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| CMS Manual System | Department of Health & Human Services (DHHS) |
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 4271 | Date: March 29, 2019 |
| | Change Request 11188 |

SUBJECT: Update to the Internet-Only-Manual (IOM) Publication (Pub.) 100-04, Chapters 1 and 3

I. SUMMARY OF CHANGES: This Change Request (CR) updates Payer Only Codes in Pub. 100-04, Chapter 1 and corrects Chapter 3, Section 90.3 by removing a duplicate section.

EFFECTIVE DATE: April 29, 2019

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: April 29, 2019

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 | 1/190/Payer Only Codes Utilized by Medicare |
| R | 3/90.3.1/Billing for Stem Cell Transplantation |
| R | 3/90.3.2/Autologous Stem Cell Transplantation (AuSCT) |
| D | 3/90.3.3 - Billing for Stem Cell Transplantation |

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: 4271 | Date: March 29, 2019 | Change Request: 11188 |
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EFFECTIVE DATE: April 29, 2019

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IMPLEMENTATION DATE: April 29, 2019

I. GENERAL INFORMATION

A. Background: This Change Request (CR) updates Payer Only Codes utilized by Medicare in chapter 1 of Pub. 100-04, Medicare Claims Processing Manual. In Addition, CMS identified section 90.3.3 as a duplicate of section 90.3.1 in chapter 3.

B. Policy: There is no change in policy. This CR updates Payer Only Value codes in chapter 1 and removes the duplicate section 90.3.3 in chapter 3.

II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | | |
|---------|--|----------------|---|-------------|-------------|---------------------------|------------------|-------------|-------------|-------|--|
| | | A/B MAC | | | D M E | Shared-System Maintainers | | | | Other | |
| | | A | B | H H H | | F M V C | M I C S | V M S | C W F | | |
| 11188.1 | Contractors shall note the revisions made to Pub 100-04, Chapter 1, Section 190 and Chapter 3, Section 90.3. | X | | | | | | | | | |

III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | | |
|--------|-------------|----------------|---|-------------|-------------|------------------|-------------|
| | | A/B MAC | | | D M E | C E D I | |
| | | A | B | H H H | | | M A C |
| | None | | | | | | |

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---------------------------------|--|
| | CR9570 - Payer Only VC for Islet isolation cell transplantation |
| | CR 10065 - Payer Only VC for Transitional Drug Add-on Payment Adjustment |

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: 0

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev. 4271, Issued: 03-29-19)

[90.3.1 - *Allogeneic*](#) Stem Cell Transplantation

90.3.1 – *Allogeneic* Stem Cell Transplantation

(Rev. 4271, Issued: 03-29-19, Effective: 04-29-19, Implementation: 04-29-19)

A. Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-admission/pre-procedure donor evaluation services;
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);
- Post-operative/post-procedure evaluation of donor; and
- Preparation and processing of stem cells.

Payment for these acquisition services is included in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting, and in the OPPS APC payment for the allogeneic stem cell transplant when the transplant occurs in the outpatient setting. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, chapter 4, §231.10 and paragraph B of this section for information regarding billing for autologous stem cell transplants).

B. Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, chapter 4, §231.11 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the outpatient setting.

When the allogeneic stem cell transplant occurs in the inpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately by using revenue code 0815 (Stem Cell Acquisition). Revenue code 0815 charges should include all services required to acquire stem cells from a donor, as defined above.

On the recipient's transplant bill, the hospital reports the acquisition charges, cost report days, and utilization days for the donor's hospital stay (if applicable) and/or charges for other encounters in which the stem cells were obtained from the donor. The donor is covered for medically necessary inpatient hospital days of care

or outpatient care provided in connection with the allogeneic stem cell transplant under Part A. Expenses incurred for complications are paid only if they are directly and immediately attributable to the stem cell donation procedure. The hospital reports the acquisition charges on the billing form for the recipient, as described in the first paragraph of this section. It does not charge the donor's days of care against the recipient's utilization record. For cost reporting purposes, it includes the covered donor days and charges as Medicare days and charges.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

The hospital shows charges for the transplant itself in revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

90.3.2 - Autologous Stem Cell Transplantation (AuSCT)

(Rev. 4271, Issued: 03-29-19, Effective: 04-29-19, Implementation: 04-29-19)

A. - General

Autologous stem cell transplantation (AuSCT) is a technique for restoring stem cells using the patient's own previously stored cells. AuSCT must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

If ICD-9-CM is applicable, use the following Procedure Codes and Descriptions

| ICD-9-CM Code | Description |
|----------------------|---|
| 41.01 | Autologous bone marrow transplant without purging |
| 41.04 | Autologous hematopoietic stem cell transplant without purging |
| 41.07 | Autologous hematopoietic stem cell transplant with purging |
| 41.09 | Autologous bone marrow transplant with purging |

If ICD-10-PCS is applicable, use the following Procedure Codes and Descriptions -

| ICD-10-PCS Code | Description |
|------------------------|--|
| 30230AZ | Transfusion of Embryonic Stem Cells into Peripheral Vein, Open Approach |
| 30230G0 | Transfusion of Autologous Bone Marrow into Peripheral Vein, Open Approach |
| 30230Y0 | Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Open Approach |
| 30233G0 | Transfusion of Autologous Bone Marrow into Peripheral Vein, Percutaneous Approach |
| 30233Y0 | Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach |

| ICD-10-PCS Code | Description |
|------------------------|--|
| 30240G0 | Transfusion of Autologous Bone Marrow into Central Vein, Open Approach |
| 30240Y0 | Transfusion of Autologous Bone Marrow into Central Vein, Open Approach |
| 30243G0 | Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach |
| 30243Y0 | Transfusion of Autologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach |
| 30250G0 | Transfusion of Autologous Bone Marrow into Peripheral Artery, Open Approach |
| 30250Y0 | Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Artery, Open Approach |
| 30253G0 | Transfusion of Autologous Bone Marrow into Peripheral Artery, Percutaneous Approach |
| 30253Y0 | Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Artery, Percutaneous Approach |
| 30260G0 | Transfusion of Autologous Bone Marrow into Central Artery, Open Approach |
| 30260Y0 | Transfusion of Autologous Hematopoietic Stem Cells into Central Artery, Open Approach |
| 30263G0 | Transfusion of Autologous Bone Marrow into Central Artery, Percutaneous Approach |
| 30263Y0 | Transfusion of Autologous Hematopoietic Stem Cells into Central Artery, Percutaneous Approach |

B. - Covered Conditions

1. Effective for services performed on or after April 28, 1989:

For acute leukemia in remission for patients who have a high probability of relapse and who have no human leucocyte antigens (HLA)-matched, the following diagnosis codes are reported:

If ICD-9-CM is applicable, use the following Diagnosis Codes and Descriptions

| Diagnosis Code | Description |
|-----------------------|--|
| 204.01 | Lymphoid leukemia, acute, in remission |
| 205.01 | Myeloid leukemia, acute, in remission |
| 206.01 | Monocytic leukemia, acute, in remission |
| 207.01 | Acute erythremia and erythroleukemia, in remission |
| 208.01 | Leukemia of unspecified cell type, acute, in remission |

If ICD-10-CM is applicable, use the following Diagnosis Codes and Descriptions -

| Diagnosis Code | Description |
|-----------------------|--|
| C91.01 | Acute lymphoblastic leukemia, in remission |
| C92.01 | Acute myeloblastic leukemia, in remission |
| C92.41 | Acute promyelocytic leukemia, in remission |
| C92.51 | Acute myelomonocytic leukemia, in remission |
| C92.61 | Acute myeloid leukemia with 11q23-abnormality in remission |
| C92.A1 | Acute myeloid leukemia with multilineage dysplasia, in remission |
| C93.01 | Acute monoblastic/monocytic leukemia, in remission |
| C94.01 | Acute erythroid leukemia, in remission |
| C94.21 | Acute megakaryoblastic leukemia, in remission |
| C94.41 | Acute parmyelosis with myelofibrosis, in remission |
| C95.01 | Acute leukemia of unspecified cell type, in remission |

For resistant non-Hodgkin's lymphomas or those presenting with poor prognostic features following an initial response the following diagnosis codes are reported:

If ICD-9-CM is applicable, use the following code ranges:

200.00 - 200.08,
 200.10 - 00.18,
 200.20 - 200.28,
 200.80 - 200.88,
 202.00 - 202.08,
 202.80 - 202.88, and
 202.90 - 202.98.

If ICD-10-CM is applicable use the following code ranges:

C82.00 - C85.29,
 C85.80 - C86.6,
 C96.4, and
 C96.Z - C96.9.

For recurrent or refractory neuroblastoma (see ICD-9-CM Neoplasm by site, malignant for the appropriate diagnosis code)

If ICD-10-CM is applicable the following ranges are reported:

C00 - C96, and
 D00 - D09 Resistant non-Hodgkin's lymphomas

For advanced Hodgkin's disease patients who have failed conventional therapy and have no HLA-matched donor the following diagnosis codes are reported:

If ICD-9-CM is applicable, 201.00-201.98.

If ICD-10-CM is applicable, C81.00 - C81.99.

2. Effective for services performed on or after October 1, 2000:

Durie-Salmon Stage II or III that fit the following requirement are covered: Newly diagnosed or responsive multiple myeloma (if ICD-9-CM is applicable, diagnosis codes 203.00 and 238.6, and, if ICD-10-CM is applicable, diagnosis codes C90.00 and D47.Z9). This includes those patients with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50% decrease either in measurable paraprotein [serum and/or urine] or in bone marrow infiltration, sustained for at least 1 month), and those in responsive relapse, and adequate cardiac, renal, pulmonary, and hepatic function.

3. Effective for Services On or After March 15, 2005

Effective for services performed on or after March 15, 2005, when recognized clinical risk factors are employed to select patients for transplantation, high-dose melphalan (HDM), together with AuSCT, in treating Medicare beneficiaries of any age group with primary amyloid light-chain (AL) amyloidosis who meet the following criteria:

- Amyloid deposition in 2 or fewer organs ; and,
- Cardiac left ventricular ejection fraction (EF) of 45% or greater.

C. - Noncovered Conditions

Insufficient data exist to establish definite conclusions regarding the efficacy of autologous stem cell transplantation for the following conditions:

- Acute leukemia not in remission:
 - If ICD-9-CM is applicable, diagnosis codes 204.00, 205.00, 206.00, 207.00 and 208.00 are noncovered;
 - If ICD-10-CM is applicable, diagnosis codes C91.00, C92.00, C92.40, C92.50, C92.60, C92.A0, C93.00, C94.00, and C95.00 are noncovered.
- Chronic granulocytic leukemia:
 - If ICD-9-CM is applicable, diagnosis codes 205.10 and 205.11;
 - If ICD-10-CM is applicable, diagnosis codes C92.10 and C92.11.
- Solid tumors (other than neuroblastoma):
 - If ICD-9-CM is applicable, diagnosis codes 140.0-199.1;
 - If ICD-10-CM is applicable, diagnosis codes C00.0 - C80.2 and D00.0 - D09.9.
- Multiple myeloma (ICD-9-CM codes 203.00 and 238.6), through September 30, 2000.
- Tandem transplantation (multiple rounds of autologous stem cell transplantation) for patients with multiple myeloma
 - If ICD-9-CM is applicable, diagnosis codes 203.00 and 238.6 and,
 - If ICD-10-CM is applicable, diagnosis codes C90.00 and D47.Z9)
- Non-primary (AL) amyloidosis,

- If ICD-9-CM is applicable, diagnosis code 277.3. Effective October 1, 2000; ICD-9-CM code 277.3 was expanded to codes 277.30, 277.31, and 277.39 effective October 1, 2006.
- If ICD-10-CM is applicable, diagnosis codes are E85.0 - E85.9. or
- Primary (AL) amyloidosis
 - If ICD-9-CM is applicable, diagnosis codes 277.30, 277.31, and 277.39 and for Medicare beneficiaries age 64 or older, effective October 1, 2000, through March 14, 2005.
 - If ICD-10-CM is applicable, diagnosis codes are E85.0 - E85.9.

NOTE: Coverage for conditions other than these specifically designated as covered or non-covered is left to the discretion of the A/B MAC (A).

D. Billing for Autologous Stem Cell Transplantation (AuSCT)

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, in revenue center code 0362 or another appropriate cost center. ICD-9-CM or ICD-10-PCS codes are used to identify inpatient procedures.

The HCPCS codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the OPSS when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in Pub. 100-04, chapter 4, §231.11 and section 90.3.1-A above for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant. The HCPCS codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPSS when provided to hospital outpatients.

Payment for autologous stem cell harvesting procedures performed in the hospital inpatient setting of care, with transplant also occurring in the inpatient setting of care, is included in the MS-DRG payment for the autologous stem cell transplant.

190 – Payer Only Codes Utilized by Medicare

(Rev. 4271, Issued: 03-29-19, Effective: 04-29-19, Implementation: 04-29-19)

This section contains the listing of payer codes designated by the National Uniform Billing Committee to be assigned by payers only. Providers shall not submit these codes on their claims forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Condition Codes

12-14 - Not currently used by Medicare.

15 – Clean claim is delayed in CMS Processing System.

16 – SNF Transition exception.

60 – Operating Cost Day Outlier.

61 – Operating Cost Outlier.

62 – PIP Bill.

63 – Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment.

64 – Other Than Clean Claim.

65 – Non-PPS Bill.

98 – Data Associated With DRG 468 Has Been Validated.

EY – Lung Reduction Study Demonstration Claims.

M0 – All-Inclusive Rate for Outpatient - Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

M1 – Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.

M2 – Allows Home Health claims to process if provider reimbursement > \$150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.

M3 – SNF 3 Day stay bypass for NG/Pioneer ACO waiver.

M4 – Presence of infected wound or wound with morbid obesity

M5 – Not currently used by Medicare

M6 – PA Rural Health Model

M7-M9 – Not currently used by Medicare.

MA – GI Bleed. *(Bill Type 72x)*

MA – Managed Care Enrollee (Bill Type 12x, 13x, and 76x)

MB – Pneumonia. (Bill Type 72x)

MC – Pericarditis. (Bill Type 72x)

MD - Myelodysplastic Syndrome. (Bill Type 72x)

ME - Hereditary Hemolytic and Sickle Cell Anemia. (Bill Type 72x)

MF - Monoclonal Gammopathy. (Bill Type 72x)

MG – Grandfathered Tribal Federally Qualified Health Centers.

MH-MO – Not currently used by Medicare.

MP – PHP claim contains initial admit week

MQ – PHP claim contains final discharge week

MR-MW – Not currently used by Medicare.

MX – Wrong Surgery on Patient (Inpatient)

MY – Surgery Wrong Body Part (Inpatient)

MY – Outlier Cap Bypass (CMHC)

MZ – Surgery Wrong Patient (Inpatient)

MZ – IOCE error code bypass

UU – Not currently used by Medicare.

Occurrence Codes

23 - Date of Cancellation of Hospice Election period.

48 - Date hospice face-to-face encounter was untimely

49 – Original Notice of Election (NOE) receipt date

Occurrence Span Codes

79 - Verified non-covered stay dates for which the provider is liable.

Value Codes

17- Operating Outlier Amount – The A/B MAC (A) reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.

18 – Operating Disproportionate Share Amount – The A/B MAC (A) REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICIALBE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

19 – The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider’s reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

19 - Operating Indirect Medical Education Amount – The A/B MAC (A) reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.

20 – Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

62 – On Type of Bill 032x: HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

On Type of Bills 081x Or 082x: Number of High Routine Home Care Days - Days that fall within the first 60 days of a routine home care hospice claim.

63 – On Type of Bill 032x: HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

On Type of Bills 081x Or 082x: Number of Low Routine Home Care Days - Days that come after the first 60 days of a routine home care hospice claim.

63 – On Type of Bills 081x Or 082x: Number of Low Routine Home Care Days - Days that come after the first 60 days of a routine home care hospice claim.

64 - HH Reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

65 - HH Reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

70 - Interest Amount - The contractor reports the amount of interest applied to this Medicare claim.

71 - Funding of ESRD Networks - The A/B MAC (A) reports the amount the Medicare payment was reduced to help fund ESRD networks.

72- Flat Rate Surgery Charge - The standard charge for outpatient surgery where the provider has such a charging structure.

73- Sequestration adjustment amount.

74 – Low volume hospital payment amount

75- Prior covered days for an interrupted stay.

76 – Provider’s Interim Rate –Provider’s percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00.

77 - Medicare New Technology Add-On Payment - Code indicates the amount of Medicare additional payment for new technology.

78 – *Off-site Zip Code* - When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, 81X, 82X, and 85X. The ZIP code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

79 – *Total payments for services applicable to the ESRD* - The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Q0 – *Pioneer Accountable Care Organization (ACO) non-model payment or Next Generation ACO non-model payment*

Q1 – *Pioneer ACO model payment amount including reduction or NG ACO payment amount including reduction*

Q2 – Hospice claim paid from Part B Trust Fund

Q3 – Prior Authorization 25% Penalty

Q4 – *PA Rural Model Exclusion - Physician Service Claim Reimbursement*

Q5 – EHR

Q6 – PQRS

Q7 – *Islet Isolation Add-on payment amount*

Q8 – *Transitional Drug Add-On Payment Adjustment (TDAPA)*

Q9 – Medicare Performance Adjustment (MPA)

QA-QC – Not used by Medicare

QD – Device Credit

QE-QL – Not used by Medicare

QM – MIPS adjustment amount

QN – First APC pass-through device offset

QO – Second APC pass-through device offset

QP – Third APC pass-through device offset

QQ – Terminated procedure with device offset

QR – First APC pass-through drug or biological offset

QS – Second APC pass-through drug or biological offset

QT – Third APC pass-through drug or biological offset

QU – Device credit with device offset

QV – Value-based purchasing adjustment amount

QW – Placeholder reserved for future use

QX-QZ – Not used by Medicare