CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13904	**Date: August 26, 2026**
	Change Request 14574

SUBJECT: Updates to Chapter One of the Medicare Claims Processing Manual (Publication (Pub.) 100-04) to Include Newly Created and Utilized Payer Only Codes

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update chapter one of the Medicare Claims Processing Manual to include newly created and utilized Payer Only Codes.

EFFECTIVE DATE: September 28, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 28, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/80.2.2 - Interest Payment on Clean Non-PIP Claims Not Paid Timely
R	1/190 – Payer Only Codes Utilized by Medicare

III. FUNDING:

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13904	Date: August 26, 2026	Change Request: 14574

SUBJECT: Updates to Chapter One of the Medicare Claims Processing Manual (Publication (Pub.) 100-04) to Include Newly Created and Utilized Payer Only Codes

EFFECTIVE DATE: September 28, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 28, 2026

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update chapter one of the Medicare Claims Processing Manual to include newly created and utilized Payer Only Codes.

II. GENERAL INFORMATION

A. Background: The purpose of this CR is to update chapter one, Payer Only Codes utilized by Medicare in Pub. 100-04, of the Medicare Claims Processing Manual.

B. Policy: This CR contains no policy changes.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14574.1	Medicare contractors shall be aware of the corrections to Pub. 100-04, chapter one, section 190, contained in this CR and make any necessary file updates.	X		X						NCH
14574.2	Medicare contractors shall recognize the new URL https://fiscal.treasury.gov/payments-from-government/prompt-payment/rates [fiscal.treasury.gov] used for access to the U.S. Treasury Department web page for Prompt Payment interest rates shown in Pub.100-04, chapter one, section 80.2.2.	X	X	X	X					

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

VI. CONTACTS

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

VII. FUNDING

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

ATTACHMENTS: 0

80.2.2 - Interest Payment on Clean Non-PIP Claims Not Paid Timely

(Rev. 13904; Issued:08-26-26; Effective: 09-28-26; Implementation: 09-28-26)

Interest must be paid on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt as described above. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2009, must have been paid before the end of business on March 31, 2009. Interest is not paid on:

- Claims requiring external investigation or development by the provider's FI or carrier;
- Claims on which no payment is due;
- Full denials;
- Claims for which the provider is receiving PIP; or
- HH PPS RAPs

Interest is paid at the rate used for §3902(a) of title 3l, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment.

This rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *https://fiscal.treasury.gov/payments-from-government/prompt-payment/rates [Fiscal.Treasury.gov]* for the correct rate. Medicare contractors shall include notification to providers of any change to the Treasury Department interest rate in their routine educational materials and/or website for providers.

Interest is calculated using the following formula:

Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

The interest period begins on the day after payment is due and ends on the day of payment.

NOTE: The example below is for one 6-month period in which the interest rate was 5.625 percent.

Milestones	**Clean Paper Claim (in calendar days)**	**Clean Electronic Claim (in calendar days)**
Date Received	March 1, 2009	March 1, 2009
Payment Due	March 31, 2009	March 31, 2009
Payment Made	April 3, 2009	April 3, 2009
Interest Begins	April 1, 2009	April 1, 2009
Days for Which Interest is Due	3	3
Amount of Payment	$100	$100
Interest Rate	5.625%	5.625%

See section 80.2.1.1 for the definition of EMC and paper

claims. The following formula is used:

For the clean paper claim - $100 X .05625 X 3 divided by 365 = $.0462 or $.05 when rounded to the nearest penny.

For the clean electronic claim - $100 X .05625 X 3 divided by 365 = $.0462 or $.05 when rounded to the nearest penny.

When interest payments are applicable, the Medicare contractor reports the amount of interest on each claim on the remittance record to the provider.

PIP/Non-PIP:

Under the periodic interim payment ("PIP") mechanism, a provider receives flat biweekly payments to approximate the average costs of covered inpatient services during a 2-week period. Non-PIP claims are claims made by a provider not under the periodic interim payment mechanism. PIP on inpatient bills does not preclude interest payments on outpatient bills.
Interest is paid on a per bill basis at the time of payment.

190 – Payer Only Codes Utilized by Medicare

(Rev. 13904; Issued:08-26-26; Effective: 09-28-26; Implementation: 09-28-26)

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

Condition Codes

12-14 – Not currently used by Medicare.

15 – Clean claim is delayed in CMS Processing System.

16 – SNF Transition exception.

62 – PIP Bill.

64 – Other Than Clean Claim.

65 – Non-PPS Bill.

98 – Data Associated With DRG 468 Has Been Validated.

EY – Lung Reduction Study Demonstration Claims.

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

M1 – Roster Billed Influenza Virus Vaccine, Covid-19 Vaccine, Hepatitis B Vaccine, or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine, Covid-19 vaccine, hepatitis B vaccine, or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.

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

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

M4 – Presence of infected wound or wound with morbid obesity

M5 – Not currently used by Medicare

M6 – PA Rural Health Model

M7 – Shared System Medicare Deductible bypass

M8 – Shared System Medicare Coinsurance bypass

M9 – Shared System Medicare Deductible/Coinsurance bypass

MA – GI Bleed. (Bill Type 072x)

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

MB – Pneumonia. (Bill Type 072x)

MC – Pericarditis. (Bill Type 072x)

MD – Myelodysplastic Syndrome. (Bill Type 072x)

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

MF – Monoclonal Gammopathy. (Bill Type 072x)

MG – Grandfathered Tribal Federally Qualified Health Centers.

MH – MAC Medicare Deductible bypass

MI – MAC Medicare Coinsurance bypass

MJ – MAC Medicare Deductible/Coinsurance bypass

MK – Not currently used by Medicare.

ML – PIP claim received usual add-on only payment

MM – Medicare Merger initiated and currently in process.

MN – PIP claim received Net Reimbursement.

MO – MAC Override Appeal Timeliness.

MP – IOP/PHP claim contains initial admit week

MQ – IOP/PHP claim contains final discharge week

MR – Not currently used by Medicare.

MS – Medicare SNF 3-day inpatient hospital stay bypass

MT – Not currently used by Medicare.

MU – Medicare Part A CWF bypass

MV – 20 hours for partial IOP/PHP subsequent week not met

MW – 20 hours for partial IOP/PHP initial week not met

MX – Wrong Surgery on Patient (Inpatient)

MY – Surgery Wrong Body Part (Inpatient)

MY – Outlier Cap Bypass (CMHC)

MZ – Surgery Wrong Patient (Inpatient)

MZ – IOCE error code bypass (Outpatient)

UU – Not currently used by Medicare.

Z0 – PACE straddle claim

Z1 – Z8 – Not currently used by Medicare.

Z9 – High Dollar Issue

ZA – No Positive COVID-19 test result in M/R

ZB – Expanded Access approval

ZC – Clinical Trial of a different product

ZD – Product not purchased in usual manner- provided at no cost.

ZE – ZZ – Not currently used by Medicare.

Occurrence Codes

23 – Date of Cancellation of Hospice Election period.

48 – Not currently used by Medicare.

49 – Original Notice of Election (NOE) receipt date.

AA-AZ – Not currently used by Medicare.

Occurrence Span Codes

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

Z0-Z9 – Not currently used by Medicare.

ZA-ZZ – Not currently used by Medicare.

Value Codes

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

18 – Operating Disproportionate Share Amount – The A/B MAC (A) reports the operating disproportionate shares amount applicable. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

19 – Outpatient Use. The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's

reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

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

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

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

62 – On Type of Bills 081x 0r 082x: Number of High Routine Home Care Days - Days that fall within the first 60 days of a routine home care hospice claim.

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

63 – On Type of Bills 081x 0r 082x: Number of Low Routine Home Care Days - Days that come after the first 60 days of a routine home care hospice claim.

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

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

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

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

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

73 – Sequestration adjustment amount.

74 – Low volume hospital payment amount

75 – Prior covered days for an interrupted stay.

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

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

78 – Off-site Zip Code – When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 012X, 013X, 014X, 022X, 023X, 034X, 072X, 074X, 075X, 081X, 082X, and 085X. The ZIP code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

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

Q0 – Amount Medicare would have paid prior to the Model reduction

Q1 – Actual Model reduction amount

Q2 – Hospice claim paid from Part B Trust Fund

Q3 – Prior Authorization 25% Penalty

Q4 – PA Rural Model Exclusion - Physician Service Claim Reimbursement

Q5 – EHR

Q6 – PQRS

Q7 – Islet Isolation Add-on payment amount

Q8 – Transitional Drug Add-On Payment Adjustment

Q9 - Medicare Performance Adjustment (MPA)

QA – IOP/PHP partial week input

QB – ESRD Treatment Choices (ETC) Model: Home Dialysis Payment Adjustment (HDPA) total bonus paid.

QC – OCM+ Adjustment

QD – Device Credit

QE – ET3 Model – ET3 15% bonus payment

QF – HHA - LATE-SUB-PENALTY-AMT

QG – ESRD – Total TPNIES Amount

QH – ESRD - TPNIES capital related assets (CRA)

QI – FQHC MDPCP DEMO

QJ – ETC Model Facility PPA

QK – Maryland Waiver Kidney Acquisition Payment

QL – Not used by Medicare

QM – MIPS adjustment amount

QN – First APC pass-through device offset

QO – Second APC pass-through device offset

QP – Second Non-Opioid surgical pain relief device payment limitation

QQ – Terminated procedure with device offset

QR – 1st APC pass-thru Drug/Biological offset / 1st Non-opioid Drug/Biological for Post Surgical Pain Relief

QS – 2nd APC pass-thru Drug/Biological offset / 2nd Non-opioid Drug/Biological for Post Surgical Pain

Relief

QT – 3rd APC pass-thru Drug/Biological offset / 3rd Non-opioid Drug/Biological for Post Surgical Pain Relief

QU –Device credit with device offset

QV – Value-based purchasing adjustment amount (Inpatient/HHA)

QV – First Non-opioid surgical pain relief device payment limitation

QW – IOP/PHP partial week output

QX – MCE bypass

QY – Not used by Medicare

QZ – QPP

Z0 – Z7 – Not used by Medicare

Z8 – Contractor Bypass APC information

Z9 – COVID-19 PHE End Date.

ZA-ZZ – Not used by Medicare

Modifiers

@0 – Not used by Medicare

@1 – System Bypass deductible

@2 – System Bypass coinsurance

@3 – System Bypass both deductible and coinsurance

@4 – MAC Bypass deductible

@5 – MAC Bypass coinsurance

@6 – MAC Bypass both deductible and coinsurance

@7-@9 – Not used by Medicare

@A-@Z – Not used by Medicare

#0 – IOCE Contractor Bypass 0

#1 – IOCE Contractor Bypass 1

#2 – IOCE Contractor Bypass 2

#3 – IOCE Contractor Bypass 3

#4 – IOCE Contractor Bypass 4

#5 – IOCE Contractor Bypass 5

#6 – IOCE Contractor Bypass 6

#7 – IOCE Contractor Bypass 7

#8 – IOCE Contractor Bypass 8

#9 – IOCE Contractor Bypass 9

#A – IOCE Contractor Bypass 10

#B – IOCE Contractor Bypass 11

#C – IOCE Contractor Bypass 12

#D – IOCE Contractor Bypass 13

#E – IOCE Contractor Bypass 14

#F – IOCE Contractor Bypass 15

#G – IOCE Contractor Bypass 16

#H – IOCE Contractor Bypass 17

#I – IOCE Contractor Bypass 18

#J – IOCE Contractor Bypass 19

#K – IOCE Contractor Bypass 20

#L – IOCE Contractor Bypass 21

#M – IOCE Contractor Bypass 22

#N – IOCE Contractor Bypass 23

#O – IOCE Contractor Bypass 24

#P – IOCE Contractor Bypass 25

#Q – IOCE Contractor Bypass 26

#R – IOCE Contractor Bypass 27

#S – IOCE Contractor Bypass 28

#T – IOCE Contractor Bypass 29

#U – IOCE Contractor Bypass 30

#V – IOCE Contractor Bypass 31

#W – IOCE Contractor Bypass 32

#X – IOCE Contractor Bypass 33

#Y – IOCE Contractor Bypass 34

#Z – IOCE Contractor Bypass 35