CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10402	**Date: October 20, 2020**
	Change Request 11729

Transmittal 10371, dated September 24, 2020, is being rescinded and replaced by Transmittal 10402, dated, October 20, 2020, to remove the Fiscal Intermediary Shared System (FISS) responsibility from business requirement 11729.9.1. All other information remains the same.

SUBJECT: Change to the Payment of Allogeneic Stem Cell Acquisition Services

I. SUMMARY OF CHANGES: This Change Request (CR) prepares the claims processing system to pay Allogeneic Stem Cell Acquisition services on a reasonable cost basis.

EFFECTIVE DATE: October 1, 2020 - For cost reporting periods beginning on or October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020 - Analysis and Design; January 4, 2021 - Design, Coding and Testing

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Addendum A/Provider Specific File

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10402	Date: October 20, 2020	Change Request: 11729

Transmittal 10371, dated September 24, 2020, is being rescinded and replaced by Transmittal 10402, dated, October 20, 2020, to remove the Fiscal Intermediary Shared System (FISS) responsibility from business requirement 11729.9.1. All other information remains the same.

SUBJECT: Change to the Payment of Allogeneic Stem Cell Acquisition Services

EFFECTIVE DATE: October 1, 2020 - For cost reporting periods beginning on or October 1, 2020
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IMPLEMENTATION DATE: October 5, 2020 - Analysis and Design; January 4, 2021 - Design, Coding and Testing

I. GENERAL INFORMATION

A. Background: Medicare reimburses allogeneic hematopoietic stem cell transplants provided to Medicare beneficiaries for the treatment of certain diagnoses if such treatment is considered reasonable and necessary. Allogeneic hematopoietic stem cell transplants involve collecting or acquiring stem cells from a healthy donor's bone marrow, peripheral blood, or cord blood for intravenous infusion to the recipient. Currently, acquisition costs associated with allogeneic hematopoietic stem cell transplants are included in the operating costs of inpatient hospital services for subsection (d) hospitals (that is, hospitals paid under the Inpatient Prospective Payment System (IPPS)). In addition, IPPS payments for acquisition services associated with allogeneic hematopoietic stem cell transplants are currently included in the Medicare Severity Diagnosis Related Groups (MS-DRGs) payments for the allogeneic hematopoietic stem cell transplants when the transplants occurred in the inpatient setting.

B. Policy: Section 108 of the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94), provides that, effective for cost reporting periods beginning on or after October 1, 2020, costs related to hematopoietic stem cell acquisition for the purpose of an allogeneic hematopoietic stem cell transplant are not included in the definition of "operating costs of inpatient hospital services" at section 1886(a)(4) of the Act. In addition, section 108 of the Further Consolidated Appropriations Act, 2020 provides that in the case of a subsection (d) hospital that furnishes an allogeneic hematopoietic stem cell transplant, payment to such hospital for hematopoietic stem cell acquisition shall be made on a reasonable cost basis. This is the same way hospitals with approved transplant centers are reimbursed for their acquisition costs for solid organs under 42 CFR 412.113(d).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11729.1	The Centers for Medicare & Medicaid Services (CMS) inpatient Provider Specific File (PSF) record shall be expanded to include a 9-byte field to carry the allogeneic stem cell acquisition pass through amount									CMS, IDR

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	and shift filler down as follows: Data Element: 65 • File position: 277 – 285 • Format: 9(7)V99 • Title: Pass Through Amount for Allogeneic Stem Cell Acquisition • Description: Enter the per diem amount based on the interim payments to the hospital. Include acquisition amounts for allogeneic stem cell Data element: 66 • File position: 286-310 • Format: X25 • Title: Filler									
11729.2	The Medicare Shared System Maintainer shall add a 9-byte field to the inpatient PSF record to carry the Pass Through Amount for Allogeneic Stem Cell Acquisition when Medicare Administrative Contractors (MACs) input the value.					X				IDR
11729.2.1	The Medicare Shared System Maintainer shall pass the new Pass Through Amount for Allogeneic Stem Cell Acquisition field to the IPPS Pricer.					X				
11729.2.2	The Medicare Shared System Maintainer shall create the following maintenance edits on the new field in business requirement 2: • ensure an amount greater than zero is only allowed for IPPS providers • the new field shall be numeric • the new field shall be zero if the fiscal year begin date is less than 10/1/20.					X				
11729.2.3	The IPPS Pricer shall accept the new field for Pass Through Amount for Allogeneic Stem Cell Acquisition.									IPPS Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11729.3	The Medicare contractors shall input the allogeneic stem cell acquisition pass through amount in new data element 65 in the inpatient PSF for those IPPS hospitals with a cost reporting period beginning on or after October 1, 2020.	X								
11729.4	The Medicare Shared System Maintainer shall report the Periodic Interim Payments (PIP)/NON PIP Allogeneic Stem Cell Pass Through Payment with Payment Types 'AP' – 'PIP Allogeneic Stem Cell' and 'AQ' – 'Non-PIP Allogeneic Stem Cell' to the Healthcare Integrated General Ledger Accounting System (HIGLAS) via HIGLAS FISS 810 Non-Claim interface. The Fiscal Intermediary Shared System (FISS)/HIGLAS Systems shall make necessary changes to re-activate Payment Type 'AP', 'AQ'.					X				HIGLAS
11729.5	HIGLAS shall process the PIP/Non-PIP Allogeneic stem cell Pass Through Non-Claim and issue payment with Part A Trust Fund.									HIGLAS
11729.6	HIGLAS shall define the following new Sub Invoice Types for the Pass Through payment types 'AP' & 'AQ' • 'AP_PIP ALLOGENEIC STEM PT' • 'AQ_NON PIP ALLOGENEIC STEM PT'									HIGLAS
11729.7	HIGLAS shall report the PIP/NON PIP Allogeneic Stem cell payments as below: • HIGLAS Provider Level Balance (PLB) Code 'AP' – 'PIP Allogeneic Stem Cell PT' • HIGLAS PLB Code 'AQ' – 'NON PIP Allogeneic Stem Cell PT' on the HIGLAS 835 Interface.									HIGLAS
11729.8	The Medicare Shared System Maintainer shall make necessary programming changes to crosswalk the HIGLAS PLB code 'AP' & 'AQ' to the corresponding					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	standard PLB code (OA – Organ Acquisition Pass Through) for the remittance included in the PLB Mapping attachment. Note: The Electronic Remittance Advice (ERA) and PC-print shall report Tissue Acquisition pass through payment as OA and shall be included in the PLB Code OA along with Organ Acquisition pass through payments. The sum shall MAP to the Standard Paper Remittance (SPR) in the Summary Pass Thru Amounts: Kidney Acquisition amount.									
11729.9	The Medicare Shared System Maintainer shall modify reports to include the addition of the Tissue Acquisition Pass Through payment.					X				
11729.9.1	The HIGLAS shall ensure the Intermediary Benefit Payment Report (IBPR) continues to report the pass through amounts as PIP and Non-PIP and new Tissue Acquisition PT (Allogeneic Stem Cell) amount shall have the same IBPR mapping as Kidney Acquisition.									HIGLAS
11729.10	The Medicare Shared System Maintainer shall modify the Financial Master screens (Menu, MAP07906 and MAP07907) to accommodate new Allogeneic Stem Cell Acquisition pass through dates and amounts and make screen changes for future use.					X				
11729.11	The Medicare Shared System Maintainer shall update edits in the Financial Master Screens that might be affected by changes made in business requirement 10.					X				
11729.12	The Medicare Shared System Maintainer shall modify the Financial Master screens to display the following pass through payments one time, remove reference to 'PIP' and 'Non-PIP' and make screen changes for future use. • Capital Pass Thru • Kidney Pass Thru • DME Pass Thru • Bad Debt Pass Thru • NPA Pass Thru • Tissue Acq Pass Thru • ROE Pass Thru					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11729.13	The Medicare Shared System Maintainer shall continue to send Pass Thru payment to HIGLAS as PIP or Non PIP as follows: • If the provider is a PIP provider the PT payments shall be sent to HIGLAS as PIP PT payments. (AA, AC, AE, AG, AL, AN, AP) • If the provider is not a PIP provider, the PT payments shall be sent to HIGLAS as Non PIP. (AB, AD, AF, AH, AM, AO, AQ) Note: A provider shall be considered PIP if the PIP payment is greater than 0.					X				
11729.14	Since the Single Testing Contractor (STC) does not interface with HIGLAS, Medicare contractors shall test HIGLAS interface business requirements (4, 5, 6 and 7).	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11729.15	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, Cami.DiGiacomo@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

Table of Contents

Addendum A - Provider Specific File

(Rev: 10402, Issued: 10-20-2020, Effective: 10-01-2020, Implementation: 10-05-2020)

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>1</td><td>1-10</td><td>X(10)</td><td>National Provider Identifier (NPI)</td><td>Alpha-numeric 10 character NPI number.</td></tr>
<tr><td>2</td><td>11-16</td><td>X(6)</td><td>Provider Oscar No.</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
Codes for special units are in the third position of the OSCAR number and should correspond to the appropriate provider type, as shown below (NOTE: SB = swing bed):
<table>
<tr><th>Special Unit</th><th>Prov. Type</th></tr>
<tr><td>M - Psych unit in CAH</td><td>49</td></tr>
<tr><td>R - Rehab unit in CAH</td><td>50</td></tr>
<tr><td>S - Psych Unit</td><td>49</td></tr>
<tr><td>T - Rehab Unit</td><td>50</td></tr>
<tr><td>U - SB for short-term hosp.</td><td>51</td></tr>
<tr><td>W - SB for LTCH</td><td>52</td></tr>
<tr><td>Y - SB for Rehab</td><td>53</td></tr>
<tr><td>Z - SB for CAHs</td><td>54</td></tr>
</table></td></tr>
<tr><td>3</td><td>17-24</td><td>9(8)</td><td>Effective Date</td><td>Must be numeric, CCYYMMDD. 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. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
Year: Greater than 82, but not greater than current year.
Month: 01-12
Day: 01-31</td></tr>
</table>

Data Element	File Position	Format	Title	Description
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital

Data Element	File Position	Format	Title	Description
				(during cost reporting periods that began on or after April 1, 1990). Eff. 10/1/12, this provider type is no longer valid. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). Eff. 10/1/12, this provider type no longer valid. 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the OSCAR number (See field #2 for a special unit-to-provider type cross-walk).

Data Element	File Position	Format	Title	Description
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific **NOTE:** When a facility is reclassified for purposes of the standard amount, the MAC changes the census division to reflect the new standardized amount location.
11	58	X(1)	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
12	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
13	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 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 will automatically default to the actual location MSA if this field is left blank.
14	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 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 for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.

Data Element	File Position	Format	Title	Description
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. Eff. 10/1/12, MDHs are no longer valid provider types.
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
17	74	X(1)	Temporary Relief Indicator	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a "Y" if the provider is considered "low volume." **IPF PPS**: Effective January 1, 2005, code a "Y" if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a "Y" for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage **LTCH PPS:** Effective 04/21/16 through 12/31/16, code a 'Y' for an LTCH that is a grandfathered HwH (hospitals that are described in § 412.23(e)(2)(i) that currently meets the criteria of § 412.22(f)); and is located in a rural area or is reclassified rural by meeting the provisions outlined in §412.103, as set forth in the regulations at §412.522(b)(4).
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all

Data Element	File Position	Format	Title	Description
				HHA providers, effective on or after 10/01/2000 0 = Pay standard percentages 1 = Pay zero percent **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. **LTCH PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002. 1 — Federal % 20 — Facility% 80 2 — Federal % 40 — Facility% 60 3 — Federal % 60 — Facility% 40 4 — Federal % 80 — Facility% 20 5 — Federal % 100 — Facility% 00 **IPF PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. 1 — Federal % 25 — Facility% 75 2 — Federal % 50 — Facility% 50 3 — Federal % 75 — Facility% 25 4 — Federal % 100 — Facility% 00
19	76-77	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code. List of valid state codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
20	78-80	X(3)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000. Note that effective 10/1/12, MDHs are no longer valid provider types.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.

Data Element	File Position	Format	Title	Description
23	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 PPS 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. The MAC is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
25	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 Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they 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." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.

Data Element	File Position	Format	Title	Description
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. 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.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the 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.
28	115-118	V9(4)	Medicaid Ratio	Enter the 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.
29	119	X(1)	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	Zero-fill for all hospitals after FY91. This Field is obsolete for hospitals as of FY92. Effective 1/1/2018, this field is used for HHAs only. Enter the HH VBP adjustment factor provided by CMS for each HHA. If no factor is provided, enter 1.00000.
31	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.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
33	138	X(1)	Special Payment Indicator	Enter the code that indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual reclassified
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.

Data Element	File Position	Format	Title	Description
			Core-Based Statistical Area (CBSA)	
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(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 CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (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 CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a "1" or "2."
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the 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.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, lung, pancreas, intestine and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero-fill if this does not apply.

Data Element	File Position	Format	Title	Description
42	179-184	9(4)V9(2)	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the 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.
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the 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
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A“08” is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard

Data Element	File Position	Format	Title	Description
				deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X(1)	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.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	This is for IPPS hospitals and IRFs only. Enter 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 §20.4.1 for inpatient acute hospital and §§140.2.4.3 and 140.2.4.5.1 for IRFs.) Zero-fill for a non-teaching hospital.
50	213-218	9(4)V9(2)	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-219	X	VBP Participant	Enter “Y” if participating in Hospital Value Based Purchasing. Enter “N” if not participating. Note if Data Element 34 (Hospital Quality Ind) is blank, then this field must = N.
52	220-231	9V9(11)	VBP Adjustment	Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank.
53	232-232	X	HRR Indicator	Enter “0” if not participating in Hospital Readmissions Reduction program. Enter “1” if participating in Hospital Readmissions Reduction program and payment adjustment is not 1.0000. Enter “2” if participating in Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor if “1” is entered in Data Element 53. Leave blank if “0” or “2” is entered in Data Element 53.
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a ‘Y’ if the hospital is subject to a reduction under the HAC Reduction Program. Enter a ‘N’ if the hospital is NOT subject to a reduction under the HAC Reduction Program.

Data Element	File Position	Format	Title	Description
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment amount calculated and published by CMS for each hospital
58	251-251	X	Electronic Health Records (EHR) Program Reduction	Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-258	9V9(6)	LV Adjustment Factor	Enter the low-volume hospital payment adjustment factor calculated and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-268	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
62	269-269	X(1)	LTCH DPP Indicator	Enter a 'Y' if the LTCH is subject to the DPP payment adjustment. Leave blank if the LTCH is not subject to the DPP payment adjustment.
63	270-275	9(2) V9(4)	Supplemental Wage Index	Enter the supplemental wage index that certain providers may be assigned. Enter zeroes if it does not apply.
64	276-276	X(1)	Supplemental Wage Index Flag	Enter the supplemental wage index flag that certain providers may be assigned: 1=Prior Year Wage Index 2= current year IPPS-comparable wage index (LTCHs only)* 3=Future use 4=Future use Enter blank if it does not apply. **Note:** For LTCHs, a value of '2' is the current year's IPPS-comparable wage index value that is used for short-stay outlier and site neutral payment rate payments.
65	277-285	9(7)V99	Pass Through Amount for Allogeneic Stem Cell Acquisition	Enter the per diem amount based on the interim payments to the hospital. Include acquisition amounts for allogeneic stem cell transplants. Zero-fill if this does not apply.
66	286-310	X(25)	Filler	

UPDATED PLB CODES TO REPORT ON THE 835 and HIGLAS HIPAA PLB CODE CROSSWALK

	HIGLAS PLB X-01 code	Code Meaning - HIGLAS	Previous FISS 835 PLB Code Usage	Previous MCS 835 PLB Code Usage	Previous VMS 835 PLB Code Usage	HIPAA PLB Codes for 835 v40101 and v5010 A1- PLB03-1	ASC X12 835 PLB Code Description	Comments
1	93	935 Cross Reference Netting	WO			**FB/WO**	Forward Balancing/Overpayment Recovery	Follow CR 6870 - for using FB and WO at step I and Step II
2	94	935 Relationship Netting	WO			**FB/WO**	Forward Balancing/Overpayment Recovery	Follow CR 6870 - for using FB and WO at step I and Step II
3	95	935 Settlement Cross Reference Netting	WO			**FB/WO**	Forward Balancing/Overpayment Recovery	Follow CR 6870 - for using FB and WO at step I and Step II
4	96	935 Settlement Relationship Netting	WO			**FB/WO**	Forward Balancing/Overpayment Recovery	Follow CR 6870 - for using FB and WO at step I and Step II
5	A1	Provider Awardee Convener Model 1 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
6	A2	Provider Awardee Convener Model 2 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
7	A3	Provider Awardee Convener Model 3 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
8	A4	Provider Awardee Convener Model 3 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
9	AA	PIP CAP PT	CV			**CV**	Capital Passthrough	PIP Capital Passthrough
10	AB	non-PIP CAP PT	CV			**CV**	Capital Passthrough	non-PIP Capital Passthrough
11	AC	PIP DME PT	DM			**DM**	Direct Medical Education Passthrough	PIP Direct Medical Education
12	AD	non-PIP DME PT	DM			**DM**	Direct Medical Education Passthrough	non-PIP Direct Medical Education
13	AE	PIP Kidney PT	OA			**OA**	Organ Acquisition Passthrough	PIP Kidney
14	AF	non-PIP Kidney PT	OA			**OA**	Organ Acquisition Passthrough	non-PIP Kidney
15	AG	PIP Bad Debt PT	BD			**BD**	Bad Debt Adjustment	PIP Bad Debt Adjustment
16	AH	non-PIP Bad Debt PT	BD			**BD**	Bad Debt Adjustment	Non-PIP Bad Debt Adjustment
17	AL	PIP non-Phy Anest PT	LS			**LS**	Lump Sum	PIP Non-Physician Anesthetists
18	AM	non-PIP non-Phy Anest PT	LS			**LS**	Lump Sum	non-PIP Non-Physician Anesthetists
19	AN	PIP ROE PT	RE			**RE**	Return on Equity	PIP ROI
20	AO	non-PIP ROE PT	RE			**RE**	Return on Equity	non-PIP ROI
21	AP	PIP Allogeneic Stem Cell PT				**OA**	Organ Acquisition Passthrough	Stem Cell Acquisition costs (CR11729)
22	AQ	NON PIP Allogeneic Stem Cell PT				**OA**	Organ Acquisition Passthrough	Stem Cell Acquisition costs (CR11729)
23	AS	Affiliate Withholdings - Settlement	OB			**OB**	Offset for Affiliated Providers	
24	AW	Affiliate Withholdings	E3			**E3**	Withholding	Affiliate Withholding
25	BN	EHR Demo		BN		**BN**	Bonus	Demonstration Project (CR 6603)
26	C1	Non-Provider Awardee Convener Model 1 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
27	C2	Non-Provider Awardee Convener Model 2 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440

Codes assigned to report
Federally mandated recoupment/bonus payment:
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UPDATED PLB CODES TO REPORT ON THE 835 and HIGLAS HIPAA PLB CODE CROSSWALK

	HIGLAS PLB X-01 code	Code Meaning - HIGLAS	Previous FISS 835 PLB Code Usage	Previous MCS 835 PLB Code Usage	Previous VMS 835 PLB Code Usage	HIPAA PLB Codes for 835 v40101 and v5010 A1- PLB03-1	ASC X12 835 PLB Code Description	Comments
28	C3	Non-Provider Awardee Convener Model 3 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
29	C4	Non-Provider Awardee Convener Model 4 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
30	CV	Converted Invoices	L3	Internal Use Only		**L3**	Penalty	PR Conversion
31	D1	Full Hold - Unfiled Cost Report	50			**50**	Late Charge	Late Filing of Cost Report
32	D2	Full Hold - Unfiled 838	L3			**L3**	Penalty	PW Unfiled 838
33	D3	Full Hold - Rejected Cost Report	L3			**L3**	Penalty	PW Rejected Cost Report
34	D4	Full Hold - Failure to comply Auditors	L3			**L3**	Penalty	PW Failure to comply Auditors
35	D5	Full Hold - DNF	L3	WO		_		RA not created
36	D6	Full Hold - Fraud and Abuse	L3	WO		**L3**	Penalty	PW Fraud and Abuse
37	D7	Full Hold - Other/Misc	L3	WO		**L3**	Penalty	PW Other/Misc
38	D8	Full Hold - AP System Hold	L3	WO		**L3**	Penalty	PWAP Hold
39	D9	Full Hold - Terminated	L3			**L3**	Penalty	PW Terminated
40	DG	Converted DNF - Pseudo Check		Internal Use Only		_		No RA
41	DM	Debit Memo	L3	WO		**E3**	Withholding	Withholding per Debit Memo
42	DP	Converted Negotiable Checks		Internal Use Only		_		No RA
43	DR	DNF Hold Release	L3	Internal Use Only		**L3**	Penalty	PR DNF
44	E1	Episode Initiator Model 1 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
45	E2	Episode Initiator Model 2 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
46	E3	Episode Initiator Model 3 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
47	E4	Episode Initiator Model 4 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
48	FB	Full Hold - Bankruptcy	L3	WO		**L3**	Penalty	PW Bankruptcy
49	FC	Full Hold - CMS Request	L3	WO		**L3**	Penalty	PW CMS Request
50	FS	BPCI Funds Switch Invoice						No RA
51	FR	Full Hold Release	L3	B2		**L3**	Penalty	PR
52	G2	Partial Hold - CMS Request	L3	WO		**L3**	Penalty	PW CMS Request
53	G3	Partial Hold - Bankruptcy	L3	WO		**L3**	Penalty	PW Bankruptcy
54	G4	Partial Hold - Unfiled Cost Report	L3			**L3**	Penalty	PW Unfiled Cost Report
55	G5	Partial Hold - Unfiled 838	L3			**L3**	Penalty	Unfiled 838 (Credit Balance Report)
56	H1	Manual Invoices - Cost Settlement Report	C5			**C5**	Temporary Allowance	Cost Report Settlement
57	H2	HITECH Recoupment				**TL**	Third Party Liability	HITECH Recoupment HIT XXXX Phone # XXX-XXX-XXXX
58	HB	HPSA	E3	B2		**BN**	Bonus	HPSA Bonus
59	IR	TPP - IRS Levy	IR	WO		**IR**	Internal Revenue Service Withholding	
60	L1	TPP - IRS Backup	IR	WO		**IR**	Internal Revenue Service Withholding	
61	L2	TPP - Garnishments	WU	WO		**CS**	Adjustment	PW Garnishments
62	L3	Third Party Payment - including Attorneys	Internal Use Only	Internal Use Only		_		No RA
63	L4	TPP - Child Support	WU	WO		**CS**	Adjustment	PW Child Support

Codes assigned to report
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UPDATED PLB CODES TO REPORT ON THE 835 and HIGLAS HIPAA PLB CODE CROSSWALK

	HIGLAS PLB X-01 code	Code Meaning - HIGLAS	Previous FISS 835 PLB Code Usage	Previous MCS 835 PLB Code Usage	Previous VMS 835 PLB Code Usage	HIPAA PLB Codes for 835 v40101 and v5010 A1- PLB03-1	ASC X12 835 PLB Code Description	Comments
64	L5	TPP - Alimony	WU	WO		**CS**	Adjustment	PW Alimony
65	L6	TPP - Secondary Corporation	WU	WO		**CS**	Adjustment	PW Secondary Corporation
66	L7	TPP - Change of Ownership	WU	WO		**CS**	Adjustment	Change of Ownership
67	L8	Accelerated/Advance Recoupments Applications	AP	WO		**WO**	Overpayment Recovery	Advance Recoupment Application
68	LE	Lump Sum Bonus Payment for the Physician Pay for Reporting (P4R) Program and ERx Initiative Payment		LE		**LE**	Levy	PQRI and ERx (CR6624) Bonus Payment
69	LS	Lump Sum Bonus Payment for the Physician Pay for Reporting (P4R) Program (valid for transactions built before January 4, 2010 only)		LE		**LE**	Levy	PQRI Bonus Payment
70	M1	Manual Invoices - Refunds	72	B2		**72**	Authorized return	Refunds - Manual Invoices
71	M2	Manual Invoices - Penalty Release	L3	B2		**L3**	Penalty	PR Penalty Release
72	M3	Manual Invoices - Insurance Companies	C5	B2		**C5**	Temporary Allowance	Manual Invoices
73	M4	Manual Invoices - Other	C5	B2		**C5**	Temporary Allowance	Manual Invoices
74	MA	Manual Invoices - Accelerated/Advance Payment	AP	B2		**AP**	Acceleration of Benefits	Manual Invoices - Accelerated/Advance Payment
75	MC	Manual Invoices - PIP	PI			**PI**	Periodic Interim Payment	
76	ML	Manual Invoices - Interim Rate Review	C5			**C5**	Temporary Allowance	Interim Rate Review
77	N1	Non-Provider Awardee Convener Model 1 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
78	N2	Non-Provider Awardee Convener Model 2 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
79	N3	Non-Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
80	N4	Non-Provider Awardee Convener Model 4 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
81	NA	Manual Non Claim Invoices - HI Positive Distribution	Internal Use Only			_		No RA
82	NB	Manual Non Claim Invoices - HI Negative Distribution	Internal Use Only			_		No RA
83	NC	Manual Non Claim Invoices - SMI Positive Distribution	Internal Use Only			_		No RA
84	ND	Manual Non Claim Invoices - SMI Negative Distribution	Internal Use Only			_		No RA
85	NR	Manual Invoices - PT	C5			**C5**	Temporary Allowance	
86	P1	Provider Awardee Convener Model 1 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440
87	P2	Provider Awardee Convener Model 2 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440
88	P3	Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440
89	P4	Provider Awardee Convener Model 4 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440

Codes assigned to report
Federally mandated recoupment/bonus payment:
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UPDATED PLB CODES TO REPORT ON THE 835 and HIGLAS HIPAA PLB CODE CROSSWALK

	HIGLAS PLB X-01 code	Code Meaning - HIGLAS	Previous FISS 835 PLB Code Usage	Previous MCS 835 PLB Code Usage	Previous VMS 835 PLB Code Usage	HIPAA PLB Codes for 835 v40101 and v5010 A1- PLB03-1	ASC X12 835 PLB Code Description	Comments
90	PL	Manual 935 ALJ Interest Refund invoice	PL	PL		**L6**	Interest Owed	'Code meaning – HIGLAS' and 'Previous MCS 835 PLB Code Usage' changed from previous version
91	PO	Partial Hold - Other/Misc	L3	WO		**L3**	Penalty	PW Other/Misc
92	PP	PIP	PI			**PI**	Periodic Interim Payment	
93	PR	Partial Hold - Release	L3	B2		**L3**	Penalty	PR Penalty Release
94	RU	Interest Refund				**L6**	Interest Owed	
95	S1	Single Awardee Model 1 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
95	S2	Single Awardee Model 2 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
96	S3	Single Awardee Model 3 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
97	S4	Single Awardee Model 4 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
98	TD	Manual Invoices - Tentative Settlement	C5			**C5**	Temporary Allowance	Tentative Settlement
99	TL	TOPS	IS			**IS**	Interim Settlement	
100	VC	Voids - Reissue Invoices	CS	Internal Use Only		**CS**	Adjustment	Reissued Invoice
101	VD	Voids - Reissue Debit Memo	CS	WO?		**CS**	Adjustment	Reissued Debit Memo
102	VO	Void - Reissue Interest Information	CS			**CS**	Adjustment	Reissued Interest
103	WO	AR/AP Netting Offset	E3	WO		**WO**	Overpayment Recovery	AR/AP Netting
104	WR	Void - Reissue Split Pay	C5			**C5**	Temporary Allowance	Reissue Split Pay
105	WS	Settlement Withholding	L3			**E3**	Withholding	Settlement Withholding
106	WU	FPLP Tax Withholding	WU	WU		**LE/WU**	Levy	1) TREASURY TAX WITHHOLD Treasury telephone xxx-xxx-xxxx 2) Any other Federally mandated payment/recoupment
107	WW	Principal Refund				**WO**	Overpayment Recovery	The amount in PLB 04 should be negative. And include identifying nos. in PLB03-2
108	ZZ	FPLP Non-tax Withholding	ZZ	ZZ		**WU/LE**		1) TREASURY NON-TAX WITHHOLD Treasury telephone xxx-xxx-xxxx 2) Any other Federally mandated payment/recoupment
109	RH	Full Hold - Revalidation Hold						No RA
110	IP	MAPC Demonstration Shared Savings payment				**BN**	Bonus	

Codes assigned to report
Federally mandated recoupment/bonus payment:
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UPDATED PLB CODES TO REPORT ON THE 835 and HIGLAS HIPAA PLB CODE CROSSWALK

	HIGLAS PLB X-01 code	Code Meaning - HIGLAS	Previous FISS 835 PLB Code Usage	Previoua MCS 835 PLB Code Usage	Previous VMS 835 PLB Code Usage	HIPAA PLB Codes for 835 v40101 and v5010 A1- PLB03-1	ASC X12 835 PLB Code Description	Comments
NON-HIGLAS USERS								
113				AP		**AP**	Acceleration of Benefits	Advance Payment
114					CS	_		Correction and Reversal at the claim/line level
115				FB		**FB**	Forward Balance	Over Payment
116					CS	**FB/WO**	Withholding	Follow CR 6870 - for using FB and WO at step I and Step II for 935 Recoupment
117					IR	**IR**	Internal Revenue Service Withholding	
118				J1		**J1**	Non-reimbursable	Adjustment per Demonstration Project
119					AP	**AP**	Acceleration of Benefits	Payment to withheld because it has been determined that the provider/supplier is on Do Not Forward (DNF) or investigated for
120				L6	L6	**L6**	Interest Owed	Interest paid on claims in this 835
121					WO	**WO**	Overpayment Recovery	AR/AP Netting
ADD-ON-PAYMENTS								
122			CS			**CS**		Outlier
123			CS			**CS/HM**		Hemo. HM is a new code available in 5010
124			CS			**CS**		New Technology
125			LS			**LS**		Indirect Medical Education

Codes assigned to report
Federally mandated recoupment/bonus payment:
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UPDATED PLB CODES TO REPORT ON THE 835 and HIGLAS HIPAA PLB CODE CROSSWALK

CHANGE LOG	
Version	**Comments**
1.0	Changes for HIGLAS PLB Codes AP & AQ for CR 11729.

Codes assigned to report
Federally mandated recoupment/bonus payment:
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