CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11836	**Date: February 2, 2023**
	Change Request 13052

SUBJECT: New Biweekly Interim Payments for Domestic N95 Respirator Procurement Cost Reimbursement

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to prepare the claims processing system for new bi-weekly interim payments for domestic N95 respirator procurement cost reimbursement.

EFFECTIVE DATE: January 1, 2023 - Effective for cost reporting periods beginning on or after January 1, 2023.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2023

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: 11836	Date: February 2, 2023	Change Request: 13052

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I. GENERAL INFORMATION

A. Background: Payment Adjustment Amounts under the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) for Domestic National Institute for Occupational Safety and Health (NIOSH)-approved Surgical N95 Respirators

The Centers for Medicare & Medicaid Services (CMS) established new payment adjustments under the OPPS and IPPS for the additional resource costs that hospitals face in procuring domestic NIOSH-approved surgical N95 respirators for cost reporting periods beginning on or after January 1, 2023. This payment adjustment is codified in the regulations at § 412.113(f) for the IPPS and § 419.43(j) for the OPPS. These payment adjustments are based on the estimated difference in the reasonable cost incurred by the hospital for domestic NIOSH-approved surgical N95 respirators purchased during the cost reporting period as compared to other NIOSH-approved surgical N95 respirators purchased during the cost reporting period. In order to calculate the payment adjustment for each eligible cost reporting period, we are creating a new supplemental cost reporting form that will collect from hospitals additional information to be used along with other information already collected on the hospital cost report to calculate the IPPS and OPPS payment adjustment amounts.

In order for the domestic NIOSH-approved surgical N95 respirators purchased during a cost reporting period to be reimbursable by Medicare, it must be wholly made in the United States. That is, based on the Berry Amendment, the respirator and all of its components are grown, reprocessed, reused, or produced in the United States. In the CY 2023 OPPS/ASC final rule (CMS-1772-FC), we indicated that a hospital may rely on a written statement from the manufacturer stating that the NIOSH-approved surgical N95 respirator the hospital purchased is domestic under our definition. The written statement must have been certified by 1 of the following:

- The manufacturer's Chief Executive Officer (CEO)
- The manufacturer's Chief Operating Officer (COO)
- An individual who has delegated authority to sign for, and who reports directly to, the manufacturer's CEO or COO

The written statement, or a copy of such statement, could be obtained by the hospital directly from the manufacturer, obtained through the supplier or Group Purchasing Organization (GPO) for the hospital who obtained it from the manufacturer, or obtained by the hospital because it was included with or printed on the packaging by the manufacturer. This written statement may be required to substantiate the data you included on the supplemental cost reporting form. (For additional information refer to the Calendar Year (CY) 2023 OPPS/ASC (Ambulatory Surgical Center) final rule).

Under the finalized policy, we also indicated that these payments would be provided biweekly as interim lump-sum payments to the hospital and reconciled at cost report settlement for cost reporting periods beginning on or after January 1, 2023. Any IPPS and or OPPS provider can make a request for these

biweekly interim lump sum payments for an applicable cost reporting period, as provided under 42 Code of Federal Regulations (CFR) 413.64 (Payments to providers: Specific rules) and 42 CFR 412.116(c) (Special interim payments for certain costs). These payment amounts shall be determined by the Medicare Administrative Contractor (MAC), consistent with existing policies and procedures for biweekly payments (for example, consistent with the current policies for medical education costs, and bad debts for uncollectible deductibles and coinsurance, which are paid on interim biweekly basis as described in CMS Pub 15-1 2405.2). Initially, MACs can determine an interim lump-sum biweekly payment, based on information the hospital provides that reflects the information that will be included on the N95 supplemental cost reporting form. In the future, MACs will determine the interim biweekly lump-sum payments utilizing information from the prior year's surgical N95 supplemental cost reporting form, which may be adjusted as appropriate based on the most current information available.

B. Policy: This payment adjustment is codified in the regulations at § 412.113(f) for the IPPS and § 419.43(j) for the OPPS.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13052.1	The CMS inpatient Provider Specific File (PSF) record shall be expanded to include a 9-byte field to carry the Pass Through Amount for Domestic N95 Respirator Procurement and shift filler down as follows: Data Element: 68 • File position: 298-306 • Format: 9(7)V99 • Title: Pass Through Amount for Domestic N95 Respirator Procurement • Description: Enter the per diem amount based on the interim payments to the hospital. Include payment adjustments for the additional cost for procurement of wholly domestically made NIOSH-approved surgical N95 respirators. Data element: 69 • File position: 307-310 • Format: X(4) • Title: Filler									CMS, IDR

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13052.2	The Shared System Maintainer (SSM) shall add a 9-byte field to the inpatient PSF record to carry the Pass Through Per Diem Amount for Domestic N95 Respirator Procurement.					X				IDR
13052.2.1	The SSM shall create the following maintenance edits on the new field in business requirement 13052.2: • The new field shall be numeric. • The new field shall be zero if the fiscal year begin date is less than January 1, 2023.					X				
13052.2.2	The SSM shall pass the new Pass Through Amount for Domestic N95 Respirator Procurement field to the Java/Cloud IPPS Pricer.					X				
13052.2.3	The Java/Cloud IPPS Pricer shall accept the new field for Pass Through Amount for Domestic N95 Respirator Procurement.									IPPS Pricer
13052.2.4	The Java/Cloud IPPS Pricer Client Application Programming Interface (API) shall be updated to include the new field for Pass Through Amount for Domestic N95 Respirator Procurement.					X				IPPS Pricer
13052.3	The Medicare contractors shall enter the per diem amount based on the interim payments to the hospital for domestic N95 respirator procurement pass through amount in new data element 68 in the inpatient PSF, for hospitals receiving Inpatient Prospective Payment System (IPPS) with a cost reporting period beginning on or after January 1, 2023. Note: Include payment adjustments for the additional cost for procurement of wholly domestically made NIOSH-approved surgical N95 respirators.	X								
13052.3.1	The Medicare Contractors shall include the per diem amount for domestic N95 respirator procurement pass through in data element 42, file position 179-184 Total Pass Through Amount, Including Miscellaneous field of the PSF.	X								
13052.4	The SSM shall report the Periodic Interim Payments (PIP)/NON PIP Domestic N95 Respirator Procurement Pass Through Payment with Payment					X				HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Types 'AT' – 'PIP Domestic N95 Respirator Procurement' and 'AV' – 'Non-PIP Domestic N95 Respirator Procurement' 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 activate Payment Type 'AT', 'AV'. Note: Please refer to PLB Codes Mapping v5.0 attachment.									
13052.5	HIGLAS shall process the PIP/Non-PIP Domestic N95 Respirator Procurement Pass Through Non-Claim and issue payment with Part A Trust Fund.									HIGLAS
13052.6	HIGLAS shall define the following new Sub Invoice Types for the Pass Through payment types 'AT' & 'AV': • 'AT_PIP N95 PROCUREMENT PT' • 'AV_NON PIP N95 PROCUREMENT PT'									HIGLAS
13052.7	HIGLAS shall report the PIP/NON PIP Domestic N95 Respirator Procurement payments as below: • HIGLAS Provider Level Balance (PLB) Code 'AT' – 'PIP Domestic N95 Respirator Procurement PT' • HIGLAS PLB Code 'AV' – 'NON PIP Domestic N95 Respirator Procurement PT' on the HIGLAS 835 Interface.									HIGLAS
13052.8	The SSM shall make necessary programming changes 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 Domestic N95 Respirator Procurement pass through payment as PLB Code 'LS'. The payments shall MAP to the Standard Paper Remittance (SPR) and PC-print in a new line 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.									
13052.9	The SSM shall modify reports to include the addition of the Domestic N95 Respirator Procurement Pass Through payment.					X				
13052.9.1	The HIGLAS shall ensure the Intermediary Benefit Payment Report (IBPR) reports the pass through amounts as PIP and Non-PIP for the new Domestic N95 Respirator Procurement Pass Through Amount mapping.									HIGLAS
13052.10	The SSM shall modify the Financial Master screens (MAP07906, and MAP07907) and editing to accommodate a new Domestic N95 Respirator Procurement pass through dates and amounts.					X				
13052.10.1	The Medicare Contractors shall utilize the new PIP/Pass Through Payment and Rates fields added to the financial master screens (MAP07906, MAP07907) to enter the interim payment amounts and effective date(s) for the total combined IPPS and/or OPPS Domestic N95 Respirator Procurement pass through payments.	X								
13052.11	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)					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Note: A provider shall be considered PIP if the PIP payment is greater than 0.									
13052.12	Since the Medicare Integrated Systems Testing (MIST) contractor does not interface with HIGLAS, Medicare contractors shall test HIGLAS interface business requirements (13052.4, 13052.5, 13052.6 and 13052.7, 13052.11).	X								
13052.13	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 N95 supplemental cost reporting form. Refer to the Calendar Year (CY) 2023 OPPS/ASC (Ambulatory Surgical Center) final rule 87, (FR 72045), Table 70: Mock N95 Supplemental Cost Reporting Form. The providers may submit a similar type worksheet/form in order to receive interim payments. In the future, MACs shall determine the interim biweekly lump-sum payments utilizing information from the prior year's surgical N95 supplemental cost reporting form, which may be adjusted as appropriate based on the most current information available needed for rate reviews, as consistent with the current rate review procedures for medical education costs, bad debts for uncollectible deductibles and coinsurance and other pass thru costs.	X								
13052.14	The Medicare Contractors shall utilize the "Other" rate type field in the System for Tracking Audit and Reimbursement (STAR) for the domestic N95 respirator procurement supplemental cost review.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13052.15	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X				

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Yvette Rivas, yvette.rivas@cms.hhs.gov (for claims processing questions) , Ayub Ibrahim, Ayub.Ibrahim@cms.hhs.gov (for policy related questions)

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

VI. FUNDING

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

ATTACHMENTS: 1

Addendum A - Provider Specific File

(Rev.11836; Issued:02-02-23; Effective: 01-01-23;) Implementation:07-03-23)

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

Data Element	File Position	Format	Title	Description
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Reserved 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (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

Data Element	File Position	Format	Title	Description
				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 24 Rural Emergency Hospitals 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Free-standing Opioid Treatment Program 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 payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to

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

Data Element	File Position	Format	Title	Description
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. Eff. 10/1/12, MDHs are no longer valid provider types.
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
17	74	X(1)	Temporary Relief Indicator	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a "Y" if the provider is considered "low volume." **IPF PPS**: Effective January 1, 2005, code a "Y" if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a "Y" for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage **LTCH PPS:** Effective 04/21/16 through 12/31/16, code a 'Y' for an LTCH that is a grandfathered HwH (hospitals that are described in § 412.23(e)(2)(i) that currently meets the criteria of § 412.22(f)); and is located in a rural area or is reclassified rural by meeting the provisions outlined in §412.103, as set forth in the regulations at §412.522(b)(4).
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** 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: 1 — Federal % 20 — Facility% 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. 1 — Federal % 25 — Facility% 75 2 — Federal % 50 — Facility% 50 3 — Federal % 75 — Facility% 25 4 — Federal % 100 — Facility% 00
19	76-77	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code. List of valid state codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
20	78-80	X(3)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000. Note that effective 10/1/12, MDHs are no longer valid provider types.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
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

Data Element	File Position	Format	Title	Description
				for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
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. Include *pass through amount for Domestic N95 Respirator Procurement.* The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, DSH adjustments, or Allogeneic Stem Cell

Data Element	File Position	Format	Title	Description
				Acquisition. Zero-fill if this does not apply.
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A“08” is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard

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

Data Element	File Position	Format	Title	Description
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment (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 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.

Data Element	File Position	Format	Title	Description
66	286-291	9(4)V9(2)	Pass Through Amount for Direct 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 Domestic N95 Respirator Procurement*	*Enter the per diem amount based on the interim payments to the hospital. Include payment adjustments for the additional cost for 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 Domestic N95 Respirator Procurement PT				**LS**	Lump Sum	PIP Domestic N95 Respirator Procurement Cost (CR13052)
25	AV	NON PIP Domestic N95 Respirator Procurement PT				**LS**	Lump Sum	Non-PIP Domestic N95 Respirator Procurement Cost (CR13052)
26	AW	Affiliate Withholdings	E3			**E3**	Withholding	Affiliate Withholding

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
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	IM	Innovation Model				**IP/WO**	/Overpayment Recovery	CR9744

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
62	IR	TPP - IRS Levy	IR	WO		**IR**	Internal Revenue Service Withholding	
63	L1	TPP - IRS Backup	IR	WO		**IR**	Internal Revenue Service Withholding	
64	L2	TPP - Garnishments	WU	WO		**CS**	Adjustment	PW Garnishments
65	L3	Third Party Payment - including Attorneys	Internal Use Only	Internal Use Only		**_**		No RA
66	L4	TPP - Child Support	WU	WO		**CS**	Adjustment	PW Child Support
67	L5	TPP - Alimony	WU	WO		**CS**	Adjustment	PW Alimony
68	L6	TPP - Secondary Corporation	WU	WO		**CS**	Adjustment	PW Secondary Corporation
69	L7	TPP - Change of Ownership	WU	WO		**CS**	Adjustment	Change of Ownership
70	L8	Accelerated/Advance Recoupments Applications	AP	WO		**WO**	Overpayment Recovery	Advance Recoupment Application
71	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
72	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
73	M1	Manual Invoices - Refunds	72	B2		**72**	Authorized return	Refunds - Manual Invoices
74	M4	Manual Invoices - Other	C5	B2		**C5**	Temporary Allowance	Manual Invoices
75	MA	Manual Invoices - Accelerated/Advance Payment	AP	B2		**AP**	Acceleration of Benefits	Manual Invoices - Accelerated/Advance Payment
76	MB	Manual Invoices – Hospice CAP Settlement				**C5**	Temporary Allowance	CR11621
77	MC	Manual Invoices - PIP	PI			**PI**	Periodic Interim Payment	
78	ML	Manual Invoices - Interim Rate Review	C5			**C5**	Temporary Allowance	Interim Rate Review
79	N1	Non-Provider Convener Participant - BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
80	N2	Non-Provider Awardee Convener Model 2 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
81	N3	Non-Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
82	N4	Non-Provider Awardee Convener Model 4 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
83	NA	Manual Non Claim Invoices - HI Positive Distribution	Internal Use Only			**_**		No RA
84	NB	Manual Non Claim Invoices - HI Negative Distribution	Internal Use Only			**_**		No RA
85	NC	Manual Non Claim Invoices - SMI Positive Distribution	Internal Use Only			**_**		No RA
86	ND	Manual Non Claim Invoices - SMI Negative Distribution	Internal Use Only			**_**		No RA
87	NR	Manual Invoices - PT	C5			**C5**	Temporary Allowance	
88	P1	Single Participant – BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
89	P2	Provider Awardee Convener Model 2 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440
90	P3	Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440
91	P4	Provider Awardee Convener Model 4 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440

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

	HIGLAS PLB X-01 code	Code Meaning - HIGLAS	Previous FISS 835 PLB Code Usage	Previous MCS 835 PLB Code Usage	Previous VMS 835 PLB Code Usage	HIPAA PLB Codes for 835 v40101 and v5010 A1- PLB03-1	ASC X12 835 PLB Code Description	Comments
92	PA	Partial Hold – Admin Freeze				**L3**		PW Admin Freeze
93	PI	Pennsylvania Rural Health Model				**PI**	Periodic Interim Payment	CR10018
94	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
95	PO	Partial Hold - Other/Misc/ PSC Request	L3	WO		**L3**	Penalty	PW Other/Misc/PSC Request
96	PP	PIP	PI			**PI**	Periodic Interim Payment	
97	PR	Partial Hold - Release	L3	B2		**L3**	Penalty	PR Penalty Release
98	RH	Full Hold - Revalidation Hold						No RA
99	RD	Rural Emergency Hospital (REH) Payment				**CS**	Adjustment	CR12820
100	RU	Interest Refund				**L6**	Interest Owed	
101	S1	Single Awardee Model 1 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
102	S2	Single Awardee Model 2 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
103	S3	Single Awardee Model 3 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
104	S4	Single Awardee Model 4 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
105	TD	Manual Invoices - Tentative Settlement	C5			**C5**	Temporary Allowance	Tentative Settlement
106	TL	TOPS	IS			**IS**	Interim Settlement	
107	UH	Beneficiary Undeliverable Full Hold						No RA
108	VC	Voids - Reissue Invoices	CS	Internal Use Only		**CS**	Adjustment	Reissued Invoice
109	VD	Voids - Reissue Debit Memo	CS	WO?		**CS**	Adjustment	Reissued Debit Memo
110	VO	Void - Reissue Interest Information	CS			**CS**	Adjustment	Reissued Interest
111	WO	AR/AP Netting Offset	E3	WO		**WO**	Overpayment Recovery	AR/AP Netting
112	WR	Void - Reissue Split Pay	C5			**C5**	Temporary Allowance	Reissue Split Pay
113	WS	Settlement Withholding	L3			**E3**	Withholding	Settlement Withholding
114	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
115	WW	Principal Refund				**WO**	Overpayment Recovery	The amount in PLB 04 should be negative. And include identifying nos. in PLB03-2
116	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:
LE
TL
WU

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

Codes assigned to report
Federally mandated recoupment/bonus payment:
LE
TL
WU

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CHANGE LOG	
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.

Codes assigned to report
Federally mandated recoupment/bonus payment:
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