CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 524	Date: July 31, 2009
	Change Request 6465

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 12, 2014. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

Subject: Comprehensive Error Rate Testing (CERT) Program Modifications for the Implementation of the Next Version of the Health Insurance Portability and Accountability Act (HIPAA)

I. SUMMARY OF CHANGES: This change request (CR) defines the file format changes to the Comprehensive Error Rate Testing (CERT) data files made necessary by the implementation of 5010. Attached to this CR are the updated layouts and specifications for the files to be created by the shared systems for the CERT program.

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers: N/A

SECTION B: 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:
One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 524	Date: July 31, 2009	Change Request: 6465

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 12, 2014. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

SUBJECT: Comprehensive Error Rate Testing (CERT) Program Modifications for the Implementation of the Next Version of the Health Insurance Portability and Accountability Act (HIPAA)

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services is in the process of implementing the next version of the HIPAA – referred to as Version 5010 in this document. A number of Change Requests (CRs) and Joint Signature Memoranda (JSMs) have been issued to define the scope and direction of the implementation, based on certain assumptions.

Comprehensive Error Rate Testing (CERT) shall provide deliverables for each of the following implementation dates;

- By July 1, 2009, CERT shall provide the FFS SSMs and other down stream entities (identified in the business requirements within this CR) the updated copybooks and/or map sets that will be implemented with the January 2010 quarterly release. These will also be provided to the FFS SSM and other down stream entities.

- For the January 2010 release, the SSMs shall implement the changes identified within this CR.

B. Policy: The Administrative Simplification provisions of HIPAA require the Secretary of HHS to adopt standard electronic transactions and code sets for administrative health care transactions. The Secretary may also modify these standards periodically.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6465.1	Shared System Maintainers shall implement record version "C" for all Part A, Part B, and DME resolution and provider address records to signify the field expansions.						X	X	X		CERT
6465.2	Shared System Maintainers shall create PWK fields in the Header claim level and the detail line items for all the Part B, DME and Part A resolution records. CMS plans to implement the PWK data fields with a future change request.						X	X	X		CERT
6465.3	Shared System Maintainers shall create filler in the Header claim level for all the Part B, DME and Part A resolution records to allow for future field expansion.						X	X	X		CERT
6465.4	Shared System Maintainers shall increase the size of the Beneficiary Last Name in the Claim portion of the Part A resolution record to 60 bytes.						X				CERT
6465.5	Shared System Maintainers shall increase the size of the Beneficiary First Name in the Claim portion of the Part A resolution record to 35 bytes.						X				CERT
6465.6	Shared System Maintainers shall update logic in order to report all dollar values as signed numeric.						X				CERT
6465.7	Shared System Maintainers shall increase the size of the Condition code in the claim portion of the Part A resolution record from 2 to 3 bytes.						X				CERT
6465.8	Shared System Maintainers shall delete the Attending Physician First Name from the Claim portion of the Part A resolution record.						X				CERT
6465.9	Shared System Maintainers shall delete the Attending Physician Middle Initial from the Claim portion of the Part A resolution record.						X				CERT
6465.10	Shared System Maintainers shall delete the Operating Physician UPIN from the Claim portion of the Part A resolution record.						X				CERT
6465.11	Shared System Maintainers shall delete the Operating Physician First Name from the Claim portion of the Part A resolution record.						X				CERT

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6465.12	Shared System Maintainers shall delete the Operating Physician Middle Initial from the Claim portion of the Part A resolution record.						X				CERT
6465.13	Shared System Maintainers shall delete the Other Physician UPIN from the claim portion of the Part A resolution.						X				CERT
6465.14	Shared System Maintainers shall delete the Other Physician First Name from the claim portion of the Part A resolution.						X				CERT
6465.15	Shared System Maintainers shall delete the Other Physician Middle Initial from the claim portion of the Part A resolution.						X				CERT
6465.16	Shared System Maintainers shall increase the number of diagnosis code fields on the Part A in the claim portion for resolution records from 9 diagnosis codes to 25 diagnosis codes. One diagnosis code for the Principle diagnosis and 24 for the secondary diagnosis codes.						X				CERT
6465.16.1	Shared System Maintainers shall increase the size of diagnosis code fields on all the Part A resolution records from 5 bytes to 7 bytes.						X				CERT
6465.17	Shared System Maintainers shall create a new diagnosis version indicator code field for each of the 25 diagnosis codes on all the Part A resolution records, to identify if these diagnosis codes are the ICD-9 or ICD-10 version. CMS plans to implement the diagnosis indicator data with a future change request.						X				CERT
6465.18	Shared System Maintainers shall increase the number of procedure code fields on the Part A claim portion for all resolution records from 6 procedure codes to 25 procedure codes. One procedure code for the Principle procedure and 24 for the secondary procedure codes.						X				CERT
6465.18.1	Shared System Maintainers shall increase the number of procedure code date fields on the Part A claim portion for all resolution records from 6 procedure code dates to 25 procedure code dates. One procedure code date for the Principle procedure and 24 for the secondary procedure codes.						X				CERT

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6465.18.2	Shared System Maintainers shall increase the size of procedure code date fields from 6 bytes to 8 bytes.						X				CERT
6465.19	Shared System Maintainers shall increase the size the procedure code fields on all the Part A resolution records from 5 bytes to 7 bytes.						X				CERT
6465.20	Shared System Maintainers shall create a new procedure version indicator code field for each of the 25 procedure codes on all the Part A resolution records, to identify if these procedure codes are the ICD-9 or ICD-10 version.						X				CERT
6465.21	Shared System Maintainers shall create 3 new Patient Reason for Visit fields of 7 bytes in the claim portion of the Part A Resolution Record Outpatient/Home Health/Hospice incoming claims record.						X				CERT
6465.21.1	Shared System Maintainers shall create a new diagnosis version indicator code field for the 3 Patient Reason for Visit diagnosis codes field in the claim portion of the Part A resolution record, to identify if these diagnosis codes are the ICD-9 or ICD-10 version.						X				CERT
6465.22	Shared System Maintainers shall create a new 37 byte Present on Admission (POA) / External Cause of Injury indicator field in the claim portion for all the Part A resolution records. Position 1 for Principle Diagnosis, positions 2-25 for the 24 Secondary Diagnosis for the Present on Admission (POA) Indicator, Positions 26 – 37 for the 12 External Cause of Injury.						X				CERT
6465.23	Shared System Maintainers shall create 12 new 7 byte External Cause of Injury Diagnosis Code fields in the header portion on all the Part A resolution records.						X				CERT
6465.23.1	Shared System Maintainers shall create a new diagnosis version indicator code field for each of the 12 External Cause of Injury Diagnosis code fields in the claim portion of all Part A resolution records, to identify if these diagnosis codes are the ICD-9 or ICD-10 version.						X				CERT

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6465.24	Shared System Maintainers shall create a new 9 digit service facility zip code field at the header (claim) level for all Part A resolution records. CMS plans to implement the service facility zip code with a future change request.						X				CERT
6465.25	The Shared systems shall create a 1-byte RAC adjustment field in the claim portion of the Part A resolution record (valid values = "R" or spaces).						X				CERT
6465.26	The Shared systems shall create a 2 position Split/Adjustment adjustment field in the claim portion of the Part A resolution record.						X				CERT
6465.27	Shared System Maintainers shall increase the size of line level Units fields on Part A resolution records to 7 bytes plus 3 with a decimal.						X				CERT
6465.28	Shared systems shall create a new 10 digit Rendering Physician NPI field at the detail line level for all Part A resolution records. CMS plans to implement the rendering physician data at the detail line lever for Part A claims with a future change request.						X				CERT
6465.28.1	Shared system shall create a new rendering physician last name at the detail line level for all Part A Resolution records. CMS plans to implement the rendering physician data at the detail line level for Part A claims with a future change request.						X				CERT
6465.29	Shared systems shall create a new 11 digit National Drug Code (NDC) field at the detail line level for all Part A resolution records. CMS plans to implement NDC data with a future change request.						X				CERT
6465.30	Shared systems shall create a new 2 digit National Drug Code (NDC) Quantity Qualifier field at the detail line level for all Part A resolution records. CMS plans to implement NDC data with a future change request.						X				CERT

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6465.31	Shared systems shall create a new 10 digit (7 plus 3 with a decimal) National Drug Code (NDC) Quantity field at the detail line level for all Part A resolution records. CMS plans to implement the NDC data with a future change request.						X				CERT
6465.32	Shared System Maintainers shall increase the size of Provider Name field on all the Part A Provider Address records to 60 bytes.						X				CERT
6465.33	Shared System Maintainers shall increase the size of beneficiary Last Name field on all Part B and DME resolution records to 60 bytes.							X	X		CERT
6465.34	Shared System Maintainers shall increase the size of beneficiary first Name field on all Part B and DME resolution records to 35 bytes.							X	X		CERT
6465.35	Shared System Maintainers shall report all dollar value fields in the Part B and DME resolution records as signed numeric.							X	X		CERT
6465.36	Shared System Maintainers shall increase the number of diagnosis code fields on the Part B and DME in the claim portion of the resolution record from 8 diagnosis codes to 12 diagnosis codes.							X	X		CERT
6465.36.1	Shared System Maintainers shall increase the size of the 13 diagnosis code fields on the Part B and DME for all resolution records. This includes the 12 diagnosis codes in the header portion and the 1 diagnosis code field in the detail line.							X	X		CERT
6465.37	Shared System Maintainers shall create a new diagnosis version indicator code field for each of the 13 diagnosis codes on the Part B and DME resolution record to identify if these diagnosis codes are the ICD-9 or ICD-10 version. This includes the 12 diagnosis codes in the header portion and the 1 diagnosis code field in the detail line. CMS plans to implement the diagnosis indicator data with a future change request.							X	X		CERT

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6465.38	The Shared systems shall create a 1-byte RAC adjustment field in the claim portion of the Part B and DME resolution record (valid values = "R" or spaces).							X	X		CERT
6465.39	The Shared systems shall create a 2 position Split/Adjustment adjustment field in the claim portion of the Part B and DME resolution record.							X	X		CERT
6465.40	The Shared system shall create a 10 byte Facility NPI field in the claim portion of the Part B and DME resolution record							X	X		CERT
6465.41	Shared System Maintainers shall increase the size of line level Units fields on Part B and DME resolution records from 3 bytes to 7 bytes plus 3 with a decimal.							X	X		CERT
6465.42	Shared System Maintainers shall create a new 9 byte Ambulance Point of Pick Up field in the line item detail of the Part B resolution record.							X	X		CERT
6465.43	Shared System Maintainers shall create a new 9 byte Ambulance Drop Off Zip Code field in the line item detail of the Part B resolution record.							X	X		CERT
6465.44	Shared System Maintainers shall increase the size of Provider Name field on all Part B and DME Provider Address records to 60 bytes.							X	X		CERT
6465.44.1	Shared System Maintainers shall include the 40 character Legal Business Name in the Provider Address records. At this time we understand that only VMS maintains more that 25 characters in this field.								X		CERT
6465.45	Shared System Maintainers shall increase the size of all zip code fields in the resolution record from 5 to 9 positions							X	X		CERT
6465.45.1	Shared System Maintainers shall increase the size of claim header level Claim Zip Code from 5 to 9 positions							X	X		CERT
6465.45.2	Shared System Maintainers shall increase the size of claim header level Beneficiary Zip Code from 5 to 9 positions							X	X		CERT
6465.45.3	Shared System Maintainers shall increase the size of line item detail Line Zip Code from 5 to 9 positions							X	X		CERT

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
None											

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:
None	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Daniel Kalwa
410-786-1352
daniel.kalwa@cms.hhs.gov

Post-Implementation Contact(s):

Daniel Kalwa
410-786-1352
daniel.kalwa@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs) and Carriers*:
Not applicable.

Section B: *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: Part A File Layout Exhibit
Part B/DME File Layout Exhibit
Summary of File Changes

Claims Resolution File				
Claims Resolution Header Record (one record per file)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Resolution Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Resolution Date
Definition: Date the Resolution Record was created.
Validation: Must be a valid date not equal to a Resolution date sent on any previous claims Resolution file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
Requirement: Required

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	“2”
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Record Number	9(1)	9	9	Zero
Mode of Entry Indicator	X(1)	10	10	Space
Original Claim Control Number	X(23)	11	33	Spaces
Internal Control Number	X(23)	34	56	Spaces
Beneficiary HICN	X(12)	57	68	Spaces
Beneficiary Last Name	X(60)	69	128	Spaces
Beneficiary First Name	X(35)	129	163	Spaces
Beneficiary Middle Initial	X(1)	164	164	Spaces
Beneficiary Date of Birth	X(8)	165	172	Spaces
Beneficiary Gender	X(1)	173	173	Spaces
Billing Provider Number	X(9)	174	182	Spaces
Attending Physician UPIN	X(6)	183	188	Spaces
Claim Paid Amount	S9(8)V99	189	198	Zeroes
Claim ANSI Reason Code 1	X(8)	199	206	Spaces
Claim ANSI Reason Code 2	X(8)	207	214	Spaces
Claim ANSI Reason Code 3	X(8)	215	222	Spaces
Claim ANSI Reason Code 4	X(8)	223	230	Spaces
Claim ANSI Reason Code 5	X(8)	231	238	Spaces
Claim ANSI Reason Code 6	X(8)	239	246	Spaces
Claim ANSI Reason Code 7	X(8)	247	254	Spaces
Statement covers From Date	X(8)	255	262	Spaces
Statement covers Thru Date	X(8)	263	270	Spaces
Claim Entry Date	X(8)	271	278	Spaces
Claim Adjudicated Date	X(8)	279	286	Spaces
Condition Code 1	X(3)	287	289	Spaces
Condition Code 2	X(3)	290	292	Spaces
Condition Code 3	X(3)	293	295	Spaces
Condition Code 4	X(3)	296	298	Spaces
Condition Code 5	X(3)	299	301	Spaces
Condition Code 6	X(3)	302	304	Spaces
Condition Code 7	X(3)	305	307	Spaces
Condition Code 8	X(3)	308	310	Spaces
Condition Code 9	X(3)	311	313	Spaces
Condition Code 10	X(3)	314	316	Spaces
Condition Code 11	X(3)	317	319	Spaces
Condition Code 12	X(3)	320	322	Spaces
Condition Code 13	X(3)	323	325	Spaces
Condition Code 14	X(3)	326	328	Spaces
Condition Code 15	X(3)	329	331	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Condition Code 16	X(3)	332	334	Spaces
Condition Code 17	X(3)	335	337	Spaces
Condition Code 18	X(3)	338	340	Spaces
Condition Code 19	X(3)	341	343	Spaces
Condition Code 20	X(3)	344	346	Spaces
Condition Code 21	X(3)	347	349	Spaces
Condition Code 22	X(3)	350	352	Spaces
Condition Code 23	X(3)	353	355	Spaces
Condition Code 24	X(3)	356	358	Spaces
Condition Code 25	X(3)	359	361	Spaces
Condition Code 26	X(3)	362	364	Spaces
Condition Code 27	X(3)	365	367	Spaces
Condition Code 28	X(3)	368	370	Spaces
Condition Code 29	X(3)	371	373	Spaces
Condition Code 30	X(3)	374	376	Spaces
Type of Bill	X(3)	377	379	Spaces
Principal Diagnosis Code	X(7)	380	386	Spaces
Principal Diagnosis Code Version Indicator Code	X(1)	387	387	Spaces
Other Diagnosis Code 1	X(7)	388	394	Spaces
Other Diagnosis Code 1 Version Indicator Code	X(1)	395	395	Spaces
Other Diagnosis Code 2	X(7)	396	402	Spaces
Other Diagnosis Code 2 Version Indicator Code	X(1)	403	403	Spaces
Other Diagnosis Code 3	X(7)	404	410	Spaces
Other Diagnosis Code 3 Version Indicator Code	X(1)	411	411	Spaces
Other Diagnosis Code 4	X(7)	412	418	Spaces
Other Diagnosis Code 4 Version Indicator Code	X(1)	419	419	Spaces
Other Diagnosis Code 5	X(7)	420	426	Spaces
Other Diagnosis Code 5 Version Indicator Code	X(1)	427	427	Spaces
Other Diagnosis Code 6	X(7)	428	434	Spaces
Other Diagnosis Code 6 Version Indicator Code	X(1)	435	435	Spaces
Other Diagnosis Code 7	X(7)	436	442	Spaces
Other Diagnosis Code 7 Version Indicator Code	X(1)	443	443	Spaces
Other Diagnosis Code 8	X(7)	444	450	Spaces
Other Diagnosis Code 8 Version Indicator Code	X(1)	451	451	Spaces
Other Diagnosis Code 9	X(7)	452	458	Spaces
Other Diagnosis Code 9 Version Indicator Code	X(1)	459	459	Spaces
Other Diagnosis Code 10	X(7)	460	466	Spaces
Other Diagnosis Code 10 Version Indicator Code	X(1)	467	467	Spaces
Other Diagnosis Code 11	X(7)	468	474	Spaces
Other Diagnosis Code 11 Version Indicator Code	X(1)	475	475	Spaces
Other Diagnosis Code 12	X(7)	476	482	Spaces
Other Diagnosis Code 12 Version Indicator Code	X(1)	483	483	Spaces
Other Diagnosis Code 13	X(7)	484	490	Spaces
Other Diagnosis Code 13 Version Indicator Code	X(1)	491	491	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Diagnosis Code 14	X(7)	492	498	Spaces
Other Diagnosis Code 14 Version Indicator Code	X(1)	499	499	Spaces
Other Diagnosis Code 15	X(7)	500	506	Spaces
Other Diagnosis Code 15 Version Indicator Code	X(1)	507	507	Spaces
Other Diagnosis Code 16	X(7)	508	514	Spaces
Other Diagnosis Code 16 Version Indicator Code	X(1)	515	515	Spaces
Other Diagnosis Code 17	X(7)	516	522	Spaces
Other Diagnosis Code 17 Version Indicator Code	X(1)	523	523	Spaces
Other Diagnosis Code 18	X(7)	524	530	Spaces
Other Diagnosis Code 18 Version Indicator Code	X(1)	531	531	Spaces
Other Diagnosis Code 19	X(7)	532	538	Spaces
Other Diagnosis Code 19 Version Indicator Code	X(1)	539	539	Spaces
Other Diagnosis Code 20	X(7)	540	546	Spaces
Other Diagnosis Code 20 Version Indicator Code	X(1)	547	547	Spaces
Other Diagnosis Code 21	X(7)	548	554	Spaces
Other Diagnosis Code 21 Version Indicator Code	X(1)	555	555	Spaces
Other Diagnosis Code 22	X(7)	556	562	Spaces
Other Diagnosis Code 22 Version Indicator Code	X(1)	563	563	Spaces
Other Diagnosis Code 23	X(7)	564	570	Spaces
Other Diagnosis Code 23 Version Indicator Code	X(1)	571	571	Spaces
Other Diagnosis Code 24	X(7)	572	578	Spaces
Other Diagnosis Code 24 Version Indicator Code	X(1)	579	579	Spaces
Principal Procedure	X(7)	580	586	Spaces
Principal Procedure Version Indicator Code	X(1)	587	587	Spaces
Principal Procedure Date	X(8)	588	595	Spaces
Other Procedure 1	X(7)	596	602	Spaces
Other Procedure 1 Version Indicator Code	X(1)	603	603	Spaces
Other Procedure 1 Date	X(8)	604	611	Spaces
Other Procedure 2	X(7)	612	618	Spaces
Other Procedure 2 Version Indicator Code	X(1)	619	619	Spaces
Other Procedure 2 Date	X(8)	620	627	Spaces
Other Procedure 3	X(7)	628	634	Spaces
Other Procedure 3 Version Indicator Code	X(1)	635	635	Spaces
Other Procedure 3 Date	X(8)	636	643	Spaces
Other Procedure 4	X(7)	644	650	Spaces
Other Procedure 4 Version Indicator Code	X(1)	651	651	Spaces
Other Procedure 4 Date	X(8)	652	659	Spaces
Other Procedure 5	X(7)	660	666	Spaces
Other Procedure 5 Version Indicator Code	X(1)	667	667	Spaces
Other Procedure 5 Date	X(8)	668	675	Spaces
Other Procedure 6	X(7)	676	682	Spaces
Other Procedure 6 Version Indicator Code	X(1)	683	683	Spaces
Other Procedure 6 Date	X(8)	684	691	Spaces
Other Procedure 7	X(7)	692	698	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Procedure 7 Version Indicator Code	X(1)	699	699	Spaces
Other Procedure 7 Date	X(8)	700	707	Spaces
Other Procedure 8	X(7)	708	714	Spaces
Other Procedure 8 Version Indicator Code	X(1)	715	715	Spaces
Other Procedure 8 Date	X(8)	716	723	Spaces
Other Procedure 9	X(7)	724	730	Spaces
Other Procedure 9 Version Indicator Code	X(1)	731	731	Spaces
Other Procedure 9 Date	X(8)	732	739	Spaces
Other Procedure 10	X(7)	740	746	Spaces
Other Procedure 10 Version Indicator Code	X(1)	747	747	Spaces
Other Procedure 10 Date	X(8)	748	755	Spaces
Other Procedure 11	X(7)	756	762	Spaces
Other Procedure 11 Version Indicator Code	X(1)	763	763	Spaces
Other Procedure 11 Date	X(8)	764	771	Spaces
Other Procedure 12	X(7)	772	778	Spaces
Other Procedure 12 Version Indicator Code	X(1)	779	779	Spaces
Other Procedure 12 Date	X(8)	780	787	Spaces
Other Procedure 13	X(7)	788	794	Spaces
Other Procedure 13 Version Indicator Code	X(1)	795	795	Spaces
Other Procedure 13 Date	X(8)	796	803	Spaces
Other Procedure 14	X(7)	804	810	Spaces
Other Procedure 14 Version Indicator Code	X(1)	811	811	Spaces
Other Procedure 14 Date	X(8)	812	819	Spaces
Other Procedure 15	X(7)	820	826	Spaces
Other Procedure 15 Version Indicator Code	X(1)	827	827	Spaces
Other Procedure 15 Date	X(8)	828	835	Spaces
Other Procedure 16	X(7)	836	842	Spaces
Other Procedure 16 Version Indicator Code	X(1)	843	843	Spaces
Other Procedure 16 Date	X(8)	844	851	Spaces
Other Procedure 17	X(7)	852	858	Spaces
Other Procedure 17 Version Indicator Code	X(1)	859	859	Spaces
Other Procedure 17 Date	X(8)	860	867	Spaces
Other Procedure 18	X(7)	868	874	Spaces
Other Procedure 18 Version Indicator Code	X(1)	875	875	Spaces
Other Procedure 18 Date	X(8)	876	883	Spaces
Other Procedure 19	X(7)	884	890	Spaces
Other Procedure 19 Version Indicator Code	X(1)	891	891	Spaces
Other Procedure 19 Date	X(8)	892	899	Spaces
Other Procedure 20	X(7)	900	906	Spaces
Other Procedure 20 Version Indicator Code	X(1)	907	907	Spaces
Other Procedure 20 Date	X(8)	908	915	Spaces
Other Procedure 21	X(7)	916	922	Spaces
Other Procedure 21 Version Indicator Code	X(1)	923	923	Spaces
Other Procedure 21 Date	X(8)	924	931	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Procedure 22	X(7)	932	938	Spaces
Other Procedure 22 Version Indicator Code	X(1)	939	939	Spaces
Other Procedure 22 Date	X(8)	940	947	Spaces
Other Procedure 23	X(7)	948	954	Spaces
Other Procedure 23 Version Indicator Code	X(1)	955	955	Spaces
Other Procedure 23 Date	X(8)	956	963	Spaces
Other Procedure 24	X(7)	964	970	Spaces
Other Procedure 24 Version Indicator Code	X(1)	971	971	Spaces
Other Procedure 24 Date	X(8)	972	979	Spaces
Claim Demonstration Identification Number	9(2)	980	981	Zeroes
PPS Indicator	X(1)	982	982	Spaces
Action Code	X(1)	983	983	Spaces
Patient Status	X(2)	984	985	Spaces
Billing Provider NPI	X(10)	986	995	Spaces
Claim Provider Taxonomy Code	X(25)	996	1020	Spaces
Medical Record Number	X(17)	1021	1037	Spaces
Patient Control Number	X(20)	1038	1057	Spaces
Attending Physician NPI	X(10)	1058	1067	Spaces
Attending Physician Last Name	X(25)	1068	1092	Spaces
Operating Physician NPI	X(10)	1093	1102	Spaces
Operating Physician Last Name	X(25)	1103	1127	Spaces
Other Physician NPI	X(10)	1128	1137	Spaces
Other Physician Last Name	X(25)	1138	1162	Spaces
Date of Admission	X(8)	1163	1170	Spaces
Type of Admission	X(1)	1171	1171	Spaces
Source of Admission	X(1)	1172	1172	Spaces
DRG	X(3)	1173	1175	Spaces
Occurrence Code 1	X(2)	1176	1177	Spaces
Occurrence Code 1 Date	X(8)	1178	1185	Spaces
Occurrence Code 2	X(2)	1186	1187	Spaces
Occurrence Code 2 Date	X(8)	1188	1195	Spaces
Occurrence Code 3	X(2)	1196	1197	Spaces
Occurrence Code 3 Date	X(8)	1198	1205	Spaces
Occurrence Code 4	X(2)	1206	1207	Spaces
Occurrence Code 4 Date	X(8)	1208	1215	Spaces
Occurrence Code 5	X(2)	1216	1217	Spaces
Occurrence Code 5 Date	X(8)	1218	1225	Spaces
Occurrence Code 6	X(2)	1226	1227	Spaces
Occurrence Code 6 Date	X(8)	1228	1235	Spaces
Occurrence Code 7	X(2)	1236	1237	Spaces
Occurrence Code 7 Date	X(8)	1238	1245	Spaces
Occurrence Code 8	X(2)	1246	1247	Spaces
Occurrence Code 8 Date	X(8)	1248	1255	Spaces
Occurrence Code 9	X(2)	1256	1257	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Occurrence Code 9 Date	X(8)	1258	1265	Spaces
Occurrence Code 10	X(2)	1266	1267	Spaces
Occurrence Code 10 Date	X(8)	1268	1275	Spaces
Occurrence Code 11	X(2)	1276	1277	Spaces
Occurrence Code 11 Date	X(8)	1278	1285	Spaces
Occurrence Code 12	X(2)	1286	1287	Spaces
Occurrence Code 12 Date	X(8)	1288	1295	Spaces
Occurrence Code 13	X(2)	1296	1297	Spaces
Occurrence Code 13 Date	X(8)	1298	1305	Spaces
Occurrence Code 14	X(2)	1306	1307	Spaces
Occurrence Code 14 Date	X(8)	1308	1315	Spaces
Occurrence Code 15	X(2)	1316	1317	Spaces
Occurrence Code 15 Date	X(8)	1318	1325	Spaces
Occurrence Code 16	X(2)	1326	1327	Spaces
Occurrence Code 16 Date	X(8)	1328	1335	Spaces
Occurrence Code 17	X(2)	1336	1337	Spaces
Occurrence Code 17 Date	X(8)	1338	1345	Spaces
Occurrence Code 18	X(2)	1346	1347	Spaces
Occurrence Code 18 Date	X(8)	1348	1355	Spaces
Occurrence Code 19	X(2)	1356	1357	Spaces
Occurrence Code 19 Date	X(8)	1358	1365	Spaces
Occurrence Code 20	X(2)	1366	1367	Spaces
Occurrence Code 20 Date	X(8)	1368	1375	Spaces
Occurrence Code 21	X(2)	1376	1377	Spaces
Occurrence Code 21 Date	X(8)	1378	1385	Spaces
Occurrence Code 22	X(2)	1386	1387	Spaces
Occurrence Code 22 Date	X(8)	1388	1395	Spaces
Occurrence Code 23	X(2)	1396	1397	Spaces
Occurrence Code 23 Date	X(8)	1398	1405	Spaces
Occurrence Code 24	X(2)	1406	1407	Spaces
Occurrence Code 24 Date	X(8)	1408	1415	Spaces
Occurrence Code 25	X(2)	1416	1417	Spaces
Occurrence Code 25 Date	X(8)	1418	1425	Spaces
Occurrence Code 26	X(2)	1426	1427	Spaces
Occurrence Code 26 Date	X(8)	1428	1435	Spaces
Occurrence Code 27	X(2)	1436	1437	Spaces
Occurrence Code 27 Date	X(8)	1438	1445	Spaces
Occurrence Code 28	X(2)	1446	1447	Spaces
Occurrence Code 28 Date	X(8)	1448	1455	Spaces
Occurrence Code 29	X(2)	1456	1457	Spaces
Occurrence Code 29 Date	X(8)	1458	1465	Spaces
Occurrence Code 30	X(2)	1466	1467	Spaces
Occurrence Code 30 Date	X(8)	1468	1475	Spaces
Value Code 1	X(2)	1476	1477	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Value Amount 1	S9(8)V99	1478	1487	Zeroes
Value Code 2	X(2)	1488	1489	Spaces
Value Amount 2	S9(8)V99	1490	1499	Zeroes
Value Code 3	X(2)	1500	1501	Spaces
Value Amount 3	S9(8)V99	1502	1511	Zeroes
Value Code 4	X(2)	1512	1513	Spaces
Value Amount 4	S9(8)V99	1514	1523	Zeroes
Value Code 5	X(2)	1524	1525	Spaces
Value Amount 5	S9(8)V99	1526	1535	Zeroes
Value Code 6	X(2)	1536	1537	Spaces
Value Amount 6	S9(8)V99	1538	1547	Zeroes
Value Code 7	X(2)	1548	1549	Spaces
Value Amount 7	S9(8)V99	1550	1559	Zeroes
Value Code 8	X(2)	1560	1561	Spaces
Value Amount 8	S9(8)V99	1562	1571	Zeroes
Value Code 9	X(2)	1572	1573	Spaces
Value Amount 9	S9(8)V99	1574	1583	Zeroes
Value Code 10	X(2)	1584	1585	Spaces
Value Amount 10	S9(8)V99	1586	1595	Zeroes
Value Code 11	X(2)	1596	1597	Spaces
Value Amount 11	S9(8)V99	1598	1607	Zeroes
Value Code 12	X(2)	1608	1609	Spaces
Value Amount 12	S9(8)V99	1610	1619	Zeroes
Value Code 13	X(2)	1620	1621	Spaces
Value Amount 13	S9(8)V99	1622	1631	Zeroes
Value Code 14	X(2)	1632	1633	Spaces
Value Amount 14	S9(8)V99	1634	1643	Zeroes
Value Code 15	X(2)	1644	1645	Spaces
Value Amount 15	S9(8)V99	1646	1655	Zeroes
Value Code 16	X(2)	1656	1657	Spaces
Value Amount 16	S9(8)V99	1658	1667	Zeroes
Value Code 17	X(2)	1668	1669	Spaces
Value Amount 17	S9(8)V99	1670	1679	Zeroes
Value Code 18	X(2)	1680	1681	Spaces
Value Amount 18	S9(8)V99	1682	1691	Zeroes
Value Code 19	X(2)	1692	1693	Spaces
Value Amount 19	S9(8)V99	1694	1703	Zeroes
Value Code 20	X(2)	1704	1705	Spaces
Value Amount 20	S9(8)V99	1706	1715	Zeroes
Value Code 21	X(2)	1716	1717	Spaces
Value Amount 21	S9(8)V99	1718	1727	Zeroes
Value Code 22	X(2)	1728	1729	Spaces
Value Amount 22	S9(8)V99	1730	1739	Zeroes
Value Code 23	X(2)	1740	1741	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Value Amount 23	S9(8)V99	1742	1751	Zeroes
Value Code 24	X(2)	1752	1753	Spaces
Value Amount 24	S9(8)V99	1754	1763	Zeroes
Value Code 25	X(2)	1764	1765	Spaces
Value Amount 25	S9(8)V99	1766	1775	Zeroes
Value Code 26	X(2)	1776	1777	Spaces
Value Amount 26	S9(8)V99	1778	1787	Zeroes
Value Code 27	X(2)	1788	1789	Spaces
Value Amount 27	S9(8)V99	1790	1799	Zeroes
Value Code 28	X(2)	1800	1801	Spaces
Value Amount 28	S9(8)V99	1802	1811	Zeroes
Value Code 29	X(2)	1812	1813	Spaces
Value Amount 29	S9(8)V99	1814	1823	Zeroes
Value Code 30	X(2)	1824	1825	Spaces
Value Amount 30	S9(8)V99	1826	1835	Zeroes
Value Code 31	X(2)	1836	1837	Spaces
Value Amount 31	S9(8)V99	1838	1847	Zeroes
Value Code 32	X(2)	1848	1849	Spaces
Value Amount 32	S9(8)V99	1850	1859	Zeroes
Value Code 33	X(2)	1860	1861	Spaces
Value Amount 33	S9(8)V99	1862	1871	Zeroes
Value Code 34	X(2)	1872	1873	Spaces
Value Amount 34	S9(8)V99	1874	1883	Zeroes
Value Code 35	X(2)	1884	1885	Spaces
Value Amount 35	S9(8)V99	1886	1895	Zeroes
Value Code 36	X(2)	1896	1897	Spaces
Value Amount 36	S9(8)V99	1898	1907	Zeroes
Claim Final Allowed Amount	S9(8)V99	1908	1917	Zeroes
Claim Deductible Amount	S9(8)V99	1918	1927	Zeroes
Claim State	X(2)	1928	1929	Spaces
Claim Zip Code	X(9)	1930	1938	Spaces
Beneficiary State	X(2)	1939	1940	Spaces
Beneficiary Zip Code	X(9)	1941	1949	Spaces
Patient Reason for Visit 1	X(7)	1950	1956	Spaces
Patient Reason for Visit 1 Version Indicator Code	X(1)	1957	1957	Spaces
Patient Reason for Visit 2	X(7)	1958	1964	Spaces
Patient Reason for Visit 2 Version Indicator Code	X(1)	1965	1965	Spaces
Patient Reason for Visit 3	X(7)	1966	1972	Spaces
Patient Reason for Visit 3 Version Indicator Code	X(1)	1973	1973	Spaces
Present on Admission/External Cause of Injury Indicator	X(37)	1974	2010	Spaces
External Cause of Injury 1	X(7)	2011	2017	Spaces
External Cause of Injury 1 Version Indicator Code	X(1)	2018	2018	Spaces
External Cause of Injury 2	X(7)	2019	2025	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
External Cause of Injury 2 Version Indicator Code	X(1)	2026	2026	Spaces
External Cause of Injury 3	X(7)	2027	2033	Spaces
External Cause of Injury 3 Version Indicator Code	X(1)	2034	2034	Spaces
External Cause of Injury 4	X(7)	2035	2041	Spaces
External Cause of Injury 4 Version Indicator Code	X(1)	2042	2042	Spaces
External Cause of Injury 5	X(7)	2043	2049	Spaces
External Cause of Injury 5 Version Indicator Code	X(1)	2050	2050	Spaces
External Cause of Injury 6	X(7)	2051	2057	Spaces
External Cause of Injury 6 Version Indicator Code	X(1)	2058	2058	Spaces
External Cause of Injury 7	X(7)	2059	2065	Spaces
External Cause of Injury 7 Version Indicator Code	X(1)	2066	2066	Spaces
External Cause of Injury 8	X(7)	2067	2073	Spaces
External Cause of Injury 8 Version Indicator Code	X(1)	2074	2074	Spaces
External Cause of Injury 9	X(7)	2075	2081	Spaces
External Cause of Injury 9 Version Indicator Code	X(1)	2082	2082	Spaces
External Cause of Injury 10	X(7)	2083	2089	Spaces
External Cause of Injury 10 Version Indicator Code	X(1)	2090	2090	Spaces
External Cause of Injury 11	X(7)	2091	2097	Spaces
External Cause of Injury 11 Version Indicator Code	X(1)	2098	2098	Spaces
External Cause of Injury 12	X(7)	2099	2105	Spaces
External Cause of Injury 12 Version Indicator Code	X(1)	2106	2106	Spaces
Service Facility Zip Code	X(9)	2107	2115	Spaces
RAC adjustment indicator	X(1)	2116	2116	Spaces
Split/Adjustment Indicator	9(2)	2117	2118	Spaces
Claim PWK	X(60)	2119	2178	Spaces
Total Line Item Count	9(3)	2179	2181	Zeroes
Record Line Item Count	9(3)	2182	2184	Zeroes
Filler	X(50)	2185	2234	Spaces
Line Item group: The following group of fields occurs from 1 to 450 times for the claim (depending on Total Line Item Count) and 1 to **75** times for the Record (depending on Record Line Item Count)				
From and Thru values relate to the 1st line item				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Revenue center code	X(4)	2235	2238	Spaces
SNF-RUG-III code	X(3)	2239	2241	Spaces
APC adjustment code	X(5)	2242	2246	Spaces
HCPCS Procedure Code	X(5)	2247	2251	Spaces
HCPCS Modifier 1	X(2)	2252	2253	Spaces
HCPCS Modifier 2	X(2)	2254	2255	Spaces
HCPCS Modifier 3	X(2)	2256	2257	Spaces
HCPCS Modifier 4	X(2)	2258	2259	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
HCPCS Modifier 5	X(2)	2260	2261	Spaces
Line Item Date	X(8)	2262	2269	Spaces
Line Submitted Charge	S9(8)V99	2270	2279	Zeroes
Line Medicare Initial Allowed Charge	S9(8)V99	2280	2289	Zeroes
ANSI Reason Code 1	X(8)	2290	2297	Spaces
ANSI Reason Code 2	X(8)	2298	2305	Spaces
ANSI Reason Code 3	X(8)	2306	2313	Spaces
ANSI Reason Code 4	X(8)	2314	2321	Spaces
ANSI Reason Code 5	X(8)	2322	2329	Spaces
ANSI Reason Code 6	X(8)	2330	2337	Spaces
ANSI Reason Code 7	X(8)	2338	2345	Spaces
ANSI Reason Code 8	X(8)	2346	2353	Spaces
ANSI Reason Code 9	X(8)	2354	2361	Spaces
ANSI Reason Code 10	X(8)	2362	2369	Spaces
ANSI Reason Code 11	X(8)	2370	2377	Spaces
ANSI Reason Code 12	X(8)	2378	2385	Spaces
ANSI Reason Code 13	X(8)	2386	2393	Spaces
ANSI Reason Code 14	X(8)	2394	2401	Spaces
Manual Medical Review Indicator	X(1)	2402	2402	Spaces
Resolution Code	X(5)	2403	2407	Spaces
Line Final Allowed Charge	S9(8)V99	2408	2417	Zeroes
Line Cash Deductible	S9(8)V99	2418	2427	Zeroes
Special Action Code/Override Code	X(1)	2428	2428	Zeroes
Units	S9(7)v999	2429	2438	Zeroes
Rendering Physician NPI	X(10)	2439	2448	Spaces
Rendering Physician Last Name	X(25)	2449	2473	Spaces
National Drug Code (NDC) field	X(11)	2474	2484	Spaces
National Drug Code (NDC) Quantity Qualifier	X(2)	2485	2486	Spaces
National Drug Code (NDC) Quantity	S9(7)v999	2487	2496	Spaces
Line PWK	X(60)	2497	2556	Spaces
Filler	X(10)	2557	2566	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A

Remarks: 2 = Claim record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Record Number
Definition: The sequence number of the record. A claim may have up to six records.
Validation: Must be between 1 and 6
Remarks: None
Requirement: Required

Data Element: Mode of Entry Indicator
Definition: Code that indicates if the claim is paper, EMC, or unknown
Validation: Must be 'E', 'P', or 'U'
Remarks E = EMC
P = Paper
U= Unknown
Use the same criteria to determine EMC, paper, or unknown as that used for workload reporting
Requirement: Required

Data Element: Original Claim Control Number
Definition: The Claim Control Number the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the contractor or shared system changed the claim control number during processing, enter the number the shared system used to look up the number needed to pull all records associated with the sample claim.
Validation: For all records in the resolution file, the Original Claim Control must match the Claim Control Number identified in the Sampled Claims Transaction File.
Remarks: N/A
Requirement: Required

Data Element: Internal Control Number
Definition: Number currently assigned by the Shared System to uniquely identify the claim

Validation: N/A
Remarks: Use the Original Claim Control Number if no adjustment has been made to the claim. This number may be different from the Original Claim Control Number if the shared system has assigned a new Claims Control Number to an adjustment to the claim requested.
Requirement: Required

Data Element: Beneficiary HICN
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Last Name
Definition: Last Name (Surname) of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary First Name
Definition: First (Given) Name of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Middle Initial
Definition: First letter from Beneficiary Middle Name
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Date of Birth
Definition: Birth date of the beneficiary
Validation: Must be a valid date
Remarks: MMDDCCYY on which the beneficiary was born
Requirement: Required

Data Element: Beneficiary Gender
Definition: Gender of the beneficiary
Validation: 'M' = Male, 'F' = Female, or 'U' = Unknown
Remarks: N/A
Requirement: Required

Data Element: Billing Provider Number
Definition: First nine characters of number used to identify the billing/pricing provider or supplier
Validation: Must be present
If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the first line of the claim
Remarks: N/A
Requirement: Required for all claims

Data Element: Attending Physician UPIN

Definition: The UPIN submitted on the claim used to identify the physician that is responsible for coordinating the care of the patient while in the facility.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Claim Paid Amount

Definition: Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier and represents what CMS paid to the institutional provider, physician, or supplier, i.e. The Claim Paid Amount is the net amount paid after co-insurance and deductibles are applied.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Claim ANSI Reason Code 1-7

Definition: Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed
Validation: Must be valid American National Standards Institute (ANSI) Ambulatory Surgical Center (ASC) claim adjustment code and applicable group code.
Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code
Requirement: Report all ANSI reason codes on the bill

Data Element: Statement Covers from Date

Definition: The beginning date of the statement
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Statement Covers thru Date

Definition: The ending date of the statement
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Claim Entry Date

Definition: Date claim entered the shared claim processing system, the receipt date
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Claim Adjudicated Date

Definition: Date claim completed adjudication, i.e., process date
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Condition Code 1-30

Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set

Remarks: This field is left justified and blank filled. Requirement: Required if there is a condition code for the bill.

Data Element: Type of Bill

Definition: A code indicating the specific type of bill (hospital, inpatient, SNF, outpatient, adjustments, voids, etc.).
This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set

Remarks: N/A

Requirement: Required

Data Element: Principal Diagnosis

Definition: The ICD--CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.

Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only ICD--CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD--CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD--CM diagnoses codes, including all seven digits where applicable

Remarks: The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered.

Requirement: Required

Data Element: Principal Diagnosis Version Indicator Code

Definition: The diagnosis version code identifying the version of ICD diagnosis code submitted.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks: With the exception of claims submitted by ambulance suppliers (specialty

Requirement: Principal Diagnosis Version Code 1 is required for ALL claims.

Data Element: Other Diagnosis Code 1-24

Definition: The ICD-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be present during treatment

Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only ICD-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including all seven digits where applicable.

Remarks: Report the full ICD-CM codes for up to 24 additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

Requirement: Required if available on the claim record.

Data Element: Other Diagnosis Version Indicator Code 1-24

Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code submitted.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks:

Requirement: Principal Diagnosis Version Code 1 is required for ALL claims. Other Diagnosis version codes 1-24 should be submitted to correspond to claim level diagnosis codes 1-24.

Data Element: Principal Procedure and Date

Definition: The ICD-9-CM code that indicates the principal procedure performed during the period covered by the institutional claim. And the Date on which it was performed.

Validation: Must be a valid ICD-9-CM procedure code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD-9-CM, Volume 3, procedure code, including all 4-digit codes where applicable.

Remarks: The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.

- The date applicable to the principal procedure is shown numerically as CCYYMMDD in the "date" portion.

Requirement: Required for inpatient claims.

Data Element: Principal Procedure Version Indicator Code

Definition: The version code identifying the version of ICD procedure code submitted.

Validation:

- Version ICD9 use Version Code ‘9’
- Version ICD10 use Version Code ‘0’

Remarks:

Requirement: Principal Procedure Code Version Code is required for ALL claims containing a Principal Procedure.

Data Element: Other Procedure and Date 1-24

Definition: The ICD-CM code identifying the procedure, other than the principal procedure, performed during the billing period covered by this bill.

Validation: Must be a valid ICD-CM procedure code

- CMS accepts only ICD-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD-CM, Volume 3, procedure code, including all seven digits where applicable.

Remarks: The date applicable to the procedure is shown numerically as CCYYMMDD in the “date” portion.

Requirement: Required if on claim record.

Data Element: Other Procedure Code Version Indicator Code 1-24

Definition: The ICD-CM diagnosis version code identifying the version of procedure code submitted.

Validation:

- Version ICD9 use Version Code ‘9’
- Version ICD10 use Version Code ‘0’

Remarks:

Requirement: Principal Procedure Version Code is required for ALL claims. Other Procedure version codes 1-24 should be submitted to correspond to other procedure code 1-24.

Data Element: Claim Demonstration Identification Number

Definition: The number assigned to identify a demonstration project.

Validation: Must be numeric or zeroes

Remarks:

Requirement: Required if available on claim record

Data Element: PPS Indicator

Definition: The code indicating whether (1) the claim is Prospective Payment System (PPS) or (0) not PPS.

Validation: 0 = Not PPS

1 = PPS

Remarks: N/A

Requirement: Required

Data Element: Action Code

Definition: Indicator identifying the type of action requested by the intermediary to be taken on an institutional claim.
Validation: Must be a valid action code as listed in http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf
Remarks: N/A
Requirement: Required

Data Element: Patient Status
Definition: This code indicates the patient's status as of the "Through" date of the billing period.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Remarks:
Requirement: Required

Data Element: Billing Provider NPI
Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required for providers using HIPAA standard transactions

Data Element: Claim Provider Taxonomy Code
Definition: The non-medical data code set used to classify health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute Accredited Standards Committee health care transaction.
Validation: Must be present
- If multiple taxonomy codes are associated with a provider number, provide the first one in sequence.

Remarks: N/A
Requirement: Required when available.

Data Element: Medical Record Number
Definition: Number assigned to patient by hospital or other provider to assist in retrieval of medical records
Validation: N/A
Remarks: N/A
Requirement: Required if available on claim record

Data Element: Patient Control Number
Definition: The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment.
Validation: N/A
Remarks: N/A
Requirement: Required if available on claim record

Data Element: Attending Physician NPI
Definition: NPI assigned to the Attending Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Attending Physician Last Name
Definition: Last Name (Surname) of the attending physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Operating Physician NPI
Definition: NPI assigned to the Operating Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Operating Physician Last Name
Definition: Last Name (Surname) of the operating physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Other Physician NPI
Definition: NPI assigned to the Other Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Other Physician Last Name
Definition: Last Name (Surname) of the other physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Date of Admission
Definition: The date the patient was admitted to the provider for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.
Validation: Must be a valid date
Remarks: Format date as CCYYDDD
Requirement: Required if on claim record.

Data Element: Type of Admission
Definition: The code indicating the type and priority of an inpatient admission associated with the service on an intermediary claim.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Code Structure:
Requirement: Required on inpatient claims only.

Data Element: Source of Admission
Definition: The code indicating the means by which the beneficiary was admitted to the inpatient health care facility or SNF if the type of admission is (1) emergency, (2) urgent, or (3) elective.

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Code Structure (For Emergency, Elective, or Other Type of Admission):
Requirement: Required when entered on the claim record.

Data Element: DRG (Diagnosis Related Group)
Definition: The code identifying the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
Validation: Must be valid per the DRG DEFINITIONS MANUAL
Remarks: N/A
Requirement: Required if available on the claim record

Data Element: Occurrence Code and Date 1-30
Definition: Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Remarks:

- Event codes are two alpha-numeric digits, and dates are shown as eight numeric digits (MM-DD-CCYY)
- When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value codes, if there is another payer involved.

Requirement: Required if available on claim record

Data Element: Value Codes and Amounts 1-36
Definition: Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Remarks:

- The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00).
- Negative amounts are not allowed except in the last entry.
- Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter.
- Some values are reported as cents, so refer to specific codes for instructions.
- If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence.
- Use the first line before the second, etc.

Requirement: Required if available on claim record

Data Element: Claim Final Allowed Amount
Definition: Final Allowed Amount for this claim.
Validation: N/A
Remarks: The Gross Allowed charges on the claim. This represents the amount paid to the provider plus any beneficiary responsibility (co-pay and deductible)
Requirement: Required.

Data Element: Claim Deductible Amount

Definition: Amount of deductible applicable to the claim.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Claim State
Definition: 2 character indicator showing the state where the service is furnished
Validation: Must be a valid USPS state abbreviation
Remarks: N/A
Requirement: Required

Data Element: Claim Zip Code
Definition: Zip code of the physical location where the services were furnished.
Validation: Must be a valid USPS zip code.
Remarks: N/A
Requirement: Required

Data Element: Beneficiary State
Definition: 2 character indicator showing the state of beneficiary residence
Validation: Must be a valid USPS state abbreviation
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Zip Code
Definition: Zip code associated with the beneficiary residence.
Validation: Must be a valid USPS zip code.
Remarks: N/A
Requirement: Required

Data Element: Patient Reason for Visit 1-3
Definition: An ICD-9-CM code on the institutional claim indicating the beneficiary's reason for visit
Validation: Must be a valid ICD-CM diagnosis code

- CMS accepts only ICD-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including all seven digits where applicable.

Remarks: Report the full ICD-CM codes for up to 3 conditions responsible for the patient’s visit.
Requirement: For OP claims, this field is populated for those claims that are required to process through OP PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services

Data Element: Patient Reason for Visit Version Indicator Code 1-3

Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code submitted.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks:

Requirement: Patient Reason for Visit Version codes must be submitted to correspond to patient reason for visit codes 1-3.

Data Element: Present on Admission/External Cause of Injury Indicator

Definition: The code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility

Validation: Position 1 for Principle Diagnosis, positions 2-25 for the 24 Secondary Diagnosis for the Present on Admission (POA) Indicator, Positions 26 – 37 for the 12 External Cause of Injury.

Remarks: N/A

Requirement: Required

Data Element: External Cause of Injury Diagnosis Codes 1-12

Definition: The ICD-CM code used to identify the external cause of injury, poisoning, or other adverse affect.

Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only ICD-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including all seven digits where applicable.

Remarks: Report the full ICD-CM codes for up to 12 conditions resulting from external causes.

Requirement: Required if available on the claim record.

Data Element: External Cause of Injury Version Indicator Code Codes 1-12

Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code identified as external cause of injury.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks:

Requirement: External Cause of Injury version codes 1-12 should be submitted to correspond to external cause of injury diagnosis codes 1-12.

Data Element: Service Facility Zip Code

Definition: Zip Code used to identify were the service was furnished.

Validation: Must be a valid Zip Code

Remarks:

Requirement: Required, if available on claim record.

Data Element: RAC Adjustment Indicator

Definition: Indicator used to identify RAC requested adjustments, which occur as a result of post-payment review activities done by the Recovery Audit Contractors (RAC).

Validation: 'R' identifies a RAC-requested adjustment

Remarks: N/A

Requirement: Required when RAC adjustment indicator was furnished to CWF.

Data Element: Split/Adjustment Indicator

Definition: Count of number of adjustments (with different DCNs) of the claim that are included in the resolution file.

Validation: '00' is used when only one DCN associated with the sampled claim is included in the resolution file.

When the resolution file contains multiple adjustments associated with a single claim, this field will provide a count of records.

- When the resolution file contains 2 DCNs related to a single claim, one of the records would contain a split/adjustment indicator of 01 and the second record would contain a split/adjustment indicator of 02.

This field is right justified and zero filled.

Remarks: This indicator does not apply when multiple records are submitted for a single claim record because of size restrictions.

CERT recognizes that Part A claims are not split. For Part A this field will identify adjustments only.

Requirement: Required when the resolution file contains multiple versions of a single claim.

Data Element: PWK Filler

Definition: PWK space -- use to be determined

Validation: N/A

Remarks: N/A

Requirement: Required when available on claim

Data Element: Total Line Item Count

Definition: Number indicating number of service lines on the claim

Validation: Must be a number 001 - 450

Remarks: N/A

Requirement: Required

Data Element: Record Line Item Count

Definition: Number indicating number of service lines on this record

Validation: Must be a number 001 - 100

Remarks: N/A

Requirement: Required

Data Element: Filler

Definition: Additional space -- use to be determined

Validation: N/A

Remarks: N/A

Requirement: Required

Claim Line Item Fields

Data Element: Revenue Center Code

Definition: Code assigned to each cost center for which a charge is billed

Validation: Must be a valid NUBC-approved code
Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set

Remarks:
Include an entry for revenue code '0001'

Requirement: Required

Data Element: SNF-RUG-III Code

Definition: Skilled Nursing Facility Resource Utilization Group Version III (RUG-III) descriptor. This is the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the Minimum Data Set (MDS) assessment reference date and (2) the type of assessment for payment purposes.

Validation: N/A

Remarks: N/A

Requirement: Required for SNF inpatient bills

Data Element: APC Adjustment Code

Definition: The Ambulatory Payment Classification (APC) Code or Home Health Prospective Payment System (HIPPS) code.

The APC codes are the basis for the calculation of payment of services made for hospital outpatient services, certain PTB services furnished to inpatients who have no Part A coverage, CMHCs, and limited services provided by CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness.

This field may contain a HIPPS code. If a HHPPS HIPPS code is down coded, the down coded HIPPS will be reported in this field.

The HIPPS code identifies (1) the three case-mix dimensions of the Home Health Resource Group (HHRG) system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, is the basis of payment for each episode.

Validation: N/A

Remarks: Left justify the APC Adjustment Code

Requirement: Required if present on claim record

Data Element: HCPCS Procedure Code or HIPPS Code

Definition: The HCPCS/CPT-4 code that describes the service or Health Insurance PPS (HIPPS) code

Validation: Must be a valid HCPCS/CPT-4 or HIPPS code

Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided

to Medicare beneficiaries and to individuals enrolled in private health insurance programs

When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXYY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without co-morbidity. The 'B' in front of the CMG is defined as with co-morbidity for Tier 1. The 'C' is defined as co-morbidity for Tier 2 and 'D' is defined as co-morbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

Requirement: Required if present on claim record

Data Element: HCPCS Modifier 1
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4
HCPCS Modifier 5

Definition: Codes identifying special circumstances related to the service
Validation: N/A
Remarks: N/A
Requirement: Required if available

Element: Line Item Date
Definition: The date the service was initiated
Validation: Must be a valid date.
Remarks: Format is CCYYMMDD
Requirement: Required if on bill and included in the shared system

Data Element: Line Submitted Charge
Definition: Actual charge submitted by the provider or supplier for the service or equipment
Validation: N/A
Remarks: This is a required field. CR3997 provided direction on how to populate this field if data is not available in the claim record.
Requirement: Required

Data Element: Line Medicare Initial Allowed Charge

Definition: Amount Medicare allowed for the service or equipment before any reduction or denial

Validation: Must be a numeric value.

Remarks: This is a required field. Use the value in FISS field FSSCPDCL-REV-COV-CHRG-AMT to populate this field (per CMS Change Request 3912)

Requirement: Required

Data Element: ANSI Reason Code 1-14

Definition: Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed

Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes

Remarks: Format is GGRRRRRR where: G is the group code and RRRRRR is the adjustment reason code

Requirement: Report all ANSI Reason Codes included on the bill.

Data Element: Manual Medical Review Indicator

Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relative pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be 'Y' or 'N'

Remarks: Set to 'Y' if service was subjected to complex manual medical review, else 'N'

Requirement: Required

Data Element: Resolution Code

Definition: Code indicating how the contractor resolved the line.

Automated Review (AM): An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system containing medical review edits.

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is

considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

Complex Manual Review (MC): Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, the review is complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be 'APP', 'APPMR', 'APPMC', 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC', 'REO', 'DENAM', 'REDAM' , INACT

Remarks:

Resolution Code	Description
APP	Approved as a valid submission without manual medical review.
APPAM	Approved after automated medical review
APPMR	Approved after manual medical review routine
APPMC	Approved after manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.
DENAM	Denied after automated medical review
DENMR	Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMC	Denied for medical review reasons or for insufficient documentation medical necessity, manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DEO	Denied for non-medical reasons, other than denied as unprocessable.
RTP	Denied as unprocessable (return/reject)
REDAM	Reduced after medical review
REDMR	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
REDMC	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
REO	Reduced for non-medical review reasons.
INACT	Claim is inactive as identified by "I" Status

Requirement: **Required**

Data Element: Final Allowed Charge
Definition: Final amount paid to the provider for this service or equipment plus patient responsibility.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Cash Deductible
Definition: The amount of cash deductible the beneficiary paid for the line item service.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Special Action/Override Code
Definition: Code used to identify special actions taken in determining payment of this line item.
Validation: Must be valid
Remarks: N/A
Requirement: Required

Data Element: Units
Definition: The total number of services or time periods provided for the line item.
Validation: N/A
Remarks: Zero filled to maintain the relative position of the decimal point. The last three positions should contain the value to the right of the decimal in the number of services. Put a zero in the last three positions for whole numbers. For example if the number of units is 10, this field would be filled as 0000010000
Requirement: Required

Data Element: Rendering Physician NPI
Definition: NPI assigned to the Rendering Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Rendering Physician Last Name
Definition: Last Name (Surname) of the rendering physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: National Drug Code (NDC) field
Definition: To be assigned at a later date.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: National Drug Code (NDC) Quantity Qualifier
Definition: To be assigned at a later date.
Validation: Must be present
Remarks: N/A

Requirement: Required when available on claim record

Data Element: National Drug Code (NDC) Quantity
Definition: To be assigned at a later date.
Validation: Must be present
Remarks: Zero filled to maintain the relative position of the decimal point. For example if the number of units is 10, this field would be filled as 0000010000
Requirement: Required when available on claim record

Data Element: PWK Filler
Definition: PWK space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required when available on claim

Data Element: Filler
Definition: Additional space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required

Claims Resolution File				
Claims Resolution Trailer Record (one record per file)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	10	10	'3'
Record Version Code	X(1)	11	11	Spaces
Contractor Type	X(1)	12	12	Spaces
Number of Claims	9(9)	13	21	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Number of Claims
Definition: Number of claim records on this file
Validation: Must be equal to the number of claim records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Claims Provider Address File				
Claims Provider Address Header Record (one record per file)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Address Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Provider Address Date
Definition: Date the Provider Address File was created.
Validation: Must be a valid date not equal to a Provider Address date sent on any previous claims Provider Address file
Remarks: Format is CCYYMMDD. May use shared system batch processing date

Requirement: Required

Provider Address File				
Provider Address Detail Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	Spaces
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Sequence Number	X(1)	9	9	Spaces
Provider Number	X(15)	10	24	Spaces
Provider Name	X(60)	25	84	Spaces
Provider Address 1	X(25)	85	109	Spaces
Provider Address 2	X(25)	110	134	Spaces
Provider City	X(15)	135	149	Spaces
Provider State Code	X(2)	150	151	Spaces
Provider Zip Code	X(9)	152	160	Spaces
Provider Phone Number	X(10)	161	170	Spaces
Provider Phone Number Extension	X(10)	171	180	Spaces
Provider FAX Number	X(10)	181	190	Spaces
Provider Type	X(1)	191	191	Spaces
Provider Address Type	9(3)	192	194	1
Provider E-mail Address	X(75)	195	269	Spaces
Provider Federal Tax number or EIN	9(10)	270	279	Zeroes
Filler	X(51)	280	330	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = Detail record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Sequence Number
Definition: Number occurrence number of addresses when there are multiple addresses for a provider.
Validation: Must be between 1 and 3
Remarks: Enter 1 if there is only one address for a provider
Requirement: Required

Data Element: Provider Number
Definition: Number assigned by Medicare to identify the provider
Validation: N/A
Remarks: Left justify
Requirement: Required

Data Element: Provider Name
Definition: Provider's name
Validation: N/A
Remarks: This is the business name associated with the provider number. Must be formatted into a name for mailing (e. g., Roger A Smith M.D. or Medical Associates, Inc.)
Requirement: Required

Data Element: Provider Address 1
Definition: First line of provider's address
Validation: N/A
Remarks: This is the first line of the address associated with the provider number indicated in the record.
Requirement: Required for all Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Address 2
Definition: Second line of provider's address
Validation: N/A
Remarks: This is the line of the address associated with the provider number indicated in the record.
Requirement: Required for all Billing Provider Numbers. Furnish as available for other types of provider numbers

Data Element: Provider City
Definition: Provider's city name
Validation: N/A
Remarks: This is the city of the provider number
Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider State Code

Definition: Provider's state code
Validation: Must be a valid state code
Remarks: This is the state associated with the address of the provider number.
Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Zip Code

Definition: Provider's zip code
Validation: Must be a valid postal zip code
Remarks: This is the zip code associated with the address furnished for the provider number identified in this record.

- Provide 9-digit zip code if available, otherwise provide 5-digit zip code

Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers

Data Element: Provider Phone Number

Definition: Provider's phone number
Validation: Must be a valid phone number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Phone Number Extension

Definition: Provider's phone number extension
Validation: Must be a valid phone number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Fax Number

Definition: Provider’s fax number
Validation: Must be a valid fax number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Type

Definition: 1=Billing Provider Number (OSCAR)
2=Attending Physician Number (UPIN)
3=Operating Physician Number (UPIN)
4=Other Physician Number (UPIN)
5=Billing Provider NPI
6=Attending Physician NPI
7=Operating Physician NPI
8=Other Physician NPI
Validation: Must be 1-8
Remarks: This field identifies the type of provider number whose name, address, phone number and identification information are included in the record
Requirement: Required

Data Element: **Provider Address Type**
Definition: The type of Provider Address furnished.
Validation: 1 = Master Address (FISS)
Legal Address (APASS)
2 = Remittance Address (FISS)
3 = Check Address (FISS) (APASS)
4 = MSP Other Address (FISS)
5 = Medical Review Address (FISS) (APASS)
6 = Other Address (FISS) (APASS)
7 = Chain Address (APASS)
8 = Correspondence Address
9 = Medical Record Address

Remarks: The first "address type" for each provider will always be a "1." Subsequent occurrences of addresses for the same provider will have the "address type" to correspond to the address submitted. When your files contain only one address for the provider, submit only one provider address record. Submit additional address records for a single provider number only when your files contain addresses that differ from the Master or Legal address.

- Correspondence Address—The Correspondence Address as indicated on the 855A. This is the address and telephone number where Medicare can directly get in touch with the enrolling provider. This address cannot be that of the billing agency, management service organization, or staffing company.
- Medical Record Address—the Location of Patients' Medical Records as indicated on the 855A. This information is required if the Patients' Medical Records are stored at a location other than the Master Address (practice location). Post Office Boxes and Drop Boxes are not acceptable as the physical address where patient's medical records are maintained.

Requirement: Required Billing Provider Numbers. Furnish as available for other types of provider numbers

Data Element: Provider E-Mail Address
Definition: Provider's e-mail address
Validation: Must be a valid e-mail address
Remarks: N/A
Requirement: Required if available

Data Element: Provider Federal Tax Number or EIN
Definition: The number assigned to the billing provider by the Federal government for tax report purposes. The Federal Tax Number is also known as a tax identification number (TIN) or employer identification number (EIN).
Validation: Must be present
Remarks: N/A
Requirement: Required for all Billing Provider Numbers. For all other types of provider numbers, the tax number is required when available

Data Element: Filler
Definition: Additional space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required

Claims Provider Address File				
Claims Provider Address Trailer Record (one record per file)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	10	10	'3'
Record Version Code	X(1)	11	11	Spaces
Contractor Type	X(1)	12	12	Spaces
Number of Records	9(9)	13	20	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Number of Records
Definition: Number of provider address records on this file
Validation: Must be equal to the number of provider address records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Claims Resolution File				
Claims Resolution Header Record (one record per file)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Resolution Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Resolution Date
Definition: Date the Resolution Record was created.
Validation: Must be a valid date not equal to a Resolution date sent on any previous claims Resolution file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
Requirement: Required

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Assignment Indicator	X(1)	9	9	Spaces
Mode of Entry Indicator	X(1)	10	10	Spaces
Original Claim Control Number	X(15)	11	25	Spaces
Claim Control Number	X(15)	26	40	Spaces
Beneficiary HICN	X(12)	41	52	Spaces
Beneficiary Last Name	X(60)	53	112	Spaces
Beneficiary First Name	X(35)	113	147	Spaces
Beneficiary Middle Initial	X(1)	148	148	Spaces
Beneficiary Date Of Birth	X(8)	149	156	Spaces
Billing Provider Number	X(15)	157	171	Spaces
Referring/Ordering UPIN	X(6)	172	177	Spaces
Claim Allowed Amount	S9(7)v99	178	186	Zeroes
Claim ANSI Reason Code 1	X(8)	187	194	Spaces
Claim ANSI Reason Code 2	X(8)	195	202	Spaces
Claim ANSI Reason Code 3	X(8)	203	210	Spaces
Claim Entry Date	X(8)	211	218	Spaces
Claim Adjudicated Date	X(8)	219	226	Spaces
Beneficiary Gender	X(1)	227	227	Spaces
Billing Provider NPI	X(10)	228	237	Spaces
Referring/Ordering Provider NPI	X(10)	238	247	Spaces
Claim Paid Amount	S9(7)v99	248	256	Zeroes
Beneficiary Paid Amount	S9(7)v99	257	265	Zeroes
Claim Diagnosis Code 1	X(7)	266	272	Spaces
Claim Diagnosis Code 1Version Indicator Code	X(1)	273	273	Spaces
Claim Diagnosis Code 2	X(7)	274	280	Spaces
Claim Diagnosis Code 2Version Indicator Code	X(1)	281	281	Spaces
Claim Diagnosis Code 3	X(7)	282	288	Spaces
Claim Diagnosis Code 3Version Indicator Code	X(1)	289	289	Spaces
Claim Diagnosis Code 4	X(7)	290	296	Spaces
Claim Diagnosis Code 4Version Indicator Code	X(1)	297	297	Spaces
Claim Diagnosis Code 5	X(7)	298	304	Spaces
Claim Diagnosis Code 5Version Indicator Code	X(1)	305	305	Spaces
Claim Diagnosis Code 6	X(7)	306	312	Spaces
Claim Diagnosis Code 6Version	X(1)	313	313	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Indicator Code				
Claim Diagnosis Code 7	X(7)	314	320	Spaces
Claim Diagnosis Code 7Version Indicator Code	X(1)	321	321	Spaces
Claim Diagnosis Code 8	X(7)	322	328	Spaces
Claim Diagnosis Code 8Version Indicator Code	X(1)	329	329	Spaces
Claim Diagnosis Code 9	X(7)	330	336	Spaces
Claim Diagnosis Code 9Version Indicator Code	X(1)	337	337	Spaces
Claim Diagnosis Code 10	X(7)	338	344	Spaces
Claim Diagnosis Code 10Version Indicator Code	X(1)	345	345	Spaces
Claim Diagnosis Code 11	X(7)	346	352	Spaces
Claim Diagnosis Code 11Version Indicator Code	X(1)	353	353	Spaces
Claim Diagnosis Code 12	X(7)	354	360	Spaces
Claim Diagnosis Code 12Version Indicator Code	X(1)	361	361	Spaces
Claim Zip Code	X(9)	362	370	Spaces
Claim Pricing State	X(2)	371	372	Spaces
Beneficiary Zip Code	X(9)	373	381	Spaces
Beneficiary State	X(2)	382	383	Spaces
Claim Demonstration Number	X(2)	384	385	Spaces
RAC Adjustment Indicator	X(1)	386	386	Spaces
Split/Adjustment Indicator	X(2)	387	388	Spaces
Facility NPI	X(10)	389	398	Spaces
Claim PWK	X(60)	399	458	Spaces
Line Item Count	9(2)	459	460	Zeroes
Filler	X(50)	461	510	Spaces

Line Item group:
The following group of fields occurs from 1 to 52 times (Depending on Line Item Count).

From and Thru values relate to the 1st line item

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Performing Provider Number	X(15)	511	525	Spaces
Performing Provider Specialty	X(2)	526	527	Spaces
HCPCS Procedure Code	X(5)	528	532	Spaces
HCPCS Modifier 1	X(2)	533	534	Spaces

HCPCS Modifier 2	X(2)	535	536	Spaces
HCPCS Modifier 3	X(2)	537	538	Spaces
HCPCS Modifier 4	X(2)	539	540	Spaces
Number of Services	S9(7)v999	541	550	Zeroes
Service From Date	X(8)	551	558	Spaces
Service To Date	X(8)	559	566	Spaces
Place of Service	X(2)	567	568	Spaces
Type of Service	X(1)	569	569	Spaces
Diagnosis Code	X(7)	570	576	Spaces
Line Diagnosis Code Version Indicator Code	X(1)	577	577	Spaces
CMN Control Number	X(15)	578	592	Spaces
Line Submitted Charge	S9(7)v99	593	601	Zeroes
Line Medicare Initial Allowed Charge	S9(7)v99	602	610	Zeroes
ANSI Reason Code 1	X(8)	611	618	Spaces
ANSI Reason Code 2	X(8)	619	626	Spaces
ANSI Reason Code 3	X(8)	627	634	Spaces
ANSI Reason Code 4	X(8)	635	642	Spaces
ANSI Reason Code 5	X(8)	643	650	Spaces
ANSI Reason Code 6	X(8)	651	658	Spaces
ANSI Reason Code 7	X(8)	659	666	Spaces
Manual Medical Review Indicator	X(1)	667	667	Space
Resolution Code	X(5)	668	672	Spaces
Line Final Allowed Charge	S9(7)v99	673	681	Zeroes
Performing Provider NPI	X(10)	682	691	Spaces
Performing Provider UPIN	X(6)	692	697	Spaces
Miles/Time/Units/Services Indicator Code	X(1)	698	698	Spaces
Line Deductible Applied	S9(7)v99	699	707	Zeroes
Line Co-Insurance	S9(7)V99	708	716	Zeroes
Line Paid Amount	S9(7)v99	717	725	Zeroes
Line MSP Code	X(1)	726	726	Spaces
Line MSP Paid Amount	S9(7)v99	727	735	Zeroes
Line Pricing Locality	X(2)	736	737	Spaces
Line Zip Code	X(9)	738	746	Spaces
Line Pricing State Code	X(2)	747	748	Spaces
Ambulance Point of Pick up Zip Code	X(9)	749	757	Spaces
Ambulance Point of Drop Off Zip Code	X(9)	758	766	Spaces
Line PWK	X(60)	767	826	Spaces
Filler	X(25)	827	851	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = Claim record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Assignment Indicator
Definition: Code indicating whether claim is assigned or non-assigned
Validation: Must be 'A' or 'N'
Remarks: A = Assigned
N = Non-assigned
Requirement: Required

Data Element: Mode of Entry Indicator
Definition: Code that indicates if the claim is paper or EMC
Validation: Must be 'E' or 'P'
Remarks: E = EMC
P = Paper
Use the same criteria to determine EMC or paper as that used for workload reporting
Requirement: Required

Data Element: Original Claim Control Number
Definition: The Claim Control Number the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the contractor or shared system changed the claim control number during processing, enter the number the shared system used to look up the number needed to pull all records associated with the sample claim.
Validation: Must match the Claim Control Number identified in the Sampled Claims Transaction File.
Remarks: N/A
Requirement: Required

Data Element: Claim Control Number
Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary HICN
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Last Name
Definition: Last Name (Surname) of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary First Name
Definition: First (Given) Name of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Middle Initial
Definition: First letter from Beneficiary Middle Name
Validation: N/A
Remarks: N/A
Requirement: Required when available

Data Element: Beneficiary Date of Birth
Definition: Date on which beneficiary was born.
Validation: Must be a valid date
Remarks: MMDDCCYY on which the beneficiary was born
Requirement: Required

Data Element: Billing Provider Number

Definition: Number assigned by the NSC or Carrier to identify the billing/pricing provider or supplier.

Validation: Must be present. Use the same requirements as for Item 33 in HCFA 1500.

- Enter the PIN, for the performing provider of service/supplier who is **not** a member of a group practice.
- Enter the group PIN, for the performing provider of service/supplier who is a member of a group practice.
- Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item.
- If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the performing provider on the first line of the claim.

Remarks: N/A

Requirement: **Required**

Data Element: Referring/Ordering UPIN

Definition: UPIN assigned to identify the referring/ordering provider.

Validation: N/A

Remarks: Enter zeros if there is no referring/ordering provider

- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient

Requirement: Required when available on the claim record.

Data Element: Claim Allowed Amount

Definition: Final Allowed Amount for this claim.

Validation: N/A

Remarks: The total allowed charges on the claim (the sum of line item allowed charges)

Requirement: Required.

Data Element: Claim ANSI Reason Code 1-3

Definition: Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed

Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes

Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code

Requirement: ANSI Reason Code 1 must be present on all claims. Codes 2 and 3 should be sent, if available.

Data Element: Claim Entry Date

Definition: Date claim entered the shared claim processing system

Validation: Must be a valid date

Remarks: Format must be CCYYMMDD

Requirement: Required

Data Element: Claim Adjudicated Date

Definition: Date claim completed adjudication

Validation: Must be a valid date. Format must be CCYYMMDD

Remarks: This must represent the processed date that may be prior to the pay date if the claim is held on the payment floor after a payment decision has been made
Requirement: Required

Data Element: Beneficiary Gender
Definition: Gender of the Beneficiary.
Validation: M=Male
F=Female
U=Unknown
Remarks: N/A
Requirement: Required

Data Element: Billing Provider NPI
Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required when available. This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

Data Element: Referring/Ordering Provider NPI
Definition: NPI assigned to the Referring/Ordering Provider.
Validation: N/A
Remarks: Enter zeros if there is no referring/ordering provider
- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient

Requirement: Required when available on the claim record.

Data Element: Claim Paid Amount
Definition: Net amount paid after co-insurance and deductible. Do not include interest you paid in the amount reported.
Validation: N/A
Remarks: Amount of payment made from the Medicare trust fund for the services covered by the claim record
Requirement: Required.

Data Element: Beneficiary Paid Amount
Definition: Amount paid by Beneficiary to the provider.
Validation: N/A
Remarks: N/A
Requirement: Required if available.

Data Element: Claim Diagnosis Code 1-12
Definition: The ICD-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided
Validation: Must be a valid ICD-CM diagnosis code
- CMS accepts only ICD-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS approved errata and supplements to this publication. The CMS approves

only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.

- Diagnosis codes must be full ICD-CM diagnoses codes, including all seven digits where applicable

Remarks:

- These fields should be left justified and space filled. For instance if the primary diagnosis on the claim is five positions long, this field should contain the diagnosis with 2 spaces at the end.
- With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures. Since this is a required field, resolution records for claims billed by Ambulance suppliers and independent clinical laboratories must include the following filler information when the diagnosis is not otherwise available:
    - Ambulance supplier (specialty 59)—amb
    - Independent Clinical Lab (specialty 69)--lab

Requirement: Claim Diagnosis 1 is required for ALL claims.
Claim diagnosis codes 2-12 should be submitted if contained on the claim record.
Enter spaces for the diagnosis code fields that are not populated on the claim record in the Shared Processing System.

Data Element: Claim Diagnosis Version Indicator Code 1-12

Definition: The ICD-9-CM diagnosis version code identifying the version of diagnosis code submitted.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'
- May be blank for claims billed by ambulance and independent laboratory suppliers.

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures.

Requirement: Claim Diagnosis Version Code 1 is required for ALL claims, except those billed by ambulance and independent laboratories. Claim diagnosis version codes 2-12 should be submitted to correspond to claim level diagnosis codes 2-12.

Data Element: Claim Zip Code

Definition: Zip Code used to identify were the service was furnished.

Validation: Must be a valid Zip Code

- This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.

Remarks: For DMERC Claims use the zip code for beneficiary residence.
For Carrier Claims, use the zip code identified in item 32 of the HCFA 1500, except in the listed situations.

- For ambulance services, identify the zip code where the patient was picked up.
- If the service was furnished in the patient's home, use the zip code from the patient's home address.
- For electronic claims, if multiple zip codes are identified enter the zip code for the line with the highest allowed amount. (If this logic is too cumbersome to implement, we can live with enter the zip code from the first line)

Requirement: Required.

Data Element: Claim Pricing State
Definition: State where services were furnished.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states
Remarks: Furnish the state associated with the Claim Zip Code.
Requirement: Required.

Data Element: Beneficiary Zip Code
Definition: Zip Code associated with the beneficiary residence.
Validation: Must be a valid Zip Code

- This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.

Remarks: Use the zip code for beneficiary residence.
Requirement: Required.

Data Element: Beneficiary State
Definition: State abbreviation identifying the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)
http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states
Remarks: N/A
Requirement: Required

Data Element: Claim Demonstration Number
Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID
Remarks: N/A
Requirement: Required when available on claim.

Data Element: RAC Adjustment Indicator
Definition: Indicator used to identify RAC requested adjustments, which occur as a result of post-payment review activities done by the Recovery Audit Contractors (RAC).
Validation: 'R' identifies a RAC-requested adjustment
Remarks: N/A
Requirement: Required when RAC adjustment indicator was furnished to CWF.

Data Element: Split/Adjustment Indicator

Definition: Count of number of splits/replicates/adjustments (with different claim control numbers (ICN/CCN)) of the sampled that are included in the resolution file.
Validation: '00' is used when only one claim control number (ICN/CCN) associated with the sampled claim is included in the resolution file.
When the resolution file contains multiple adjustments/splits/replicates associated with a single claim, this field will provide a count of records.

- For example, if the file contains the original, replicate and adjustment claims, one record would have an indicator of 01, one record would have an indicator of 02, and the third record would have an indicator of 03.

Remarks: This indicator does not apply when multiple records are submitted for a single claim record because of size restrictions.
This field is right justified and zero filled.
Requirement: Required when the resolution file contains multiple versions of a single claim.

Data Element: Facility NPI
Definition: The NPI of the facility at which the service was performed.
Validation: N/A
Remarks: N/A
Requirement: Required when available on the claim record.

Data Element: PWK
Definition: Space reserved for future use.
Validation: N/A
Remarks: N/A
Requirement: Required when available on the claim record.

Data Element: Line Item Count
Definition: Number indicating number of service lines on the claim
Validation: Must be a number 01 – 52
Remarks: N/A
Requirement: Required

Data Element: Filler
Definition: Additional space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: Performing Provider Number
Definition: Number assigned by the shared system to identify the provider who performed the service or the supplier who supplied the medical equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Performing Provider Specialty
Definition: Code indicating the primary specialty of the performing provider or supplier

Validation: Must be a valid Provider Specialty per IOM 10.4 ch26 10.8
Remarks: N/A
Requirement: Required

Data Element: HCPCS Procedure Code
Definition: The HCPCS/CPT-4 code that describes the service
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: HCPCS Modifier 1-4
Definition: Codes identifying special circumstances related to the service
Validation: N/A
Remarks: N/A
Requirement: Required if available

Data Element: Number of Services
Definition: The number of service rendered in days or units
Validation: N/A
Remarks: Zero filled to maintain the relative position of the decimal point. The last three positions should contain the value to the right of the decimal in the number of services. Put a zero in the last three positions for whole numbers. For example if the number of units is 10, this field would be filled as 0000010000.
Requirement: Required

Data Element: Service from Date
Definition: The date the service was initiated
Validation: Must be a valid date less than or equal to Service to Date
Remarks: Format is MMDDCCYY
Requirement: Required

Data Element: Service to Date
Definition: The date the service ended
Validation: Must be a valid date greater than or equal to Service from Date
Remarks: Format is MMDDCCYY
Requirement: Required

Data Element: Place of Service
Definition: Code that identifies where the service was performed
Validation: N/A
Remarks: Must be a value in the range of 00 □ 99
Requirement: Required

Data Element: Type of Service
Definition: Code that classifies the service
Validation: The code must match a valid CWF type of service code
Remarks: N/A
Requirement: Required

Data Element: Diagnosis Code

Definition: Code identifying a diagnosed medical condition resulting in the line item service

Validation: Must be a valid ICD-CM diagnosis code

- CMS accepts only ICD-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including all seven digits where applicable

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures. Since this is a required field, resolution records for claims billed by Ambulance suppliers and independent clinical laboratories must include the following filler information when the diagnosis is not otherwise available:

- Ambulance supplier (specialty 59)—**amb**
- Independent Clinical Lab (specialty 69)--**lab**

Requirement: Required

Data Element: Line Diagnosis Code Version Indicator Code

Definition: The ICD-9-CM diagnosis version code identifying the version of diagnosis code submitted.

Validation:

- Version ICD9 use Version Code ‘9’
- Version ICD10 use Version Code ‘0
- May be blank for claims billed by ambulance and independent laboratory suppliers.

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures.

Requirement: Diagnosis Version Code is required for ALL lines, except those billed by ambulance and independent clinical laboratory suppliers.

Data Element: CMN Control Number

Definition: Number assigned by the shared system to uniquely identify a Certificate of Medical Necessity

Validation: N/A

Remarks: Enter a zero if no number is assigned

Requirement: Required on DMERC claims

Data Element: Line Submitted Charge

Definition: Actual charge submitted by the provider or supplier for the service or equipment

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Line Medicare Initial Allowed Charge

Definition: Amount Medicare allowed for the service or equipment before any reduction or denial

Validation: N/A

Remarks: This charge is the lower of the fee schedule or billed amount (i.e., Submitted Charge), except for those services (e.g., ASC) that are always paid at the fee schedule amount even if it is higher than the Submitted Charge. If there is no fee schedule amount, then insert the Submitted Charge.

- Use MPFDB, Clinical Lab FS, Ambulance FS, ASC FS, drug and injectable FS, or DME fee schedule as appropriate.

Requirement: Required

Data Element: ANSI Reason Code 1-7

Definition: Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed

Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes

Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code

Requirement: ANSI Reason Code 1 must be present on all claims with resolutions of 'DENMR', 'DENMC' ,'DEO', 'RTP', 'REDMR', 'REDMC', or 'REO','APPAM','DENAM','REDAM'.

Data Element: Manual Medical Review Indicator

Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex.

Validation: Must be 'Y' or 'N'

Remarks: Set to 'Y' if service was subjected to complex manual medical review, else 'N'

Requirement: Required

Data Element: Resolution Code

Definition: Code indicating how the contractor resolved the line.

Automated Review (AM): An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system containing medical review edits.

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the contractor's internal documentation, such as claims history file or policy

documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

Complex Manual Review (MC): Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, the review is complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be 'APP', 'APPMR', 'APPMC', 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC', 'REO', 'DENAM', 'REDAM' , 'DELET', or 'TRANS',

Remarks:

Resolution Code	Description
APP	Approved as a valid submission without manual medical review.
APPAM	Approved after automated medical review
APPMR	Approved after manual medical review routine
APPMC	Approved after manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.
DENAM	Denied after automated medical review
DENMR	Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMC	Denied for medical review reasons or for insufficient documentation medical necessity, manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DEO	Denied for non-medical reasons, other than denied as unprocessable.
RTP	Denied as unprocessable (return/reject)
REDAM	Reduced after medical review
REDMR	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
REDMC	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
REO	Reduced for non-medical review reasons.

Resolution Code	Description
DELET	Claim deleted from processing system—AC maintains record of claim on system
TRANS	Claim was originally submitted to the wrong contractor and has been transferred to the contractor with jurisdiction.

Requirement: Required

Data Element: Line Final Allowed Charge
Definition: Final Amount allowed for this service or equipment after any reduction or denial
Validation: N/A
Remarks: This represents the contractor's value of the service/item gross of co-pays and deductibles
Requirement: Required

Data Element: Performing Provider NPI
Definition: NPI assigned to the Performing Provider.
Validation: N/A
Remarks: N/A.
Requirement: This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

Data Element: Performing Provider UPIN
Definition: Unique Physician Identifier Number (UPIN) that identifies the physician supplier actually performing/providing the service.
Validation: N/A
Remarks: N/A.
Requirement: Required, **when available**.

Data Element: Miles/Time/Units/Services Indicator
Definition: Code indicating the units associated with services needing unit reporting on the line item for the carrier claim.
Validation: Must be a valid Indicator as identified in IOM 10.4 ch26 10.10
0 - No allowed services
1- Ambulance transportation miles
2- Anesthesia Time Units
3 - Services
4- Oxygen units
5- Units of Blood
Remarks: N/A
Requirement: Required

Data Element: Line Deductible Applied
Definition: Amount of deductible applied for this service or equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Line Co-Insurance Amount
Definition: Amount of co-insurance due for this service or equipment
Validation: N/A

Remarks: N/A
Requirement: Required

Data Element: Line Paid Amount
Definition: Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim
Validation: N/A
Remarks: This represents the contractor's value of the claim after co-pays and deductibles
Requirement: Required

Data Element: Line MSP Code
Definition: Code indicating primary payor for services on this line item
Validation: A-Working Aged
B-ESRD
D-No-Fault
E-Workers' Compensation
F-Federal (Public Health)
G-Disabled
H-Black Lung
I-Veterans
L-Liability
Remarks: N/A
Requirement: Required , when contained on the claim record.

Data Element: Line MSP Paid Amount
Definition: The amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or tertiary).
Validation: N/A
Remarks: Amount paid by Primary Payer
Requirement: Required , when contained on the claim record.

Data Element: Line Pricing Locality
Definition: Code denoting the carrier-specific locality used for pricing this claim.
Validation: Must be a valid pricing locality
- Enter '00' for claims priced at a statewide locality.

Requirement: Required.

Data Element: Line Zip Code
Definition: Zip Code used to determine claim pricing locality.
Validation: Must be a valid Zip Code
This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.
Remarks: For DMERC Claims use the zip code for beneficiary residence.
For Carrier Claims, use the zip code identified in item 32 of the HCFA 1500, unless the service was furnished in the patient's home. If the service was furnished in the patient's home, use the zip code from the patient's home address.
Requirement: Required.

Data Element: Line Pricing State
Definition: State where services were furnished.

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states
Remarks: Furnish the state associated with the Line Zip Code.
Requirement: Required.

Data Element: Ambulance Point of Pick-up Zip Code
Definition: Zip Code identifying the ambulance point of pick up.
Validation: Must be a valid Zip Code
Remarks: This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.
Requirement: Required for ambulance claims.

Data Element: Ambulance Drop Off Zip Code
Definition: Zip Code identifying the ambulance drop off point.
Validation: Must be a valid Zip Code
Remarks: This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros. Requirement: Required for ambulance claims.

Data Element: PWK
Definition: Space reserved for future use.
Validation: N/A
Remarks: N/A
Requirement: Required when available on the claim record.

Data Element: Filler
Definition: Additional space TBD
Validation: N/A
Remarks: N/A
Requirement: None

Claims Resolution File				
Claims Resolution Trailer Record (one record per file)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	16	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Number of Claims
Definition: Number of claim records on this file
Validation: Must be equal to the number of claim records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Claims Provider Address File				
Claims Provider Address Header Record (one record per file)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Address Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Provider Address Date
Definition: Date the Provider Address File was created.
Validation: Must be a valid date not equal to a Provider Address date sent on any previous claims Provider Address file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
Requirement: Required

Provider Address File				
Provider Address Detail Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	’2’
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Number/NPI	X(15)	9	23	Spaces
Provider Name	X(60)	24	83	Spaces
Provider Address 1	X(25)	84	108	Spaces
Provider Address 2	X(25)	109	133	Spaces
Provider City	X(15)	134	148	Spaces
Provider State Code	X(2)	149	150	Spaces
Provider Zip Code	X(9)	151	159	Spaces
Provider Phone Number	X(10)	160	169	Spaces
Provider Phone Number Extension	X(10)	170	179	Spaces
Provider Fax Number	X(10)	180	189	Spaces
Provider Type	X(2)	190	191	Spaces
Provider Address Order	X(2)	192	193	Spaces
Provider Address Type	9(3)	194	196	Zero
Provider E-mail Address	X(75)	197	271	Spaces
Provider Federal Tax number or EIN	9(10)	272	281	Zeroes
Provider Taxonomy Code	9(10)	282	291	Zeroes
Provider License Number	X(16)	292	307	Spaces
Provider License State	X(2)	308	309	Spaces
Filler	X(25)	310	334	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor’s CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = claim record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A

Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Provider Number/NPI
Definition: Number assigned by the AC/NSC or NPI agency to identify the provider
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Provider Name
Definition: Provider's name
Validation: N/A
Remarks: This is the name of the provider
The provider name must be formatted into a business name for mailing (e.g. Roger A Smith M.D. or Medical Associates, Inc).
Where possible this should contain the Legal Business Name as carried in the Shared Processing System.
Requirement: Required

Data Element: Provider Address 1
Definition: 1st line of provider's address
Validation: N/A
Remarks: This is the address1of the provider
Requirement: Required

Data Element: Provider Address 2
Definition: 2nd line of provider's address
Validation: N/A
Remarks: This is the address2 of the provider
Requirement: Required if available

Data Element: Provider City
Definition: Provider's city name
Validation: N/A
Remarks: This is the city of the provider's address.
Requirement: Required

Data Element: Provider State Code
Definition: Provider's state code
Validation: Must be a valid state code
Remarks: This is the state of the provider's address.
Requirement: Required

Data Element: Provider Zip Code
Definition: Provider's zip code

Validation: Must be a valid postal zip code
Remarks: This is the zip code of the provider's address. Provide 9-digit zip code if available, otherwise provide 5-digit zip code
This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.
Requirement: Required

Data Element: Provider Phone Number
Definition: Provider's telephone number
Validation: Must be a valid telephone number
Remarks: This is the phone number
Requirement: None

Data Element: Provider Phone Number Extension
Definition: Provider's telephone number Extension
Validation: Must be a valid telephone number
Remarks: This is the phone number
Requirement: None

Data Element: Provider Fax Number
Definition: Provider's fax number
Validation: Must be a valid fax number
Remarks: This is the fax number of the provider
Requirement: None

Data Element: Provider Type
Definition: 1=billing/pricing provider number (Assigned by carrier or NSC)
2= referring/ordering provider (UPIN)
3=Performing/rendering provider (Assigned by carrier or NSC)
4=Entity is both billing/pricing and performing/rendering provider
5=Entity is both referring/ordering and performing/rendering provider
6=Entity is all (billing/pricing AND referring/ordering AND performing/rendering provider)
7=billing/pricing provider number (NPI)
8= referring/ordering provider (NPI)
9=Performing/rendering provider (NPI)
10=Entity is both billing/pricing and performing/rendering provider (NPI)
11=Entity is both referring/ordering and performing/rendering provider (NPI)
12=Entity is all (billing/pricing AND referring/ordering AND performing/rendering provider) (NPI)
Validation: Must be a valid provider type
Remarks: This field indicates for which provider number associated with a sampled claim the address information is furnished.
Requirement: Required

Data Element: Address Order
Definition: The order in which the records of provider addresses for the provider are entered into the provider address file detailed record. This field in combination with the Contractor ID, Provider number, and Provider Type will make each record in the file unique.

Validation: Must be a valid number between 01 and 99
Remarks: This field indicated the order in which records containing the addresses for a provider are entered into the detail file. For instance, if there are three addresses for a provider, the record for the first address for that provider with contain an '01' in this field; and the record for the second address for that provider will contain a '02' in this field.
Requirement: Required

Data Element: Provider Address Type
Definition: The type of Provider Address furnished.
Validation: 1 = Practice Address (MCS)
Provider address (VMS)
2 = Pay To Address (MCS)
Payee Address (VMS)
3 = Billing Address (VMS)
4 = Correspondence Address
5 = Medical Record Address
Remarks: The first "address type" for each provider will always be a "1." Subsequent occurrences of addresses for the same provider will have the "address type" to correspond to the address submitted. When your files contain only one address for the provider, submit only one provider address record. Submit additional address records for a single provider number only when your files contain addresses that differ from the Master or Legal address.

- Correspondence Address—The Correspondence Address as indicated on the 855. This is the address and telephone number where Medicare can directly get in touch with the enrolling provider. This address cannot be that of the billing agency, management service organization, or staffing company.
- Medical Record Address—the Location of Patients' Medical Records as indicated on the 855. This information is required if the Patients' Medical Records are stored at a location other than the Master Address (practice location). Post Office Boxes and Drop Boxes are not acceptable as the physical address where patient's medical records are maintained

Requirement: Required

Data Element: Provider E-Mail Address
Definition: Provider's e-mail address
Validation: Must be a valid e-mail address
Remarks: N/A
Requirement: Required if available

Data Element: Provider Federal Tax Number or EIN
Definition: The number assigned to the provider by the Federal government for tax report purposes. The Federal Tax Number is also known as a tax identification number (TIN) or employer identification number (EIN).
Validation: Must be present
Remarks: N/A
Requirement: Required for all provider numbers

Data Element: Provider Taxonomy Code
Definition: The non-medical data code set used to classify health care providers according to provider type or practitioner specialty in an electronic environment, specifically

	within the American National Standards Institute Accredited Standards Committee health care transaction.
Validation:	Must be present
Remarks:	If multiple taxonomy codes are available, furnish the first one listed.
Requirement:	Required if available

Data Element: Provider License Number

Definition:	The professional business license required to provide health care services.
Validation:	Must be present
Remarks:	N/A
Requirement:	Required if available

Data Element: Provider License State

Definition:	Identify the state that issued the providers professional business license
Validation:	Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states
Remarks:	N/A
Requirement:	Required if available

Data Element:	Filler
Definition:	Additional space TBD
Validation:	N/A
Remarks:	N/A
Requirement:	

Claims Provider Address File				
Claims Provider Address Trailer Record (one record per file)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Records	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code
Definition: The code indicating the record version of the Provider Address file
Validation: Provider Address files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Number of Records
Definition: Number of provider records on this file
Validation: Must be equal to the number of provider records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Version 'C'
Detailed Specs
6/19/09

The CERT Version 'B' format is changing due to the upcoming implementation of HIPAA Version 5010. HIPAA legislation mandates the use of standard transaction formats and code sets. The primary driver of this change is the change from ICD-9 to ICD-10.

ADDITIONS TO EXISTING VERSION 'B' FORMAT

All Claim Types

1. Diagnosis Version Indicator Code – a 1 position field used to identify if the diagnosis code is an ICD-9 or ICD-10 code. This field is associated with all diagnosis code fields (Principal Diagnosis, External Cause of Injury, Admitting Diagnosis, Patient Reason for Visit, Claim Diagnosis and Line Diagnosis.

2. RAC adjustment indicator – Indicator used to identify RAC requested adjustments, which occur as a result of post-payment review activities done by the Recovery Audit Contractors (RAC).

3. Split Adjustment Indicator – a 2 position indicator to count multiple versions of a single claim.

4. Filler – a 50 position field at the claim level to accommodate future data needs.

5. Claim PWK Code – field used to identify the type of attachment that was received with a claim. Field added at the claim level on all claim types.

6. Line PWK Code – field added at the line level on all claim types (revenue center and line item)

Institutional Claim Types (Inpatient/SNF, Outpatient, Home Health, Hospice)

7. Claim External Cause of Injury – up to 12 occurrences of the ICD-CM code used to identify the external cause of injury, poisoning, or other adverse affect

8. Inpatient Claim POA/External Cause of Injury Indicator – The code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

9. Outpatient Claim Patient Reason for Visit Code – up to 3 occurrences, containing the patient reason for visit diagnosis code.

10. Claim Service Facility Zip Code – 9 digit service facility zip code

11. Revenue Center Rendering Physician NPI Number

12. Revenue Center Rendering Physician Surname

13. Revenue Center NDC Quantity Qualifier Code – a position field added to the Revenue Center line.

14. Revenue Center NDC Quantity – a 9 position field added to the Revenue Center line.

Non-Institutional Claims (Carrier/DMERC)

15. Ambulance Point of Pick-Up Zip Code – 9-byte field added to Line Item record

16. Ambulance Drop Off Zip Code – 9-byte field added to Line Item record.

17. Facility NPI –10-byte field added to Line Item Record.

DELETIONS FROM EXISTING VERSION 'B' FORMAT

Institutional Claim Types (Inpatient/SNF, Outpatient, Home Health, Hospice)

18. Attending Physician First Name

19. Attending Physician Middle Initial

20. Operating Physician UPIN

21. Operating Physician First Name,

22. Operating Physician Middle Initial

23. Other Physician UPIN

24. Other Physician First Name

25. Other Physician Middle initial.

FORMAT CHANGES

All Claim Types

26. Record Version Code change from "B" to "C" for all resolution and provider address records.

27. All ICD Diagnosis Code fields will be expanded from 5 to 7 bytes

28. All ICD Procedure code fields will be expanded from 4 to 7 bytes

29. All Provider Business name fields in Provider Address File will be expanded from 25 to 60 bytes.

30. All Beneficiary Last name fields will be expanded from 25 to 60 bytes.

31. All Beneficiary First name fields will be expanded from 10 to 35 bytes.

32. All dollar fields will be reported as signed numeric

Institutional Claim Types (Inpatient/SNF, Outpatient, Home Health, Hospice)

33. Condition Code 1-30 fields will be expanded from 2 to 3 bytes.

34. Diagnosis Code occurrences expanded to 25 occurrences

35. Procedure Code occurrences expanded to 25 occurrences

36. Procedure Date (Principal and Other Procedures) expanded from 6 to 8 bytes.

37. Line Units - expanded to S9(7)V999

Non-Institutional Claims (Carrier & DMERC)

38. Claim Diagnosis – expanded to 12 occurrences

39. Line Number of Services – expanded to S9(7)V999

40. Zip Codes – all zip codes have been expanded from 5 to 9 positions.