

Worksheet S-12

When to Use the Median Allowed Amount

A quick guide to help you choose the appropriate data source for reporting Medicare Advantage negotiated charges by MS-DRG.

Who This Is For

- Hospital reimbursement and finance leaders
- Teams preparing Worksheet S-12 on the Medicare cost report for cost reporting periods ending on or after January 1, 2026

The Question

In what circumstances does CMS require hospitals to use the allowed amount as the data source to calculate the median [Medicare Advantage negotiated charge](#) by MS-DRG to complete Worksheet S-12 on the Medicare cost report?

The Answer

The Outpatient Prospective Payment System (OPPS) final rule for calendar year (CY) 2026 requires hospitals to encode the “median allowed amount” (MAA) and related allowed-amount fields when a payor-specific negotiated charge (PSNC) is based on a percentage or algorithm.

Separately, the rule requires Worksheet S-12 reporting to use the Medicare Advantage Organization (MAO) PSNC information disclosed in the hospital’s most recent machine-readable file (MRF).

Read together, these provisions support using the MAA for percentage- or algorithm-based arrangements, while using the negotiated dollar amount when the negotiated charge is expressed as a fixed dollar amount.

In short:

If the MAO negotiated charge is ...	Use this for Worksheet S-12
Based on a percentage or algorithm	The median allowed amount (MAA)
Expressed as a fixed dollar amount	The negotiated dollar amount

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What CMS Says

The table below outlines support for this interpretation based on specific language in the [CY 2026 OPPS final rule](#).

Concept	CMS Language	Page Number
When the MAA applies	“We are finalizing with modification revisions to 45 CFR 180.20 to add definitions for ‘tenth (10th) percentile allowed amount’, ‘median allowed amount’, and ‘ninetieth (90th) percentile allowed amount’, which are values a hospital will encode when a payer-specific negotiated charge is based on a percentage or algorithm, to more accurately reflect the distribution of actual amounts that a hospital has received for an item or service.”	pg. 53452
Replacement of estimated allowed amount	“We are finalizing revisions to §180.50 to remove the requirement for hospitals to disclose the estimated allowed amount, and, instead, require hospitals to disclose the 10th percentile, median, and 90th percentile allowed amounts, as well as the count of allowed amounts, in MRFs when payer-specific negotiated charges are based on percentages or algorithms.”	pg. 53452
Mandatory nature of reporting	“We [are] finalizing a policy to require hospitals to report four new data elements when the payer-specific negotiated charge is based on a percentage or algorithm—the median allowed amount ... the 10th percentile allowed amount, the 90th percentile allowed amount, and the count of allowed amounts.”	pg. 53453
Data source used to calculate the MAA	“We are also finalizing with modification our proposal to require that hospitals use electronic data interchange (EDI) 835 electronic remittance advice (ERA) transaction data or an alternative, equivalent source of remittance data to calculate and encode the allowed amounts.”	pg. 53452
What the allowed-amount fields represent	The fields are intended “to more accurately reflect the distribution of actual amounts that a hospital has received for an item or service.”	pg. 53452
Negotiated charges based on algorithm or percentages	CMS requires the new allowed-amount fields “when a payer-specific negotiated charge is based on a percentage or algorithm.”	pg. 53452
Worksheet S-12 reporting source	“The hospital will be required to report the median of the payer-specific negotiated charges by MS-DRG that the hospital has disclosed for all of its MAOs on the most recent version of the machine-readable file (MRF) that the hospital is required to disclose under the hospital price transparency regulations at 45 CFR part 180.”	pg. 53452
Worksheet S-12 regulatory purpose	CMS finalized reporting of market-based rate information “on the Medicare cost report for cost reporting periods ending on or after January 1, 2026,” with the information intended for a market-based MS-DRG relative-weight methodology beginning in FY 2029.	pg. 53452

Learn more about [cost report requirements for Medicare Advantage negotiated rates](#).

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