Frequently Asked Questions

This section provides answers to the following frequently asked questions, organized into general, technical, reimbursement, and provider-specific questions:

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- Who should I call if I have questions about specific report types?

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1 General Questions

1. What does PS&R stand for? What is the PS&R?

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

The PS&R provides the following:

- All providers can request their own summary reports directly in the system.
- Users can define report selection criteria such as the report types, report numbers, service types and date ranges to include in the reports.
- Providers can submit online requests for detail reports. The provider's FI/MAC then authorizes the request and sends authorized reports to the provider.
- Reduces the time to obtain the data used to complete the cost reports by providing a central repository for all claims data.

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2. What is a Cost Report?

An annual report submitted by all institutional providers participating in the Medicare program. The report is submitted on prescribed forms, depending on the type of provider (for example, hospital, skilled nursing facility, etc.). The cost information and statistical data reported must be current, accurate and in sufficient detail to support an accurate determination of payments made for the services rendered. The cost report contains provider information such as facility characteristics, utilization data, and financial statement data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS).

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3. When must the Cost Report be filed?

The Cost Reports are generally due at the end of the fifth month after the end of the provider's fiscal year. However, for specific instructions and definitions, refer to the Provider Reimbursement Manual (CMS Pub. 15-1 and 15-2) on the CMS Website:

CMS Pub. 15-1

CMS Pub. 15-2

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4. What is IACS?

Individuals Authorized to Access CMS Computer Services (IACS) is a CMS-wide enterprise security and authentication system that will be the gateway to many CMS systems, including the PS&R system. It is a set of common security services that will be deployed throughout CMS IT systems to control both the issuance of electronic identities and access to CMS applications. IACS is an on-line system to support:

a. Delegated Administration
b. Self-Registration
c. Self-Management (of user data)
d. Approval workflows to manage access requests
e. Single Sign-on

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5. How do I get to IACS? And where do I find more information about IACS?

Provider access to IACS is located at:

https://applications.cms.hhs.gov/

IACS information has been distributed in a series of MLN Matters articles on the CMS Website:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf

Links to user manuals are located within the above articles.

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6. Does my IACS password expire?

Yes, IACS requires the following;

- The password must be changed at least every 60 days
- The password must be 8 characters long
- The password must contain at least 2 letters and 1 number
- Letters must be mixed case (i.e. – your password must have at least 1 upper case letter and 1 lower case letter).
- The password must not contain your User ID
- The password must not contain 4 consecutive characters from any of your previous 6 passwords
- The password must be different from your previous 6 passwords

IACS passwords also require that certain words not be used as part or all of a password

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7. Can I have more than one user in my organization request PS&R reports?

Yes, more than one user at a provider may request access to PS&R through IACS.

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8. Can the summary report be viewed in something other than PDF (i.e. a text image file that is used in Legacy)?

No, the text image file has been replaced by the PDF format. CSV format is also provided for analysis and extraction into other programs / formats.

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9. When should I run the PS&R reports that I will use to file my cost report?

Cost reports will continue to be due, as a general rule, 5 months after the end of your fiscal year (see FAQ #3 for further detail). It is suggested that you wait ample time after your fiscal year end to allow claims that may have been paid after the fiscal year end to be included in the PS&R. However, you should also attempt to run the reports with enough time before the cost report is due to ensure that you are able to obtain the reports and have all the data needed to file your cost report timely.

If you are unable to obtain your reports or have questions about the data within them, you should contact your Fiscal Intermediary/Medicare Administrative Contractor at least 45 days prior to your cost report due date. This will ensure that you will be able to obtain all data needed to timely file your cost report.

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10. What do I do if I have a change of staff? How can I prevent that person from accessing the PS&R?

Within IACS, the User Group Administrator has the ability to remove or suspend users at any time. Also, for security purposes, all user passwords will expire and will require the user to be periodically approved by the user group administrator.

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11. What do I do if one of my providers is not available in the list of providers in the PS&R system?

A provider should contact their Fiscal Intermediary/Medicare Administrative Contractor for assistance.

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12. Who do I call if I have questions or I am having problems navigating through the system?

A provider user has detailed help available in the PS&R application. If the help information and training documentation cannot answer the questions, please refer to the following:

If you are having problems logging in to IACS or are having issues with your IACS account, CMS has established an External User Services (EUS) Help Desk to assist with your access to IACS. The EUS Help Desk may be reached by E-mail at ***EUSSupport@cgi.com*** or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

If you have questions about the specific PS&R reports or the data contained within them, you should contact your Fiscal Intermediary/Medicare Administrative Contractor for assistance.

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13. Will my Fiscal Intermediary/Medicare Administrative Contractor continue to send me my PS&R reports?

No. It is expected that all providers will be able to obtain their PS&R reports via the PS&R website, however, if you are unable to obtain your reports, please contact your Fiscal Intermediary/Medicare Administrative Contractor.

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14. What is the turn around time for receiving detail requests from Fiscal Intermediary/Medicare Administrative Contractors?

The recommended turn around time for processing detail requests for Fiscal Intermediaries/Medicare Administrative Contractors is within 30 days. The actual turn around time will depend on the individual request and the current workload of the contractor.

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15. As a provider, why can't I get detail reports sent to my inbox?

Detail reports contain specific claims information, which includes personal health information. Since this data is sensitive, it must only be made available via the most secure methods. You may request a detail report from your Fiscal Intermediary/Medicare Administrative Contractor through the PS&R system. Upon approval, the reports will be sent to you via a secure method.

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16. Are there limits to how many Summary PS&R reports I can run at one time?

There is not a limit in the number of requests for Summary PS&R reports.

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17. Is there a size limitation for individual Detail PS&R requests?

For detail PS&R requests, the system sets a limit on the number of pages in a PDF format of 500 pages. If a detail request is in excess of 500 pages, an error is received due to the size of the request. You will be required to change the request to CSV format.

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18. How do I get PS&R reports for my company if I am a Home Office?

PS&R reports can only be generated by a participating Medicare provider that is required to complete a Medicare Cost Report (Part A providers). A home office will have to obtain the PS&R reports through their providers.

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19. How do providers determine which report types to order?

For cost report filing and reconciliation purposes, providers should request ALL reports. If specific information is needed for analysis of a particular service type, they can request individual reports or groups of reports (i.e. Inpatient only or Outpatient only).

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20. Is there a limit in the number of PS&R detail requests per year?

PS&R Detail Reports are available upon request. Providers may request one detail report (including sub-units) per fiscal year for cost report purposes at no charge. Requests for multiple years of detail reports or any other request for PS&R detail data are considered Special Requests and are outside of normal business, and thus there will be a charge.

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21. What are the major enhancements of the PS&R Redesigned system?

The major enhancements of the PS&R Redesigned system include the following:

Web-based Provider Access: The redesigned PS&R allows providers to directly access the PS&R system through the internet. The Providers can request and receive their own summary reports. It allows them to get their reports faster than the current process.

Receive Reports Online: CMS Fiscal Intermediary users can receive their requested reports online in their inbox. Requests for detail reports by providers will be sent to their Fiscal Intermediary, who will review, approve, and generate the report. The Fiscal Intermediary will get the generated report in their inbox and send it to the provider in the appropriate medium in accordance with the HIPAA regulations.

Reduce Cost Report Filing Time: The redesigned system will provide online extract files directly to providers. Providers also benefit by no longer depending upon Fiscal Intermediaries to provide this service.

Select Report Format and Type: The redesigned system provides more flexibility to providers, Fiscal Intermediaries, and CMS staff in requesting reports and also allows for fast and secure electronic delivery of the reports. This will allow report distribution by type of report (e.g. Summary or Detail) and format (e.g. paper or various electronic formats) as desired by each user group.

Visually Appealing Layouts: The new reports are visually appealing to the user as well as easier to read. The redesigned system uses an industry leading business intelligence software package, which allows for a highly customized formatting and structure to the reports. It gives the ability to structure the report in different sections and add colors to truly customize the report layout as desired. It also provides the ability to generate reports in PDF format and CSV format.

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2 Technical Questions

1. What cost reports will the PS&R Redesign be used for?

The PS&R Redesign will be utilized to file all cost reports with fiscal years ending on or after January 31, 2009. The Legacy PS&R data will be utilized to file all cost reports with fiscal years ending prior to January 31, 2009. The Fiscal Intermediaries/Medicare Administrative Contractors will settle the cost reports using the same system used by the provider to file the cost report.

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2. What PS&R inpatient reports are used to prepare the Cost Report?

The inpatient / outpatient reports that are generated in PS&R that are used to prepare the Cost Report can be found using the PS&R / Cost Report Crosswalk (also know as the Cost Report Mapping spreadsheet, located within the online documentation).

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3. How often does the PS&R get updated with the latest claims?

PS&R is updated once the Paid Claim submitted from the Fiscal Intermediary/Medicare Administrative Contractor clears the PSR Load Control process. The most recent paid date can be found on the *Select Service Periods and Paid Dates* screen. Refer to the To date under Select Paid Dates which will default to the most recent paid date. Data available can vary due to the payment schedule of each Fiscal Intermediary/Medicare Administrative Contractor.

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4. What output format can I get PS&R summary and detail reports?

The Provider Statistical and Reimbursement System can generate summary and detail reports in either Portable Document Format (PDF) or Comma-Separated Values (CSV).

Portable Document Format is a file format that has captured all the elements of a printed document as an electronic image that you can view, navigate, print, or forward to someone else. PDF files are created

using Adobe Acrobat, Acrobat Capture, or similar products. To view and use the files, you need the free Acrobat Reader, which you can easily download. Once you have downloaded the Reader, it will start automatically whenever you want to look at a PDF file.

The comma-separated values file format is a file type that stores tabular data (like in an Excel spreadsheet). The file contains fields/columns separated by the comma character and records/rows separated by new lines. These file formats can be converted into Microsoft Excel and Access files. It may also be possible to upload a CSV file into a cost reporting vendor's software for interpretation and analysis.

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5. What is different about the PS&R Payment Reconciliation Report?

The PS&R Payment Reconciliation Report contains relatively the same data as the Legacy Report, and much more. There are many new informational fields that will benefit providers and FI/MAC's. The layout of the report is in a more organized and visually appealing presentation. The reports are available in CSV or PDF. The preferred option of CSV is more user friendly, and the data can be converted into various formats.

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6. Why am I unable to see the detail report I requested even though the report cover sheet indicates one page was produced?

There were no claims that satisfied the request criteria. The report cover sheet indicates the reports that the system attempted to generate based on your request. When you click on the report link, you will advance to the blank page that was produced, indicating that no claims met the requested criteria.

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3 Reimbursement Questions

1. Will service periods shown on Legacy PS&R display in the redesigned system?

No. The redesigned PS&R system will only display service periods applicable to cost reporting periods ending on or after 01/31/2009. The legacy PS&R system will only display service periods applicable to cost reporting periods ending before 01/31/2009.

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2. Would there ever be straddle service periods? Use of both Legacy and Redesign systems? E.g. FYE 06/30/2007 (includes before/after 02/27/07 service periods)

No. Refer to the FAQ above for further explanation.

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3. What does the MSP-Recon field represent? Used for cost report settlement?

11x -MSP PASS THRU RECON- 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. This field is informational only and should not be included in the cost report.

xxP- 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(obligated to accept payment as full) or MSP-LCC (Medicare Secondary Payment Lower of Cost or Charge). Cost reporting form 2552-96: W/S E Part Line 30.99 or J-3 line 23 (to subtract a positive PS&R amount from allowable cost); form 1728: W/S CM-3 line 21 (to subtract a positive PS&R amount from allowable cost); or form 2088: W/S D lines 16.5-16.9 (enter a positive PS&R amount as a positive and a negative PS&R amount as a negative).

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4. What does the PIP amount represent in the Info Only section?

CALCULATED NET REIMB FOR PIP CLAIMS – Indicates that provider received PIP payments. Not used for cost reporting; for intermediary use.

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. Cost reporting forms 2552-96 or 2540-96, W/S E-1 Line 1 Col 2.

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5. Will the Fiscal Intermediary/Medicare Administrative Contractor continue to send other important cost report items previously sent with the PS&R?

The only requirement that will change is the Fiscal Intermediary/Medicare Administrative Contractor requirement to send the PS&R reports, as they may be generated by the provider. All other requirements remain.

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4 Provider-specific Questions

1. Do I need to get my PS&R reports for HHA and Hospice from the RHHI processor?

All requests should be submitted through the PS&R Redesign system. If there are any further questions, please contact your Audit Intermediary/Medicare Administrative Contractor.

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2. Are the HHA Redesigned summary reports different from the Legacy reports?

Yes, the summary reports are formatted in a slightly different manner. The Episode Report and MSA Report are combined under the Redesigned System.

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3. Does the system show pre-PPS periods for Home Health Agencies?

No. Pre PPS services (prior to 10/01/00) are only included in Legacy PS&R.

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4. Does the system show fee reimbursed services on different PS&R reports like Legacy did?

Yes, all fee reimbursed services are included on the XX5 reports. A header has been added to remind providers that the data on these reports is not to be included on the Medicare cost report.

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5. What do I do if I cannot obtain my PS&R reports?

It is expected that all providers will be able to obtain their PS&R reports via the PS&R website, however, if you are unable to obtain your reports, please contact your Fiscal Intermediary/Medicare Administrative Contractor.

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6. Who should I call if I have questions about specific report types?

Providers should refer to the on-line help and PS&R documentation. If that does not answer the question, the provider should contact their FI/MAC for assistance.

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