Worksheet S-10 is here to stay: Programme update and a look at MAC S-10 audits

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Abstract This paper discusses the change to the Inpatient Prospective Payment System Medicare (IPPS) Disproportionate Share (DSH) programme, the introduction of Worksheet S-10 to distribute payments and the history of S-10 audits that are a result of the new methodology. The paper provides insights to help hospitals and hospital system providers understand what they can expect in S-10 audits and tips to help them prepare their organisation.

KEYWORDS: hospital, Medicare reimbursement, Worksheet S-10, Medicare DSH, inpatient prospective payment system, uncompensated care, S-10 audits

As a result of the Affordable Care Act (ACA), which was passed in 2010, the Federal Medicare Disproportionate Share (DSH) payment calculation was bifurcated, with 25 per cent of the computed amount going directly to hospitals under the historical Medicare DSH formula — called the empirically justified amount — and the remaining 75 per cent establishing a new fixed, uncompensated care (UC) pool shared by qualifying hospitals nationally. The rationale for the change was to try and get dollars more directly allocated to the hospitals that were bearing the brunt of UC costs. It was implemented also because, according to government studies, only 25 per cent of the amount previously paid was empirically justified as it relates to the original purpose of the Medicare DSH payment. This new payment methodology is the product of three factors computed by the Centers for Medicare and Medicaid Services (CMS).[1] These factors and estimates are reported each year in the hospital Inpatient Prospective Payment System (IPPS) payment rule-making issuance. As of the publication of this paper, we currently find ourselves in the federal fiscal year (FFY) 2021 rule-making cycle. These changes came into effect on 1 October 2020.

Factor 1 is an estimate of what Medicare DSH would have been in FFY 2021 absent the enactment of the ACA less the 25 per cent empirically justified amount that will be paid directly to hospitals and settled in annual cost reports. CMS used the most recently available projections of Medicare DSH as calculated by the CMS Office of the Actuary (OACT) from cost reports to estimate what Medicare DSH would have been absent the ACA. The FFY 2021 estimate of what Medicare DSH would have been is US$15.171bn. After deducting the 25 per cent empirically justified amount, the amount of the net Factor 1 is US$11.378bn.

Factor 2 is the result of taking Factor 1 and adjusting it for the change in the national uninsured rate compared with the uninsured rate in 2013 as published by the Congressional Budget Office (CBO). CMS used the most recent period data estimates produced by the CMS OACT as part of the development of the National Health Expenditure Accounts (NHEA). CBO estimates the uninsured rate in 2013 was 14 per cent. OACT, for calendar years (CY) 2020 and 2021, estimates the uninsured rates are 10.3 per cent and 10.2 per cent, respectively. These estimates result in a Factor 2 value of 72.86 per cent.

When Factor 2 is applied to Factor 1 (US$11.378bn $\times$ 0.7286), the result is an UC pool amount of approximately US$8.290bn, to be shared by 2,401 qualifying hospitals on the basis of their Factor 3 calculation. See the trend of the UC pool since the programme began in 2014 in the following table (Figure 1).

From a trend perspective, the UC pool in 2014 was US$9.033bn, which then steadily declined as the rate of the uninsured declined in the United States as the provisions of the ACA took effect, or, at least was estimated to decline according to CBO data. Since the switch from CBO data to NHEA data metric in 2018, and as a result of changes to various factors that impact coverage decisions under the ACA, the rate of uninsured ticked up in 2018 and 2019 and nearly flattened in 2020 and 2021. The size of the pool increased as pre-ACA DSH estimates have increased when more current fiscal years are used as the basis for computing the estimates of Factor 1, but for 2021, the pre-ACA DSH estimate decreased for the first time since the UC pool was established.

Finally, Factor 3, which is the primary subject of this paper, is the basis used for distributing the pool to the qualifying hospitals and is defined as the percentage of each subsection (d) hospital's amount of UC as a percentage of the UC of all hospitals qualified for payment from the UC pool. Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of UC payment each eligible hospital will receive.

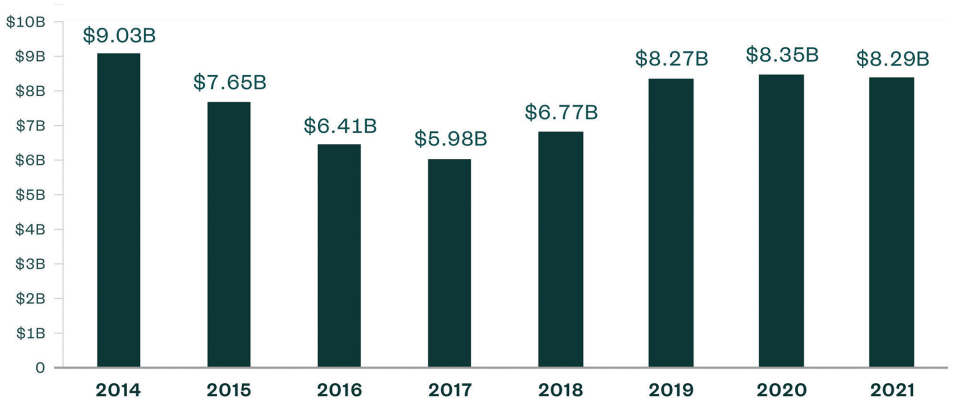

Figure 1: Uncompensated care pool trends
Source: Centers for Medicare & Medicaid Services.

Initially, the amount of the UC pool was distributed on the basis of low-income days — Medicaid days and Medicare/Supplemental Security Income (SSI) days. In its FY 2018 IPPS final rule-making, however, CMS announced that it was phasing out the use of Medicaid and Medicare/SSI days. CMS would begin incorporating UC cost data (defined as charity care and bad debt costs) from Medicare cost report Worksheet S-10, Line 30, to calculate one-third of Factor 3, which determines a hospital's share of the federal UC pool.

Then, in its FY 2019 IPPS rule-making, CMS continued with the use of Worksheet S-10 and further transitioned to utilise charity care and bad debt costs reported on Medicare cost report Worksheet S-10 to calculate qualifying hospitals' federal UC reimbursement. CMS advanced the time period of the S-10 data used in FY 2018 by one year to further phase out the low-income days proxy by using two fiscal years of S-10 cost report data to calculate UC Factor 3 as follows for FFY 2019:

- FY 2013 low-income insured days and FY 2016 SSI data
- FY 2014 UC cost per Worksheet S-10
- FY 2015 UC cost per Worksheet S-10

In the FY 2020 round of IPPS rule-making, CMS abandoned the average of three cost reporting periods as described earlier and used only one year of S-10 data from FY 2015 for FY 2020 UC allocation purposes. The shift from low-income days to UC costs as the primary driver in distributing the pool continued to result in a shift in reimbursement dollars around the country.[2] The large shift in dollars is not necessarily a product of what hospitals are reporting in their annual cost reports but, instead, is more likely because of the change in the basis of the distribution. The low-income day methodology measured insured low-income utilisation, that is, Medicaid days plus Medicare days for patients also qualifying for SSI. With the shift to calculated UC costs per cost report Worksheet S-10, the distribution of the dollars shifted towards uninsured, UC even though it still captures a measure of insured UC dollars, just in a different way than the low-income day utilisation method. It was widely noted in various federal register notices and other communications that UC costs per Worksheet S-10 would be an adequate proxy for distributing these payments. There was, however, significant criticism by the provider community that the data reported on S-10 was inconsistent and incomplete, largely owing to a lack of clear and consistent reporting instructions. In addition, the provider community asserted that the S-10 information should be audited before its use. As a result, CMS delayed the

implementation of the use of S-10 data for a number of years so that these issues could be addressed. Some changes were made to reporting instructions, and CMS began the process of auditing the data. Once audited data for at least a subset of the qualifying hospitals was available, CMS moved to change the distribution metric to S-10 data from low-income days data.

In terms of type of hospital, in comparing FY 2020 with FY 2019, governmental hospitals saw an estimated increase of US$431m, while not-for-profit hospitals and proprietary hospitals saw a decrease of US$334m million and US$19m, respectively. There was also a significant redistribution of dollars among the states. The following chart shows the five states that experienced the greatest increase in payments and the five states with the greatest decreases in payments (Figure 2). You can see that Texas was by far the most positively impacted with a pickup of over US$270m compared with the UC for 2019, which was more than that of the next four states combined. It is not just the dollars but the massive shifts in percentage changes as Texas, Virginia and Georgia saw increases of close to 25–30 per cent compared with the 2019 UC payment. California experienced a sharp drop, of almost 30 per cent, that equated to a US$213m decrease in UC reimbursement. These same-sized shifts occurred in the previous two years as the UC calculation moved from low-income days as the proxy and was replaced with UC costs from Worksheet S-10. This shift to UC cost, in part, better reflected the result of policy decisions in certain states. For example, Texas did not expand Medicaid under ACA and therefore now has a significant number of uninsured patients compared with states that did expand Medicaid. As a result, Texas saw a substantial increase in payments once the distribution metric was changed to UC costs. Obviously, the reverse would be true for states that did expand Medicaid as their number of uninsured patients would have dropped and their allocation of UC dollars would have declined.

In the most recent round of rule-making — FY 2021 — CMS will use S-10 data

LARGEST DOLLAR GAINS AND LOSSES

STATE	PROVIDERS	2019 UNCOMPENSATED CARE (UC) PAYMENT	2020 UC PAYMENT	VARIANCE	PERCENT
Texas	192	1,134,121,758	1,404,145,653	270,023,896	23.81%
Georgia	83	352,654,727	440,883,263	88,228,535	25.02%
Virginia	50	182,649,119	242,090,467	59,441,348	32.54%
Florida	130	787,929,035	828,687,438	40,758,403	5.17%
New York	113	618,993,624	653,350,191	34,356,567	5.55%
California	248	712,550,378	499,244,876	(213,305,502)	-29.94%
Michigan	69	180,859,966	116,468,773	(64,391,193)	-35.60%
Ohio	100	263,440,205	210,414,259	(53,025,945)	-20.13%
Indiana	71	217,959,667	181,835,382	(36,124,285)	-16.57%
Kentucky	58	99,645,559	64,475,468	(35,170,091)	-35.30%

Figure 2: Net reimbursement shifts by state

Source: FFY 2019 and FFY 2020 Factor 3 files published during CMS annual rulemaking.

from FY 2017 for FY 2021 UC allocation purposes.

While Worksheet S-10 has been used for UC reimbursement purposes only for a short time, audits of the S-10 data to ensure its accuracy and consistency have long been a high priority for hospital providers. During the 2019 final IPPS rule-making, CMS stated that owing to the overwhelming feedback from commenters emphasising the importance of audits, they would begin the inaugural audits in fall 2018, which they did. CMS performed audit work on FY 2015 S-10 data for approximately 600 of the 2,400 qualifying hospitals. This first full round of audits was completed in early 2019, and, in fact, two more rounds of audits have been conducted since. It is important for hospitals to gain some insight into the audits, especially given that 100 per cent of future UC payments — nearly US$8.290bn in FY 2021 — will be derived solely from one year of S-10 data, and CMS has indicated they expect the number of audits to increase in future cost reporting years.

INAUGURAL AUDITS OF 2015 S-10 DATA

Hospitals nationwide received audit request letters from their Medicare Administrative Contractors (MACs) that required the submission of data and detailed explanations supporting the charity care and bad debt data reported on their FY 2015 Medicare cost report, Worksheet S-10. In many cases, the hospitals selected for audit were given a very short time frame, typically 2 weeks, to respond to the MAC's initial questions and the requests for data, which were very extensive and included up to 18[3] required items.

Some of the notable components of the requests from the MACs included:

- A copy of the hospital's charity care policy and/or financial assistance policy (for both uninsured and insured patients) along with an explanation of how hospital personnel determine insurance status and charity care write-offs.
- Additional details to assist the auditor in understanding the financial assistance policies and how they are operationally implemented.
- Information on how the hospital's S-10 was actually populated.
- Patient-detailed charity care listings that tie to the cost report and include approximately 20 data elements, including name, dates of service, date of birth, social security number, gender and write-off date, as well as revenue codes, payments received and contractual accounts for every transaction related to the stay.
- A comparison of current versus prior year charity care charges from the hospitals' audited financial statements with an explanation for any significant changes between the years and a reconciliation if the detail listing does not agree with the amounts reported on S-10.
- Patient-level Medicare and non-Medicare bad debt listings (with similar elements to the charity care listings mentioned previously) and a two-part reconciliation of the bad debt write-offs from the financial accounting records to the bad debts reported on Line 26 of Worksheet S-10.

2015 AUDIT CHALLENGES

As you would imagine, the inaugural 2015 S-10 audits posed several challenges for providers as they waded their way through the extensive request. One recurring theme came as a by-product just from the sheer size of the audit request letter. Hospitals had difficulty in meeting the time frame to submit the requested information. Providers were given only 2 weeks (or less) to compile all of the data. Of all the providers we were involved with through the audit process, not one had all of the data on hand and prepared in the requested format and structure. The

hospitals had to supplement the files they had previously prepared for their cost report filing to meet MAC audit requirements.

For the charity care and bad debt patient listings, file size became a barrier hospitals had to overcome. For example, the MAC requested every transaction and revenue code charge for each patient claimed on charity Line 20, Columns 1 and 2. Based on work that we performed for hospitals, for the average 100-bed hospital, the data set could easily be in the millions of records,[4] and hospitals and MACs alike had difficulties handling the large files.

Year-over-year comparisons and reconciliations were also challenging. Considerable time was spent by both sides to reconcile and understand the variances. Hospitals may also have had a system conversion or personnel turnover at their facility between the time of filing and the time of audit, so providing an explanation for any variance was challenging. Given that the instructions called for reporting charity charges at total charges and based on service date, some hospitals struggled to reconcile the detail to their financial statements where charity charges are based on the charity write-off amounts and their posting date. Finally, and perhaps the most difficult item from the entire request, was the bad debt reconciliation.

2015 SAMPLING AND AUDIT FINDINGS

On submission of the audit support, MACs began sampling the data, which generally included 40–60 patients covering four categories: insured, uninsured, inpatient and outpatient. Actual criteria for sampling varied by MAC. The required sample support consisted primarily of patient UB-04s, remittance advice, proof of income, charity applications and approval forms. As you can imagine, providing documentation from three to four years ago to an auditor within the required, tight time frame was tough. If any of the required items were missing or could not be provided, the hospital was then subject to adverse audit adjustments that could include large extrapolations. On completing their review of the documentation related to the sample population, MACs presented hospitals with findings, proposed adjustments and provided only a short time in which to respond. It also appeared that there were some inconsistencies with how auditors handled findings.

POST-2015 AUDITS AND ROUND TWO

CMS wasted no time after the conclusion of the 2015 S-10 audits. They continued full steam ahead and moved on to FY 2017 data. After conducting a comparison of 2015 and 2017 S-10 data, CMS instructed MACs to reach out to certain providers in April 2019 regarding 2017 S-10 data that appeared aberrant and asked those hospitals to justify their reporting fluctuations to the MAC. If necessary, hospitals could amend their 2017 report.

Shortly after, we learned that not only did MACs review 2017 potentially aberrant S-10 data, but that they also cast a wider net and proceeded with a roll-out of full 2017 S-10 audits. In June of 2019, we became aware that the MAC audits of Worksheet S-10 were starting for FY 2017. Approximately 650 hospitals were slated to be audited in this round. A number of hospitals that were selected for FY 2015 S-10 audits were also selected for FY 2017, but there were also a good number of first-timers in the 2017 S-10 audit pool.

2017 S-10 AUDIT LETTER

The 32 S-10 MAC audit letter requests we reviewed, which included five different MACs, essentially mirrored each other and the initial requests for data from FY 2015, with a few minor exceptions. Much like the 2015 audits, providers were not given

much time to turn the requests around — only 2 weeks. There were generally nine items requested up front in the 2017 letters, compared with up to 18 for 2015. While the list may have been shorter in the second iteration, the data required was very similar, as previously discussed. The reduction in items was attributed mainly to the removal of requested explanations, reconciliations and data reminders.

The 2017 S-10 audit letter generally requested:

1. A copy of the hospital's charity care policy and financial assistance policy (FAP) that was in effect during the cost report period under review.
2. A copy of the hospital's audited financial statements and/or working trial balance for the cost report period under review.
3. A reconciliation of the bad debts claimed on Worksheet S-10, Line 26, to the audited financial statements and/or working trial balance.
4. A detailed listing of the hospital's transaction codes and their descriptions/explanations, such as write-off codes, discount codes and contractual adjustment codes.
5. Detailed query logic that describes how the hospital identified patient charges included in the patient listing used to support charges on Worksheet S-10, Line 20.
6. Detailed query logic that describes how the hospital identified patient payments included in the patient listing used to support payments on Worksheet S-10, Line 22.
7. New for 2017 audits: Detailed query logic that describes how the hospital identified bad debts included in the patient listing used to support bad debts on Worksheet S-10, Line 26.
8. Detailed patient listing (an Excel template was provided for required detail fields) of charges claimed on Worksheet S-10, Line 20, Columns 1 and 2.
9. Detailed patient listing (an Excel template was provided for required detail fields) of bad debts claimed on Worksheet S-10, Line 26, Columns 1 and 2.

Something new on these 2017 audits was the request regarding revenue code detail. MACs, however, were making an exception regarding the request for revenue code detail. Specifically, if a hospital tracked professional fees/physician charges in a separate system from the hospital charges, then hospitals did not have to provide revenue code detail in the patient listings. Hospitals had to be sure to indicate that professional/physician charges were kept in a separate system in the cover letter when requested documentation was returned to the MAC to avoid pulling revenue code data. If professional fees/physician fees were comingled with hospital charges, however, then revenue code detail was required as part of the audit request so that the MAC could verify that the professional fees/physician fees were not included on Worksheet S-10. We recommended that hospitals test their data by querying their revenue code detail to verify whether or not professional fees/physician charges were included. The letter concluded with a warning that if hospitals did not respond in time, their future Medicare UC payments could be significantly decreased or eliminated.

Unlike the 2015 audit letters, an Excel spreadsheet template was included along with the 2017 audit request letter. The template appeared to contain an updated version of Worksheet S-10 instructions that were last updated on 2 May 2019, according to a note in the file. There was only one change, however, and that was to correct a typo. Also included in the Excel file were general instructions for submitting patient detail supporting Worksheet S-10 data, the required data elements and individual tabs to append charity care, patient cash collections and bad debt data. CMS tried to simplify the process of the overall data request by

providing a universal template that every MAC is using. Every provider was to append their detail files that tie back to S-10 to this exact template without changing any of the column headings or layout. Extra fields could have been added if the provider felt they were necessary, but they must have been added either to the end of the file or in a supplemental file.

2017 AUDIT CHALLENGES

Providers faced many of the same audit challenges as they did with the 2015 audits in regard to the sheer size of the request and the tight deadline on supplying all of this information to their MAC. There was also now the added challenge of supplying the support for the charity and bad debt detail into a required template that most providers had never seen before. This template was not available at the time the cost reports were filed, and it took a considerable effort to format the files and supply all of the additional information that was requested in the template. In virtually all cases, populating the data elements of the template required the hospitals to pull additional data fields on all of their charity and bad debt write-offs within the short window of the audit request deadline. The additional information was not just related to demographic data — it also required payment activity on the entire account, and that payment activity had to be separated into multiple fields depending on the type of transaction and had to ensure that the account reconciled from total charges less all activity to the account's current balance. This required having an intimate knowledge of the hospital's patient financial system that could accurately parse the data and ensure accurate data was supplied to the auditor for their review.

The other major challenge and a departure from the audit protocol in FY 2015 was the sampling of bad debt write-offs for all hospitals. By the nature of bad debt, the service dates for these patients can typically be much older than charity accounts. With older records, there is a higher likelihood of not being able to produce the needed documentation at the time of sample to support the bad debt write-off. Hospitals struggled pulling support such as UBs, explanation of benefits, and remits from archived systems that then led to the potential for audit findings that included large extrapolations for want of documentation.

2017 AUDIT SAMPLING AND FINDINGS

The charity sampling for 2017 mirrored prior year requests. Again, MACs varied greatly in the sizes of each sample and even in how they identified those samples for further review. UBs, remits, account histories and the underlying support — such as charity application, pay stubs and presumptive score sheets — for the charity determination were all requested as part of the charity audit sample. If this information was not available or the documentation did not support the write-off, the account was removed from S-10, and an extrapolation was applied to the population.

This same scenario played out on the bad debt side with varying sample sizes and extrapolations applied where support was insufficient. Non-Medicare bad debt has historically not been reviewed or scrutinised at the MAC or hospital level in the same manner as Medicare bad debt, and there were some significant findings in those areas. There were several cases where support was unavailable or reversals of bad debt write-offs did not use the correct associated bad debt transaction code, and, therefore, the bad debt detail was overstated. Again, just as in FY 2015, the handling of these errors found during sampling varied greatly among each MAC and individual auditor.

ROUND THREE — 2018 S-10 AUDITS

Hospitals did not get much of a reprieve from audits after 2017 was completed. MACs indicated that audits of FY 2018 onwards would be increased significantly. In fact, multiple MACs indicated that FY 2018 S-10 data would be audited for all hospitals (similar to Wage Index). In March 2020, MACs began requesting data for FFY 2018 S-10 audits. For the over 200 audit letters we have reviewed, these audit requests are virtually identical to the FY 2017 along with the same charity and bad debt templates used during the prior year review. MACs also indicated that their audit protocol has remained unchanged from the 2017 reviews. The auditors, after reviewing the patient detail, will again pull samples from the charity and bad debt listings and verify that the write-offs are accurate. For charity care, MACs will ensure write-offs are claimed in the correct uninsured or insured column and that these write-offs meet the requirements of the hospital's policy. The results of these audits must be finalised and uploaded into Healthcare Cost Report Information System (HCRIS) by 31 December 2020.

One thing to note about these reviews is that, compared with the previous year, over 1,800 more reviews will be conducted during this audit cycle. To account for this increase in workload, MACs had to ramp up their staffing considerably or subcontract these reviews to outside firms. There are a large number of first-time auditors along with first-time hospitals subject to these S-10 reviews, and it is critical during these reviews that there is an open dialogue from the MAC and provider so audits are conducted as smoothly as possible.

WHAT IS NEXT

Barring some dramatic action by the courts in ongoing litigation around the ACA, it is clear that S-10 will impact provider reimbursement for the foreseeable future. In the FY 2021 IPPS rule, CMS also proposed that future UC calculations would use data from the latest available audited cost reporting year. This is a signal that these Worksheet S-10 audits will continue in the future with the current expectation that all of the Medicare DSH eligible FY 2019 cost reports will be audited in 2021. And, on the basis of the first three rounds of S-10 audits, hospitals must be able to provide support for each sampled patient during the audit that verifies the patient met the criteria stated in the hospital's FAP. As we saw during the course of the S-10 reviews previously performed by MACs, a hospital that was unable to provide sufficient documentation or unwilling to justify its cost report had its Worksheet S-10 adjusted to zero. This would result in not receiving any UC payments. As we also observed in all rounds of audits, small sample sizes have the potential for large extrapolations, so we recommend that every hospital complete an audit readiness test to determine how they would fare not if but when their hospital is selected for audit.

S-10 programmes should be the chief consideration for qualifying hospitals, and it is important to keep in mind that if you are selected for audit, there may be no avenue that allows hospitals the opportunity to appeal adverse findings for purposes of the UC calculation. Hospitals should assume that any audit of S-10 data will be the only opportunity to have the correct S-10 data incorporated into the UC DSH calculation.

Looking forward, hospitals should place an absolute premium on getting the correct S-10 data into the initial cost report filing. Hospitals should have patient detail that ties to Worksheet S-10, complies with the most recent reporting instructions and is supported by the hospital's financial assistance policies. If not already doing so, hospitals should evaluate FFY 2019 and FFY 2020 data and submit revisions where appropriate. They should also keep in mind that CMS is requiring hospitals to submit

a detailed listing of charity patients for cost reports with periods beginning on or after 1 October 2018, or the report will be rejected. One of the biggest issues we have seen in performing hundreds of S-10 reviews and seeing these audits first hand is the difficulty many hospitals have had in obtaining the patient detail to support the filed S-10. Hospitals and hospital systems need to designate an individual or a team to prepare the S-10 for filing and support it during the audit process. These S-10 reports take considerable time and resources to prepare. For the 2015 and 2017 reviews, the MACs budgeted anywhere from 80 to 120 hours for each review, but it is fair to assume that even more time may be needed to ensure accuracy. To accurately report charity and bad debt on S-10, there needs to be coordination between the designated S-10 preparer and hospital departments such as reimbursement, revenue cycle, accounting, IT and, potentially, policy, compliance and/or legal if revisions are necessary to any policy. The designated S-10 preparer will also need to stay abreast of any regulatory changes regarding the reporting of S-10 along with updates on audit findings to better prepare their hospital for future S-10 reviews.

Additionally, several states, such as Texas and New Mexico, have state-specific UC waiver programmes. As these waivers matured and were renegotiated, UC as reported on Worksheet S-10 became the data set used to distribute reimbursement for these critical state programmes. As more state UC waiver programmes mature, it will be interesting to see if a similar model is approved, further increasing the importance of UC reporting and Worksheet S-10.

In conclusion, S-10 is here to stay as long as the ACA remains intact; however, as of July 2020, the ACA is currently subject to litigation by the current administration, and in a recent filing before the United States Supreme Court the government asserts the entire ACA is unconstitutional. Right now, however, this programme is driving a nearly US$8.290bn billion federal reimbursement pool, so hospitals should make every effort to analyse their UC data, including a review of all transaction codes, review their processes for collecting and maintaining the data, and, most importantly at this time, take a deep-dive look at their charity and other financial assistance policies and ensure they conform to the programme requirements. These best practices will be critical to surviving MAC reviews.

Notes

1. All estimates and factors are published in the annual Inpatient PPS payment rule.
2. All estimates and factors are published in the annual Inpatient PPS payment rule.
3. Items were detailed in letters sent to providers from the MACs.
4. File sizes seen are based on the authors' direct experience in preparing and revising previously prepared Worksheet S-10 data at the detailed patient level based on individual transaction codes.