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 report contains provider information such as facility characteristics, utilization data, and financial statement data.

If you did not furnish any covered services to Medicare beneficiaries or had low utilization of such services in a reporting period, a full cost report need not to be filed. Conditions for qualifying for a low/ no utilization cost report filing are described below:

• There was no Medicare activity during the reporting period. A no-activity filing requires that you submit a statement on the agency's letterhead, signed by an authorized official, identifying the cost report period. This must state 1) no covered services were furnished during the reporting period, and 2) no claims for Medicare reimbursement will be filed for this reporting period.

• There was low Medicare utilization during the reporting period, defined as net Medicare reimbursement less than $200,000. A low utilization filing requires that you submit the S series of the cost report and the worksheets that present the balance sheet and statement of revenues and expenses. A copy of the agency's trial balance should accompany this. By submitting a low-utilization filing, you agree that there will be no retroactive adjustment to the amounts received by your facility for the cost reporting period.