Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1848

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3656.3 (Cont.) – 3656.3 (Cont.)	6-319 – 6-323.1 (6 pp.)	6-319 – 6-323.1 (6 pp.)
3850 – 3850.1	9-173.2 – 9-173.3 (2 pp.)	9-173.2 – 9-173.3 (2 pp.)
3850.1 (Cont.) – 3850.2 (Cont.)	9-173.6 – 9-173.9C (7 pp.)	9-173.6 – 9-173.9B (6 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: 1/1/02*
IMPLEMENTATION DATE: 1/1/02

Section 3656.3, PPS PRICER Program, has been amended to include data requirements specific to Inpatient Rehabilitation PPS.

Section 3850, Provider-Specific Payment Data, has been amended to include data requirements specific to inpatient rehabilitation PPS.

Section 3850.1, Provider-Specific Data Record Layout and Description, has been amended to include data requirements specific to inpatient rehabilitation PPS.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

File Position	Format	Title	Description
			Leave blank for hospitals if there has not been a Lugar reclassification. For hospice providers only, enter a 6, 7, 8 or 9 if the hospice is located in one of the four special hospice MSAs.
74	X	Temporary Relief Indicator	Enter a Y if this provider qualifies for a payment update under the temporary relief provision. Blank if not Y.
75	X	Federal PPS Blend Indicator	SNF: Enter the appropriate code for the blend ratio between federal and facility rates. For PPS SNF's eff. for cost reporting period beginning on or after 7/1/98. 1 = Federal 25% / Facility 75% 2 = Federal 50% / Facility 50% 3 = Federal 75% / Facility 25% 4 = Federal 100% / Facility 00% HHA: Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000. 0 = Pay standard percentages 1 = Pay zero percent IRF: Effective for all providers with cost reporting periods beginning on or after 1/1/2002. Must be 3 or 4. 3 = blend (66 2/3 and 33 1/3) 4 = 100% Federal All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002.
76-80	X(5)	Filler	Blank.
81-87	9(5)V9(2)	Case Mix Adjusted Cost per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state nonexcluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §3610.17 for sole community and Medicare-dependent hospitals on or after 04/01/90. Must be updated effective October 1, 1994. For PPS SNF's that

File Position	Format	Title	Description
			qualify for the transition period eff. with cost reporting periods beginning on or after 7/1/98, enter the facility specific payment rate.
88-91	9V9(3)	Cost of Living Adjustment	Enter the appropriate cost of living adjustment for the current fiscal year as published in the Federal Register.
92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full-time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. You are responsible for reviewing hospital records and making any necessary changes in the count at the end of the cost reporting period. Enter zero for nonteaching hospitals.
97-101	9(5)	Bed Size	Indicate the number of adult hospital beds and pediatric beds available for lodging inpatients. (See Provider Reimbursement Manual, §2405.3G.) If there is a change during the year, make an adjustment if it would make a significant difference in the payment amount.
102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by the Medicare covered charges. Obtain Medicare operating costs from the Medicare cost report Form HCFA-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare

File Position	Format	Title	Description
			covered charges from your billing file, i.e., PS&R record. For hospitals for which you are unable to compute a reasonable cost-to-charge ratio, use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the ***Federal Register***. These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the ***Federal Register***.
106-110	9V9(4)	Case Mix Index	The case mix index used to complete positions 81-87. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
111-114	V9(4)	Supplemental Security Income Ratio	SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
115-118	V9(4)	Medicaid Ratio	Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
119	X	Provider PPS Period	This field is obsolete as of 4/1/91. Leave blank for periods on or after 4/1/91.
120-125	9V9(5)	Special Provider Update Factor	Zero fill for all hospitals after FY91. This field is obsolete as of FY92.
126-129	V9(4)	Operating DSH	Disproportionate share adjustment percentage. PRICER calculates the operating DSH effective 10/1/91 and bypasses this field. Zero fill for all hospitals 10/1/91 and later.

File Position	Format	Title	Description
130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
138-160	X(23)	Filler	Blank.
161-166	9(4)V99	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. (See Provider Reimbursement Manual §2405.2.) Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero fill if this does not apply.
167-172	9(4)V99	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital. (See Provider Reimbursement Manual §2405.2.) Zero fill if this does not apply.
173-178	9(4)V99	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart and liver transplants. Do not include acquisition costs for bone marrow transplants. (See Provider Reimbursement Manual §2405.2.) Zero fill if this does not apply.
179-184	9(4)V99	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital. (See Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts: certified registered nurse anesthetists (CRNAs) are paid as part of miscellaneous pass through for rural hospitals that perform fewer than 500 surgeries per year; and nursing and allied health professional education when conducted by a provider in an approved program. Do not include amounts paid for indirect medical education, hemophilia clotting factors, or DSH adjustments. Zero fill if this does not apply.

File Position	Format	Title	Description
185	X	Capital PPS Payment Code	Type of capital payment methodology: for hospitals: A=Hold harmless-cost payment for old capital B=Hold harmless-100% Federal rate C=Fully prospective blended rate Blank if a "Y" is entered in position 207.
186-191	9(4)V99	Hospital-Specific Capital Rate	Numeric.Hospital's allowable adjusted base year inpatient capital costs per discharge.
192-197	9(4)V99	Old Capital Hold Harmless Rate	Numeric. Hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
198-202	9V9(4)	New Capital-Hold Harmless Ratio	Numeric. Ratio of hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
203-206	9V999	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which you are unable to compute a reasonable cost-to-charge ratio, use the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the ***Federal Register***. These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the ***Federal Register***. A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a three standard deviation band. Use the hospital's ratio rather than the statewide average if you agree the hospital's ratio is justified.

File Position	Format	Title	Description
207	X	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
208-212	9V9(4)	Capital Indirect Medical Education Ratio	The ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §3611.1.) Zero fill for a non-teaching hospital.
213-218	9(4)V99	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §3611.7.)
219-240	X(22)	Filler	Blank.

3850. PROVIDER-SPECIFIC PAYMENT DATA

Submit a file of provider-specific payment data to CO every 3 months for PPS and non-PPS hospitals, inpatient rehabilitation hospitals or units (referred to as IRFs), SNF's, and hospices, including those in Maryland. Regional home health intermediaries (RHHIs) submit a file of provider specific data for all home health agencies. Intermediaries serving as the audit intermediary for hospital based HHAs do not submit a file of provider specific data for HHAs. Create a new record any time a change occurs for a provider. Report data for the following periods: October 2 - January 1, January 2 - April 1, April 2 - July 1, and July 2 - October 1. This file must be received in CO within 7 calendar days after the end of the period being reported.

NOTE: Submit your latest available provider-specific data for the entire reporting period to CO by the 7 calendar day deadline. If CO fails to issue applicable instructions concerning changes or additions to the file fields by 10 calendar days before the end of the reporting period you may delay reporting of data related to the CO instructions until the next file due date. For example, if CO instructions changing a file field are issued on or after September 21 with an effective date of October 1, you may exclude the October 1 CO-required changes from the file you submit by October 9. Include the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

A. PPS Hospitals.--Submit all records (past and current) for all PPS providers every 3 months. Duplicate the provider file used in the "PRICER" module of your claims processing system.

B. Non-PPS Hospitals and Exempt Units.--Create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Submit the current and the preceding fiscal years every 3 months. Code Y in position 49 (waiver code) if you want to maintain the record in your PRICER PROV file.

C. Hospice.--Create a provider specific history file using the following data elements for each hospice. Submit the current and the preceding fiscal years every 3 months. Code Y in position 49 (waiver code) if you want to maintain the record in your PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for this provider type.

D. Skilled Nursing Facility (SNF).--Create a provider specific history file using the following data elements for each SNF beginning with their first cost reporting period that starts on or after July 1, 1998. Submit the current and the preceding fiscal years every 3 months. Code Y in position 49 (waiver code) if you want to maintain the record in your PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, 19, and 21 are required. All other data elements are optional for this provider type.

E. HHA.--Create a provider specific history file using the following data elements for each HHA. RHHIs submit the current and the preceding fiscal years every 3 months. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13 and 19 are required. All other data elements are optional for this provider type. All fields must be zero filled if not completed. Update the effective date in data element 4 annually. Ensure that the current census division in data element 11 is not zero. Ensure that the waiver indicator in data element 8 is N. Ensure that the MSA code reported in data element 13 is a valid MSA code.

Send a paper listing copy to your RO. If you service providers outside of your area, submit a hardcopy of the file to the RO in which the facility is located. (For example, Mutual of Omaha submits a hardcopy of the file to the Denver, San Francisco, Atlanta, and Dallas ROs.)

NOTE: The intermediary servicing Indian Health Facilities needs to submit a hardcopy of the file only to the Dallas RO.

The provider specific file (PSF) should be transferred to CO using the Network Data Mover (NDM) system, COPY TO and RUN JOB statements, which will notify CO of PSF file transfer. You must setup an NDM transfer from your system for which you are responsible. It is critical that the provider specific data is copied to the CMS Data Center using the following input data set names. 99999 should be changed to your five digit intermediary number.

Data set Name ---**COPY TO**: --**MU00.@FPA2175.FI99999**
DCB=(**HCFA1.MODEL,BLKSIZE=2400,LRECL=2400,RECFM=FB)**
Data set Name ---**RUN JOB**: --**MU00.@FPA2175.CLIST(FI99999)**

F. Inpatient Rehabilitation Facilities (IRFs).--Create a provider specific history file using the following data elements for each IRF beginning with their first cost reporting period that starts on or after January 1, 2002. Submit the current and the preceding fiscal years every 3 months. Code Y in position 49 (waiver code) if you want to maintain the record in your PRICER PROV file. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type.

3850.1 Provider-Specific Data Record Layout and Description.--Complete all fields below. Use the space bar to indicate a (blank). Do not enter zeroes, nines or nulls in these fields.

	Field	Format	Location	Coding and Edits
1.	National Provider Identifier (NPI)	X(8)	1-8	NA
2.	NPI - Filler	X(2)	9-10	NA
3.	Provider Oscar No.	X(6)	11-16	Alpha/Numeric - Cross check to Item 10, provider type. Positions 3 and 4 of: Provider # — Type (see field 10) 00-08 — Blanks, 00, 07-11, 13-17, 21-22 12 — 18 13 — 23, 37 20-22 — 02 30 — 04 33 — 05 40-44 — 03 50-64 — 32-34, 38 15-17 — 35 70-84, 90-99 — 36 Codes for special units S, T, U, V, W, Y and Z are in the third position of the provider number and should be type 06 (hospital distinct parts).
4.	Effective Date	9(8)	17-24	Month 01-12, day 01-31, year greater than 82 but not greater than current year. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file.

Field	Format	Location	Coding and Edits
			This must be equal to or greater than the fiscal year begin date for this record. Must be numeric, CCYYMMDD.
13. Actual Geographic Location-MSA	X(4)	59-62	Must be (blank)(blank) 2-digit code if rural or MSA # 0040 - 9360.
14. Wage Index MSA Location--MSA	X(4)	63-66	The appropriate code for the 0040-9965, or the rural area, (blank) (blank) (2-digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. PRICER automatically defaults to the actual location MSA if this is left blank.
15. Standardized Amount MSA Location--MSA	X(4)	67-70	The appropriate code for the 0040-9965, or the rural area, (blank) (blank) (2-digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location MSA (field 13) if not reclassified. PRICER automatically defaults to the actual location MSA if this is left blank.
16. Sole Community Medicare Dependent Hospital --Base Year	X(2)	71-72	Leave blank if not an SCH or effective with cost reporting periods that began on or after 4/1/90, except FY 95-97. If an SCH or an MDH, must show the base year for the operating hospital specific rate, either 82 or 87. Must be left blank if an SCH or a MDH did not operate in 82 or 87.
17. Change Code for Lugar Reclassification	X	73	"L" must be entered if the wage index was reclassified under the Lugar Amendment for ASC-approved services provided on an outpatient basis. Blank if not reclassified under the Lugar Amendment or hospice provider.

	Field	Format	Location	Coding and Edits
				For hospice providers only, from 10/1/97-9/30/99, enter a "6", "7", "8" or "9" if the hospice is located in one of the four special hospice MSAs.
18.	Temporary Relief Indicator	X	74	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision. Blank if not "Y".
19.	Federal PPS Blend Indicator	X	75	SNF: The appropriate code for the blend ratio between federal and facility rates. For PPS SNF's eff. for cost reporting period beginning on or after 7/1/98. If present, must be 1, 2, 3 or 4.

	Federal %	Facility %
1	25	75
2	50	50
3	75	25
4	100	00

HHA: Effective for all HHA providers on and after 10/01/2000, the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers.

0 = Pay standard percentages
1 = Pay zero percent

Must be a numeric value of 0 – 9. Values not listed above are unassigned.

IRF: Effective for all providers with cost reporting periods beginning on or after 1/1/2002. Must be 3 or 4.
3 = blend (66 2/3 and 33 1/3)
4 = 100% Federal

All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002.

20.	Filler	X(5)	76-80	Blank.

	Field	Format	Location	Coding and Edits
21.	Case Mix Adjusted Cost Per Discharge/ Facility Specific Rate	9(5)V9(2)	81-87	For PPS hospitals and waiver State nonexcluded hospitals, enter the PPS base year cost per discharge divided by the case mix index. Enter zero for new providers. See§3610.17 for sole community and Medicare-dependent hospitals on or after 04/01/90. For PPS SNF's that qualify for the transition period eff. with cost reporting periods beginning on or after 7/1/98, enter the facility specific payment rate. For all others, see § 3610.B. Verify if figure is greater than $10,000.
22.	Cost of Living Adjustment	9V9(3)	88-91	For PPS hospitals report the adjustment in these positions of your PROV file. All hospitals except Alaska and Hawaii use 1.000.
23.	Intern-Bed Ratio	9V9(4)	92-96	See §3656.3B for the calculation of the provider's intern-to-bed ratio. Does not include residents in anesthesiology employed to replace anesthetists or those assigned to PPS excluded units. Enter zeros for non-teaching hospitals.
24.	Bed Size	9(5)	97-101	Enter the number of hospital beds available. See §3656.3B for definition. Must be greater than zero.
25.	Operating Cost-to-Charge Ratio	9V9(3)	102-105	Derived from latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare Operating Cost (from the cost report) by the Medicare Covered Charge (from the billing file, i.e., the PS&R record). For hospitals for which you are unable to compute a reasonable cost-to-charge ratio, use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS. Use these average ratios to calculate cost outlier payments for hospitals where you compute cost-to-charge ratios that are not within the limits published in the ***Federal Register***.

	Field	Format	Location	Coding and Edits
26.	Case Mix Index	9V9(4)	106-110	For PPS hospitals, enter the case mix index used to compute field 21. Zero fill for all others.
27.	Supplemental Security Income Ratio	V9(4)	111-114	SSI ratio used to determine if the hospital qualifies for the disproportionate share adjustment, and to determine the size of the capital and operating DSH adjustments.
28.	Medicaid Ratio	V9(4)	115-118	Medicaid ratio used to determine if the hospital qualifies for the disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29.	Provider PPS Period	X	119	This field is obsolete as of 4/1/91. Leave blank for periods on or after 4/1/91.
30.	Special Provider Update Factor	9V9(5)	120-125	Zero fill for all hospitals after FY91. This filed is obsolete as of FY92.
31.	Operating DSH	V9(4)	126-129	Disproportionate share adjustment percentage. PRICER calculates the operating DSH effective 10/1/91 and bypasses this field. Zero fill for all hospitals 10/1/91 and later.
32.	Fiscal Year End	9(8)	130-137	This field is no longer used. If present, must be CCYYMMDD.
33.	Filler	X(23)	138-160	Blank.
34.	Pass Through Amount for Capital	9(4)V99	161-166	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C.
35.	Pass Through Amount For Direct Graduate Medical Education	9(4)V99	167-172	Per diem amount based on the interim payments to the hospital. Zero fill if this does not apply.
36.	Pass Through Amount for Organ Acquisition	9(4)V99	173-178	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart and liver transplants. Do not include acquisition costs for bone marrow transplants. (See Provider Reimbursement Manual §2405.2.) Zero fill if this does not apply.

	Field	Format	Location	Coding and Edits
37.	Total Pass Through Amount, Including Miscellaneous	9(4)V99	179-184	Per diem amount based on interim payments to the hospital. Must be equal to or greater than the sum of the 3 pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts: Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year; and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH Adjustments. Zero fill if this does not apply.
38.	Capital PPS Payment code	X	185	Type of capital payment methodology for hospitals: A=Hold harmless-cost payment for old capital B=Hold harmless-100% Federal rate C=Fully prospective blended rate Must be present unless a "Y" is entered in location 49 or 207, or 08 is entered in location 55-56 or a termination date is present in location 41-48.
39.	Hospital Specific Capital Rate	9(4)V99	186-191	The FY 93 hospital specific rate should be entered in this field. Do not update this field after FY 93, except to reflect the effects of a hospital specific rate redetermination. PRICER applies the appropriate update factor automatically after 10/01/93. Numeric. Hospital's allowable adjusted base year inpatient capital costs per discharge.

Field	Format	Location	Coding and Edits
40. Old Capital-Hold Harmless Rate	9(4)V99	192-197	Numeric. Hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired by December 31, 1990 (or incurred subsequent to December 31, 1990, but allowed as "obligated" capital) for capital PPS. Must be updated annually.
41. New Capital-Hold Harmless Ratio	9V9(4)	198-202	Numeric. Ratio of hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Must be updated annually.
42. Capital Cost-to-Charge Ratio	9V999	203-206	Computed by dividing the Medicare capital costs by the Medicare covered charges in the PS&R record. For hospitals for which you cannot calculate a capital cost-to-charge ratio, use the appropriate statewide average cost-to-charge ratio calculated annually by CMS, or an alternate justified capital cost-to-charge ratio. (See §3656.3B.)
43. New Hospital	X	207	Enter "Y" if a hospital is in its first 2 years of operation under the capital regulation. Otherwise leave blank.
44. Capital Indirect Medical Education Ratio	9V9(4)	208-212	Enter the ratio of residents to the hospital's average daily census. Zero fill for a non-teaching hospital.
45. Capital Exception Payment Rate	9(4)V99	213-218	Enter the per discharge exception payment to which a hospital is entitled.
46. Filler	X(22)	219-240	Blank.

3850.2 Intermediary Responsibilities.--Create a new record when a change occurs for a provider. You may have multiple records for a single provider within a quarter.

Prior to submitting the file to CMS, print and review the data. Edit all items for accuracy. Correct any errors before submitting the file. Some edit examples:

- o Effective date other than CCYYMMDD;
- o Facility has two or more records with different provider numbers for the same month;

- Non-PPS facility with incorrect provider type;
- Incorrect census division for a redesignated facility;
- MSA field with other than (blank) (blank) (2-digit State number) for a rural provider; and
- Questionable pattern of coding, e.g., all provider types in field 10 are identical, all case mix indexes in field 26 are identical.

Provider-specific payment data must be received in CO within 7 calendar days of the end of the reporting period. The data will be evaluated based on the following criteria:

- Files conform to specifications;
- Files reflect data from all required providers; and
- Files are submitted in the correct record format.

CO will forward an error listing to you for correction. Submit corrected data files to CO within 10 calendar days of notification.