CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal:12615	Date: May 2, 2024
	Change Request 13590

NOTE: This Transmittal is no longer sensitive and is being re-communicated October 07, 2024. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: New Biweekly Interim Payments for Inpatient Prospective Payment System (IPPS) Separate Payment for Additional Resource Costs of Establishing and Maintaining Access to Buffer Stocks of Essential Medicines

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to prepare the claims processing system for a new separate payment under IPPS to small, independent hospitals for the costs of voluntarily establishing and maintaining access to buffer stocks of essential medicines via biweekly interim payments.

EFFECTIVE DATE: October 1, 2024 - For cost reporting periods beginning on or after October 1, 2024.
*Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: October 7, 2024

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: 12615	Date: May 2, 2024	Change Request: 13590

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I.   SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to prepare the claims processing system for a new separate payment under IPPS to small, independent hospitals for the costs of voluntarily establishing and maintaining access to buffer stocks of essential medicines via biweekly interim payments.

II.   GENERAL INFORMATION

A.   Background: Payment Adjustment Amounts under the Inpatient Prospective Payment System (IPPS) for Establishing and Maintaining Access to Essential Medicines

In the FY 2025 IPPS Rule, we are proposing to make separate payments for the IPPS shares of these additional resource costs of establishing and maintaining access to buffer stocks of essential medicines. Payment could be provided as a lump sum at cost report settlement or biweekly as interim lump-sum payments to the hospital, which would be reconciled at cost report settlement. In accordance with the principles of reasonable cost as set forth in section 1861(v)(1)(A) of the Act and in 42 CFR 413.1 and 413.9, Medicare could make a lump-sum payment for Medicare's share of these additional inpatient costs at cost report settlement. Alternatively, a provider could make a request for these biweekly interim lump sum payments for an applicable cost reporting period, as provided under 42 CFR 413.64 (Payments to providers: Specific rules) and 42 CFR 412.116(c) (Special interim payments for certain costs). These payment amounts would be determined by the Medicare Administrative Contractor (MAC) consistent with existing policies and procedures. In general, interim payments are determined by estimating the reimbursable amount for the year using Medicare principles of cost reimbursement and dividing it into 26 equal biweekly payments. The estimated amount is based on the most current cost data available, which will be reviewed and, if necessary, adjusted at least twice during the reporting period. (See CMS Pub 15–1 2405.2 for additional information.) The MACs would determine the interim lump-sum payments based on the data the hospital may provide that reflects the information that would be included on the new supplemental cost reporting form. In future years, the MACs could determine the interim biweekly lump-sum payments utilizing information from the prior year's cost report, which may be adjusted based on the most current data available. This would be consistent with the current policies for medical education costs, and bad debts for uncollectible deductibles and coinsurance paid on interim biweekly basis as noted in CMS Pub 15–1 2405.2. It is also consistent with the payment adjustment for domestically sourced NIOSH approved surgical N95 respirators (87 FR 72037).

B.   Policy: This payment adjustment shall be codified in the regulations at § 412.113(g) for the IPPS.

III.   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	
13590.1	The CMS inpatient Provider Specific File (PSF) record shall be updated to relabel the Pass Through Amount for Domestic N95 Respirator Procurement field as follows: Data Element: 68 • File position: 298-306 • Format: 9(7)V99 • Title: Pass Through Amount for Supply Chain Costs • Description: Enter the per diem amount based on the interim payments to the hospital. Include payment adjustments for the additional resource costs of establishing and maintaining access to buffer stocks of essential medicines. Also include payment adjustments for the additional cost for procurement of wholly domestically made NIOSH-approved surgical N95 respirators.									CMS, IDR
13590.2	The Shared System Maintainer (SSM) shall update the inpatient PSF record for the Pass Through Per Diem Amount					X				IDR

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	for Supply Chain Costs.									
13590.2.1	The SSM shall continue to pass the relabeled Pass Through Amount for Supply Chain Costs field to the Java/Cloud IPPS Pricer.					X				
13590.2.2	The Java/Cloud IPPS Pricer shall continue to accept the relabeled field for Pass Through Amount for Supply Chain Costs.									IPPS Pricer
13590.2.3	The Java/Cloud IPPS Pricer Client Application Programming Interface (API) shall be updated to relabel the input field for Pass Through Amount for Supply Chain Costs.					X				IPPS Pricer
13590.3	The Medicare contractors shall enter the per diem amount based on the interim payments to the hospital for supply chain costs in data element 68 in the inpatient PSF, for small, independent hospitals receiving Inpatient Prospective Payment System (IPPS) with a cost reporting period beginning on or after October 1, 2024. **Note:** Include payment adjustments to small, independent hospitals for the additional resource costs of establishing and maintaining access to buffer stocks of essential medicines. Continue to include payment adjustments for the additional cost for procurement of wholly	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	domestically made NIOSH-approved surgical N95 respirators.									
13590.3.1	The Medicare Contractors shall include the per diem amount for supply chain costs pass through in data element 42, file position 179-184 Total Pass Through Amount, Including Miscellaneous field of the PSF.	X								
13590.4	The SSM shall relabel and update the amounts reported for the Periodic Interim Payments to (PIP)/NON PIP Supply Chain Costs Pass Through Payment with Payment Types 'AT' – 'PIP Supply Chain Costs' and 'AV' – 'Non-PIP Supply Chain Costs' 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 updated and relabeled Payment Type 'AT', 'AV'. Note: Please refer to PLB Codes Mapping v7.0 attachment. These amounts are relabeled from the previous "PIP and NON PIP Domestic N95 Respirator Procurement PT".					X				HIGLAS
13590.5	HIGLAS shall continue to process the relabeled PIP/Non-PIP Supply Chain Costs Pass Through Non-									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Claim and issue payment with Part A Trust Fund.									
13590.6	HIGLAS shall create new Sub Invoice Types for the Pass Through payment types 'AT' & 'AV': • 'AT_PIP SUPPLY CHAIN COSTS PT' • 'AV_NON PIP SUPPLY CHAIN COSTS PT'									HIGLAS
13590.7	HIGLAS shall report the PIP/NON PIP Supply Chain Costs payments as below: • HIGLAS Provider Level Balance (PLB) Code 'AT' – 'PIP Supply Chain Costs PT' • HIGLAS PLB Code 'AV' – 'NON PIP Supply Chain Costs PT' on the HIGLAS 835 Interface.									HIGLAS
13590.8	The SSM shall continue to crosswalk the HIGLAS PLB code 'AT' & 'AV' to the corresponding standard PLB code 'LS' for the remittance included in the PLB Mapping attachment. The SSM shall update the Electronic Remittance Advice (ERA) and PC-print to report Supply Chain Costs pass through payment as PLB Code 'LS'. The payments shall MAP to the Standard Paper Remittance (SPR) and PC-print in					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the SUMMARY Pass Thru Amounts area of the SPR/PC-print and shall be included in the TOTAL PASS THRU field. Note: The SSM shall continue to report PIP/NON PIP Non-Physician Anesthetists pass through payments identified with standard PLB Code 'LS' to the existing Non-Physician Anesthetists SUMMARY Pass Through Amounts area of the SPR/PC Print.									
13590.9	The SSM shall modify reports to redefine the Supply Chain Costs Pass Through payment.					X				
13590.9.1	The HIGLAS shall ensure the Intermediary Benefit Payment Report (IBPR) reports the redefined pass through amounts as PIP and Non-PIP for the relabeled Supply Chain Costs Pass Through Amount mapping.									HIGLAS
13590.10	The SSM shall modify the Financial Master screens (MAP07902, MAP07906, and MAP07907) and Online Remittance Advice Summary Screen (MAP07959) to relabel the existing fields for Domestic N95 Respirator Procurement pass through as the Supply Chain Costs pass through amount.					X				
13590.11	The Medicare Contractors shall utilize the redefined PIP/Pass Through Payment and Rates fields relabeled	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	on the financial master screens (MAP07906, MAP07907) to enter the interim payment amounts and effective date(s) for the Supply Chain Costs pass through payments. Note: Include payment adjustments for the additional resource costs of establishing and maintaining access to buffer stocks of essential medicines. Also include payment adjustments for the additional cost for procurement of wholly domestically made NIOSH-approved surgical N95 respirators.									
13590.12	The SSM shall continue to send Pass Thru (PT) 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, AT,) • 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, AV,) Note: A provider shall be considered PIP if the PIP payment is greater than 0.					X				
13590.13	Since the Medicare Integrated Systems Testing (MIST) contractor	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	does not interface with HIGLAS, Medicare contractors shall test all HIGLAS interface business requirements.									
13590.14	Initially, the Medicare Contractors shall determine an interim lump-sum biweekly payment, based on information the hospital provides that reflects the information that will be included on the cost reporting form for the additional resource costs of establishing and maintaining access to buffer stocks of essential medicines. *Note:* Hospitals and Medicare Contractors should refer to the supplemental cost report form and instructions named: PAYMENT ADJUSTMENTS FOR ESTABLISHING AND MAINTAINING ACCESS TO A BUFFER STOCK OF ESSENTIAL MEDICINES.	X								
13590.15	The Medicare Contractors shall utilize the "Other" rate type field in the System for Tracking Audit and Reimbursement (STAR) for the essential medicine buffer stock supplemental cost review.	X								

IV.   PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13590.16	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.	X				

V. 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

VI. CONTACTS

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

VII. 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
(Rev. 12615; Issued: 05-02-24)

Addendum A - Provider Specific File
(Rev. 12615; Issued: 05-02-24; Effective: 10-01-24; Implementation: 10-07-24)

Data Element	File Position	Format	Title	Description
1	1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character NPI number.
	11-16	X(6)	Provider CMS Certification Number (CCN)	Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:

Provider #	Provider Type
00-08	Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12
12	18
13	23,37
20-22	02
30	04
33	05
40-44	03
50-64	32-34, 38
15-17	35
70-84, 90-99	36

Codes for special units are in the third position of the provider CMS Certification Number (CCN) and should correspond to the appropriate provider type, as shown below (**NOTE:** SB = swing bed):

Special Unit	Prov. Type
M - Psych unit in CAH	49
R - Rehab unit in CAH	50
S - Psych Unit	49
T - Rehab Unit	50
U - SB for short-term hosp.	51
W - SB for LTCH	52
Y - SB for Rehab	53
Z - SB for CAHs	54

Data Element	File Position	Format	Title	Description
3	17-24	9(8)	Effective Date	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

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).
				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).
				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 provider CMS Certification Number (CCN) (See field #2 for a special unit-to-provider type cross-walk).
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for

Data Element	File Position	Format	Title	Description

				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.
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:** For "From" dates before 1/1/2021: Enter the value to indicate if normal percentage payments should be made on RAP and/or whether payment

Data Element	File Position	Format	Title	Description
				should be reduced under the Quality Reporting Program. Valid values: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0% NOTE: All new HHAs enrolled after January 1, 2019 must have this value set to 1 or 3 (no RAP payments). For "From" dates on or after 1/1/2021: Enter the value to indicate whether payment should be reduced under the Quality Reporting Program. Valid values: 0 = Make normal percentage payment 2 = Make final payment reduced by 2% **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. **LTCH PPS:** For cost reporting periods beginning on or after 10/01/2002, enter the appropriate code for the blend ratio between federal and facility rates for the LTCH provider:

	Federal %	Facility%
1	20	80
2	40	60
3	60	40
4	80	20
5	100	00

For LTCH cost reporting periods beginning on or after 10/01/2015 enter the appropriate code for the blend year representing 50% site neutral payment and 50 % standard payment.

6 –Blend Year 1 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2015 through 09/30/16)

7 - Blend Years 2 through 4 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018 or FY 2019

Data Element	File Position	Format	Title	Description
				8 - Blank – Transition Blend no longer applies with cost reporting periods beginning in on or after 10/01/2019. Full Site Neutral payment
				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.
				<table><tr><td></td><td>Federal %</td><td>Facility%</td></tr><tr><td>1</td><td>25</td><td>75</td></tr><tr><td>2</td><td>50</td><td>50</td></tr><tr><td>3</td><td>75</td><td>25</td></tr><tr><td>4</td><td>100</td><td>00</td></tr></table>
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.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
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

Data Element	File Position	Format	Title	Description
				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.
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.

Data Element	File Position	Format	Title	Description
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 Core-Based Statistical Area (CBSA)	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.
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)

Data Element	File Position	Format	Title	Description
				(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.
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. *Supply Chain Costs,* 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, DSH adjustments, or Allogeneic Stem Cell Acquisition. Zero-fill if this does not apply.

Data Element	File Position	Format	Title	Description
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 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

Data Element	File Position	Format	Title	Description
				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.
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment (UCP) amount or enter the total of the estimated per discharge UCP amount and estimated per discharge supplemental payment amount, calculated and published by CMS for each hospital. Effective 10/1/2022, the estimated per discharge supplemental payment is for eligible Indian Health Service/Tribal hospitals and hospitals located in Puerto Rico.
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 in accordance

Data Element	File Position	Format	Title	Description
				with the low-volume hospital payment regulations at § 412.101.
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=Special IPPS-comparable Wage Index* 3=Future use

Enter blank if it does not apply

*Only for LTCH providers. Pricer will override the otherwise determined IPPS-comparable wage index with this value. |
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	286-291	9(4)V9(2)	Pass Through Amount for Direct *Graduate* Medical Education (Medicare Advantage (MA) Exclusion)	Per diem amount of direct graduate medical education to be excluded from MA capitation rates per regulation. Zero-fill if this does not apply.
67	292-297	9(4)V9(2)	Pass Through Amount for Kidney Acquisition (MA Exclusion)	Per diem amount of kidney acquisition costs to be excluded from MA capitation rates per regulation. Zero-fill if this does not apply.
68	298-306	9(7)V99	Pass Through Amount for *Supply Chain Costs*	Enter the per diem amount based on the interim payments to the hospital. *Include payment adjustments for the additional resource costs of establishing and maintaining access to buffer stocks of essential medicines. Also* Include payment adjustments for the additional cost for

Data Element	File Position	Format	Title	Description
				procurement of wholly domestically made NIOSH-approved surgical N95 respirators.
69	307-310	X(4)	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 4 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	AT	PIP Supply Chain Costs PT				**LS**	Lump Sum	Changed HIGLAS code meaning to PIP Supply Chain Costs PT (CR 13590)
25	AV	NON PIP Supply Chain Costs PT				**LS**	Lump Sum	Changed HIGLAS code meaning to NON PIP Supply Chain Costs PT (CR 13590)
26	AW	Affiliate Withholdings	E3			**E3**	Withholding	Affiliate Withholding

Codes assigned to report
Federally mandated recoupment/bonus payment:
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	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
27	BN	EHR Demo		BN		BN	Bonus	Demonstration Project (CR 6603)
28	C1	Provider Convener Participant - BPCI Advanced				LE/WU	Levy/Unspecified Recovery	CR11110
29	C2	Non-Provider Awardee Convener Model 2 BPCI Transaction (does NOT own Episode Initiators)				LE/WU	Levy/Unspecified Recovery	CR8440
30	C3	Non-Provider Awardee Convener Model 3 BPCI Transaction (does NOT own Episode Initiators)				LE/WU	Levy/Unspecified Recovery	CR8440
31	C4	Non-Provider Awardee Convener Model 4 BPCI Transaction (does NOT own Episode Initiators)				LE/WU	Levy/Unspecified Recovery	CR8440
32	CH	Full Hold - Hospice Cap Settlement				50	Late Charge	CR11621
33	CV	Converted Invoices	L3	Internal Use Only		L3	Penalty	PR Conversion
34	D1	Full Hold - Unfiled Cost Report	50			50	Late Charge	Late Filing of Cost Report
35	D2	Full Hold - Unfiled 838	L3			L3	Penalty	PW Unfiled 838
36	D3	Full Hold - Rejected Cost Report	L3			L3	Penalty	PW Rejected Cost Report
37	D4	Full Hold - Failure to comply Auditors	L3			L3	Penalty	PW Failure to comply Auditors
38	D5	Full Hold - DNF	L3	WO		_		RA not created
39	D6	Full Hold - Fraud and Abuse	L3	WO		L3	Penalty	PW Fraud and Abuse
40	D7	Full Hold - Other/Misc	L3	WO		L3	Penalty	PW Other/Misc
41	D8	Full Hold - AP System Hold	L3	WO		L3	Penalty	PWAP Hold
42	D9	Full Hold - Terminated	L3			L3	Penalty	PW Terminated
43	DG	Converted DNF - Pseudo Check		Internal Use Only		_		No RA
44	DM	Debit Memo	L3	WO		E3	Withholding	Withholding per Debit Memo
45	DP	Converted Negotiable Checks		Internal Use Only		_		No RA
46	DR	DNF Hold Release	L3	Internal Use Only		L3	Penalty	PR DNF
47	E1	Episode Initiator - BPCI Advanced				LE/WU	Levy/Unspecified Recovery	CR11110
48	E2	Episode Initiator Model 2 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
49	E3	Episode Initiator Model 3 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
50	E4	Episode Initiator Model 4 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
51	FB	Full Hold - Bankruptcy	L3	WO		L3	Penalty	PW Bankruptcy
52	FC	Full Hold - CMS Request	L3	WO		L3	Penalty	PW CMS Request
53	FS	BPCI Funds Switch Invoice						No RA
54	FR	Full Hold Release	L3	B2		L3	Penalty	PR
55	G2	Partial Hold - CMS Request	L3	WO		L3	Penalty	PW CMS Request
56	G3	Partial Hold - Bankruptcy	L3	WO		L3	Penalty	PW Bankruptcy
57	G4	Partial Hold - Unfiled Cost Report	L3			L3	Penalty	PW Unfiled Cost Report
58	G5	Partial Hold - Unfiled 838	L3			L3	Penalty	Unfiled 838 (Credit Balance Report)
59	H1	Manual Invoices - Cost Settlement Report	C5			C5	Temporary Allowance	Cost Report Settlement
60	HB	HPSA	E3	B2		BN	Bonus	HPSA Bonus
61	HR	Payment Suspension Full Hold Release				L3	Penalty	CR13177

Codes assigned to report
Federally mandated recoupment/bonus payment:
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	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**
62	IM	Innovation Model				**IP/WO**	/Overpayment Recovery	CR9744
63	IR	TPP - IRS Levy	IR	WO		**IR**	Internal Revenue Service Withholding	
64	L1	TPP - IRS Backup	IR	WO		**IR**	Internal Revenue Service Withholding	
65	L2	TPP - Garnishments	WU	WO		**CS**	Adjustment	PW Garnishments
66	L3	Third Party Payment - including Attorneys, IRSBW payee, CMSHQ payee, Providers, and Beneficiaries	Internal Use Only	Internal Use Only		**_**		No RA
67	L4	TPP - Child Support	WU	WO		**CS**	Adjustment	PW Child Support
68	L5	TPP - Alimony	WU	WO		**CS**	Adjustment	PW Alimony
69	L6	TPP - Secondary Corporation	WU	WO		**CS**	Adjustment	PW Secondary Corporation
70	L7	TPP - Change of Ownership	WU	WO		**CS**	Adjustment	Change of Ownership
71	L8	Accelerated/Advance Recoupments Applications	AP	WO		**WO**	Overpayment Recovery	Advance Recoupment Application
72	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
73	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
74	M1	Manual Invoices - Refunds	72	B2		**72**	Authorized return	Refunds - Manual Invoices
75	M4	Manual Invoices - Other	C5	B2		**C5**	Temporary Allowance	Manual Invoices
76	MA	Manual Invoices - Accelerated/Advance Payment	AP	B2		**AP**	Acceleration of Benefits	Manual Invoices - Accelerated/Advance Payment
77	MB	Manual Invoices – Hospice CAP Settlement				**C5**	Temporary Allowance	CR11621
78	MC	Manual Invoices - PIP	PI			**PI**	Periodic Interim Payment	
79	ML	Manual Invoices - Interim Rate Review	C5			**C5**	Temporary Allowance	Interim Rate Review
80	N1	Non-Provider Convener Participant - BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
81	N2	Non-Provider Awardee Convener Model 2 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
82	N3	Non-Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
83	N4	Non-Provider Awardee Convener Model 4 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
84	NA	Manual Non Claim Invoices - HI Positive Distribution	Internal Use Only			**_**		No RA
85	NB	Manual Non Claim Invoices - HI Negative Distribution	Internal Use Only			**_**		No RA
86	NC	Manual Non Claim Invoices - SMI Positive Distribution	Internal Use Only			**_**		No RA
87	ND	Manual Non Claim Invoices - SMI Negative Distribution	Internal Use Only			**_**		No RA
88	NR	Manual Invoices - PT	C5			**C5**	Temporary Allowance	
89	P1	Single Participant – BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
90	P2	Provider Awardee Convener Model 2 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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	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
91	P3	Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators				LE/WU	Levy/Unspecified Recovery	CR8440
92	P4	Provider Awardee Convener Model 4 BPCI Transaction (owns SOME or ALL Episode Initiators				LE/WU	Levy/Unspecified Recovery	CR8440
93	PA	Partial Hold – Admin Freeze				L3		PW Admin Freeze
94	PI	Pennsylvania Rural Health Model				PI	Periodic Interim Payment	CR10018
95	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
96	PO	Partial Hold - Other/Misc/ PSC Request	L3	WO		L3	Penalty	PW Other/Misc/PSC Request
97	PP	PIP	PI			PI	Periodic Interim Payment	
98	PR	Partial Hold - Release	L3	B2		L3	Penalty	PR Penalty Release
99	RH	Full Hold - Revalidation Hold						No RA
100	RD	Rural Emergency Hospital (REH) Payment				CS	Adjustment	CR12820
101	RU	Interest Refund				L6	Interest Owed	
102	S1	Single Awardee Model 1 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
103	S2	Single Awardee Model 2 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
104	S3	Single Awardee Model 3 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
105	S4	Single Awardee Model 4 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
106	SH	Payment Suspension Full Hold				L3	Penalty	CR13177
107	TD	Manual Invoices - Tentative Settlement	C5			C5	Temporary Allowance	Tentative Settlement
108	TL	TOPS	IS			IS	Interim Settlement	
109	UH	Beneficiary Undeliverable Full Hold						No RA
110	VC	Voids - Reissue Invoices	CS	Internal Use Only		CS	Adjustment	Reissued Invoice
111	VD	Voids - Reissue Debit Memo	CS	WO?		CS	Adjustment	Reissued Debit Memo
112	VO	Void - Reissue Interest Information	CS			CS	Adjustment	Reissued Interest
113	WO	AR/AP Netting Offset	E3	WO		WO	Overpayment Recovery	AR/AP Netting
114	WR	Void - Reissue Split Pay	C5			C5	Temporary Allowance	Reissue Split Pay
115	WS	Settlement Withholding	L3			E3	Withholding	Settlement Withholding
116	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
117	WW	Principal Refund				WO	Overpayment Recovery	The amount in PLB 04 should be negative. And include identifying nos. in PLB03-2
118	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

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
					NON-HIGLAS USERS			
119				AP		**AP**	Acceleration of Benefits	Advance Payment
120					CS	**–**		Correction and Reversal at the claim/line level
121				FB		**FB**	Forward Balance	Over Payment
122					CS	**FB/WO**	Withholding	Follow CR 6870 - for using FB and WO at step I and Step II for 935 Recoupment
123					IR	**IR**	Internal Revenue Service Withholding	
124				J1		**J1**	Non-reimbursable	Adjustment per Demonstration Project
125					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
126				L6	L6	**L6**	Interest Owed	Interest paid on claims in this 835
127					WO	**WO**	Overpayment Recovery	AR/AP Netting
					ADD-ON-PAYMENTS			
128			CS			**CS**		Outlier
129			CS			**CS/HM**		Hemo. HM is a new code available in 5010
130			CS			**CS**		New Technology
131			LS			**LS**		Indirect Medical Education

Codes assigned to report
Federally mandated recoupment/bonus payment:
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Version	**Comments**
1.0	Changes for HIGLAS PLB Codes AP & AQ for CR 11729.
2.0	Changes for HIGLAS PLB Codes PA & PO for CR 11930.
3.0	Corrections as follows:
	Updated Code Meaning for PLB Codes C1, E1, N1, P1 for CR 11110.
	Removed HIGLAS PLB Code IP for CR 11760.
	Removed HIGLAS PLB Codes H2, M2 and M3.
	Added HIGLAS PLB Code IM for CR 9744.
	Added HIGLAS PLB Code PI for CR 10018.
	Added HIGLAS PLB Code UH for CR 10439.
	Added new HIGLAS PLB Code 'RD' for CR 12820.
4.0	Added new HIGLAS PLB Codes CH & MB for CR 11621.
5.0	Added new HIGLAS PLB Codes AT & AV for CR 13052.
6.0	Updated HIGLAS PLB code L3 Code Meaning for CR 12944.
	Added new HIGLAS PLB Codes SH & HR for CR 13177.
7.0	Changes for HIGLAS PLB Codes AT & AV meaning for CR 13590.
	Updated HIGLAS PLB code L3 Code Meaning for Cleanup/User CR 13170.

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
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 4 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	AT	PIP Supply Chain Costs PT				**LS**	Lump Sum	Changed HIGLAS code meaning to PIP Supply Chain Costs PT (CR 13590)
25	AV	NON PIP Supply Chain Costs PT				**LS**	Lump Sum	Changed HIGLAS code meaning to NON PIP Supply Chain Costs PT (CR 13590)
26	AW	Affiliate Withholdings	E3			**E3**	Withholding	Affiliate Withholding

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	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
27	BN	EHR Demo		BN		**BN**	Bonus	Demonstration Project (CR 6603)
28	C1	Provider Convener Participant - BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
29	C2	Non-Provider Awardee Convener Model 2 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
30	C3	Non-Provider Awardee Convener Model 3 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
31	C4	Non-Provider Awardee Convener Model 4 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
32	CH	Full Hold - Hospice Cap Settlement				**50**	Late Charge	CR11621
33	CV	Converted Invoices	L3	Internal Use Only		**L3**	Penalty	PR Conversion
34	D1	Full Hold - Unfiled Cost Report	50			**50**	Late Charge	Late Filing of Cost Report
35	D2	Full Hold - Unfiled 838	L3			**L3**	Penalty	PW Unfiled 838
36	D3	Full Hold - Rejected Cost Report	L3			**L3**	Penalty	PW Rejected Cost Report
37	D4	Full Hold - Failure to comply Auditors	L3			**L3**	Penalty	PW Failure to comply Auditors
38	D5	Full Hold - DNF	L3	WO		**_**		RA not created
39	D6	Full Hold - Fraud and Abuse	L3	WO		**L3**	Penalty	PW Fraud and Abuse
40	D7	Full Hold - Other/Misc	L3	WO		**L3**	Penalty	PW Other/Misc
41	D8	Full Hold - AP System Hold	L3	WO		**L3**	Penalty	PWAP Hold
42	D9	Full Hold - Terminated	L3			**L3**	Penalty	PW Terminated
43	DG	Converted DNF - Pseudo Check		Internal Use Only		**_**		No RA
44	DM	Debit Memo	L3	WO		**E3**	Withholding	Withholding per Debit Memo
45	DP	Converted Negotiable Checks		Internal Use Only		**_**		No RA
46	DR	DNF Hold Release	L3	Internal Use Only		**L3**	Penalty	PR DNF
47	E1	Episode Initiator - BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
48	E2	Episode Initiator Model 2 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
49	E3	Episode Initiator Model 3 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
50	E4	Episode Initiator Model 4 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
51	FB	Full Hold - Bankruptcy	L3	WO		**L3**	Penalty	PW Bankruptcy
52	FC	Full Hold - CMS Request	L3	WO		**L3**	Penalty	PW CMS Request
53	FS	BPCI Funds Switch Invoice						No RA
54	FR	Full Hold Release	L3	B2		**L3**	Penalty	PR
55	G2	Partial Hold - CMS Request	L3	WO		**L3**	Penalty	PW CMS Request
56	G3	Partial Hold - Bankruptcy	L3	WO		**L3**	Penalty	PW Bankruptcy
57	G4	Partial Hold - Unfiled Cost Report	L3			**L3**	Penalty	PW Unfiled Cost Report
58	G5	Partial Hold - Unfiled 838	L3			**L3**	Penalty	Unfiled 838 (Credit Balance Report)
59	H1	Manual Invoices - Cost Settlement Report	C5			**C5**	Temporary Allowance	Cost Report Settlement
60	HB	HPSA	E3	B2		**BN**	Bonus	HPSA Bonus
61	HR	Payment Suspension Full Hold Release				**L3**	Penalty	CR13177

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	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**
62	IM	Innovation Model				**IP/WO**	/Overpayment Recovery	CR9744
63	IR	TPP - IRS Levy	IR	WO		**IR**	Internal Revenue Service Withholding	
64	L1	TPP - IRS Backup	IR	WO		**IR**	Internal Revenue Service Withholding	
65	L2	TPP - Garnishments	WU	WO		**CS**	Adjustment	PW Garnishments
66	L3	Third Party Payment - including Attorneys, IRSBW payee, CMSHQ payee, Providers, and Beneficiaries	Internal Use Only	Internal Use Only		**_**		No RA
67	L4	TPP - Child Support	WU	WO		**CS**	Adjustment	PW Child Support
68	L5	TPP - Alimony	WU	WO		**CS**	Adjustment	PW Alimony
69	L6	TPP - Secondary Corporation	WU	WO		**CS**	Adjustment	PW Secondary Corporation
70	L7	TPP - Change of Ownership	WU	WO		**CS**	Adjustment	Change of Ownership
71	L8	Accelerated/Advance Recoupments Applications	AP	WO		**WO**	Overpayment Recovery	Advance Recoupment Application
72	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
73	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
74	M1	Manual Invoices - Refunds	72	B2		**72**	Authorized return	Refunds - Manual Invoices
75	M4	Manual Invoices - Other	C5	B2		**C5**	Temporary Allowance	Manual Invoices
76	MA	Manual Invoices - Accelerated/Advance Payment	AP	B2		**AP**	Acceleration of Benefits	Manual Invoices - Accelerated/Advance Payment
77	MB	Manual Invoices – Hospice CAP Settlement				**C5**	Temporary Allowance	CR11621
78	MC	Manual Invoices - PIP	PI			**PI**	Periodic Interim Payment	
79	ML	Manual Invoices - Interim Rate Review	C5			**C5**	Temporary Allowance	Interim Rate Review
80	N1	Non-Provider Convener Participant - BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
81	N2	Non-Provider Awardee Convener Model 2 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
82	N3	Non-Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
83	N4	Non-Provider Awardee Convener Model 4 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
84	NA	Manual Non Claim Invoices - HI Positive Distribution	Internal Use Only			**_**		No RA
85	NB	Manual Non Claim Invoices - HI Negative Distribution	Internal Use Only			**_**		No RA
86	NC	Manual Non Claim Invoices - SMI Positive Distribution	Internal Use Only			**_**		No RA
87	ND	Manual Non Claim Invoices - SMI Negative Distribution	Internal Use Only			**_**		No RA
88	NR	Manual Invoices - PT	C5			**C5**	Temporary Allowance	
89	P1	Single Participant – BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
90	P2	Provider Awardee Convener Model 2 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440

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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
91	P3	Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators				LE/WU	Levy/Unspecified Recovery	CR8440
92	P4	Provider Awardee Convener Model 4 BPCI Transaction (owns SOME or ALL Episode Initiators				LE/WU	Levy/Unspecified Recovery	CR8440
93	PA	Partial Hold – Admin Freeze				L3		PW Admin Freeze
94	PI	Pennsylvania Rural Health Model				PI	Periodic Interim Payment	CR10018
95	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
96	PO	Partial Hold - Other/Misc/ PSC Request	L3	WO		L3	Penalty	PW Other/Misc/PSC Request
97	PP	PIP	PI			PI	Periodic Interim Payment	
98	PR	Partial Hold - Release	L3	B2		L3	Penalty	PR Penalty Release
99	RH	Full Hold - Revalidation Hold						No RA
100	RD	Rural Emergency Hospital (REH) Payment				CS	Adjustment	CR12820
101	RU	Interest Refund				L6	Interest Owed	
102	S1	Single Awardee Model 1 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
103	S2	Single Awardee Model 2 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
104	S3	Single Awardee Model 3 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
105	S4	Single Awardee Model 4 BPCI Transaction				LE/WU	Levy/Unspecified Recovery	CR8440
106	SH	Payment Suspension Full Hold				L3	Penalty	CR13177
107	TD	Manual Invoices - Tentative Settlement	C5			C5	Temporary Allowance	Tentative Settlement
108	TL	TOPS	IS			IS	Interim Settlement	
109	UH	Beneficiary Undeliverable Full Hold						No RA
110	VC	Voids - Reissue Invoices	CS	Internal Use Only		CS	Adjustment	Reissued Invoice
111	VD	Voids - Reissue Debit Memo	CS	WO?		CS	Adjustment	Reissued Debit Memo
112	VO	Void - Reissue Interest Information	CS			CS	Adjustment	Reissued Interest
113	WO	AR/AP Netting Offset	E3	WO		WO	Overpayment Recovery	AR/AP Netting
114	WR	Void - Reissue Split Pay	C5			C5	Temporary Allowance	Reissue Split Pay
115	WS	Settlement Withholding	L3			E3	Withholding	Settlement Withholding
116	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
117	WW	Principal Refund				WO	Overpayment Recovery	The amount in PLB 04 should be negative. And include identifying nos. in PLB03-2
118	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

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				NON-HIGLAS USERS				
119				AP		**AP**	Acceleration of Benefits	Advance Payment
120					CS	**–**		Correction and Reversal at the claim/line level
121				FB		**FB**	Forward Balance	Over Payment
122					CS	**FB/WO**	Withholding	Follow CR 6870 - for using FB and WO at step I and Step II for 935 Recoupment
123					IR	**IR**	Internal Revenue Service Withholding	
124				J1		**J1**	Non-reimbursable	Adjustment per Demonstration Project
125					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
126				L6	L6	**L6**	Interest Owed	Interest paid on claims in this 835
127					WO	**WO**	Overpayment Recovery	AR/AP Netting
				ADD-ON-PAYMENTS				
128			CS			**CS**		Outlier
129			CS			**CS/HM**		Hemo. HM is a new code available in 5010
130			CS			**CS**		New Technology
131			LS			**LS**		Indirect Medical Education

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

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<tr><th>Version</th><th>Comments</th></tr>
<tr><td>1.0</td><td>Changes for HIGLAS PLB Codes AP & AQ for CR 11729.</td></tr>
<tr><td>2.0</td><td>Changes for HIGLAS PLB Codes PA & PO for CR 11930.</td></tr>
<tr><td>3.0</td><td>Corrections as follows:
Updated Code Meaning for PLB Codes C1, E1, N1, P1 for CR 11110.
Removed HIGLAS PLB Code IP for CR 11760.
Removed HIGLAS PLB Codes H2, M2 and M3.
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