Texas Department of Insurance
Life, Health & Licensing Program– General Management, Mail Code 107-2A
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HEALTH CARE CLAIMS REIMBURSEMENT RATE REPORT

Section A - Instructions for Completion of the Health Care Claims Reimbursement Rate Report

This section of Form No. LHL616 (Health Care Claims Reimbursement Rate Report) sets forth the instructions and additional definitions necessary to complete the Health Care Claims Reimbursement Rate Report required pursuant to 28 TAC §21.4506. These instructions and additional definitions shall be used in conjunction with the following form sections:

- Section B – Cover Page
- Section C – Professional Services - General
- Section D – Professional Services - Pathology
- Section E – Professional Services - Anesthesiology
- Section F – Professional Services - Radiology
- Section G – Professional Services - Neonatology/Newborn Care
- Section H – Professional Services - Outpatient Health Care Claims
- Section I – Institutional Provider - Outpatient Health Care Claims
- Section J – Institutional Provider – Inpatient Health Care Claims

I. Cover Page Instructions- Section B

1. **Plan Type**: Check the appropriate box to indicate whether the report is for "PPBP" (preferred provider benefit plan) or "HMO" (health maintenance organization) plans. HMO and PPBP reimbursement rate information must be reported separately, regardless of whether a group health benefit plan issuer provides both HMO and PPBP coverage under a single Company Number.

   Reporting Solely for Governmental Employee Plan?: Check "yes" if this submission is solely as or on behalf of a governmental employee plan. For purposes of this data submission, a governmental employee plan includes only a basic coverage plan under the Insurance Code Chapter 1551, a basic plan under the Insurance Code Chapter 1575, a primary care coverage plan under the Insurance Code Chapter 1579, and a basic coverage plan under the Insurance Code Chapter 1601. Check "no" if this submission is not by or on behalf of a governmental employee plan.

2. **Governmental Employee Plan(s)**: If the report includes information submitted on behalf of a governmental employee plan, solely or in addition to a health benefit plan issuer's own data, specify the governmental employee plan(s) for which data is included in the report. If the report includes no governmental employee plan data, enter "n/a."

A governmental employee plan shall either independently submit this report or authorize and require the entity administering the governmental employee plan to submit this report on behalf of the governmental employee plan. An entity submitting this report on behalf of a governmental employee plan may include information with respect to the governmental employee plan with information submitted on its own behalf as an independent health benefit plan issuer or, if appropriate, may submit separate information on behalf of the governmental employee plan.

3. **NAIC Company No.**: Enter the health benefit plan issuer's NAIC Company number or "n/a" if not applicable.

4. **TDI Company No.**: Enter the health benefit plan issuer's TDI Company No. or "n/a" if not applicable.

5. **Reporting Period**: The Department will pre-populate this field with the year that corresponds to the current reporting period.

6. **Company/Plan Name**: Enter the company name, or enter the plan name if there is not a company name.

7. **Group Name**: Enter the group name or "n/a" if not applicable.

8. **Total Enrollment on Dec. 31**: Enter the total number of lives covered under all individual policies, group certificates, or evidence of coverage documents in private market preferred provider benefit plans, if reporting data related to preferred provider benefit plans, or private market health maintenance organization plans, if reporting data related to health maintenance organization plans, offered by the health benefit plan issuer in Texas as of December 31 of the year preceding the reporting period. Health benefit plan issuers should not report enrollment for plans for which only administrative services are provided. Include all family members covered in the total. Enter "n/a" if reporting solely as or on behalf of a governmental employee plan.

9. **Total Enrollment on June 30**: Enter the total number of lives covered under all individual policies, group certificates, or evidence of coverage documents in private market preferred provider benefit plans, if reporting data related to preferred provider benefit plans, or private market health maintenance organization plans, if reporting data related to health maintenance organization plans, offered by the health benefit plan issuer in Texas as of June 30 of the current reporting period. Health benefit plan issuers should not report enrollment for plans for which only administrative services are provided. Include all family members covered in the total. Enter "n/a" if reporting solely as or on behalf of a governmental employee plan.

10. **Total Premiums**: Enter the total dollar amount of premium written on all individual policies, group certificates, or evidence of coverage documents for private market preferred provider benefit plans or private market health maintenance organization plans offered by the health benefit plan issuer in Texas for the year preceding the reporting period. Include all premium for plans for which this report is required, regardless of whether the group health benefits plan issuer is asserting an exemption as provided for in 28 TAC § 21.4506(e). An entity submitting this report on behalf of a governmental employee plan may include premium information with respect to the governmental employee plan with information submitted on its own behalf as an independent health

benefit plan issuer or, if appropriate, may submit separate information on behalf of the governmental employee plan.

11. **Total Claims Paid**: Enter the total dollar amount of all claims paid under the policies or evidence of coverage documents issued by a plan or group health benefit plan issuer as described in 28 TAC § 21.4502(a) and (b). This includes claims not otherwise reflected in this report, such as capitation payments and payments for coded services not requested in this report. This also includes claims for which a health benefit plan issuer is otherwise asserting exemption from reporting requirements pursuant to 28 TAC § 21.4506(e). Include claims paid in the reporting calendar year, even if incurred in the prior year. An entity submitting this report on behalf of a governmental employee plan shall either include paid claims information with respect to the governmental employee plan with information submitted on its own behalf as an independent health benefit plan issuer or, if appropriate, submit separate information on behalf of the governmental employee plan.

12. **Exemption Statement**: If asserting an exemption for submission of Sections C - J of this report, check the box that appropriately identifies the basis for the assertion as set forth at 28 TAC §21.4506(e). Assertion of such an exemption does not negate the requirement to submit all information required on this Cover Page.

13. **Contact Name/Title/Direct Telephone No./Extension No.**: Enter the contact name (first and last name) for the person designated by the company or plan to discuss the report with Department staff. Enter the contact person's title, direct telephone number, and extension or "n/a" if there is no extension.

14. **Mailing Address/City/State/ZIP Code**: Enter the contact person's mailing address, city, state, and 5-digit ZIP Code.

15. **Email**: Enter the contact person's email address or "n/a" if not applicable.

16. **Release of email address**: Check "yes" to indicate that TDI may release the contact person's email address or "no" to request that the Department not release the email address.

17. **Electronic signature and certification of data**: Enter the name and the electronic signature of the individual authorized by the plan or health benefit plan issuer certifying that the information provided is a full and true statement of the data required in accordance with the instructions provided according to the best of the individual's information, knowledge and belief.

II. Definitions

The following words and terms when used in Form No. LHL616 (Health Care Claims Reimbursement Rate Report), Sections B through J, shall have the following meanings unless the context clearly indicates otherwise.

Aggregate allowed amount--For all paid claims, the total, aggregated amount which the group health benefit plan issuer allows as reimbursement for services corresponding to a specific CPT or MS-DRG code, including reimbursement amounts for which a patient is responsible due to deductibles, copayments or coinsurance.

Aggregate contracted rate--The aggregate of the fee or reimbursement amounts for a physician or provider's services, treatments, or supplies for the indicated CPT or MS-DRG code for all reported claims, as established directly or indirectly by agreement between the physician or provider and the plan or group health benefit plan issuer.

CC--A complication or comorbidity.

In-network provider--A physician or provider to whom a group health benefit plan issuer or plan furnishes reimbursement for covered services that are provided to an insured or enrollee based upon a direct contract under which the physician or provider agrees to accept reimbursement as designated by the contract. The term does not include a physician or provider to whom the group health benefit plan issuer or plan furnishes reimbursement solely on the basis of assignment of benefit. The term includes a physician or provider to whom a group health benefit plan issuer furnishes reimbursement for covered services that are provided to an insured or enrollee based upon an indirect contract with the physician or provider if such physician or provider is a member of the HMO's delivery network or the preferred provider benefit plan issuer's or plan's preferred provider network.

CPT code--The most current procedural terminology and codes as published by the American Medical Association. *CPT code descriptions provided in this report are summary descriptions only.*

MS-DRG code--The most current diagnosis-related group code as maintained and released by the Centers for Medicare and Medicaid Services. *MS-DRG code descriptions provided in this report are summary descriptions only.*

Inpatient health care claims--Claims for health care services furnished to a patient who is formally admitted to an institutional provider.

Institutional provider--An institution providing health care services, including but not limited to hospitals, other licensed inpatient centers, ambulatory surgical centers, skilled nursing centers, and residential treatment centers.

Outpatient health care claims--Claims for health care services furnished to a patient who is not formally admitted to an institutional provider, including observation status services.

Secondary plan--As defined in 28 Texas Administrative Code §3.3506.

Total amount paid--The total dollar amount paid by the health benefit plan issuer for medical care or health care services included on all claims submitted by a physician or provider with respect to the indicated CPT or MS-DRG code for all reported claims.

Total billed charges--The total of charges for medical care or health care services included on all claims submitted by a physician or provider with respect to the indicated CPT or MS-DRG code for all reported claims.

Total claim units--The total number of separate claims for which a plan or health benefit plan issuer furnishes reimbursement for a specified CPT or MS-DRG code, including covered claims for which some or all of the reimbursement is attributed to patient responsibility such as

deductibles, copayments or coinsurance, and excluding claims with respect to which the plan or health benefit plan constitutes a secondary plan.

III. General Instructions for Form No. LHL616 (Health Care Claims Reimbursement Rate Report), Sections B through J

1. Region Key and Region: The Department will pre-populate these fields to specify the respective geographic regions for which the plan or health benefit plan issuer shall submit information. Submit this information for each of the eleven geographic regions identified in 28 TAC §21.4504. Region designations are as follows:

   Region 1 – Panhandle
   Region 2 – Northwest Texas
   Region 3 – Metroplex
   Region 4 – Northeast Texas
   Region 5 – Southeast Texas
   Region 6 – Gulf Coast
   Region 7 – Central Texas
   Region 8 – South Central Texas
   Region 9 – West Texas
   Region 10 – Far West Texas
   Region 11 – Rio Grande Valley

   For the ZIP Code designations for each geographic region, please see 28 TAC §21.4504.

2. ***In-Network.*** For each specified CPT or MS-DRG code for which reimbursement is paid to an *in-network provider* located in the indicated region for a covered claim during the reporting period, submit the following information on an aggregate basis: (1) total billed charges; (2) total claim units; (3) total amount paid; and (4) aggregate contracted rate. This includes covered claims for which some or all of the reimbursement is attributed to patient responsibility such as deductibles, copayments or coinsurance. Do not include claims for which the plan or health benefit plan issuer provides reimbursement as a secondary plan. Do not include claims for payment which was made at a higher percentage of reimbursement solely because of the emergent nature of the services or because no in-network provider was available within the service area.

3. ***Out-of-network.*** For each specified CPT or MS-DRG code for which reimbursement is paid to a physician or provider located in the indicated region for a covered claim during the reporting period on an *out-of-network* claim basis, submit the following information on an aggregate basis: (1) total billed charges; (2) total claim units; (3) total amount paid; and (4) aggregate allowed amount. This includes covered claims for which some or all of the reimbursement is attributed to patient responsibility such as deductibles, copayments or coinsurance. Do not include claims for which the plan or health benefit plan issuer provides reimbursement as a secondary plan. This also includes claims for which payment was made at a higher percentage of reimbursement solely because of the emergent nature of the services or because no in-network provider was available within the service area.

4. Report all dollar amounts in whole dollars only, rounding cents to the nearest dollar. For example, report $8.49 as $8, but report $8.50 as $9.

5. Do not include claims that are rejected or denied in any field on this form.

6. Do not include in any field claim information regarding claims for which full or partial payment is made pursuant to a capitation agreement.

7. Do not include claims that contain procedure modifiers unless specifically noted in these instructions or unless the reimbursement rate for the procedure without modifiers is the same as the reimbursement rate for the procedure with the modifier.

IV. Additional instructions for Form No. LHL616 (Health Care Claims Reimbursement Rate Report), Sections C, D, and F

8. Items in the CPT Code column of Form No. LHL616 (Health Care Claims Reimbursement Rate Report), **Sections C, D, and F,** with the "*26" notation are CPT codes that reflect the special additional code "26" representing the professional component alone. All data for these rows should be reported accordingly.

VI. Additional instructions for Form No. LHL616 (Health Care Claims Reimbursement Rate Report), Sections F - J

9. Items in the CPT column of No. LHL616 (Health Care Claims Reimbursement Rate Report), **Section F,** for which the code begins with a "G" are based upon the most current Health Care Common Procedure Coding System (HCPCS) Level II temporary code set as established and maintained by the Centers for Medicare and Medicaid Services HCPCS Workgroup. All data for these rows should be reported accordingly.

10. In reporting data for No. LHL616 (Health Care Claims Reimbursement Rate Report), **Sections H and I**, do not include claims with a multiple procedure modifier, and report only outpatient health care claims.

11. Items in the CPT column of Form No. LHL616 (Health Care Claims Reimbursement Rate Report), **Section I,** with the "*TC" notation are CPT codes that reflect the special additional code "TC" representing the technical component alone. All data for these rows should be reported accordingly.

12. In reporting data for No. LHL616 (Health Care Claims Reimbursement Rate Report), **Section J**, report only inpatient health care claims.

Texas Department of Insurance

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SECTION B

Cover Page

Company Information		
1	Plan Type:	☐ PPBP ☐ HMO
	Reporting Solely for Governmental Employee Plan?	☐ Yes ☐ No
2	Governmental Employee Plan(s):	
3	NAIC Company No.:	
4	TDI Company No.:	
5	Reporting Period:	
6	Company/Plan Name:	
7	Group Name:	
8	Total Enrollment on Dec. 31:	
9	Total Enrollment on June 30:	
10	Total Premiums:	
11	Total Claims Paid:	
12	Exemption Statement:	☐ Enrollment less than 10,000 covered lives in PPBP ☐ Enrollment less than 10,000 covered lives in HMO

	Contact Information	
13	Contact Name:	
	Title:	
	Direct Telephone No.:	
	Extension No.:	
14	Mailing Address:	
	City:	
	State:	
	ZIP Code (5-digit):	
15	Email:	
16	May TDI release this email address in response to a public information request?	☐ Yes ☐ No
	Data Certification	
17	Name of the person authorized by the reporting plan or health benefit plan issuer to certify the data submitted in each section of this report:	
	Electronic signature confirming the following certification statement: "All the information submitted in each section of this report constitutes a full and true statement in accordance with the instructions provided according to the best of my information, knowledge and belief."	

SECTION C

The five character codes included in the Health Insurance Reimbursement Rate Information Form are obtained from Current Procedural Terminology (CPT®), copyright 2008 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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Professional Services - General

Region Key	Region	CPT Code	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		58140								
		58150								
		58180								
		58260								
		58550								
		58552								
		59025								
		59400								
		59510								
		90657								
		90658								
		90669								
		90700								
		90707								
		90713								
		90716								
		90718								
		90744								
		90746								
		90806								
		92004								
		92014								
		93000								
		93307								

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Professional Services - General

Region Key	Region	CPT Code	In-Network: Total Billed Charges	In-Network: Total Claim Units	In-Network: Total Amount Paid	In-Network: Aggregate Contracted Rate	Out-of-Network: Total Billed Charges	Out-of-Network: Total Claim Units	Out-of-Network: Total Amount Paid	Out-of-Network: Aggregate Allowed Amount
		93307 *26								
		93510								
		93510 *26								
		95004								
		95117								
		95165								
		96372								
		96413								
		97140								
		98940								
		98941								
		98942								
		99201								
		99202								
		99203								
		99204								
		99205								
		99212								
		99213								
		99214								
		99215								
		99231								
		99232								
		99233								
		99243								
		99244								
		99245								
		99281								
		99282								
		99283								
		99284								
		99285								
		99391								
		99392								
		99393								
		99394								
		99395								
		99396								

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Professional Services - General

Region Key	Region	CPT Code	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		99397								

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SECTION D

Professional Services - Pathology (including office-based physicians and clinical reference laboratories)

Region Key	Region	CPT Code	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		80048								
		80053								
		80061								
		81000								
		81025								
		82270								
		82947								
		82962								
		84153								
		84443								
		85018								
		85025								
		85610								
		87491								
		87880								
		88142								
		88304								
		88304 *26								
		88305								
		88305 *26								
		88307								
		88307 *26								
		88309								
		88309 *26								
		88312								
		88331								
		88331 *26								
		88342								
		88342 *26								

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SECTION E

Professional Services - Anesthesiology

Region Key	Region	CPT Code	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		00142								
		00160								
		00300								
		00320								
		00400								
		00630								
		00670								
		00740								
		00790								
		00810								
		00840								
		00944								
		01400								
		01402								
		01480								
		01630								
		01810								
		01961								
		01967								
		01992								

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SECTION F

Professional Services - Radiology

Region Key	Region	CPT Code	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		G0202*								
		G0202* 26								
		G0204*								
		G0204* 26								
		G0206*								
		G0206* 26								
		70450								
		70450 *26								
		70460								
		70460 *26								
		70470								
		70470 *26								
		70486								
		70486 *26								
		70487								
		70487 *26								
		70488								
		70488 *26								
		70498								
		70498 *26								
		70543								
		70543 *26								
		70544								
		70544 *26								
		70549								
		70549 *26								
		70551								
		70551 *26								
		70552								
		70552 *26								
		70553								
		70553 *26								
		71010								
		71010 *26								
		71020								
		71020 *26								
		71250								

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Professional Services - Radiology

Region Key	Region	CPT Code	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		71250 *26								
		71260								
		71260 *26								
		71270								
		71270*26								
		71275								
		71275 *26								
		72131								
		72131 *26								
		72132								
		72132 *26								
		72133								
		72133 *26								
		72141								
		72141 *26								
		72146								
		72146 *26								
		72148								
		72148 *26								
		72156								
		72156 *26								
		72157								
		72157 *26								
		72158								
		72158 *26								
		72191								
		72191 *26								
		72192								
		72192 *26								
		72193								
		72193 *26								
		72195								
		72195 *26								
		72197								
		72197 *26								
		73090								
		73090 *26								
		73120								

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Professional Services - Radiology

Region Key	Region	CPT Code	In-Network Total Billed Charges	In-Network Total Claim Units	In-Network Total Amount Paid	In-Network Aggregate Contracted Rate	Out-of-Network Total Billed Charges	Out-of-Network Total Claim Units	Out-of-Network Total Amount Paid	Out-of-Network Aggregate Allowed Amount
		73120 *26								
		73130								
		73130 *26								
		73206								
		73206 *26								
		73218								
		73218 *26								
		73220								
		73220 *26								
		73221								
		73221 *26								
		73222								
		73222 *26								
		73223								
		73223 *26								
		73510								
		73510 *26								
		73520								
		73520 *26								
		73550								
		73550 *26								
		73560								
		73560 *26								
		73564								
		73564 *26								
		73565								
		73565 *26								
		73600								
		73600 *26								
		73610								
		73610 *26								
		73620								
		73620 *26								
		73630								
		73630 *26								
		73700								
		73701								
		73701 *26								

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Professional Services - Radiology

Region Key	Region	CPT Code	In-Network Total Billed Charges	In-Network Total Claim Units	In-Network Total Amount Paid	In-Network Aggregate Contracted Rate	Out-of-Network Total Billed Charges	Out-of-Network Total Claim Units	Out-of-Network Total Amount Paid	Out-of-Network Aggregate Allowed Amount
		73702								
		73702 *26								
		73706								
		73706 *26								
		73718								
		73718 *26								
		73720								
		73720 *26								
		73721								
		73721 *26								
		73723								
		73723 *26								
		74000								
		74000 *26								
		74022								
		74022 *26								
		74150								
		74150 *26								
		74160								
		74160 *26								
		74170								
		74170 *26								
		74175								
		74175 *26								
		74181								
		74181 *26								
		74183								
		74183 *26								
		74241								
		74241 *26								
		76645								
		76645 *26								
		76700								
		76700 *26								
		76801								
		76801 *26								
		76805								
		76805 *26								

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Professional Services - Radiology

Region Key	Region	CPT Code	In-Network Total Billed Charges	In-Network Total Claim Units	In-Network Total Amount Paid	In-Network Aggregate Contracted Rate	Out-of-Network Total Billed Charges	Out-of-Network Total Claim Units	Out-of-Network Total Amount Paid	Out-of-Network Aggregate Allowed Amount
		76817								
		76817 *26								
		76830								
		76830 *26								
		76856								
		76856 *26								
		77051								
		77051 *26								
		77052								
		77052 *26								
		77055								
		77055 *26								
		77056								
		77056 *26								
		77057								
		77057 *26								
		77078								
		77078 *26								
		77080								
		77080 *26								
		77081								
		77081 *26								
		77082								
		77082 *26								
		77418								
		77427								
		78814								
		78814 *26								
		78815								
		78815 *26								
		78816								
		78816 *26								

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SECTION G

Professional Services - Neonatology Critical Care/Newborn Care

Region Key	Region	CPT Code	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		99460								
		99461								
		99462								
		99463								
		99464								
		99465								
		99468								
		99469								
		99478								
		99479								
		99480								

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SECTION H

Professional Services - Outpatient Health Care Claims

Region Key	Region	CPT Code	In-Network Total Billed Charges	In-Network Total Claim Units	In-Network Total Amount Paid	In-Network Aggregate Contracted Rate	Out-of-Network Total Billed Charges	Out-of-Network Total Claim Units	Out-of-Network Total Amount Paid	Out-of-Network Aggregate Allowed Amount
		19102								
		19103								
		19120								
		29824								
		29826								
		29827								
		29877								
		29879								
		29880								
		29881								
		29888								
		31255								
		36561								
		42820								
		43234								
		43235								
		43239								
		45378								
		45380								
		45384								
		45385								
		47000								
		49505								
		52332								
		58558								
		58563								
		58661								
		58662								
		62311								
		64721								
		66984								
		69436								

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SECTION I

Institutional Provider - Outpatient Health Care Claims

Region Key	Region	CPT Code	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		19102								
		19103								
		19120								
		29824								
		29826								
		29827								
		29877								
		29879								
		29880								
		29881								
		29888								
		31255								
		36561								
		42820								
		43234								
		43235								
		43239								
		45378								
		45380								
		45384								
		45385								
		47000								
		49505								
		52332								
		58558								
		58563								
		58661								
		58662								
		62311								
		64721								
		66984								
		69436								
		88304 *TC								
		88305 *TC								
		88307 *TC								
		88309 *TC								
		88312 *TC								

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Institutional Provider - Outpatient Health Care Claims

Region Key	Region	CPT Code	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		88331 *TC								
		88342 *TC								

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SECTION J

Institutional Provider - Inpatient Health Care Claims

Region Key	Region	MS-DRG	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		64								
		65								
		66								
		190								
		191								
		192								
		193								
		194								
		195								
		202								
		203								
		246								
		247								
		286								
		287								
		291								
		292								
		293								
		313								
		329								
		330								
		331								
		341								
		342								
		343								
		391								
		392								
		417								
		418								
		419								
		438								
		439								
		440								
		469								
		470								
		473								
		490								

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Institutional Provider - Inpatient Health Care Claims

Region Key	Region	MS-DRG	In-Network				Out-of-Network			
			Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Contracted Rate	Total Billed Charges	Total Claim Units	Total Amount Paid	Aggregate Allowed Amount
		491								
		602								
		603								
		619								
		620								
		621								
		742								
		743								
		765								
		766								
		767								
		774								
		775								
		781								
		790								
		792								
		793								
		794								
		795								
		846								
		847								
		848								
		885								
		945								
		946								

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