CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11729	**Date: December 6, 2022**
	Change Request 12820

Note: This Transmittal is no longer sensitive and is being re-communicated December 6, 2022. This instruction may now be posted to the Internet. Transmittal 11518, dated July 28, 2022, is being rescinded and replaced by Transmittal 11729, dated, December 6, 2022, to correct policy section final rule monthly REH facility payment language, and manual attachment regulatory definition of REHs. All other information remains the same.

SUBJECT: Implementation of Rural Emergency Hospital (REH) Provider Type

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to provide the background, policy, and contractor instructions to test and implement the enrollment, billing, and payment for Rural Emergency Hospitals, effective January 1, 2023.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 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
R	4/10/10.6.1 - TOC
D	4/10/10.6.4 - TOC
N	4/10/10.6.4 - Payment Adjustment for Rural Emergency Hospitals
R	4/50/50.1- Outpatient 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: 11729	Date: December 6, 2022	Change Request: 12820

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SUBJECT: Implementation of Rural Emergency Hospital (REH) Provider Type

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

I. GENERAL INFORMATION

A. Background: Section 125 of the Consolidated Appropriations Act, 2021 ("CAA, 2021"), Division CC establishes Medicare Payment for emergency hospital services, observation services, and other services as defined by the Secretary furnished by a Rural Emergency Hospital (REH) on or after January 1, 2023, by amending section 1861 of the Social Security Act ("the Act") to add new subsection (kkk) "Rural Emergency Hospital Services" and section 1834 of the Act to add new subsection (x) "Payment for Rural Emergency Hospital Services." The purpose of this Change Request (CR) is to implement the system requirements for this new Part A provider type, including payment for a January 2023 implementation CR.

B. Policy: Section 125 of the CAA, 2021, Division CC, defines an REH as a facility that: Is enrolled in the Medicare program; does not provide any acute care inpatient services (other than post-hospital extended care services furnished in a distinct part unit licensed as a Skilled Nursing Facility (SNF)); has a transfer agreement in effect with a level I or level II trauma center; meets certain licensure requirements; meets requirements to be a staffed emergency department; meets staff training and certification requirements established by the Secretary; and meets Conditions of Participation (CoPs) applicable to Critical Access Hospitals (CAHs) with respect to emergency services and, as determined applicable by the Secretary, to hospital emergency departments. CAHs and small rural hospitals that convert to REHs may furnish rural emergency hospital services for Medicare payment beginning in 2023.

Additionally, section 125 of the CAA, 2021, Division CC, states that REH services include emergency department services and observation services, and, at the election of the REH, other medical and health services furnished on an outpatient basis, as specified by the Secretary. The REH must also have a staffed emergency department 24 hours a day, 7 days a week, with staffing requirements similar to those for CAHs.

Starting on January 1, 2023, an REH that provides rural emergency hospital services (as defined in section 1861(kkk)(1) of the Act) will receive Medicare payment for those services pursuant to section 1834(x)(1) of the Act that reflects a 5 percent increase over the payment rate the provider would otherwise receive through the hospital outpatient prospective payment system (OPPS). Any co-payments for these services will be calculated based on the standard OPPS rate for the service excluding the 5 percent payment increase. An REH also may provide outpatient services that are consistent with the statutory requirements governing this provider type and the regulatory REH Conditions of Participations, that do not meet the definition of REH services. These services will be paid at the same rate the service would be paid if performed by a hospital outpatient department and paid under a fee schedule other than the OPPS. There is no payment increase for

these services.

REHs will receive an additional facility payment pursuant to section 1834(x)(2) of the Act. The annual payment amount for 2023 will be determined based on the excess (if any) of the total amount that was paid to all CAHs in 2019 over the estimated total amount that would have been paid to CAHs in 2019 if payment were made for inpatient hospital, outpatient hospital, and skilled nursing facility services under the applicable prospective payment systems for such services during such year. This excess amount is divided by the total number of CAHs in 2019. After the initial Medicare subsidy amount is calculated for calendar year 2023, the additional facility payments in subsequent years will be the payment amount determined for the preceding year increased by the hospital market basket percentage increase. REHs will receive these additional facility payments in twelve monthly installments. REHs also will be required to maintain detailed information as to how they have used these payments. The calendar year (CY) 2023 monthly REH facility payment is: $272,866.

This CR implements payment to REHs effective for dates of service on or after January 1, 2023.

All institutional Rural Emergency Hospitals billing Medicare will be required to enroll with Medicare as a Rural Emergency Hospital and submit claims to the Part A Medicare Administrative Contractor using an institutional claim form.

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	
12820.1	The Medicare Systems (e.g., Medicare claims processing systems, state systems, financial systems, etc.) shall make the necessary changes to accept the following provider range as part of the CCN for Rural Emergency Hospitals. The provider range is listed below: 0001 through 0879 **NOTE:** Provider Type “24” is to be a valid provider type for Rural Emergency Hospital (REH) providers.	X				X				BCRC, BCRS, CERT, FPS, HIGLAS, MAS, PECOS, PS&R, QIES, RAC
12820.2	Contractors shall accept CMS-855A submissions with the provider type "Other" option selected, specifying "Rural Emergency Hospital" until the forms can be updated with the new provider type.	X								
12820.3	PECOS shall begin sending enrollment records for the new Provider Type to FISS in the FISS extract with									PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the implementation of the January 2023 quarterly release. The new Provider Type shall appear in PECOS as follows: "Rural Emergency Hospital (REH)" with Provider Type code "24".									
12820.4	Contractors shall process the PECOS records for the new "Rural Emergency Hospital (REH)" with Provider Type code "24".					X				
12820.5	Contractors shall create a process that makes an additional, non-claims related monthly payment to REHs with a provider type 24 and no cancel date present in the provider file. Note: The monthly payment amount will be 6 digits left of the decimal point in size. (i.e., $999,999.99)					X				
12820.5.1	CMS shall send the value for the facility payment that is to be applied monthly for all REH providers.									CMS
12820.5.2	Contractors shall develop a new recurring process to apply and pay the annual monthly REH facility payment amount.					X				CMS
12820.5.3	Contractors shall receive an annual recurring CR with the REH monthly facility payment rate and create a process to apply this rate each month on the remit for the last day of the month with an update on an annual basis, effective January 1, 2023.					X				CMS
12820.6	Contractors shall populate the REH monthly facility payment information on the Special Payments Aging Report.					X				
12820.7	Contractors shall populate the REH monthly facility payment information on the Remittance advice summary screen (MAP 07959).					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12820.8	The Medicare Shared System Maintainer shall report the REH monthly facility payment with Payment Type Code 'RD' – "Rural Emergency Hospital (REH) Payment" to the Healthcare Integrated General Ledger Accounting System (HIGLAS) via HIGLAS FISS 810 Non-Claim interface.					X				HIGLAS
12820.9	HIGLAS shall process the Rural Emergency Hospital (REH) Non-Claim monthly facility payment and issue payment with 'HI' Fund.									HIGLAS
12820.10	HIGLAS shall define the new Sub Invoice Type for the Rural Emergency Hospital (REH) Payment type 'RD' as "RD_REH".									HIGLAS
12820.11	HIGLAS shall report the Rural Emergency Hospital (REH) monthly facility payments as listed below on 835 Interface: PLB 0X-01 code – RD (HIGLAS 835 will report 'RD' as PLB code) PLB 0X-02 (Positions 1 – 25) – AP Invoice Number PLB 0X-02 (Positions 26 – 50) – Blank									HIGLAS
12820.12	The Medicare Shared System Maintainer shall make necessary programming changes to crosswalk the HIGLAS PLB code 'RD' to HIPAA PLB Code 'CS' (per attached crosswalk) for the remittance PLB Mapping.					X				HIGLAS
12820.13	Contractors shall use the payment date in BPR16 from the HIGLAS 835 file and populate 'REH Payment' in PLB03-2, Reference Identification field, when new PLB code "RD" is received from HIGLAS that maps to a HIPAA PLB code "CS". **Note:** This is a Summary - Type 3 payment.					X				HIGLAS
12820.14	Contractors shall perform necessary Shared System internal HIGLAS changes to capture the information needed to support the Accredited Standards Committee (ASC) X12 835 Electronic Remittance Advice (ERA) and the standard paper remittance (SPR) sent to the provider.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12820.14.1	Contractors shall include the REH monthly payment on the HAFDHOOBR01 Provider Out of Balance Report.					X				
12820.15	Contractors shall allow provider type “24” on the outpatient provider specific file (OPSF) for REH providers. All other OPSF information remains as standard information required for completion of hospital provider types editing.	X				X				
12820.16	Contractors shall allow REH providers to bill outpatient services claims with Type of Bill (TOB) 013x and 014x . Inpatient hospital services are not allowed for REH providers.	X				X				
12820.17	Contractors shall allow REH covered services to be paid at existing standard payment rates as identified by the Status Indicators under Outpatient Prospective Payment System (OPPS) plus a 5% increase for the REH providers. Current deductible rules apply. Current coinsurance rules apply, except coinsurance will not be calculated on the 5% payment increase.	X				X				OPPS Pricer
12820.17.1	Contractors shall calculate payment for covered services processed by the OPPS Pricer with a 5% payment increase for the REH providers identified with provider type “24”.									OPPS Pricer
12820.17.2	Contractors shall calculate payment for covered services not processed by the OPPS Pricer with a Status Indicator (SI) of G or K with a 5% payment increase for the REH providers identified with provider type “24”. Services paid at reasonable cost (SI=F or L) do not receive the 5% payment increase.					X				
12820.17.3	Contractors shall separately capture the 5% payment increase for the REH providers and report the increase for items not paid with the OPPS Pricer on the ERA for balancing purposes as follows: Group Code: CO					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CARC: 172									
12820.17.4	Contractors shall calculate payment for REH covered services that are manually priced for HCPCS code C9399 using their normal processes. FISS shall calculate the 5% payment increase.	X				X				
12820.17.5	Contractors shall ensure that the non-OPPS line-level 5% payment increase is passed to the downstream systems.					X				BCRC, IDR, PS&R
12820.17.6	CWF shall ensure that the non-OPPS line-level 5% payment increase is passed to the downstream systems.								X	NCH
12820.18	Contractors shall create a new reason code to limit the billable TOBs to 13X and 14X for REH providers.					X				
12820.19	Contractors shall ensure that an OPPS Flag “1” is sent on REH claims passed through the Integrated Outpatient Code Editor.					X				
12820.20	OPPS Pricer shall not calculate Section 603 payment reductions for covered services processed for the REH providers identified with provider type “24”.									OPPS Pricer
12820.21	PECOS, MACs, HIGLAS, and FISS shall participate in the UAT kick off call and twice a week UAT status calls. The UAT kick off call is scheduled on November 22, 2022 and UAT is scheduled between November 28 2022 and December 22, 2022. NOTE: FISS and HIGLAS participation is requested, but is optional.	X				X				HIGLAS, PECOS
12820.22	FISS shall support MACs in PECOS UAT testing.					X				
12820.23	Parties interested in attending the PECOS UAT calls shall send their names and email addresses to the following:	X				X				HIGLAS, PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Pamela Rumber - Pamela.rumber@cms.hhs.gov • Kusum Jha - Kusum.jha2@cms.hhs.gov									
12820.24	HIGLAS IBPR report shall show the REH 837 claims in line 5 of HOSPITALS. Line 5 is driven by the provider range and since these are mapped to provider range 0001-0879 and these shall be included in total for HOSPITALS.									HIGLAS
12820.25	HIGLAS IBPR report shall show the REH 810 claims in Line 34 (Additional Providers Section as 34. B) as "REH facility payment/subsidy payments" and Line 36 shall show the Total including REH.									HIGLAS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12820.26	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): Yvonne Young, 410-786-1886 or yvonne.young@cms.hhs.gov (Part A claims processing) , Josh McFeeters, 410-786-9732 or joshua.mcfeeters@cms.hhs.gov (REH payment policy)

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

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	AW	Affiliate Withholdings	E3			**E3**	Withholding	Affiliate Withholding
25	BN	EHR Demo		BN		**BN**	Bonus	Demonstration Project (CR 6603)
26	C1	Provider Convener Participant - BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110

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
27	C2	Non-Provider Awardee Convener Model 2 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
28	C3	Non-Provider Awardee Convener Model 3 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
29	C4	Non-Provider Awardee Convener Model 4 BPCI Transaction (does NOT own Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
30	CV	Converted Invoices	L3	Internal Use Only		**L3**	Penalty	PR Conversion
31	D1	Full Hold - Unfiled Cost Report	50			**50**	Late Charge	Late Filing of Cost Report
32	D2	Full Hold - Unfiled 838	L3			**L3**	Penalty	PW Unfiled 838
33	D3	Full Hold - Rejected Cost Report	L3			**L3**	Penalty	PW Rejected Cost Report
34	D4	Full Hold - Failure to comply Auditors	L3			**L3**	Penalty	PW Failure to comply Auditors
35	D5	Full Hold - DNF	L3	WO		**_**		RA not created
36	D6	Full Hold - Fraud and Abuse	L3	WO		**L3**	Penalty	PW Fraud and Abuse
37	D7	Full Hold - Other/Misc	L3	WO		**L3**	Penalty	PW Other/Misc
38	D8	Full Hold - AP System Hold	L3	WO		**L3**	Penalty	PWAP Hold
39	D9	Full Hold - Terminated	L3			**L3**	Penalty	PW Terminated
40	DG	Converted DNF - Pseudo Check		Internal Use Only		**_**		No RA
41	DM	Debit Memo	L3	WO		**E3**	Withholding	Withholding per Debit Memo
42	DP	Converted Negotiable Checks		Internal Use Only		**_**		No RA
43	DR	DNF Hold Release	L3	Internal Use Only		**L3**	Penalty	PR DNF
44	E1	Episode Initiator - BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
45	E2	Episode Initiator Model 2 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
46	E3	Episode Initiator Model 3 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
47	E4	Episode Initiator Model 4 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
48	FB	Full Hold - Bankruptcy	L3	WO		**L3**	Penalty	PW Bankruptcy
49	FC	Full Hold - CMS Request	L3	WO		**L3**	Penalty	PW CMS Request
50	FS	BPCI Funds Switch Invoice						No RA
51	FR	Full Hold Release	L3	B2		**L3**	Penalty	PR
52	G2	Partial Hold - CMS Request	L3	WO		**L3**	Penalty	PW CMS Request
53	G3	Partial Hold - Bankruptcy	L3	WO		**L3**	Penalty	PW Bankruptcy
54	G4	Partial Hold - Unfiled Cost Report	L3			**L3**	Penalty	PW Unfiled Cost Report
55	G5	Partial Hold - Unfiled 838	L3			**L3**	Penalty	Unfiled 838 (Credit Balance Report)
56	H1	Manual Invoices - Cost Settlement Report	C5			**C5**	Temporary Allowance	Cost Report Settlement
57	HB	HPSA	E3	B2		**BN**	Bonus	HPSA Bonus
58	IM	Innovation Model				**IP/WO**	/Overpayment Recovery	CR9744
59	IR	TPP - IRS Levy	IR	WO		**IR**	Internal Revenue Service Withholding	
60	L1	TPP - IRS Backup	IR	WO		**IR**	Internal Revenue Service Withholding	
61	L2	TPP - Garnishments	WU	WO		**CS**	Adjustment	PW Garnishments
62	L3	Third Party Payment - including Attorneys	Internal Use Only	Internal Use Only		**_**		No RA

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
63	L4	TPP - Child Support	WU	WO		**CS**	Adjustment	PW Child Support
64	L5	TPP - Alimony	WU	WO		**CS**	Adjustment	PW Alimony
65	L6	TPP - Secondary Corporation	WU	WO		**CS**	Adjustment	PW Secondary Corporation
66	L7	TPP - Change of Ownership	WU	WO		**CS**	Adjustment	Change of Ownership
67	L8	Accelerated/Advance Recoupments Applications	AP	WO		**WO**	Overpayment Recovery	Advance Recoupment Application
68	LE	Lump Sum Bonus Payment for the Physician Pay for Reporting (P4R) Program and ERx Initiative Payment		LE		**LE**	Levy	PQRI and ERx (CR6624) Bonus Payment
69	LS	Lump Sum Bonus Payment for the Physician Pay for Reporting (P4R) Program (valid for transactions built before January 4, 2010 only)		LE		**LE**	Levy	PQRI Bonus Payment
70	M1	Manual Invoices - Refunds	72	B2		**72**	Authorized return	Refunds - Manual Invoices
71	M4	Manual Invoices - Other	C5	B2		**C5**	Temporary Allowance	Manual Invoices
72	MA	Manual Invoices - Accelerated/Advance Payment	AP	B2		**AP**	Acceleration of Benefits	Manual Invoices - Accelerated/Advance Payment
73	MC	Manual Invoices - PIP	PI			**PI**	Periodic Interim Payment	
74	ML	Manual Invoices - Interim Rate Review	C5			**C5**	Temporary Allowance	Interim Rate Review
75	N1	Non-Provider Convener Participant - BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
76	N2	Non-Provider Awardee Convener Model 2 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
77	N3	Non-Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
78	N4	Non-Provider Awardee Convener Model 4 BPCI Transaction (owns SOME or ALL Episode Initiators)				**LE/WU**	Levy/Unspecified Recovery	CR8440
79	NA	Manual Non Claim Invoices - HI Positive Distribution	Internal Use Only			**_**		No RA
80	NB	Manual Non Claim Invoices - HI Negative Distribution	Internal Use Only			**_**		No RA
81	NC	Manual Non Claim Invoices - SMI Positive Distribution	Internal Use Only			**_**		No RA
82	ND	Manual Non Claim Invoices - SMI Negative Distribution	Internal Use Only			**_**		No RA
83	NR	Manual Invoices - PT	C5			**C5**	Temporary Allowance	
84	P1	Single Participant – BPCI Advanced				**LE/WU**	Levy/Unspecified Recovery	CR11110
85	P2	Provider Awardee Convener Model 2 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440
86	P3	Provider Awardee Convener Model 3 BPCI Transaction (owns SOME or ALL Episode Initiators				**LE/WU**	Levy/Unspecified Recovery	CR8440
87	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:
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
88	PA	Partial Hold – Admin Freeze				L3		PW Admin Freeze
89	PI	Pennsylvania Rural Health Model				**PI**	Periodic Interim Payment	CR10018
90	PL	Manual 935 ALJ Interest Refund invoice	PL	PL		**L6**	Interest Owed	'Code meaning – HIGLAS' and 'Previous MCS 835 PLB Code Usage' changed from previous version
91	PO	Partial Hold - Other/Misc/ PSC Request	L3	WO		**L3**	Penalty	PW Other/Misc/PSC Request
92	PP	PIP	PI			**PI**	Periodic Interim Payment	
93	PR	Partial Hold - Release	L3	B2		**L3**	Penalty	PR Penalty Release
94	RH	Full Hold - Revalidation Hold						No RA
95	RD	Rural Emergency Hospital (REH) Payment				**CS**	Adjustment	CR12820
96	RU	Interest Refund				**L6**	Interest Owed	
97	S1	Single Awardee Model 1 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
98	S2	Single Awardee Model 2 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
99	S3	Single Awardee Model 3 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
100	S4	Single Awardee Model 4 BPCI Transaction				**LE/WU**	Levy/Unspecified Recovery	CR8440
101	TD	Manual Invoices - Tentative Settlement	C5			**C5**	Temporary Allowance	Tentative Settlement
102	TL	TOPS	IS			**IS**	Interim Settlement	
103	UH	Beneficiary Undeliverable Full Hold						No RA
104	VC	Voids - Reissue Invoices	CS	Internal Use Only		**CS**	Adjustment	Reissued Invoice
105	VD	Voids - Reissue Debit Memo	CS	WO?		**CS**	Adjustment	Reissued Debit Memo
106	VO	Void - Reissue Interest Information	CS			**CS**	Adjustment	Reissued Interest
107	WO	AR/AP Netting Offset	E3	WO		**WO**	Overpayment Recovery	AR/AP Netting
108	WR	Void - Reissue Split Pay	C5			**C5**	Temporary Allowance	Reissue Split Pay
109	WS	Settlement Withholding	L3			**E3**	Withholding	Settlement Withholding
110	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
111	WW	Principal Refund				**WO**	Overpayment Recovery	The amount in PLB 04 should be negative. And include identifying nos. in PLB03-2
112	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								
113				AP		**AP**	Acceleration of Benefits	Advance Payment
114					CS	**–**		Correction and Reversal at the claim/line level
115				FB		**FB**	Forward Balance	Over Payment
116					CS	**FB/WO**	Withholding	Follow CR 6870 - for using FB and WO at step I and Step II for 935 Recoupment
117					IR	**IR**	Internal Revenue Service Withholding	
118				J1		**J1**	Non-reimbursable	Adjustment per Demonstration Project
119					AP	**AP**	Acceleration of Benefits	Payment to withheld because it has been determined that the provider/supplier is on Do Not Forward (DNF) or investigated for
120				L6	L6	**L6**	Interest Owed	Interest paid on claims in this 835
121					WO	**WO**	Overpayment Recovery	AR/AP Netting
ADD-ON-PAYMENTS								
122			CS			**CS**		Outlier
123			CS			**CS/HM**		Hemo. HM is a new code available in 5010
124			CS			**CS**		New Technology
125			LS			**LS**		Indirect Medical Education

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

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

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

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

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

(Rev. 11729; 12-06-22)

Addendum A - Provider Specific File

(Rev. 11729; Issued: 12-06-22, Effective: 01-01-23; Implementation:01-01-03-23)

Data Element	File Position	Format	Title	Description
1	1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character NPI number.

Data Element	File Position	Format	Title	Description
2	11-16	X(6)	Provider CMS Certification Number (CCN)	Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:

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

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

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

3	17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date. Year: Greater than 82, but not greater than current year. Month: 01-12 Day: 01-31

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

Data Element	File Position	Format	Title	Description
				08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990). Eff. 10/1/12, this provider type is no longer valid. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). Eff. 10/1/12, this provider type no longer valid. 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital *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

Data Element	File Position	Format	Title	Description
				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 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

Data Element	File Position	Format	Title	Description
				_ _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.
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.

Data Element	File Position	Format	Title	Description
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 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

Data Element	File Position	Format	Title	Description
				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:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002. 1 Federal % 20 Facility% 80 2 40 60 3 60 40 4 80 20 5 100 00 **IPF PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. 1 Federal % 25 Facility% 75 2 50 50 3 75 25 4 100 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	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

Data Element	File Position	Format	Title	Description
			Facility Specific Rate	§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 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.)

Data Element	File Position	Format	Title	Description
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.
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.

Data Element	File Position	Format	Title	Description
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

Data Element	File Position	Format	Title	Description
				automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a "1" or "2."
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero-fill if this does not apply.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, lung, pancreas, intestine and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero-fill if this does not apply.

Data Element	File Position	Format	Title	Description
42	179-184	9(4)V9(2)	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero-fill if this does not apply.
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A“08” is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.

Data Element	File Position	Format	Title	Description
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X(1)	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	This is for IPPS hospitals and IRFs only. Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient 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

Data Element	File Position	Format	Title	Description
				"1" if participating in Hospital Readmissions Reduction program and payment adjustment is not 1.0000. Enter "2" if participating in Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor if "1" is entered in Data Element 53. Leave blank if "0" or "2" is entered in Data Element 53.
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a 'Y' if the hospital is subject to a reduction under the HAC Reduction Program. Enter a 'N' if the hospital is NOT subject to a reduction under the HAC Reduction Program.
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment amount calculated and published by CMS for each hospital
58	251-251	X	Electronic Health Records (EHR) Program Reduction	Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-258	9V9(6)	LV Adjustment Factor	Enter the low-volume hospital payment adjustment factor calculated and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-268	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
62	269-269	X(1)	LTCH DPP Indicator	Enter a 'Y' if the LTCH is subject to the DPP payment adjustment. Leave blank if the LTCH is not subject to the DPP payment adjustment.
63	270-275	9(2) V9(4)	Supplemental Wage Index	Enter the supplemental wage index that certain providers may be assigned. Enter zeroes if it does not apply.

Data Element	File Position	Format	Title	Description
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=Future use 3=Future use Enter blank if it does not apply **Note:** For LTCH's providers this is the IPPS prior year wage index.
65	277-310	X(34)	Filler	

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev. 11729; 12-06-22)

Transmittals for Chapter 4

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10.6.1 - Payment Adjustment for Rural *Sole Community* Hospitals

(Rev. 11729; Issued: 12-06-22, Effective: 01-01-23; Implementation:01-01-03-23)

Beginning January 1, 2006, rural sole community hospitals (SCHs), including essential access community hospitals (EACHs), receive a 7.1 percent increase in payments for most services, with certain exceptions. Services which are excepted from the increase in payments include, but are not limited to, separately paid drugs and biologicals and items paid at charges adjusted to cost. This adjustment is authorized under Section 1833(t)(13)(B) of the Act, and implemented in accordance with Section 419.43(g) of the regulations. The adjustment is automatically applied in Pricer.

10.6.4 - Payment Adjustment for Rural Emergency Hospitals[1]

(Rev. 11729; Issued: 12-06-22, Effective: 01-01-23; Implementation:01-01-03-23)

A rural emergency hospital (REH), as defined in § 419.91, is an entity that operates for the purpose of providing emergency department services, observation care, and other outpatient medical and health services specified by the Secretary in which the annual per patient average length of stay does not exceed 24 hours. The time calculation for determining the length of stay of a patient receiving REH services begins with the registration, check-in or triage of the patient (whichever occurs first) and ends with the discharge of the patient from the REH. The discharge occurs when the physician or other appropriate clinician has signed the discharge order, or at the time the outpatient service is completed and documented in the medical record. The entity must not provide inpatient services, except those furnished in a unit that is a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services.

Rural emergency hospital services, as defined in § 419.91, are all covered outpatient department (OPD) services, as defined in section 1833(t)(1)(B) of the Act, excluding services described in section 1833(t)(1)(B)(ii), furnished by an REH that would be paid under the OPPS when provided in a hospital paid under the OPPS for outpatient services, provided that such services are furnished consistent with the conditions of participation at 42 C.F.R. §§ 485.510 - 485.544.

A. Payment for REH Services

Beginning January 1, 2023, a REH that provides a REH service will receive a Medicare payment for the service that is equal to the amount of payment that would otherwise apply under section 1833(t) of the Act for the equivalent covered OPD service, increased by 5 percent to reflect the higher costs incurred by such hospitals. The beneficiary co-payment for the service is calculated the same way as it is calculated under section 1833(t)(8) of the Act for the equivalent covered OPD service, excluding the 5 percent payment increase.

EXAMPLE:

1. Service/Rate x 0.05 = Increase Amount for REH Services

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[1] *The information described in Section 10.6.4 of this Manual is based on proposed policies to implement payment for REHs, published as a rider to the CY2023 OPPS proposed rule. All policies are subject to change pending the publication of the final policies concerning this new provider type, including associated REH payment policies, in the CY2023 OPPS Final Rule, CMS-1772-FC. If there are changes to these proposed policies made in response to public comments in the final rule, CMS will update this section accordingly.*

$100.00/Rate x 0.05 = $5.00 Increase Amount for REH Services

2. Service/Rate + Increase Amount for REH Services = Allowed Amount
$100.00 + $5.00 = $105.00 Allowed Amount

3. Service/Rate x 0.20 = Coinsurance
*$100.00 * 0.20 = $20.00 Coinsurance*

Claims for REH services are paid based on OPPS prospective rates and are adjudicated based on OPPS payment policies and rules. Services performed by an REH that do not meet the definition of an REH service (i.e. certain outpatient services that may be provided on an outpatient basis by OPPS hospitals but are not paid under the OPPS) are paid at the same rate as the service would be paid if performed at an OPPS hospital and paid based on the applicable fee schedule outside of the OPPS. Such services are not considered REH services and do not receive the additional 5 percent payment that REH services receive. Ambulance services furnished by an entity owned and operated by a rural emergency hospital are paid under the ambulance fee schedule as described at section 1834(l) of the Act. Post-hospital extended care services furnished by a rural emergency hospital that has a unit that is a distinct part licensed as a skilled nursing facility are paid under the skilled nursing facility prospective payment system described at section 1888(e) of the Act.

B. Monthly REH Facility Payment

In addition to payment for individual claims, section 1834(x)(2) of the Act requires REHs to be paid a monthly facility payment. The monthly facility payment for every REH is the same. There is no adjustment to the facility payment because of the size of the REH or amount of revenue generated by the REH. For 2024 and subsequent years, this payment will be updated annually by the hospital market basket percentage increase.

50.1 - Outpatient Provider Specific File

(Rev. 11729; Issued: 12-06-22, Effective: 01-01-23; Implementation:01-01-03-23)

The Outpatient Provider Specific File (OPSF) contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and formats are shown below. Contractors must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Contractors must also furnish CMS a quarterly file in the same format.

NOTE: All data elements, whether required or optional, must have a default value of “0” (zero) if numerical, or blank if alphanumerical.

File Position	Format	Title	Description
1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the 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.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The created/run date of the PROV report for submittal to CO.
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeroes or contain a termination date. (Once the official “tie-out” notice from CMS is received). Must be equal to or greater than the effective date. (Termination date is the date on which the reporting contractor ceased servicing the provider in question).

49	X(1)	Waiver Indicator	Enter a “Y” or “N.” Y = waived (provider is not under OPPS) For End Stage Renal Disease (ESRD) facilities provider waived blended payment, pay full PPS. N = not waived (provider is under OPPS) For ESRD facilities provider did not waive blended payment. Pay according to transitional payment method for ESRD PPS through 2013.
50-54	9(5)	Intermediary Number	Enter the Contractor #.

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 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 Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration 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
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. For End Stage Renal Disease (ESRD) facilities value "Y" equals low volume adjustment applicable.
58	X(1)	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank) (blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.

63-66	X(4)	Wage Index Location—MSA	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 wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio. Does not apply to ESRD Facilities.
71-72	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. Contractors shall enter a "10" for Florida's State Code. List of valid State Codes is located in Pub. 10007, Chapter 2, Section 2779A1.
73	X(1)	TOPs Indicator	Enter the code to indicate whether TOPs applies or not. Y = qualifies for TOPs N = does not qualify for TOPs

74	X(1)	Quality Indicator Field	Hospital: Enter the code to indicate whether the hospital meets data submission criteria per HOP QDRP requirements. 1 = Hospital quality reporting standards have been met or hospital is not required to submit quality data (e.g., hospitals that are specifically excluded from the IPPS or which are not paid under the OPPS, including psychiatric, rehabilitation, long-term care and children's and cancer hospitals, Maryland hospitals, Indian Health Service hospitals, or hospital units; or hospitals that are located in Puerto Rico or the U.S. territories). The reduction does not apply to hospices, CORFs, HHAs, CMHCs, critical access hospitals or to any other provider type that is not a hospital. Blank = Hospital does not meet criteria. Independent and Hospital-based End Stage Renal Disease (ESRD)Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction * Please refer to file position 101 for ESRD Children's Hospitals Quality Indicator.
75	X(1)	Filler	Blank.

76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data. See §10.11 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio. Does not apply to ESRD Facilities.
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank) (blank) (blank) 2 digit numeric State code such as _ _ _ 3 6 for Ohio, where the facility is physically located.
85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 0000189999, 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 Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	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 equals a "1" or "2."
96	X(1)	Special Payment Indicator	The following codes indicate 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

97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.
101	X(1)	Quality Indicator ESRD Children's Hospitals	Children's Hospitals for End Stage Renal Disease (ESRD) Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction
102-105	9V9(3)	Device department's Cost-to-Charge Ratio	Derived from the latest available cost report data. Does not apply to ESRD Facilities.
106-112	X(7)	Carrier/Locality code	The carrier/locality code for the provider service facility. The first five positions represent the carrier code and the last two positions represent the locality code.
113-117	9(5)	County Code	Enter the County Code. Must be 5 numbers.
118-122	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 0000189999, 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 Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.

123-128	9V9(5)	Payment Model Adjustment (PMA)	Derived from payment model Technical Direction Letter.
129-133	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
134-139	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.
140-140	X(1)	Supplemental Wage Index Flag	Enter the supplemental wage index flag: 1=Prior Year Wage Index 2=Future use 3=Future use Enter blank if it does not apply.
141-162	X(22)	FILLER	

The contractor enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 999. Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to system's capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.