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.
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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.
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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.)
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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.
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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.
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Report Type	Data Element	Description
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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.)
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23P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
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23P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
24P	CLAIMS	Currently this field has no cost report usage.
24P	UNITS	The number of units applicable to each revenue code.
24P	CHARGES	The charges applicable to each revenue code.
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34P	CLAIMS	Currently this field has no cost report usage.
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71P	UNITS	The number of units applicable to each revenue code.
71P	CHARGES	The charges applicable to each revenue code.
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73P	CLAIMS	Currently this field has no cost report usage.
73P	UNITS	The number of units applicable to each revenue code.
73P	CHARGES	The charges applicable to each revenue code.
73P	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.)
73P	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.)
73P	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
73P	GROSS APC PAYMENT	The gross APC amount paid to the provider on a claim-by-claim basis as determined by the OPPS Pricer.
73P	OUTLIER	The outlier portion of the OPPS payment for the APC.
73P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
73P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
73P	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
73P	COINSURANCE	The actual coinsurance amount from the paid claim record.
73P	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.
73P	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.
73P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
73P	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
73P	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.
73P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
74P	CLAIMS	Currently this field has no cost report usage.
74P	UNITS	The number of units applicable to each revenue code.
74P	CHARGES	The charges applicable to each revenue code.
74P	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.)
74P	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.)
74P	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
74P	GROSS APC PAYMENT	The gross APC amount paid to the provider on a claim-by-claim basis as determined by the OPPS Pricer.
74P	OUTLIER	The outlier portion of the OPPS payment for the APC.
74P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
74P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
74P	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
74P	COINSURANCE	The actual coinsurance amount from the paid claim record.
74P	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.
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74P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
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Report Type	Data Element	Description
74P	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.
74P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
75P	CLAIMS	Currently this field has no cost report usage.
75P	UNITS	The number of units applicable to each revenue code.
75P	CHARGES	The charges applicable to each revenue code.
75P	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.)
75P	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.)
75P	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
75P	GROSS APC PAYMENT	The gross APC amount paid to the provider on a claim-by-claim basis as determined by the OPPS Pricer.
75P	OUTLIER	The outlier portion of the OPPS payment for the APC.
75P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
75P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
75P	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
75P	COINSURANCE	The actual coinsurance amount from the paid claim record.
75P	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.
75P	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.
75P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
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Report Type	Data Element	Description
75P	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.
75P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
76P	CLAIMS	Currently this field has no cost report usage.
76P	UNITS	The number of units applicable to each revenue code.
76P	CHARGES	The charges applicable to each revenue code.
76P	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.)
76P	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.)
76P	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
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76P	OUTLIER	The outlier portion of the OPPS payment for the APC.
76P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
76P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
76P	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
76P	COINSURANCE	The actual coinsurance amount from the paid claim record.
76P	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.
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76P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
76P	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
76P	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.
76P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
81P	CLAIMS	Currently this field has no cost report usage.
81P	UNITS	The number of units applicable to each revenue code.
81P	CHARGES	The charges applicable to each revenue code.
81P	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.)
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81P	OUTLIER	The outlier portion of the OPPS payment for the APC.
81P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
81P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
81P	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
81P	COINSURANCE	The actual coinsurance amount from the paid claim record.
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81P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
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Report Type	Data Element	Description
81P	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.
81P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
82P	CLAIMS	Currently this field has no cost report usage.
82P	UNITS	The number of units applicable to each revenue code.
82P	CHARGES	The charges applicable to each revenue code.
82P	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.)
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82P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
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82P	COINSURANCE	The actual coinsurance amount from the paid claim record.
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82P	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.
82P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
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Report Type	Data Element	Description
82P	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.
82P	ELECTED COINSURANCE	The OPPS reduced coinsurance amount that the provider has elected to receive under the OPPS regulations. This is an information only field.
83P	CLAIMS	Currently this field has no cost report usage.
83P	UNITS	The number of units applicable to each revenue code.
83P	CHARGES	The charges applicable to each revenue code.
83P	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.)
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83P	OUTLIER	The outlier portion of the OPPS payment for the APC.
83P	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
83P	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
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83P	OTHER ADJUSTMENTS	This amount should be zero. If not please investigate the amount by using Detail Other Reports.
83P	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
83P	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.
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.)
12Z	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.)
12Z	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
12Z	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
12Z	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
12Z	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
12Z	COINSURANCE	The actual coinsurance amount from the paid claim record.
12Z	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.
12Z	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.)
12Z	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.
13Z	CLAIMS	Currently this field has no cost report usage.

Report Type	Data Element	Description
13Z	UNITS	The number of units applicable to each revenue code.
13Z	CHARGES	The charges applicable to each revenue code.
13Z	GROSS FEE AMT	This is an accumulation of 100% fee reimbursed ambulance services. Sorted by trips and mileage.
13Z	TOTAL AMBULANCE TRIPS	Accumulated number of trips from paid claims.
13Z	TOTAL AMBULANCE MILES	Accumulated number of miles from paid claims.
13Z	TOTAL GROSS FEE SCHEDULE AMT	This is an accumulation of 100% fee reimbursed ambulance services.
13Z	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.)
13Z	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.)
13Z	TOTAL COVERED CHARGES	All Medicare covered charges associated with revenue codes designated as ancillary.
13Z	GROSS REIMBURSEMENT	The gross amount paid to the provider on a claim-by-claim basis.
13Z	CASH DEDUCTIBLE	The actual cash deductible amount from the paid claim record.
13Z	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
13Z	COINSURANCE	The actual coinsurance amount from the paid claim record.
13Z	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.
13Z	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.)
13Z	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.
22Z	CLAIMS	Currently this field has no cost report usage.
22Z	UNITS	The number of units applicable to each revenue code.
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.
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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.
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23Z	TOTAL AMBULANCE TRIPS	Accumulated number of trips from paid claims.
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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.
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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.
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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.)
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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.
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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.)
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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.
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750	BLOOD DEDUCTIBLE	The actual blood deductible amount from the paid claim record.
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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.
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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.)
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760	COINSURANCE	The actual coinsurance amount from the paid claim record.
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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.)
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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.
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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.

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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.

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329	LUPA 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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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.
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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.

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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.
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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.

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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.
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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.
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329	FULL 0623 - Displays by itself	These fields are not populated on this report.
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329	LUPA 0023 - Does not display	These fields are not populated on this report.
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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.

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	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.

Report Type	Data Element	Description
339	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
339	TOTAL 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
339	TOTAL 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
339	TOTAL 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.
339	TOTAL 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
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.
339	TOTAL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	TOTAL 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
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.

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.

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	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.

Report Type	Data Element	Description
339	TOTAL 042X - All revenue code lines where the first three positions = '042' are rolled up	These fields are not populated on this report.
339	TOTAL 043X - All revenue code lines where the first three positions = '043' are rolled up	These fields are not populated on this report.
339	TOTAL 044X - All revenue code lines where the first three positions = '044' are rolled up	These fields are not populated on this report.
339	TOTAL 055X - All revenue code lines where the first three positions = '055' are rolled up	These fields are not populated on this report.
339	TOTAL 056X - All revenue code lines where the first three positions = '056' are rolled up	These fields are not populated on this report.
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.
339	TOTAL 059X - All revenue code lines where the first three positions = '059' are rolled up	These fields are not populated on this report.
339	TOTAL 060X - All revenue code lines where the first three positions = '060' are rolled up	These fields are not populated on this report.
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	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.

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.