Update Service Dates by Provider(s))	All	Only numeric characters.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."	E038
	All	Entry must be in MM/DD/YYYY format.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."	E038
	All	Month, Day, and Year values must be valid.	"Error E001: Service Date(s) entry for Provider <ID #> contains an invalid month, day, and/or year."	E001
	All	Entry must be greater than or equal to corresponding Service Period From Date.	"Error E312: Service dates for Provider (ID #) do not have a valid date range. From: (from date), To: (to date)"	E312
	All	Entry must be less than the next Service Period From Date (this assures chronological service periods and that there is no overlapping service periods).	"Error E092: Service Periods overlap and/or are not chronological for Provider <ID #>."	E092
	All	Field must not be null.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
Paid Date From Date	All	Only numeric characters.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
	All	Entry must be in MM/DD/YYYY format.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
	All	Month, Day, and Year values must be valid.	"Error E001: Paid Date(s) entry contains an invalid month, day, and/or year."	E001

Form / Field	User Type	Validation	Error / Warning Message	ID
	All	Entry must be greater than or equal to 01/01/2006	"Error E008: Paid "From" date must be on or after 01/01/2006."	E008
	All	Entry must be less than or equal to the Paid Date "To" Date	"Error E312: Paid Dates do not have a valid date range. From: <from date>, To: <to date>."	E312
	All	Field must not be null.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
Paid Date To Date	All	Only numeric characters.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
	All	Entry must be in MM/DD/YYYY format.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
	All	Month, Day, and Year values must be valid.	"Error E001: Paid Date(s) entry contains an invalid month, day, and/or year."	E001
	All	Entry must be less than or equal to the default date CMS User – the latest paid date from any paid claim file FI/MAC User – the latest paid date from a paid claim file loaded for that FI/MAC Parent Provider and Freestanding/Child Provider User - the latest paid date from a paid claim file loaded for the provider's FI/MAC	"Error E007: Paid "To" date must be on or before <default date>."	E007
	All	Entry must be greater than or equal to the Paid Date "From" Date.	"Error E312: Paid Dates do not have a valid date range. From: <from date>, To: <to date>."	E312

Form / Field	User Type	Validation	Error / Warning Message	ID
Parent Provider no longer has access to a provider	Parent Provider	If you are requesting a report from when a parent provider owned a child provider, it must be in the range of when the Provider owned the child.	"Warning W008: Service dates requested do not coincide with requestor access rights for Provider (ID). These dates will be modified on the Confirm Report Request screen to reflect valid access dates." "Do you wish to Continue?"	W008

C.5 Summary Report Request, Select Report Format

The Summary Report Request, Select Report Format page error messages are presented in the following table.

Exhibit C-5 Summary Report Request, Select Report Format Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
"CSV" Radio Button	All	If the "PDF" radio button is not selected, this must be selected.	"Error E046: No report format was selected. Please choose a report format before continuing."	E046
"PDF" Radio Button	All	If the "CSV" radio button is not selected, this must be selected.	"Error E046: No report format was selected. Please choose a report format before continuing."	E046
"CSV" Format Selected	All	If the Report 1000 was selected from the Select Report(s) screen, the "PDF" format should be selected.	Warning W009: The 1000 report will not generate in CSV format. Do you wish to continue?	W009
"PDF & CSV" Format Selected	All	If the Report 1000 was selected from the Select Report(s) screen, the "PDF" format should be selected.	Warning W009: The 1000 report will not generate in CSV format. Do you wish to continue?	W009
Incorrect Output Format Selected	All	When the incorrect output format is selected.	"Error E169: Output Format is not PDF or CSV."	E169

C.6 Summary Report Request, Report Request Confirmation

The Summary Report Request, Report Request Confirmation page error messages are presented in the following table.

Exhibit C-6 Summary Report Request, Report Request Confirmation Page Error Messages

Form / Field	User Type	Validation	Error Message	ID

Form / Field	User Type	Validation	Error Message	ID
"Exclude" Checkbox	CMS, FI/MAC, Parent Provider	At least one provider's "Exclude" checkbox must not be selected.	"Error E311: At least one provider's "Exclude" checkbox must not be selected."	E311
"Your Request Name" Field	All	The "Your Request Name" field cannot be null.	"Error E047: "Your Request Name" is not entered. Please enter a request name to proceed."	E047
	All	This field can only contain alpha-numeric characters and the following special characters: - _ , .	"Error E152: Request Name can only contain alpha-numeric characters and the following special characters: - _ , ."	E152
No Data Available	All	The number of reports generated must be greater than zero	"Error E315: The request will not generate any reports"	E315
"Save Request as Favorite" Checkbox selected	All	The "Favorite Name" field must contain valid data if the "Save Request as Favorite" checkbox is selected.	"Error E333: "Favorite Name" is not entered. Please enter a favorite name to proceed."	E333
"Favorite Name" field	All	This field can only contain alpha-numeric characters and the following special characters: - _ , .	"Error E334: Favorite Name can only contain alpha-numeric characters and the following special characters: - _ , ."	E334
Insufficient Room in the Favorites Request's Inbox	All	Users may only save up to 100 requests.	Warning W010: The number of Saved Favorites limit has been reached. This request will be submitted, but not saved. Do you wish to continue?	W010
"Favorite Name" field	All	The "Favorite Name" that was entered already exists.	Warning W011: A Favorite Request with this name already exists. Its saved parameters will be lost. Do you wish to continue?	W011

C.7 Detail Report Request, Select Provider(s)

The Detail Report Request, Select Provider(s) page error messages are presented in the following table.

Exhibit C-7 Detail Report Request, Select Provider(s) Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
"List Box 2 – Selected Items"	CMS, FI/MAC, Provider	Must contain at least one provider.	"Error E025: No provider number(s) were chosen."	E025

C.8 Detail Report Request, Select Report(s)

The Detail Report Request, Select Report(s) page error messages are presented in the following table.

Exhibit C-8 Detail Report Request, Select Report(s) Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
"By Service Type" Radio Button	All	If "By Report Type" radio button or "By Report Number" radio button is not clicked, this radio button must be clicked.	"Error E034: No reports were selected."	E034
"By Service Type" Inpatient Providers only	All	If the provider is only given access to Inpatient, the 998 report cannot be selected	"Error E326: The 998 Report is only applicable to outpatient Providers."	E326
"By Report Group" Radio Button	All	If radio button is clicked, at least one report group must be selected.	"Error E036: "By Report Type" option selected, but no report group(s) chosen."	E036
		If "By Service Type" radio button or "By Report Type" radio button is not clicked, this radio button must be clicked.	"Error E034: No reports were selected."	E034
"By Report Group" Inpatient Providers only	All	If the provider is only given access to Inpatient, the 998 report cannot be selected.	"Error E326: The 998 Report is only applicable to outpatient Providers."	E326
"By Report Type" Radio Button	All	If radio button is clicked, at least one report type must be selected.	"Error E037: "By Report Type" option selected, but no report number(s) chosen."	E037
		If "By Service Type" radio button or "By Report Type" radio button is not clicked, this radio button must be clicked.	"Error E034: No reports were selected."	E034

C.9 Detail Report Request, Select Service Period(s)

The Detail Report Request, Select Service Period(s) page error and warning messages are presented in the following table.

Exhibit C-9 Detail Report Request, Select Service Period(s) Page Error and Warning Messages

Form / Field	User Type	Validation	Error / Warning Message	ID
"Update Service Dates by Interval"	All	Date field must not be null.	"Error E322: Period 1 Start Date contains a non-numeric character or is not in MM/DD/YYYY format."	E322
	All	Date field must contain only numeric characters.	"Error E322: Period 1 Start Date contains a non-numeric character or is not in MM/DD/YYYY format."	E322
	All	Date field entry must be in MM/DD/YYYY format.	"Error E322: Period 1 Start Date contains a non-numeric character or is not in MM/DD/YYYY format."	E322
	All	The date field's Month, Day, and Year values must be valid.	"Error E001: Period 1 Start Date contains an invalid month, day, and/or year."	E001
"Update Service Dates by Period"	All	All date field entries must contain only numeric characters.	"Error E069: Service Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E069
	All	All date field entries must be in MM/DD/YYYY format.	"Error E069: Service Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E069
	All	All date fields' Month, Day, and Year values must be valid.	"Error E001: Service Date(s) entry contains an invalid month, day, and/or year."	E001
	All	If one service period's "To" date is populated, it must be greater than or equal to its corresponding "From" date.	"Error E312: Period (#) service dates do not have a valid date range. From: (from date), To: (to date)"	E312
Update Service Dates by Provider(s) Start Date	All	Service start dates must come after the provider's 2006 FYE Date plus one day.	"Error E008: Service start date must be on or after (2006 FYE Date plus 1 day)."	E008
Update Service Dates by Provider(s) "From" Date	All	Field must not be null.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."	E038

Form / Field	User Type	Validation	Error / Warning Message	ID
	All	Only numeric characters.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."	E038
	All	Entry must be in MM/DD/YYYY format.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."	E038
	All	Month, Day, and Year values must be valid.	"Error E001: Service Date entry for Provider (ID #) contains an invalid month, day, and/or year."	E001
	All	Entry must be less than or equal to corresponding Service Period To Date.	"Error E312: Period (#) service dates do not have a valid date range for Provider (ID #). From: (from date), To: (to date)"	E312
	All	Entry must be greater than the previous Service Period To Date (this assures chronological service periods and that there is no overlapping service periods).	"Error E092: Service Periods overlap and/or are not chronological for Provider (ID #)."	E092
	All user types except for Freestanding Providers.	Entry is one day greater than previous Service Period To Date (this checks to see if the service periods are consecutive).	"Warning W001: You have selected non-consecutive service periods for provider(s): &arg1. Do you wish to continue?"	W001
	Freestanding Providers only.	Entry is one day greater than previous Service Period To Date (this checks to see if the service periods are consecutive).	"Warning W003: You have selected non-consecutive service periods. Do you wish to continue?"	W003
Update Service Dates by Provider(s) "To" Dates	All	Field must not be null.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."	E038
	All	Only numeric characters.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."	E038

Form / Field	User Type	Validation	Error / Warning Message	ID
	All	Entry must be in MM/DD/YYYY format.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."	E038
	All	Month, Day, and Year values must be valid.	"Error E001: Service Date(s) entry for Provider (ID #) contains an invalid month, day, and/or year."	E001
	All	Entry must be greater than or equal to corresponding Service Period From Date.	"Error E312: Service dates for Provider (ID #) do not have a valid date range. From: (from date), To: (to date)."	E312
	All	Entry must be less than the next Service Period From Date (this assures chronological service periods and that there is no overlapping service periods).	"Error E092: Service Periods overlap and/or are not chronological for Provider (ID #)."	E092
Paid Date From Date	All	Field must not be null.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
	All	Only numeric characters.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
	All	Entry must be in MM/DD/YYYY format.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
	All	Month, Day, and Year values must be valid.	"Error E001: Paid Date(s) entry contains an invalid month, day, and/or year."	E001
	All	Entry must be greater than or equal to 01/01/2006	"Error E008: Paid "From" date must be on or after 01/01/2006."	E008
	All	Entry must be less than or equal to the Paid Date "To" Date	"Error E312: Paid Dates do not have a valid date range. From: (from date), To: (to date)."	E312
Paid Date To Date	All	Field must not be null.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042

Form / Field	User Type	Validation	Error / Warning Message	ID
	All	Only numeric characters.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
	All	Entry must be in MM/DD/YYYY format.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
	All	Month, Day, and Year values must be valid.	"Error E001: Paid Date(s) entry contains an invalid month, day, and/or year."	E001
	All	Entry must be less than or equal to the default date Default/Boundary Date: CMS User – the latest paid date from any paid claim file FI/MAC Admin User – the latest paid date from a paid claim file loaded for that FI Parent Provider and Freestanding/Child Provider User - the latest paid date from a paid claim file loaded for the provider's FI.	"Error E007: Paid "To" date must be on or before (boundary date)."	E007
	All	Entry must be greater than or equal to the Paid Date "From" Date.	"Error E312: Paid Dates do not have a valid date range. From: (from date), To: (to date)."	E312
Parent Provider is no longer an owner of a child	Parent Provider	If you are requesting a report from when a parent provider owned a child provider, it must be in the range of when the Provider owned the child.	"Warning W008: Service dates requested do not coincide with requestor access rights for Provider (ID). These dates will be modified on the Confirm Report Request screen to reflect valid access dates." "Do you wish to Continue?"	W008
Parent Provider does not have access rights for the dates requested	Parent Provider	If you are requesting a report from when a parent provider owned a child provider, it must be in the range of when the Provider owned the child.	Error E323: Service dates requested do not coincide with requestor access rights for Provider <provider number>.	E323

C.10 Detail Report Request, Select Report Format

The Detail Report Request, Select Report Format page error messages are presented in the following table.

Exhibit C-10 Detail Report Request, Select Report Format Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
"CSV" Radio Button	CMS, FI/MAC	If the "PDF" radio button is not selected, this must be selected.	"Error E046: No report format was selected. Please choose a report format before continuing."	E046
"PDF" Radio Button	CMS, FI/MAC	If the "CSV" radio button is not selected, this must be selected.	"Error E046: No report format was selected. Please choose a report format before continuing."	E046
Selection of the "PDF" Format, and then clicking Continue	All	If the "PDF" selected request results in a PDF file which is over the allowable PDF file size, and then clicks Continue.	"Error E330: This request exceeds the maximum allowable PDF file size for Provider(s): (*providers which exceed pdf file size limitations inserted here separated by commas*). Please select "CSV" or change request parameters."	E330
Primary "First Name" field	Provider	Field must not be null.	"Error E112: No primary "First Name" entered. Please enter a primary First Name to proceed."	E112
Primary "Last Name" field	Provider	Field must not be null.	"Error E113: No primary "Last Name" entered. Please enter a primary Last Name to proceed."	E113
Primary "Phone #" field	Provider	Field must not be null.	"Error E114: No primary "Phone #" entered. Please enter a primary phone number to proceed."	E114
	Provider	Field must be 10 digits.	"Error E115: This is not a valid Primary phone number. Please reenter a valid 10 digit phone number to proceed."	E115
Primary "E-mail" field	Provider	Field must not be null.	"Error E121: No primary "E-mail" entered. Please enter a Primary E-mail address to proceed."	E121
	Provider	Field must contain the "@" symbol.	"Error E122: Please enter a valid primary e-mail address."	E122

Form / Field	User Type	Validation	Error Message	ID
Primary “Fax #” field	Provider	If data is provided, entry must be 10 digits.	“Error E118: This is not a valid primary “Fax #”. Please reenter a valid 10 digit fax number to proceed.”	E118
Secondary “Phone #” field	Provider	If data is provided, entry must be 10 digits.	“Error E124: This is not a valid Secondary phone number. Please reenter a valid 10 digit phone number to proceed.”	E124
Secondary “E-mail” field	Provider	If data is provided, entry must contain the “@” symbol.	“Error E130: Please enter a valid secondary e-mail address.”	E130
Secondary “Fax #” field	Provider	If data is provided, entry must be 10 digits.	“Error E127: This is not a valid secondary “Fax #”. Please reenter a valid 10 digit fax number to proceed.”	E127
“Reason for Request” field	FI/MAC (Non Admin)	Field must not be null.	“Error E325: No Primary Reason For Request entered. Please enter Primary Reason For Request to proceed.”	E325
Incorrect Output Format Selected	All	When the incorrect output format is selected.	“Error E169: Output Format is not PDF or CSV.”	E169

C.11 Detail Report Request, Report Request Confirmation

The Detail Report Request, Report Request Confirmation page error messages are presented in the following table.

Exhibit C-11 Detail Report Request, Report Request Confirmation Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
“Your Request Name” Field	All	The “Your Request Name” field cannot be null.	“Error E047: “Your Request Name” is not entered. Please enter a request name to proceed.”	E047
	All	This field must not contain special characters: \ / : * ? " < > |	“Error E152: Request Name can not contain special characters: \ / : * ? " < > |”	E152
“Exclude” Checkbox	CMS, FI/MAC, Parent Provider	At least one provider’s “Exclude” checkbox must not be selected.	“Error E311: At least one provider’s “Exclude” checkbox must not be selected.”	E311
“Save Request as Favorite” Checkbox selected	All	The “Favorite Name” field must contain valid data if the “Save Request as Favorite” checkbox is selected.	“Error E333: “Favorite Name” is not entered. Please enter a favorite name to proceed.”	E333

Form / Field	User Type	Validation	Error Message	ID
"Favorite Name" field	All	This field can only contain alpha-numeric characters and the following special characters: - _ , .	"Error E334: Favorite Name can only contain alpha-numeric characters and the following special characters: - _ , ."	E334
Insufficient Room in the Favorites Request's Inbox	All	Users may only save up to 100 requests.	Warning W010: The number of Saved Favorites limit has been reached. This request will be submitted, but not saved. Do you wish to continue?	W010
"Favorite Name" field	All	The "Favorite Name" that was entered already exists.	Warning W011: A Favorite Request with this name already exists. Its saved parameters will be lost. Do you wish to continue?	W011

C.12 Detail Report Request, FI/MAC Provider Requests

The Detail Report Request, FI/MAC Provider Requests page error messages are presented in the following table.

Exhibit C-12 Detail Report Request, FI/MAC Provider Requests Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
FI/MAC, Provider Requests - "Your Request Name" Textbox	FI/MAC Admin	The "Your Request Name" field cannot be null.	"Error E047: "Your Request Name" is not entered. Please enter a request name to proceed."	E047
	All	This field must not contain special characters: \ / : * ? " < > |	"Error E152: Request Name can not contain special characters: \ / : * ? " < > |"	E152
FI/MAC, Provider Requests - "Modify" button	FI/MAC Admin	If the modify button is clicked, and a part of the report is changed, Comments must be entered in the comment field before submission	"Error E150: Decline/Modify Comments are required"	E150
FI/MAC, Provider Requests - "Decline" button	FI/MAC Admin	Comments must be entered in the comment field before "Decline" button can be clicked	"Error E150: Decline/Modify Comments are required"	E150

Form / Field	User Type	Validation	Error Message	ID
FI/MAC, Provider Requests – "Back" button on the "2. Select Reports" Screen	FI/MAC Admin	If a user wants to change providers, warning message must appear	"Warning" "The Selected Report Types will be lost, if the provider selection is changed" "If provider selection is changed, the report types needs to be reselected." "Do you wish to go back to the Provider Selection List?"	W005
FI/MAC, Provider Requests – "Select Provider(s) Screen	FI/MAC Admin	If Providers have been changed by the FI/MAC admin, display warning message after the admin clicks "Continue" from the Select Provider(s) screen	"Warning" "The original requestor's provider selection has been changed" "The selected provider(s) may not belong to the requestor. Do you wish to continue?"	W006
FI/MAC, Provider Requests – "Select Service Period Date(s)" Screen	FI/MAC Admin	If Service Period Dates have been changed by the FI/MAC admin, display warning message after the admin clicks "Continue" from the Select Service Period Date(s) screen	"Warning" "The selected Service Periods may be outside the requestor's selected range" "The new Service Periods may contain data which does not belong to the requestor. Do you wish to continue?"	W007
"Mailed Date" Field from the Provider Request Results Page	FI/MAC Admin	Mailed Date cannot be before the date the request was submitted.	"Error E336: Mailed Date can not be before completion date of <completion date>."	E336
"Mailed Date" contains an invalid character	FI/MAC Admin	Mailed Date cannot contain invalid characters.	"Error E042: Mailed Date contains a non-numeric character or is not in MM/DD/YYYY format."	E042
"Mailed Date" is not in MM/DD/YYYY format	FI/MAC Admin	Mailed Date must be in MM/DD/YYYY format.	"Error E042: Mailed Date contains a non-numeric character or is not in MM/DD/YYYY format."	E042
"Mailed Date" contains an invalid month, day, and/or year	FI/MAC Admin	Mailed Date must be an existing calendar day.	"Error E001: Mailed Date contains an invalid month, day, and/or year."	E001
"Mailed Date" has been successfully updated	FI/MAC Admin	Mailed Date was successfully updated by the user.	"The Mailed Date has been successfully updated."	S001

C.13 Miscellaneous Report Request, Select Reports

The Miscellaneous Report Request, Select Reports page error messages are presented in the following table.

Exhibit C-13 Miscellaneous Report Request, Select Reports Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
"Invalid Report Types" Radio Button	CMS, FI/MAC Admin	If the "Certified Load Reports" radio button is not selected, this must be selected.	"Error E317: No reports were selected."	E317
"Certified Load Control Report" Radio Button	CMS, FI/MAC Admin	If the "Invalid Report Types" or the "Claim Load Control Report" radio button is not selected, this must be selected.	"Error E317: No reports were selected."	E317
Select Load Date From	CMS, FI/MAC Admin	Field must not be null.	"Error E042: Load Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
Select Load Date From	CMS, FI/MAC Admin	Only numeric characters.	"Error E042: Load Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
Select Load Date From	CMS, FI/MAC Admin	Entry must be in MM/DD/YYYY format.	"Error E042: Load Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
Select Load Date From	CMS, FI/MAC Admin	Month, Day, and Year values must be valid.	"Error E001: Load Date(s) entry contains an invalid month, day, and/or year."	E001
Select Load Date From	CMS, FI/MAC Admin	Entry must be less than or equal to corresponding Load Date To date.	"Error E312: Load Dates do not have a valid date range. From: <from date>, To: <to date>"	E312
Select Load Date To	CMS, FI/MAC Admin	Field must not be null.	"Error E042: Load Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
Select Load Date To	CMS, FI/MAC Admin	Only numeric characters.	"Error E042: Load Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042
Select Load Date To	CMS, FI/MAC Admin	Entry must be in MM/DD/YYYY format.	"Error E042: Load Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."	E042

Form / Field	User Type	Validation	Error Message	ID
Select Load Date To	CMS, FI/MAC Admin	Month, Day, and Year values must be valid.	"Error E001: Load Date(s) entry contains an invalid month, day, and/or year."	E001
Select Load Date To	CMS, FI/MAC Admin	Entry must be greater than or equal to corresponding Load Date From date.	"Error E312: Load Dates do not have a valid date range. From: <from date>, To: <to date>"	E312
Submit	CMS, FI/MAC Admin	If the report request yields no results	"Error E: No report can be generated for the parameters selected."	

C.14 Detail Report Request, Load Control

The Detail Report Request, Load Control page error messages are presented in the following table.

Exhibit C-14 Detail Report Request, Load Control Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
Load Control - Miscellaneous Report Request Select Format Page	CMS, FI/MAC Admin	You must select either PDF or CSV as the report format to continue	"Error E046: No report format was selected. Please choose a report format before continuing."	E046
Load Control - Confirmation Page after selecting a format type from the miscellaneous Report Request page	CMS, FI/MAC Admin	The "Your Request Name" field cannot be null.	"Error E047: "Your Request Name" is not entered. Please enter a request name to proceed."	E047
"Your Request Name"	All	This field must not contain special characters: \ / : * ? " < > |	"Error E152: Request Name can not contain special characters: \ / : * ? " < > |"	E152
"Select Report Format"	CMS, FI/MAC	If the user selects "PDF" and the page limit is over 500 pages.	"Error E385: This request exceeds the maximum allowable PDF file size. Please select "CSV" or change request parameters."	E385
Incorrect Output Format Selected	All	When the incorrect output format is selected.	"Error E169: Output Format is not PDF or CSV."	E169

C.15 Detail Report Request, Miscellaneous

The Detail Report Request, Miscellaneous page error messages are presented in the following table.

Exhibit C-15 Detail Report Request, Miscellaneous Page Error Messages

Form / Field	User Type	Validation	Error Message	ID
Processing Error	PS&R	While pages are processing, a user should not click the "Back" button in the Internet Explorer browser.	"Error E100: Report request must start from the navigation bar. Back button processing not allowed after submit is performed."	E100
Application Down	PS&R	Cognos ReportNet is down and therefore requesting reports is not possible.	"Error E014: Application down. Not able to make ReportNet connection at this point"	E014
Cognos ReportNet Error	PS&R	If a Job ID has been deleted on the Reporting side, there will be no history of that job.	"Error E172: No Job History found for the job with Job ID: <job ID>"	E172
Illegal Character Security Error	Valid for the entire PS&R system excluding the "Your Request Name" field of the Confirmation Screens. Please refer to Error E152 for documentation relating to the "Your Request Name" field.	All non-alpha-numeric characters excluding the following characters: '&' '?' '=' '.' ':' '_' '-' '/' ' ' ',' '@' '*' '\'' '(' ')' '%' will generate a security error.	"Error E331: Security Exception encountered. Please call Help Desk."	E331

C.16 Miscellaneous System Error Messages

Miscellaneous system error messages are presented in the following table.

Exhibit C-16 Miscellaneous System Error Messages

Form / Field	User Type	Validation	Error Message	ID
Login	PS&R	User session has expired. Please login before continuing	"Error E011: User not logged in. Please login"	E011
System Error	PS&R	Exception occurred in the selectProviderRanges method	"E012: Caught exception in selectProviderRanges: &arg1 &arg2"	E012
System Error	PS&R	Exception occurred in the selectReports method	"E013: Caught exception in selectReports: &arg1"	E013

Form / Field	User Type	Validation	Error Message	ID
System Error	PS&R	Application is not able to make reportNet connection at this point. Please try again la	"Error E014: Application down. Not able to make reportNet connection at this point."	E014
System Error	PS&R	User ID and/or password may be invalid	"Error E015: Invalid user ID and/or password."	E015
System Error	PS&R	Exception occurred in the LoginAction:perform method	"Error E016: LoginAction:perform() - &arg1"	E016
System Error	PS&R	Exception occurred in the selectCMS method	"Error E018: Caught exception in selectCMS: &arg1 &arg2"	E018
System Error	PS&R	Exception occurred in the selectCMSProvidersByType method	"Error E023: Caught exception in selectCMSProvidersByType: &arg1"	E023
System Error	PS&R	Exception occurred in the selectFIs method	"Error E029: Caught exception in selectFIs: &arg1 &arg2"	E029
System Error	PS&R	Exception occurred in the selectResults method	"Error E030: Caught exception in selectResults: &arg1 &arg2"	E030
System Error	PS&R	Exception occurred in the selectReportsByProviderType method	"Error E032: Caught exception in selectReportsByProviderType: &arg1 &arg2"	E032
System Error	PS&R	If the admission report radio button is checked, at least one report admission type must be selected	"Error E035: admission report requested but none selected. Please choose a admission type before continuing"	E035
System Error	PS&R	Could not find the range ID for the provider	"Error E050: No range id found for provider: &arg1"	E050
System Error	PS&R	Exception occurred in the selectReportsByProviderType method	"Error E051: Caught exception in selectReportsByProviderType: &arg1 "	E051
System Error	PS&R	Exception occurred in the selectProvidersByType method	"Error E052: Caught exception in selectProvidersByType: &arg1 "	E052
System Error	PS&R	Exception occurred in the retrieveResults method	"Error E054: Caught exception in retrieveResults: &arg1"	E054
System Error	PS&R	Exception occurred in the selectProviders method	"Error E083: Caught exception in selectProviders: &arg1 &arg2"	E083
System Error	PS&R	Exception occurred in the setUpChildProvider method	"Error E084: Caught exception in setUpChildProvider: &arg1 &arg2 "	E084
System Error	PS&R	No Providers were selected	"Error E086: No Providers available in buildSelected"	E086
System Error	PS&R	Please enter both From and To Date for a particular period	"Error E087: Both From and To Date has to be present for period &arg1"	E087

Form / Field	User Type	Validation	Error Message	ID
System Error	PS&R	Period 1 From and To Dates must be entered for all selected providers	"Error E088: Period 1 From and To dates are required for all Providers."	E088
System Error	PS&R	Empty Service Period is not allowed between two populated Service Period	"Error E089: Empty Service Period not allowed between two populated Service Period"	E089
System Error	PS&R	Please enter valid date value(s)	"Error E090: Dates are not allowed to be empty."	E090
System Error	PS&R	Exception occurred in the selectProviderParentByType method	"Error E135: Caught exception in selectProviderParentByType: &arg1"	E135
System Error	PS&R	No Providers are available	"Error E136: No providers are available"	E136
System Error	PS&R	SDK Error: Batch Job Creation Failed	"Error E165: Error while trying to Build Batch Job: &arg1. Batch Job Creation Failed. &arg2"	E165
System Error	PS&R	SDK Error: Batch JobStep Creation Failed	"Error E166: Batch JobStep Creation Failed, for Job Step: &arg1. &arg2"	E166
System Error	PS&R	SDK Error: Error in Building a Folder	"Error E167: Error while trying to Build Folder: &arg1 &arg2"	E167
System Error	PS&R	SDK Error: Error in Submitting a Job	"Error E168: Error while trying to Submit Batch Job. Build Parameter Creation Failed. &arg1"	E168
System Error	PS&R	SDK Error: Build Run Option failed	"Error E170: Build Run Option failed for Job Step: &arg1 . &arg2"	E170
System Error	PS&R	Job History is not found for the selected Job ID	"Error E172: No Job History found for the job with Job ID: &arg1"	E172
System Error	PS&R	SDK Error : Error retrieving the job history	"Error E173: Error while retrieving the jobHistory from ReportNet. &arg1"	E173
System Error	PS&R	Job History is not found for the selected Request Name	"Error E174: No Job History found for the job with Request Name: &arg1"	E174
System Error	PS&R	SDK Error: Error retrieving the job history	"Error E176: Error while retrieving the jobHistory from ReportNet."	E176
System Error	PS&R	SDK Error: Cannot get the ReportNet Services (Service Exception)	"Error E179: Error while trying to get ReportNet Services. Service Exception. &arg1"	E179
System Error	PS&R	SDK Error: Cannot get the ReportNet Services (MalformedURL Exception)	"Error E180: Error while trying to get ReportNet Services. MalformedURL Exception. &arg1"	E180
System Error	PS&R	SDK Error: Cannot get the ReportNet Services	"Error E181: Error while trying to get ReportNet Services. Unhandled Exception. &arg1"	E181

Form / Field	User Type	Validation	Error Message	ID
System Error	PS&R	SDK Error: Error submitting Batch Job	"Error E183: Error while trying to Submit Batch Job. Summary Batch Job Submit Failed. &arg1"	E183
System Error	PS&R	SDK Error: Error submitting Batch Job	"Error E185: Error while trying to Submit Batch Job. Summary Batch Job Submit Failed."	E185
System Error	PS&R	Error while preparing to find FI	"Error E186: Error preparing to find FI: &arg1"	E186
System Error	PS&R	Cannot find the FI with the specified key	"Error E187: FI not found with key &arg1"	E187
System Error	PS&R	Error while retrieving FI	"Error E188: Error retrieving FI: &arg1"	E188
System Error	PS&R	Error when closing connection	"Error E189: Error closing connection: &arg1"	E189
System Error	PS&R	Error while preparing to find load control records	"Error E190: Error preparing to find load control records: &arg1"	E190
System Error	PS&R	Error retrieving load control reports	"Error E191: Error retrieving load control records: &arg1"	E191
System Error	PS&R	Error while preparing to find last available paid date records	"Error E192: Error preparing to find last avail paid date records: &arg1"	E192
System Error	PS&R	Cannot find the last available paid date for the specified FI	"Error E193: No last avail paid date found for FI &arg1"	E193
System Error	PS&R	Error retrieving the last available paid date records	"Error E194: Error retrieving last avail paid date records: &arg1"	E194
System Error	PS&R	Error while preparing to get Report Results	"Error E195: Error preparing to get Report Results: &arg1"	E195
System Error	PS&R	Error retrieving the Report Results	"Error E196: Error retrieving Report Results: &arg1"	E196
System Error	PS&R	Error while preparing to get Load Control Main records	"Error E197: Error preparing to get Load Control Main: &arg1"	E197
System Error	PS&R	Error retrieving Load Control Main records	"Error E198: Error retrieving Load Control Main: &arg1"	E198
System Error	PS&R	Error while preparing to get Load Control Hold records	"Error E199: Error preparing to get Load Control Hold: &arg1"	E199
System Error	PS&R	Error retrieving the Load Control Hold records	"Error E200: Error retrieving Load Control Hold: &arg1"	E200
System Error	PS&R	Error while preparing to get Load Control Release records	"Error E201: Error preparing to get Load Control Rlse: &arg1"	E201
System Error	PS&R	Error retrieving the Load Control Release records	"Error E202: Error retrieving Load Control Rlse: &arg1"	E202
System Error	PS&R	Error while preparing to get Load Detail Hold reports	"Error E203: Error preparing to get Load Detail Hold Report: &arg1"	E203

Form / Field	User Type	Validation	Error Message	ID
System Error	PS&R	Error retrieving the Load Detail Hold reports	"Error E204: Error retrieving Load Detail Hold Report: &arg1"	E204
System Error	PS&R	Error while preparing to get Load Detail Hold History reports	"Error E205: Error preparing to get Load Detail Hold History Report: &arg1"	E205
System Error	PS&R	Error retrieving the Load Detail Hold History reports	"Error E206: Error retrieving Load Detail Hold History Report: &arg1"	E206
System Error	PS&R	Error while preparing to get Load Detail Release History reports	"Error E207: Error preparing to get Load Detail Rlse History Report: &arg1"	E207
System Error	PS&R	Error retrieving the Load Detail Release History reports	"Error E208: Error retrieving Load Detail Rlse History Report: &arg1"	E208
System Error	PS&R	Error while preparing to find the selected provider	"Error E209: Error preparing to find Provider: &arg1"	E209
System Error	PS&R	Cannot find the provider with the specified key	"Error E210: Provider not found with key &arg1"	E210
System Error	PS&R	Error retrieving the selected provider	"Error E211: Error retrieving Provider: &arg1"	E211
System Error	PS&R	Error when closing the connection	"Error E212: Error closing connection"	E212
System Error	PS&R	Error while preparing to find the selected providers	"Error E213: Error preparing to find Providers: &arg1"	E213
System Error	PS&R	Error retrieving the selected providers	"Error E214: Error retrieving Providers: &arg1"	E214
System Error	PS&R	Error while preparing to find the provider FYEs	"Error E215: Error preparing to find Provider FYEs: &arg1"	E215
System Error	PS&R	Error retrieving the provider FYEs	"Error E216: Error retrieving Providers FYEs: &arg1"	E216
System Error	PS&R	Error while preparing to find the providers by parent	"Error E217: Error preparing to find providers by parent: &arg1"	E217
System Error	PS&R	Error retrieving the providers by parent	"Error E218: Error retrieving providers by parent: &arg1"	E218
System Error	PS&R	Error while preparing to find child by provider	"Error E219: Error preparing to find child by provider: &arg1"	E219
System Error	PS&R	Error retrieving the child by provider	"Error E220: Error retrieving child by provider: &arg1"	E220
System Error	PS&R	Error while preparing to load the provider ranges	"Error E221: Error preparing to load Provider ranges: &arg1"	E221
System Error	PS&R	Error retrieving the provider ranges	"Error E222: Error retrieving Provider ranges: &arg1"	E222
System Error	PS&R	Error while preparing to find providers for FI by type	"Error E223: Error preparing to find providers for FI by type: &arg1"	E223

Form / Field	User Type	Validation	Error Message	ID
System Error	PS&R	Error retrieving the providers for FI by type	“Error E224: Error retrieving providers for FI by type: &arg1”	E224
System Error	PS&R	Error while preparing to find CMS providers by type	“Error E225: Error preparing to find CMS providers by type: &arg1”	E225
System Error	PS&R	Error retrieving the CMS providers by type	Error E226: Error retrieving CMS providers by type: &arg1	E226
System Error	PS&R	Error while preparing to find providers for provider parent by type	“Error E227: Error preparing to find providers for provider parent by type: &arg1”	E227
System Error	PS&R	Error retrieving the providers for provider parent by type	“Error E228: Error retrieving providers for provider parent by type: &arg1”	E228
System Error	PS&R	Error while preparing to find ownership date for providers	“Error E229: Error preparing to find ownership date for providers: &arg1”	E229
System Error	PS&R	Error retrieving the ownership date for providers	“Error E230: Error retrieving ownership date for providers: &arg1”	E230
System Error	PS&R	Error while preparing to find Report Codes	“Error E233: Error preparing to find Report Codes: &arg1”	E233
System Error	PS&R	Error retrieving the Report Codes	“Error E234: Error retrieving ReportCode: &arg1”	E234
System Error	PS&R	SQL Exception Occurred	“Error E235: SQLException caught! &arg1”	E235
System Error	PS&R	Naming Exception Occurred	“Error E243: NamingException caught during init &arg1“	E243
System Error	PS&R	No results found for the FI	“Error E248: Results do not exist for FI: &arg1”	E248
System Error	PS&R	SQL Exception Occurred	“Error E249: SQLException caught!”	E249
System Error	PS&R	No results found for the Load Control Main	“Error E250: Results do not exist for LCMain, for User: &arg1”	E250
System Error	PS&R	No results found for the Load Control Hold	“Error E252: Results do not exist for LCHold, for User: &arg1”	E252
System Error	PS&R	No results found for the Load Control Release	“Error E254: Results do not exist for LCRlse, for User: &arg1”	E254
System Error	PS&R	No results found for the Load Control Detail Hold Report	“Error E256: Results do not exist for LCDetailHoldReport, for User: &arg1”	E256
System Error	PS&R	SQLException caught	“Error E257: SQLException caught! &arg1”	E257

Form / Field	User Type	Validation	Error Message	ID
System Error	PS&R	No results found for the Load Control Hold History	“Error E258: Results do not exist for LCHold History, for User: &arg1”	E258
System Error	PS&R	No results found for the Load Control Release History	“Error E260: Results do not exist for LCRlse History, for User: &arg1”	E260
System Error	PS&R	Cannot find the provider for the specified key	“Error E263: Provider doesn't exist for key &arg1”	E263
System Error	PS&R	SQL Exception Occurred	“Error E264: SQLException! &arg1”	E264
System Error	PS&R	Cannot find the providers	“Error E265: No Providers found for &arg1”	E265
System Error	PS&R	Cannot find the ownership date	“Error E276: No Ownership Date found for &arg1”	E276
System Error	PS&R	End Date contains invalid numeric data	“Error E277: end date contains invalid numeric data = &arg1”	E277
System Error	PS&R	Start Date contains invalid numeric data	“Error E278: start date contains invalid numeric data = &arg1”	E278
System Error	PS&R	Cannot find the report	“Error E289: No Report found for &arg1”	E289
System Error	PS&R	Error in CreateParms Method	“Error E290: create parms failed due to: &arg1”	E290
System Error	PS&R	No results found for the specified user	“Error E293: Results do not exist for user: &arg1”	E293
System Error	PS&R	Parameter 'OP', describing the Operation to be performed, has to be set	“Error E297: The operation was not set, please set the 'op' parameter in the form”	E297
System Error	PS&R	Define the Operation before using it	“Error E298: The operation '&arg1' has not been defined”	E298
System Error	PS&R	An Action object must derive from AbstractAction class	“Error E299: An Action object must be of type org.brw_air.control.AbstractAction”	E299
System Error	PS&R	Exception occurred in the FrontController:getAction method	“Error E300: FrontController:getAction() - &arg1“	E300
System Error	PS&R	Please specify the input file path for the XML file	“Error E301: XML input file path was null or blank”	E301
System Error	PS&R	An action must be specified	“Error E302: Action is null”	E302
System Error	PS&R	An action has an invalid format	“Error E303: An action has an invalid format,current &arg1 and Class= &arg2”	E303
System Error	PS&R	I/O Exception occurred while reading the Application Properties file	“Error E304: IO Exception reading the Application properties file.”	E304

Form / Field	User Type	Validation	Error Message	ID
System Error	PS&R	Cannot find the Application Properties File	"Error E305: Application properties file not found"	E305
System Error	PS&R	Login Credentials do not belong to a PSR User Group	"Error E327: Invalid PSR User. Please call Help Desk."	E327
System Error	PS&R	Logged in user has an invalid Organization ID in his/her profile	"Error E328: PSR User does not have a valid Organization ID. Please call Help Desk."	E328
System Error	PS&R	Logged in user has an invalid &arg1 ID in his/her profile	"Error E329: PSR User does not have a valid &arg1 ID. Please call Help Desk."	E329

C.17 Error Codes in Numeric Order

The following table presents the error messages used throughout the PS&R System in numeric order.

Exhibit C-17 Error Messages in Numeric Order

ID	Form / Field	User Type	Validation	Error Message
	Change Periods with Specific Dates 'Apply' button	All	If multiple service period date ranges are provided, service periods 2, 3, and 4's "From" date entry must be greater than the previous service period's "To" Date (note: "previous service period" refers to any prior service period that has an entry – this may require ignoring service periods without entries. This validation assures chronological service periods and that there are no overlapping service periods).	"Error: Service Periods overlap and/or are not chronological."
	Parent Provider is no longer an owner of a child	Parent Provider	If you are requesting a report from when a parent provider owned a child provider, it must be in the range of when the Provider owned the child	"Warning: Service dates requested do not coincide with requestor access rights for Provider (ID). These dates will be modified on the Confirm Report Request screen to reflect valid access dates." "Do you wish to Continue?"

ID	Form / Field	User Type	Validation	Error Message
	Parent Provider no longer has access to a provider	Parent Provider	If you are requesting a report from when a parent provider owned a child provider, it must be in the range of when the Provider owned the child.	"Warning: Service dates requested do not coincide with requestor access rights for Provider (ID). These dates will be modified on the Confirm Report Request screen to reflect valid access dates." "Do you wish to Continue?"
E001	Change Periods with Specific Dates 'Apply' button	All	All date fields' Month, Day, and Year values must be valid.	"Error E001: Service Date(s) entry contains an invalid month, day, and/or year."
E001	Interval 'Apply' Button	All	The date field's Month, Day, and Year values must be valid.	"Error E001: Period 1 Start Date contains an invalid month, day, and/or year."
E001	Paid Date From Date	All	Month, Day, and Year values must be valid.	"Error E001: Paid Date(s) entry contains an invalid month, day, and/or year."
E001	Paid Date To Date	All	Month, Day, and Year values must be valid.	"Error E001: Paid Date(s) entry contains an invalid month, day, and/or year."
E001	Select Paid From Date	All	Month, Day, and Year values must be valid.	"Error E001: From Paid Date entry contains an invalid month, day, and/or year."
E001	Select Paid To Date	All	Month, Day, and Year values must be valid.	"Error E001: Paid To Date entry contains an invalid month, day, and/or year."
E001	Service Period From Date	All	Month, Day, and Year values must be valid.	"Error E001: Service Date entry for Provider <ID #> contains an invalid month, day, and/or year."
E001	Service Period From Dates (in "Selected Service Periods Table")	All	Month, Day, and Year values must be valid.	"Error E001: Service Date entry for Provider <ID #> contains an invalid month, day, and/or year."

ID	Form/Field	User Type	Validation	Error Message
E001	Service Period To Dates	All	Month, Day, and Year values must be valid.	"Error E001: Service Date(s) entry for Provider <ID #> contains an invalid month, day, and/or year."
E001	Service Period To Dates (in "Selected Service Periods Table")	All	Month, Day, and Year values must be valid.	"Error E001: Service Date(s) entry for Provider <ID #> contains an invalid month, day, and/or year."
E007	Paid Date To Date	All	Entry must be less than or equal to the default date CMS User – the latest paid date from any paid claim file FI/MAC User – the latest paid date from a paid claim file loaded for that FI/MAC Provider User - the latest paid date from a paid claim file loaded for the provider's FI/MAC	"Error E007: Paid "To" date must be on or before <default date>."
E007	Select Paid To Date	All	Entry must be less than or equal to the default date CMS User – the latest paid date from any paid claim file FI/MAC User – the latest paid date from a paid claim file loaded for that FIMAC Provider User - the latest paid date from a paid claim file loaded for the provider's FI/MAC	"Error E007: Paid "To" date must be on or before <default date>."
E008	Paid Date From Date	All	Entry must be greater than or equal to 01/01/2006	"Error E008: Paid "From" date must be on or after 01/01/2006."
E008	Select Paid From Date	All	Entry must be greater than or equal to 01/01/2006	"Error E008: Paid "From" date must be on or after 01/01/2006."
E008	Service Period From Dates (in "Selected Service Periods Table")	All	Fields must not be null.	"Error E008: Service start date must be on or after (2006 FYE Date plus 1 day)."
E008	Service Period Start Date	Parent Provider, Freestanding/ Child Provider	Service start dates must come after the provider's 2006 FYE Date plus one day.	"Error E008: Service start date must be on or after (2006 FYE Date plus 1 day)."

ID	Form/Field	User Type	Validation	Error Message
E010 E010A	Login – Expired Session	PS&R	Session will expire after 20 min of inactivity.	“Error E010: Session expired. Please login before continuing”
E014	Application Down	PS&R	Cognos ReportNet is down and therefore requesting reports is not possible.	“Error E014: Application down. Not able to make ReportNet connection at this point”
E015	Login – Null	PS&R	A User ID and Password must be entered to login to the PS&R system	"Error E015: Invalid user ID and/or password."
E015	Login – Password	PS&R	Password must be valid for the User ID	"Error E015: Invalid user ID and/or password."
E015	Login – User ID	PS&R	User ID must be valid	"Error E015: Invalid user ID and/or password."
E024	“All Providers”	Parent Provider	If “By Provider Type” or “By Provider Number” radio button is not clicked, this radio button must be clicked.	“Error E024: Please select provider(s).”
E024	“By Provider Number” Radio Button	CMS, FI/MAC, Parent Provider	If “By Provider Type within Contractor” (CMS users only) or “By Provider Type” or “All Providers” (Parent Provider users only) radio button is not clicked, this radio button must be clicked.	“Error E024: Please select provider(s).”
E024	“By Provider Type Within Contractor” Radio Button	CMS	If “By Provider Number” radio button is not clicked, this radio button must be clicked.	“Error E024: Please select provider(s).”
E024	“By Provider Type” Radio Button	FI/MAC, Parent Provider	If “By Provider Number” radio button or “All Providers” (Parent Provider users only) is not clicked, this radio button must be clicked.	“Error E024: Please select provider(s).”
E025	“By Provider Number”	CMS, FI/MAC Non-Admin	If no provider is selected from the “By Provider Number” list box	“Error E025: No provider number(s) were chosen.”
E025	“By Provider Number” Radio Button	CMS, FI/MAC, Parent Provider	If radio button is clicked, at least one provider number must be selected.	“Error E025: No provider number(s) were chosen.”
E025	“List Box 2 – Selected Items”	CMS, FI/MAC, Provider	Must contain at least one provider.	“Error E025: No provider number(s) were chosen.”
E026	“By Provider Type” Radio Button	FI/MAC, Parent Provider	If radio button is clicked, at least one provider type must be selected.	“Error E026: “By Provider Type” option selected, but no provider type(s) chosen.”

ID	Form/Field	User Type	Validation	Error Message
E027	“By Provider Type Within Contractor” Radio Button	CMS	If radio button is clicked, at least one provider type and one contractor must be selected.	“Error E027: If the “By Provider Type Within Contractor” option is selected, at least one provider type and one contractor must be selected.”
E034	“By Report Group” Radio Button	All	If “By Service Type” radio button or “By Report Type” radio button is not clicked, this radio button must be clicked.	“Error E034: No reports were selected.”
E034	“By Report Type” Radio Button	All	If “By Service Type” radio button or “By Report Group” radio button is not clicked, this radio button must be clicked.	“Error E034: No reports were selected.”
E034	“By Service Type” Radio Button	All	If “By Report Type” radio button or “By Report Number” radio button is not clicked, this radio button must be clicked.	“Error E034: No reports were selected.”
E036	“By Report Group” Radio Button	All	If radio button is clicked, at least one report group must be selected.	“Error E036: “By Report group” option selected, but no report group(s) chosen.”
E037	“By Report Type” Radio Button	All	If radio button is clicked, at least one report type must be selected.	“Error E037: “By Report Type” option selected, but no report type(s) chosen.”
E038	Service Period From Date	All	Field must not be null.	“Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format.”
E038	Service Period From Date	All	Only numeric characters.	“Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format.”
E038	Service Period From Date	All	Entry must be in MM/DD/YYYY format.	“Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format.”

ID	Form / Field	User Type	Validation	Error Message
E038	Service Period From Dates (in "Selected Service Periods Table")	All	Fields must not be null.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."
E038	Service Period From Dates (in "Selected Service Periods Table")	All	Only numeric characters.	"Error E038: Service Date(s) entry for Provider (ID #) contains a non-numeric character or is not in MM/DD/YYYY format."
E038	Service Period From Dates (in "Selected Service Periods Table")	All	Entry must be in MM/DD/YYYY format.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."
E038	Service Period To Dates	All	Field must not be null.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."
E038	Service Period To Dates	All	Only numeric characters.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."
E038	Service Period To Dates	All	Entry must be in MM/DD/YYYY format.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."
E038	Service Period To Dates (in "Selected Service Periods Table")	All	Field must not be null.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."
E038	Service Period To Dates (in "Selected Service Periods Table")	All	Only numeric characters.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."

ID	Form/Field	User Type	Validation	Error Message
E038	Service Period To Dates (in "Selected Service Periods Table")	All	Entry must be in MM/DD/YYYY format.	"Error E038: Service Date(s) entry for Provider <ID #> contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Paid Date From Date	All	Only numeric characters.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Paid Date From Date	All	Entry must be in MM/DD/YYYY format.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Paid Date From Date	All	Field must not be null.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Paid Date To Date	All	Only numeric characters.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Paid Date To Date	All	Entry must be in MM/DD/YYYY format.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Paid Date To Date	All	Field must not be null.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Select Paid From Date	All	Field must not be null.	"Error E042: Paid From Date entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Select Paid From Date	All	Only numeric characters.	"Error E042: Paid From Date entry contains a non-numeric character or is not in MM/DD/YYYY format."

ID	Form/Field	User Type	Validation	Error Message
E042	Select Paid From Date	All	Entry must be in MM/DD/YYYY format.	"Error E042: Paid From Date entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Select Paid To Date	All	Field must not be null.	"Error E042: Paid To Date entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Select Paid To Date	All	Only numeric characters.	"Error E042: Paid To Date entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Select Paid To Date	All	Entry must be in MM/DD/YYYY format.	"Error E042: Paid To Date entry contains a non-numeric character or is not in MM/DD/YYYY format."
E042	Service Period To Dates (in "Selected Service Periods Table")	All	Field must not be null.	"Error E042: Paid Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."
E046	"CSV" Radio Button	All	If the "PDF" radio button is not selected, this must be selected.	"Error E046: No report format was selected. Please choose a report format before continuing."
E046	"CSV" Radio Button	CMS, FI/MAC	If the "PDF" radio button is not selected, this must be selected.	"Error E046: No report format was selected. Please choose a report format before continuing."
E046	"PDF" Radio Button	All	If the "CSV" radio button is not selected, this must be selected.	"Error E046: No report format was selected. Please choose a report format before continuing."
E046	"PDF" Radio Button	CMS, FI/MAC	If the "CSV" radio button is not selected, this must be selected.	"Error E046: No report format was selected. Please choose a report format before continuing."

ID	Form/Field	User Type	Validation	Error Message
E046	Load Control - Miscellaneous Report Request Select Format Page	CMS, FI/MAC Admin	You must select either PDF or CSV as the report format to continue	"Error E046: No report format was selected. Please choose a report format before continuing."
E047	"Your Request Name" Field	All	The "Your Request Name" field cannot be null.	"Error E047: "Your Request Name" is not entered. Please enter a request name to proceed."
E047	FI/MAC, Provider Requests - "Your Request Name" Textbox	FI/MAC Admin	The "Your Request Name" field cannot be null.	"Error E047: "Your Request Name" is not entered. Please enter a request name to proceed."
E047	Load Control - Confirmation Page after selecting a format type from the miscellaneous Report Request page	CMS, FI/MAC Admin	The "Your Request Name" field cannot be null.	"Error E047: "Your Request Name" is not entered. Please enter a request name to proceed."
E066	"Include 110 DRG Section"	All	If the box is checked, service type selected must be "All" or "Inpatient", Report Group must be 11x, or Report Type must be 110.	"Error E066: The DRG Section is only valid with selections of "All", "Inpatient", "11x", or "110"."
E069	Change Periods with Specific Dates 'Apply' button	All	All date field entries must contain only numeric characters.	"Error E069: Service Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."
E069	Change Periods with Specific Dates 'Apply' button	All	All date field entries must be in MM/DD/YYYY format.	"Error E069: Service Date(s) entry contains a non-numeric character or is not in MM/DD/YYYY format."
E081	"Filter by FYE Date" Checkbox	FI/MAC, Parent Provider	If box is checked, a month must be selected from the "Month" drop-down menu.	"Error E081: "Filter by FYE Date" chosen, but month not selected."
E092	Service Period From Date	All	Entry must be greater than the previous Service Period To Date (this assures chronological service periods and that there is no overlapping service periods).	"Error E092: Service Periods overlap and/or are not chronological for Provider <ID #>."

ID	Form/Field	User Type	Validation	Error Message
E092	Service Period From Dates (in "Selected Service Periods Table")	All	Entry must be greater than the previous Service Period To Date (this assures chronological service periods and that there are no overlapping service periods).	"Error E092: Service Periods overlap and/or are not chronological for Provider ID: <ID #>."
E092	Service Period To Dates	All	Entry must be less than the next Service Period From Date (this assures chronological service periods and that there is no overlapping service periods).	"Error E092: Service Periods overlap and/or are not chronological for Provider <ID #>."
E092	Service Period To Dates (in "Selected Service Periods Table")	All	Entry must be less than the next Service Period From Date (this assures chronological service periods and that there is no overlapping service periods).	"Error E092: Service Periods overlap and/or are not chronological for Provider <ID #>."

ID	Form/Field	User Type	Validation	Error Message
E094	Service Period From Dates (in "Selected Service Periods Table")	All	Entry is one day greater than previous Service Period To Date (this checks to see if the service periods are consecutive).	If the "Include Extract File" was selected: "Warning: You have selected non-consecutive service periods for Provider <ID #>. This will exclude cost report data on the extract file. Do you wish to continue?" Clicking the 'Continue' button will bring user to next request page, clicking the 'Back' button will bring user back to the dates page and allow them to make any changes. OR If the "Include Extract File" was not selected: "Warning: You have selected non-consecutive service periods for Provider <ID #>. Do you wish to continue?" Clicking the 'Continue' button will bring user to next request page, clicking the 'Back' button will bring user back to the dates page and allow them to make any changes.
E100	Processing Error	PS&R	While pages are processing, a user should not click the "Back" button in the Internet Explorer browser.	"Error E100: Report request must start from the navigation bar. Back button processing not allowed after submit is performed."
E101	"All Providers" (Parent Provider users only) or "By Provider Type" and "Filter by FYE Date" Checkbox	CMS, FI/MAC, Parent Provider	Provider type(s) and FYE date selected must have at least one applicable provider.	"Error E101: No providers of the selected Provider Type(s) are applicable."
E101	"By Provider Type" Drop Down Menu	CMS, FI/MAC, Parent Provider	Provider type selected must apply to at least one provider applicable to the FI/PP.	"Error E101: No providers of the selected Provider Type(s) are applicable."

ID	Form / Field	User Type	Validation	Error Message
E102	“Exclude” Checkbox		For each provider, at least one service period’s “Exclude” checkbox must not be selected.	“Error E102: All service periods excluded for Provider <ID #>”
E112	Primary “First Name” field	Provider	Field must not be null.	“Error E112: No primary “First Name” entered. Please enter a primary First Name to proceed.”
E113	Primary “Last Name” field	Provider	Field must not be null.	“Error E113: No primary “Last Name” entered. Please enter a primary Last Name to proceed.”
E114	Primary “Phone #” field	Provider	Field must not be null.	“Error E114: No primary “Phone #” entered. Please enter a primary phone number to proceed.”
E115	Primary “Phone #” field	Provider	Field must be 10 digits.	“Error E115: This is not a valid Primary phone number. Please reenter a valid 10 digit phone number to proceed.”
E118	Primary “Fax #” field	Provider	If data is provided, entry must be 10 digits.	“Error E118: This is not a valid primary “Fax #”. Please reenter a valid 10 digit fax number to proceed.”
E121	Primary “E-mail” field	Provider	Field must not be null.	“Error E121: No primary “E-mail” entered. Please enter a Primary E-mail address to proceed.”
E122	Primary “E-mail” field	Provider	Field must contain the “@” symbol.	“Error E122: Please enter a valid primary e-mail address.”
E124	Secondary “Phone #” field	Provider	If data is provided, entry must be 10 digits.	“Error E124: This is not a valid Secondary phone number. Please reenter a valid 10 digit phone number to proceed.”
E127	Secondary “Fax #” field	Provider	If data is provided, entry must be 10 digits.	“Error E127: This is not a valid secondary “Fax #”. Please reenter a valid 10 digit fax number to proceed.”
E130	Secondary “E-mail” field	Provider	If data is provided, entry must contain the “@” symbol.	“Error E130: Please enter a valid secondary e-mail address.”

ID	Form/Field	User Type	Validation	Error Message
E150	FI/MAC, Provider Requests - “Decline” button	FI/MAC Admin	Comments must be entered in the comment field before “Decline” button can be clicked	“Error E150: Decline/Modify Comments are required”
E150	FI/MAC, Provider Requests - “Modify” button	FI/MAC Admin	If the modify button is clicked, and a part of the report is changed, Comments must be entered in the comment field before submission	“Error E150: Decline/Modify Comments are required”
E152	“Your Request Name”	All	This field must not contain special characters: \ / : * ? " < > |	“Error E152: Request Name can not contain special characters: \ / : * ? " < > |”
E152	“Your Request Name” Field	All	This field can only contain alpha-numeric characters and the following special characters: - _ , .	“Request Name can only contain alpha-numeric characters and the following special characters: - _ , .”
E152	FI/MAC, Provider Requests - “Your Request Name” Textbox	All	This field must not contain special characters: \ / : * ? " < > |	“Error E152: Request Name can not contain special characters: \ / : * ? " < > |”
E172	Cognos ReportNet Error	PS&R	If a Job ID has been deleted on the Reporting side, there will be no history of that job.	“Error E172: No Job History found for the job with Job ID: <job ID>”
E310	“Filter by FYE Date” Checkbox – “Day” Drop-Down Menu	FI/MAC, Parent Provider	The day selected must be in the month selected.	“Error E310: <date> is not a valid date.”
E311	“Exclude” Checkbox	CMS, FI/MAC, Parent Provider	At least one provider’s “Exclude” checkbox must not be selected.	“Error E311: At least one provider’s “Exclude” checkbox must not be selected.”
E312	Change Periods with Specific Dates ‘Apply’ button	All	If one service period’s “To” date is populated, it must be greater than or equal to its corresponding “From” date.	“Error E312: Period (#) service dates do not have a valid date range. From: (from date), To: (to date)”
E312	Paid Date From Date	All	Entry must be less than or equal to the Paid Date “To” Date	“Error E312: Paid Dates do not have a valid date range. From: <from date>, To: <to date>.”
E312	Paid Date To Date	All	Entry must be greater than or equal to the Paid Date “From” Date.	“Error E312: Paid Dates do not have a valid date range. From: <from date>, To: <to date>.”

ID	Form/Field	User Type	Validation	Error Message
E312	Select Paid From Date	All	Entry must be less than or equal to corresponding Service Period To Date.	“Error E312: Paid Dates do not have a valid date range. From: <from date>, To: <to date>”
E312	Service Period From Date	All	Entry must be less than or equal to corresponding Service Period To Date.	“Error E312: Period (#) service dates do not have a valid date range for Provider <ID #>. From: <from date>, To: <to date>”
E312	Service Period From Dates (in “Selected Service Periods Table”)	All	Entry must be less than or equal to its corresponding Service Period To Date.	“Error E312: Service date(s) for Provider (ID #) do not have a valid date range. From: (from date), To: (to date)”
E312	Service Period To Dates	All	Entry must be greater than or equal to corresponding Service Period From Date.	“Error E312: Service dates for Provider (ID #) do not have a valid date range. From: (from date), To: (to date).”
E312	Service Period To Dates (in “Selected Service Periods Table”)	All	Entry must be greater than or equal to corresponding Service Period From Date.	“Error E312: Service dates for Provider (ID #) do not have a valid date range. From: (from date), To: (to date)”
E315	No Data Available	All	The number of reports generated must be greater than zero	“Error E315: The request will not generate any reports”
E316	“Select FI/MAC(s)’	FI/MAC	Must select an FI/MAC(s)	“Error E316: No FI/MAC(s) were selected."
E317	“Claim Load Reports” Radio Button	CMS	If the “Invalid Report Types” radio button is not selected, this must be selected.	“Error E317: No reports were selected.”
E317	“Invalid Report Types” Radio Button	CMS, FI/MAC	If the “Claim Load Reports” radio button is not selected, this must be selected.	“Error E317: No reports were selected.”
E318	No Claims loaded	PS&R	There must be claims loaded for a given provider. No reports will be generated with 0 claims loaded.	“Error E318: No claims have been loaded for provider <ID #>.”

ID	Form/Field	User Type	Validation	Error Message
E320	“The 329 and 339 Patient CBSA Visit Section”		Box checked: None of the providers in the request is an HHA Provider (two ways to determine if there is an HHA provider in the request: a) in the report type box a 32x, 33x, or 34x report is included, or b) HHA Provider is in the xx3100-xx3199,xx7000-xx8499,xx9000-xx9799 range.)	“Error E320: The 329 and 339 Patient CBSA Visit Section is only applicable to HHA Providers and reports 329 and 339.”
E321	“The 329 and 339 Patient CBSA Visit Section”		Box Checked: At least one provider is an HHA Provider, but the request is not "Outpatient", or “All” (By Service Type), OR "32x", "33x", "xx9" (By Report Group), OR "329", "339" (By Report Type).	“Error E321: The 329 and 339 Patient CBSA Visit Section is only applicable to HHA Providers and reports 329 and 339.”
E322	Interval ‘Apply’ Button	All	Date field must not be null.	“Error E322: Period 1 Start Date contains a non-numeric character or is not in MM/DD/YYYY format.”
E322	Interval ‘Apply’ Button	All	Date field must contain only numeric characters.	“Error E322: Period 1 Start Date contains a non-numeric character or is not in MM/DD/YYYY format.”
E322	Interval ‘Apply’ Button	All	Date field entry must be in MM/DD/YYYY format.	“Error E322: Period 1 Start Date contains a non-numeric character or is not in MM/DD/YYYY format.”
E325	“Reason for Request” field	FI/MAC (Non Admin)	Field must not be null.	“Error E325: No Primary Reason For Request entered. Please enter Primary Reason For Request to proceed.”
E326	“By Report Group” Inpatient Providers only	All	If the provider is only given access to Inpatient, the 998 report cannot be selected.	"Error E326: The 998 Report is only applicable to outpatient Providers."
E326	“By Service Type” Inpatient Providers only	All	If the provider is only given access to Inpatient, the 998 report cannot be selected	“Error E326: The 998 Report is only applicable to outpatient Providers."

ID	Form / Field	User Type	Validation	Error Message
E330	Selection of the "PDF" Format, and then clicking Continue	All	If the "PDF" selected request results in a PDF file which is over the allowable PDF file size, and then clicks Continue.	"Error E330: This request exceeds the maximum allowable PDF file size for Provider(s): (*providers which exceed pdf file size limitations inserted here separated by commas*). Please select "CSV" or change request parameters."
E331	Illegal Character Security Error	Valid for the entire PS&R system excluding the "Your Request Name" field of the Confirmation Screens. Please refer to Error E152 for documentation relating to the "Your Request Name" field.	All non-alpha-numeric characters excluding the following characters: '&' '?' '=' '.' ':' '_' '-' '/' ' ' ',' '@' '*' '\'' '(' ')' '%' will generate a security error.	"Error E331: Security Exception encountered. Please call Help Desk."
E331	Login – Security	PS&R	A security exception was encountered.	"Security Exception encountered. Please call Help Desk."
E385	Detailed Load Control Report Request PDF Size Limitation	CMS, FI/Mac	If the user selects PDF as a report format and the page limit exceeds 500	Error E385: This request exceeds the maximum allowable PDF file size. Please select "CSV" or change request parameters."
W001, W002, W003 or W004	Service Period From Date	All	Entry is one day greater than previous Service Period To Date (this checks to see if the service periods are consecutive).	"Warning: You have selected non-consecutive service periods for Provider <ID #>. This will exclude cost report data from the results. Do you wish to continue?" Clicking the 'Continue' button will bring user to next request page, clicking the 'Back' button will bring user back to the dates page and allow them to make any changes.

ID	Form/Field	User Type	Validation	Error Message
W005	FI/MAC, Provider Requests – "Back" button on the "2. Select Reports" Screen	FI/MAC Admin	If a user wants to change providers, warning message must appear	"Warning" "The Selected Report Types will be lost, if the provider selection is changed" "If provider selection is changed, the report types needs to be reselected." "Do you wish to go back to the Provider Selection List?"
W006	FI/MAC, Provider Requests – "Select Provider(s) Screen	FI/MAC Admin	If Providers have been changed by the FI/MAC admin, display warning message after the admin clicks "Continue" from the Select Provider(s) screen	"Warning" "The original requestor's provider selection has been changed" "The selected provider(s) may not belong to the requestor. Do you wish to continue?"
W007	FI/MAC, Provider Requests – "Select Service Period Date(s)" Screen	FI/MAC Admin	If Service Period Dates have been changed by the FI/MAC admin, display warning message after the admin clicks "Continue" from the Select Service Period Date(s) screen	"Warning" "The selected Service Periods may be outside the requestor's selected range" "The new Service Periods may contain data which does not belong to the requestor. Do you wish to continue?"
W008	Parent Provider is no longer an owner of a child	Parent Provider	If you are requesting a report from when a parent provider owned a child provider, it must be in the range of when the Provider owned the child	"Warning W008: Service dates requested do not coincide with requestor access rights for Provider (ID). These dates will be modified on the Confirm Report Request screen to reflect valid access dates." "Do you wish to Continue?"
W009	"CSV" Format Selected	All	If the Report 1000 was selected from the Select Report(s) screen, the "PDF" format should be selected.	Warning W009: The 1000 report will not generate in CSV format. Do you wish to continue?
W009	"PDF & CSV" Format Selected	All	If the Report 1000 was selected from the Select Report(s) screen, the "PDF" format should be selected.	Warning W009: The 1000 report will not generate in CSV format. Do you wish to continue?

ID	Form/Field	User Type	Validation	Error Message
W010	Insufficient Room in the Favorites Request's Inbox	All	Users may only save up to 100 requests.	Warning W010: The number of Saved Favorites limit has been reached. This request will be submitted, but not saved. Do you wish to continue?
W011	"Favorite Name" field	All	The "Favorite Name" that was entered already exists.	Warning W011: A Favorite Request with this name already exists. Its saved parameters will be lost. Do you wish to continue?
W012	Deleting one or more Requests	All	After selecting a "Delete" checkbox for one or more given request names, the user clicks the "Delete" button.	"Warning W012: You are about to delete <number of requests selected for deletion> requests from your <Inbox Request> Report Inbox".
W013	Removing one or more Favorite Requests	All	After selecting a "Remove Favorite" checkbox for one or more given favorite names, the user clicks the "Remove" button.	"Warning W013: You are about to remove <number of requests> requests from your Favorites. Do you wish to continue?"
W015	Load Control – Load Certification button	FI/MAC Admin	After clicking the "Certify" button for a load that was completed, the following warning is displayed.	"Warning W015: By clicking Continue, you are certifying that you agree with the following statement: I have reviewed this load control entry and have determined that the associated claims supplied by the FISS financial cycle do balance as processed by the PS&R load function."
W016	Load Control – Load Certification button	FI/MAC Admin	After clicking the "Certify" button for a load that has failed, the following warning is displayed.	"Warning W016: By clicking Continue, you are certifying that you agree with the following statement: I acknowledge that this load failed."

D Glossary

This appendix contains a list of terms and abbreviations that are relevant to the PS&R System.

Exhibit D-1 Glossary

Term	Definition
Active	A provider that is active for a Fiscal Intermediary. Fiscal Intermediaries service many providers. When a provider obtains a Provider Agreement with Medicare and a Fiscal Intermediary/Medicare Administrative Contractor is assigned, that provider is said to be "active" for that Fiscal Intermediary/Medicare Administrative Contractor. When the provider is terminated from Medicare, or is assigned to a different FI/MAC, the provider is said to be "inactive" for that FI/MAC; any provider that is inactive for a FI/MAC is one that the FI/MAC used to service, but no longer does.
ASC	Ambulatory Surgical/Surgery Center.
Centers for Medicare and Medicaid Services (CMS)	The Health and Human Services (HHS) agency responsible for Medicare and parts of Medicaid. The Centers for Medicare and Medicaid Services (CMS) responsibilities include: managing contractor claims payment; fiscal audit and/or overpayment prevention and recovery; developing and monitoring payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.
Certificate of Medical Necessity (CMN)	A form required by Medicare that allows you to use certain durable medical equipment prescribed by your doctor or one of the doctor's office staff.
Comma-Separated Values (CSV)	The comma-separated values file format is a file type that stores tabular data (like in an Excel spreadsheet). The file contains fields/columns separated by the comma character and records/rows separated by new lines. Fields that contain a special character (comma, new line, or double quote), must be enclosed in double quotes. However, if a line contains a single entry that is the empty string, it may be enclosed in double quotes. If a field's value contains a double quote character it is escaped by placing another double quote character next to it. The CSV file format does not require a specific character encoding, byte order, or line terminator format.
Community Mental Health Center (CMHC)	A facility that provides the following services: • Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharge from inpatient treatment at a mental health facility, • 24 hour a day emergency care services, • Day treatment, other than partial hospitalization services, or psychosocial rehabilitation services, • Screening for patients considered for admission to State mental health facilities to determine the appropriateness of such admission, and • Consultation and education services.

Term	Definition
Comprehensive Inpatient Rehabilitation Facility (CIRF)	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
Comprehensive Outpatient Rehabilitation Facility (CORF)	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
Contractors	Private health insurers or private organizations that contracted by CMS to provide various services, including processing and paying Medicare claims and/or bills and performing other claim-related activities, such as medical review and fraud investigations.
Continuing Care Retirement Community (CCRC)	A housing community that provides different levels of care based on what each resident needs over time. This is sometimes called “life care” and can range from independent living in an apartment to assisted living to full-time care in a nursing home. Residents move from one setting to another based on their needs but continue to live as part of the community. Care in CCRCs is usually expensive. Generally, CCRCs require a large payment before you move in and charge monthly fees.
Cost Report	An annual report submitted by all institutional providers participating in the Medicare program. The report is submitted on prescribed forms, depending on the type of provider (for example, hospital, skilled nursing facility, etc.). The cost information and statistical data reported must be current, accurate and in sufficient detail to support an accurate determination of payments made for the services rendered. The cost report contains provider information such as facility characteristics, utilization data, and financial statement data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). The types of cost reports are: Hospital Cost Report (CMS-2552-96), Skilled Nursing Facility Cost Report (CMS-2540-96), Home Health Agency Cost Report (CMS-1728-94), Renal Facility Cost Report (CMS-265-94), and Hospice Cost Report (CMS-1984-99).
CPT Codes	“Current Procedural Terminology Codes” – The coding system for healthcare services developed by the CPT Editorial Panel of the American Medical Association (AMA).
Critical Access Hospital (CAH)	A healthcare facility that provides limited outpatient and inpatient hospital services to people in rural areas.
Crossover Claims	Medicare claims that are covered by other insurance (Medigap, private business, etc.). This term is usually reserved for Medicare / Medicaid.
Deductible	The amount that must be paid by a beneficiary before Medicare will pay for any items or services for that individual.
Department of Health and Human Services (HHS)	Federal Government Department that is the parent of the Centers for Medicare and Medicaid Services.
Dialysis Center (Renal)	A hospital unit that is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of the ESRD dialysis patients (including inpatient dialysis) furnished directly or under arrangement.

Term	Definition
Dialysis Facility (Renal)	A unit (hospital based or freestanding) that is approved to furnish dialysis services directly to End Stage Renal Disease patients.
DRG	Diagnostic Related Group (patients with similar illness).
End-Stage Renal Disease (ESRD)	Permanent kidney failure requiring a regular course of dialysis or kidney transplantation to maintain life.
End Stage Renal Disease Treatment Facility	A facility, other than a hospital, that provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
Federally Qualified Health Center (FQHC)	Health centers that have been approved by the government for a program to give low cost health care in a medically underserved area. Medicare pays for some health services in Federally Qualified Health Centers that are not usually covered, like preventive care. Federally Qualified Health Centers include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.
Fiscal Intermediary (FI)	An agency or organization under contract with CMS that performs any or all of the following functions: processing claims (all claims for Medicare Part A services and for certain part B services furnished by institutional providers), determining reasonable charges, determining accuracy and coverage of claims and making Medicare payment for only covered and medically necessary services. Organizationally, each intermediary has a component responsible for the detection, development, and referral of fraud and abuse cases to the OIFO.
FI/MAC	Fiscal Intermediary/Medicare Administrative Contractor.
Fiscal Intermediary Standard System (FISS)	The data source for the PS&R System. Paid Claims are transmitted to the CMS Data Center once they are paid/finalized in the FISS. FISS processing is supported by up to eight (8) Medicare Data Centers nationwide for Fiscal Intermediaries and Medicare Administrative Contractors.
Fiscal Year (FY)	Year long period used for budgeting. The federal fiscal year begins October 1 and ends September 30.
FSP	Federal Specific Portion.
HCPCS	“HCFA Common Procedure Coding System” – A uniform method for providers and suppliers to report professional services, procedures, and supplies. HCPCS includes: CPT codes (Level I), national alpha-numeric codes (Level II), and local codes (Level III) assigned and maintained by local Medicare carriers.
Health Insurance Claim (HIC) Number	The unique alpha-numeric Medicare entitlement number assigned to a Medicare beneficiary that appears on the Medicare card. The HIC number is a unique identifier for each Medicare beneficiary. The majority of the time, it consists of a Social Security or Railroad Retirement Board (RRB) account number plus a Beneficiary Identification Code (BIC).

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA) of 1996	A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191. HIPAA also: • limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage; • usually gives you credit for health coverage you have had in the past; • may give you special help with group health coverage when you lose coverage or have a new dependent; and • generally, guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.
Health Maintenance Organization (HMO)	An entity that provides health insurance coverage and health care services for a fixed, pre-paid premium (and modest additional co-payments and deductibles). RISK HMOs have contracts with Medicare on a prospective capitation payment basis for providing health care to Medicare beneficiaries.
HCRIS	Healthcare Provider Cost Reporting Information System.
Home Health Agency (HHA)	A public or private organization that provides home care services, such as skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
Home Health Care	Health care services provided in the home on a part time basis for the treatment of an illness or injury. Medicare pays for home care only if the type of care needed is skilled and required on an intermittent basis and is intended to help people recover or improve from an illness, not to provide unskilled services over a long period of time.
Hospice	A publicly or privately operated program primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.
Individuals Authorized Access to CMS Computer Services (IACS)	IACS is an on-line application used to register and provision authorized users for access to CMS Part C and D business applications and systems.
Inactive	A provider that is inactive for a Fiscal Intermediary. Fiscal Intermediaries service many providers. When a provider obtains a Provider Agreement with Medicare and a Fiscal Intermediary/Medicare Administrative Contractor is assigned, that provider is said to be "active" for that Fiscal Intermediary/Medicare Administrative Contractor. When the provider is terminated from Medicare, or is assigned to a different FI/MAC, the provider is said to be "inactive" for that FI/MAC; any provider that is inactive for an FI/MAC is one that the FI/MAC serviced previously, but no longer services.

Term	Definition
Incentive Reward Program (IRP)	An incentive reward program established in order to encourage individuals to report information on individuals and entities that are engaged in or have engaged in acts or omissions that constitute grounds for the imposition of a sanction under §§1128, 1128A, or 1128B of the Act, or who have otherwise engaged in sanctionable fraud and abuse against the Medicare program under title XVIII of the Social Security Act.
Inpatient Services	Health care that you get when you are admitted to a hospital.
Inpatient	A person who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health service.
International Classification of Diseases (ICD-9)	A national coding method to enable providers to effectively document the medical condition, symptom, or complaint that is the basis for rendering a specific service(s). This coding system consists of three to five digit numeric or alpha-numeric codes for reporting purposes.
Jurisdiction	The territory, subject matter, or persons as determined by statute or constitution responsibility, over which lawful authority may be exercised by a court or other justice agency.
LTHC	Long Term Health Care.
Maximum Allowable Charge	The maximum allowable cost for prescription drugs under Medicaid.
Medicaid	Health care program cooperatively administered by federal and state governments to provide medical assistance to eligible needy individuals. State programs of public assistance to persons regardless of age whose income and resources are insufficient to pay for health care. Title XIX of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.
Medically Necessary	Services or supplies that meet the following: 1) they are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; 2) they are provided for the diagnosis or direct care and treatment of medical conditions; 3) they meet the standards of good medical practice within the medical community in the service area; 4) they are not primarily for the convenience of the patient or provider; 5) they are the most appropriate level or supply of service that can safely be provided. Medical necessity must be established (via diagnostic and/or other information presented on the claim under consideration) before the carrier or insurer will make payment.
Medically Unnecessary	Items and services that are not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a body part. In order to be reasonable and necessary, the item/service must be safe, effective, appropriate, and not experimental or investigational.
Medicare	A nationwide, federal health insurance program for people aged 65 and older, people with disabilities, or people with End-Stage Renal Disease (ESRD). Medicare Part A covers hospital insurance; Medicare Part B covers physicians' services.
MSP-LCC	Medicare Secondary Payer - Lower Cost or Charge.

Term	Definition
National Provider Identifier (NPI)	A standard unique health identifier for all health care providers as mandated by the Health Insurance Portability and Accountability Act of 1996. As of May 2007 the NPI is mandated for use on Medicare claims. Although not required by the cost reporting system supported by the PS&R System, the NPI will be available in the PS&R System claim database. The National Provider Identifiers (NPIs) will eventually current Unique Physician Identification Numbers and local contractor-assigned provider numbers. The goal is to give providers one uniform number to use for all government health care programs. Each 10 digit NPI belongs to the designated provider for life, regardless of location or specialty changes.
Nursing Facility	A facility which primarily provides to residents skilled nursing care and relate services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
Nursing Home	A residence that provides a room, meals, and help with activities of daily living and recreation. Generally, nursing home residents have physical or mental problems that keep them from living on their own, usually requiring daily assistance.
OPPS	Outpatient Prospective Payment System.
Outlier	Additions to a full episode payment in cases where costs of services delivered are estimated to exceed a fixed loss threshold. HH PPS outliers are computed as part of Medicare claims payment by Pricer Software.
Outpatient	A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in organized programs, such as outpatient clinics.
Outpatient Care	Medical or surgical care that does not include an overnight hospital stay.
Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
Outpatient Services	A service provided in one day (24 hours) at a hospital outpatient department or community mental health center.
Part A	Part A is the hospital insurance portion of Medicare. It was established by §1811 of Title XVIII of the Social Security Act of 1965, as amended, and covers inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.
Part B	Medicare Supplementary Medical Insurance also referred to as "SMI." Medicare insurance that pays for inpatient hospital stay, care in a skilled nursing facility, home health care, and hospice care. Part B is the supplementary or "physicians" insurance portion of Medicare. It was established by 1831 of the Title XVIII of the Social Security Act of 1965 as amended, and covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare.
PHI	Personal Health Information or Protected Health Information.

Term	Definition
Portable Document Format (PDF)	A file format that has captured all the elements of a printed document as an electronic image that you can view, navigate, print, or forward to someone else. PDF files are created using Adobe Acrobat, Acrobat Capture, or similar products. To view and use the files, you need the free Acrobat Reader, which you can easily download. Once you have downloaded the Reader, it will start automatically whenever you want to look at a PDF file.
Quality Improvement Organization (QIO)	A group of clinicians/doctors paid under contract with the federal government to review the medical care given to Medicare patients by other doctors and hospitals.
RAP	Request for Anticipation of Payment.
Regional Home Health Intermediary (RHHI)	A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.
Renal Transplant Center	A hospital unit that is approved to furnish transplantation and other medical and surgical specialty services directly for the care of End Stage Renal Disease transplant patients, including inpatient dialysis furnished directly or under arrangement.
RUG	Resource Utilization Group.
Rural Health Center	An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.
SA	System Administrator.
Skilled Nursing Facility (SNF)	A facility (meeting specific regulatory certification requirements) that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. (Pronounced “sniff”.)
Social Security Administration (SSA)	The independent agency that operates the various programs funded under the Social Security Act. It also determines when an individual becomes eligible for Medicare benefits.
SSN	Social Security Number.