

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10186	Date: June 19, 2020
	Change Request 11820

SUBJECT: Updates to Chapter 1, Payer Only Codes in the Medicare Claims Processing Manual

I. SUMMARY OF CHANGES: This Change Request removes condition codes 60 and 61 from the payer only code list.

EFFECTIVE DATE: July 21, 2020

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

IMPLEMENTATION DATE: July 21, 2020

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	4/190 – Payer Only Codes Utilized by Medicare

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: 10186	Date: June 19, 2020	Change Request: 11820
-------------	--------------------	---------------------	-----------------------

SUBJECT: Updates to Chapter 1, Payer Only Codes in the Medicare Claims Processing Manual

EFFECTIVE DATE: July 21, 2020

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

IMPLEMENTATION DATE: July 21, 2020

I. GENERAL INFORMATION

A. Background: This Change Request (CR) makes updates to Chapter 1, Payer Only Codes Utilized by Medicare in Pub. 100-04, Medicare Claims Processing Manual.

B. Policy: This CR contains no policy changes.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
11820.1	Medicare contractors shall be aware of the corrections to Pub. 100-04 contained in this Change Request.	X								

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
--------------------------------	--

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

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@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

190 – Payer Only Codes Utilized by Medicare

(Rev.10186, Issued: 06-19-2020, Effective: 07-21-2020, Implementation: 07-21-2020)

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.

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 072x)

MA – Managed Care Enrollee (Bill Type 012x, 013x, and 076x)

MB – Pneumonia. (Bill Type 072x)

MC – Pericarditis. (Bill Type 072x)

MD – Myelodysplastic Syndrome. (Bill Type 072x)

ME – Hereditary Hemolytic and Sickle Cell Anemia. (Bill Type 072x)

MF – Monoclonal Gammopathy. (Bill Type 072x)

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-MU – Not currently used by Medicare.

MV – 20 hours for partial PHP subsequent week not met

MW – 20 hours for partial PHP initial week net met

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 (Outpatient)

UU – Not currently used by Medicare.

Occurrence Codes

23 – Date of Cancellation of Hospice Election period.

48 – Not currently used by Medicare.

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 – Outpatient Use. 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 – Inpatient Use. 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.

62 – 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.

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: 012X, 013X, 014X, 022X, 023X, 034X, 072X, 074X, 075X, 081X, 082X, and 085X. 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

Q9 - Medicare Performance Adjustment (MPA)

QA – PHP partial week input

QB-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 – PHP partial week output

QX-QZ – Not used by Medicare