

One Time Notification

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SUBJECT: Comprehensive Error Rate Testing (CERT) Program - Requirements Update for Medicare Part A Provider Address File and Sample Claims Resolution File

I - GENERAL INFORMATION:

A. Background: CMS' Office of Financial Management, Program Integrity Group, developed the CERT program to produce national, contractor specific, and benefit category specific paid claim error rates. This instruction updates the record format requirements for the CERT provider address file and the sample claims resolution file. There is new information regarding record sizes and field definitions in this instruction.

Overview of the CERT Process

The process begins at the Medicare contractor-processing site where claims that have entered the standard claims processing system on a given day are extracted to create a *claims universe file*. This file is transmitted each day to the CERT operations center, where it is processed through a random sampling process. Claims that are selected as part of the sample are downloaded to the *sampled claims database*. This database holds all sampled claims from all Medicare contractors. Periodically, sampled claim key data are extracted from the *sampled claims database* to create a *sampled claims transaction file*. This file is transmitted back to the Medicare contractor and matched to the Medicare contractor's claims history and provider files. A *sampled claims resolution file*, a *claims history replica file*, and a *provider address file* are created by the Medicare contractor and transmitted to the CERT operations center. They are used to update the *sampled claims database* with claim resolutions and provider addresses; the *Claims History Replica* records are added to a database for future analysis.

Software applications at the CERT operations center are used to review, track, and report on the sampled claims. Requests are made of Medicare contractors to provide information supporting decisions on denied/reduced claims or claim line items and claims that have been subject to their medical review processes. Reports identifying incorrect claim payment are sent to the appropriate contractor for follow-up. Medicare contractors are to report on their agreement and disagreement with CERT decisions, status of overpayment collections, and status of claims that go through the appeals process.

Impact on FIs and RHHIs

In previous requirements CMS required FIs and RHHIs to support the CERT project as follows:

Coordinate with the CERT contractor to provide the requested information for claims identified in the sample in an electronic format (**Note:** Systems maintainers must make changes to the standard system. The sampling module will reside on a server in the CMS Data Center (HDC). Use of the sampling module will be under the supervision of the CERT operations center).

Submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims entered during the day.

There are no changes to these requirements.

Impact on FISS and APASS Standard Systems

CMS previously required the FISS and APASS Systems to create and transmit four files and receive and process one file. The revised formats for three of those files for FISS and APASS standard systems are included in Attachment 1.

The formats for these requirements only apply to CERT reporting and not to coding for the standard processing system.

Claims Universe File

The FISS and APASS standard systems are required to create a daily *claims universe file*, which will be transmitted daily to the CERT operations center. The file will be processed through a sampling module residing on the server at HDC. Therefore, it is important that the elements contained in the *claims universe file* are sufficient to support all levels of stratification (by bill, benefit, and provider type) that are to be considered when drawing a sample of claims. The *claims universe file* must contain all claims, except HHA RAP claims, adjustments, and inpatient hospital PPS claims, that have entered the FI and RHHI standard claims processing system on any given day. Any claim must be included only once and only on the day that it enters the system.

Sampled Claims Transaction File, Sampled Claims Resolution File and Claims History Replica File

The FISS and APASS standard system will periodically receive a *sampled claims transaction file* from the CERT operations center. This file will include claims that were sampled from the daily *claims universe files*. The FISS and APASS standard system will be required to match the *sampled claims transaction file* against the standard system claims history file to create a *sampled claims resolution file* and a *claims history replica file*. **This instruction revises the *sampled claims resolution file* to include a units field for each line.** The *claims history replica file* will be a dump of the standard system claims history file in the standard system format. These files will be transmitted to the CERT operations center. The *sampled claims resolution file* will be input to the CERT claim resolution process and the *claims history replica file* will be added to the Claims History Replica database. If a claim identified on the *sampled claims transaction file* is not found on the standard system claims history file, no record should be created for that claim. It is important that if the claim number changes within the standard system as a result of adjustments, replicates, or other actions taken by the Medicare contractor, that the *sampled claims resolution file(s)* and *claims history replica file(s)* be provided for each iteration of the claim (e.g., that adjustments and other actions be contained in the transmitted files). The *sampled claims transaction file* will always contain the claim control number of the original claim.

Provider Address File

The names, addresses, and telephone numbers of the billing providers and attending physicians must also be transmitted in a separate file to the CERT operations center along with the *sampled claims resolution file*. The *provider address file* will contain the mailing and telephone contact information for each billing provider and the mailing and telephone contact information, when available, for the attending physician for all claims on the *sampled claims resolution file*. Each unique provider name, address, and telephone number must be included only once on the *provider address file*. **If a provider has more than one address listed in the contractor files, include one record with each address in the provider address file. This instruction revises the file format for the provider address file to allow unique identification of a provider address in cases where there is more than one address for the provider.** If the contractor has neither an address nor a telephone number for the provider, do not include a record for that provider in a provider address file. If the contractor has only partial information on a provider, e.g., a telephone number but no address, the system should include on the provider address file the information the contractor has and leave the rest of the fields on the record blank.

Summary of Major Changes from Previous CRs

1. We have documented the updated definition of PPS in the *Claims Universe File* to indicate that “2” is a valid value.
2. CMS has added a PPS indicator to the claim level section of the Sampled Claims Resolution Claim Detailed Record in the *Sampled Claims Resolution File*.

3. We have added a new item to the end of the line level section of the Sampled Claims Resolution Claim Detailed Record of the *Sample Claims Resolution File* before the filler. The item will contain a number of “units” for the service identified on the line.
4. CMS has added a sequence number field to the *Provider Address File*.
5. We have added a new item to the end of the Provider address detail record of the *Provider Address File* before the filler. That item will contain a “Provider Address Type” that will identify the address, and in combination with the sequence indicator will uniquely identify each occurrence of each address in the file. These provider address types will correspond to the provider address inquiry file as contained in the FISS and APASS standard systems.

B. Policy: Necessary changes in the Medicare Carrier Manual (MCM), Medicare Intermediary Manual (MIM), or the Program Integrity Manual (PIM) will be forthcoming.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

“Shall” denotes a mandatory requirement

“Should” denotes an optional requirement

Requirement #	Requirements	Responsibility
1	In time for contractor data centers to meet the implementation date of this instruction, standard system maintainers shall revise the detailed record of the <i>sampled claims resolution file</i> to include a “PPS indicator” (position 378 of the attached format) and a “units” field (positions 565 through 568 in the attached format) for each line as specified in Attachment 1 .	Standard System Maintainers
2	In time for contractor data centers to meet the implementation date of this instruction, standard system maintainers must revise the provider address file so that, if a provider has more than one address listed in the contractor files, the system shall include one record with each address in the provider address file. Attachment 1 of this instruction revises the file format for the provider address file detailed record (position 7 in the attached format) and an address type field (positions 145 through 147 in the attached format) to allow unique identification of a provider address in cases where there is more than one address for the provider.	Contractor Data Centers
3	The CERT contractor will make all requests for information or data through via CONNECT:Direct. Medicare contractor data centers shall provide responses in electronic format as described in Attachment 1. Responses provided in electronic form must be made within five working days of a request.	Contractor Data Centers

Requirement #	Requirements	Responsibility
4	<p>Contractor data centers shall transmit files to the CERT operations center via CONNECT:Direct.</p> <p>Target data set names for the <i>sampled claim resolution files</i> are in the format: P#CER.#NCHPSC.A*****. CERTRSLN. The data center for the transmitting contractor replaces "*****" with the contractor number.</p> <p>Target data set names for the <i>provider address files</i> are in the format: P#CER.#NCHPSC.A*****.CERTPROV. The data center for the transmitting contractor replaces "*****" with the contractor number.</p>	

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: None

F. Testing Considerations: None

IV. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date: April 1, 2004</p> <p>Implementation Date: April 5, 2004</p> <p>Pre-Implementation Contact(s): John Stewart (410) 786-1189</p> <p>Post-Implementation Contact(s): John Stewart at (410) 786-1189</p>	<p>These instructions should be implemented within your current operating budget.</p>
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ATTACHMENT

**ATTACHMENT 1
CERT FILE DESCRIPTIONS FOR
PART A CONTRACTORS
AND
STANDARD SYSTEMS**

Sampled Claims Resolution File Format

Sampled Claims Resolution File

Sampled Claims Resolution File Header Record (one record per file)

<i>Field Name</i>	<i>Picture</i>	<i>From</i>	<i>Thru</i>	<i>Initialization</i>
<i>Contractor ID</i>	<i>X(5)</i>	<i>1</i>	<i>5</i>	<i>Spaces</i>
<i>Record Type</i>	<i>X(1)</i>	<i>6</i>	<i>6</i>	<i>'1'</i>
<i>Contractor Type</i>	<i>X(1)</i>	<i>7</i>	<i>7</i>	<i>Spaces</i>

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: **Contractor Type**

Definition: Type of Medicare contractor(s) included in the file

Validation: Must be 'A' or 'R'

Where the **Type of Bill**, 1st position = 3, **Claim Type** should be 'R'.

Where the **Type of Bill**, 1st/2nd positions = 81 or 82, **Claim Type** should be 'R'.

All others will be **Claim Type** 'A'.

Remarks: A = FI only

R = RHHI only or both FI and RHHI

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 Number	9(1)	7	7	Zero
Claim Type	X(1)	8	8	Space
Mode of Entry Indicator	X(1)	9	9	Space
Original Claim Control Number	X(23)	10	32	Spaces
Internal Control Number	X(23)	33	55	Spaces
Beneficiary HICN	X(12)	56	67	Spaces
Beneficiary Name	X(30)	68	97	Spaces
Beneficiary Date of Birth	X(8)	98	105	Spaces
Beneficiary Gender	X(1)	106	106	Spaces
Billing Provider Number	X(9)	107	115	Spaces
Attending Physician Number	X(15)	116	130	Spaces
Claim Paid Amount	9(7)v99	131	139	Zeros
Claim ANSI Reason Code 1	X(8)	140	147	Spaces
Claim ANSI Reason Code 2	X(8)	148	155	Spaces
Claim ANSI Reason Code 3	X(8)	156	163	Spaces
Claim ANSI Reason Code 4	X(8)	164	171	Spaces
Claim ANSI Reason Code 5	X(8)	172	179	Spaces
Claim ANSI Reason Code 6	X(8)	180	187	Spaces
Claim ANSI Reason Code 7	X(8)	188	195	Spaces
Statement covers From Date	X(8)	196	203	Spaces
Statement covers Thru Date	X(8)	204	211	Spaces
Claim Entry Date	X(8)	212	219	Spaces
Claim Adjudicated Date	X(8)	220	227	Spaces
Condition Code 1	X(2)	228	229	Spaces
Condition Code 2	X(2)	230	231	Spaces
Condition Code 3	X(2)	232	233	Spaces
Condition Code 4	X(2)	234	235	Spaces
Condition Code 5	X(2)	236	237	Spaces
Condition Code 6	X(2)	238	239	Spaces
Condition Code 7	X(2)	240	241	Spaces
Condition Code 8	X(2)	242	243	Spaces
Condition Code 9	X(2)	244	245	Spaces
Condition Code 10	X(2)	246	247	Spaces
Condition Code 11	X(2)	248	249	Spaces
Condition Code 12	X(2)	250	251	Spaces
Condition Code 13	X(2)	252	253	Spaces
Condition Code 14	X(2)	254	255	Spaces
Condition Code 15	X(2)	256	257	Spaces
Condition Code 16	X(2)	258	259	Spaces
Condition Code 17	X(2)	260	261	Spaces
Condition Code 18	X(2)	262	263	Spaces
Condition Code 19	X(2)	264	265	Spaces
Condition Code 20	X(2)	266	267	Spaces

Sampled Claims Resolution File
Sampled Claims Resolution Claim Detailed Record

Field Name	Picture	From	Thru	Initialization
Condition Code 21	X(2)	268	269	Spaces
Condition Code 22	X(2)	270	271	Spaces
Condition Code 23	X(2)	272	273	Spaces
Condition Code 24	X(2)	274	275	Spaces
Condition Code 25	X(2)	276	277	Spaces
Condition Code 26	X(2)	278	279	Spaces
Condition Code 27	X(2)	280	281	Spaces
Condition Code 28	X(2)	282	283	Spaces
Condition Code 29	X(2)	284	285	Spaces
Condition Code 30	X(2)	286	287	Spaces
Type of Bill	X(3)	288	290	Spaces
Diagnosis Code 1	X(5)	291	295	Spaces
Diagnosis Code 2	X(5)	296	300	Spaces
Diagnosis Code 3	X(5)	301	305	Spaces
Diagnosis Code 4	X(5)	306	310	Spaces
Diagnosis Code 5	X(5)	311	315	Spaces
Diagnosis Code 6	X(5)	316	320	Spaces
Diagnosis Code 7	X(5)	321	325	Spaces
Diagnosis Code 8	X(5)	326	330	Spaces
Diagnosis Code 9	X(5)	331	335	Spaces
ICD9-CM Procedure Code 1	X(4)	336	339	Spaces
ICD9-CM Procedure Code 2	X(4)	340	343	Spaces
ICD9-CM Procedure Code 3	X(4)	344	347	Spaces
ICD9-CM Procedure Code 4	X(4)	348	351	Spaces
ICD9-CM Procedure Code 5	X(4)	352	355	Spaces
ICD9-CM Procedure Code 6	X(4)	356	359	Spaces
ICD9-CM Procedure Code 7	X(4)	360	363	Spaces
ICD9-CM Procedure Code 8	X(4)	364	367	Spaces
ICD9-CM Procedure Code 9	X(4)	368	371	Spaces
ICD9-CM Procedure Code 10	X(4)	372	375	Spaces
Claim Demonstration Identification Number	9(2)	376	377	Zeroes
PPS Indicator	X(1)	378	378	Spaces
Total Line Item Count	9(3)	379	381	Zeroes
Record Line Item Count	9(3)	382	384	Zeroes

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 150 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)	385	388	Spaces

Field Name	Picture	From	Thru	Initialization
SNF-RUG-III code	X(3)	389	391	Spaces
APC adjustment code	X(5)	392	396	Spaces
HCPCS Procedure Code	X(5)	397	401	Spaces
HCPCS Modifier 1	X(2)	402	403	Spaces
HCPCS Modifier 2	X(2)	404	405	Spaces
HCPCS Modifier 3	X(2)	406	407	Spaces
HCPCS Modifier 4	X(2)	408	409	Spaces
HCPCS Modifier 5	X(2)	410	411	Spaces
Line Item Date	X(8)	412	419	Spaces
Submitted Charge	9(7)v99	420	428	Zeroes
Medicare Initial Allowed Charge	9(7)v99	429	437	Zeroes
ANSI Reason Code 1	X(8)	438	445	Spaces
ANSI Reason Code 2	X(8)	446	453	Spaces
ANSI Reason Code 3	X(8)	454	461	Spaces
ANSI Reason Code 4	X(8)	462	469	Spaces
ANSI Reason Code 5	X(8)	470	477	Spaces
ANSI Reason Code 6	X(8)	478	485	Spaces
ANSI Reason Code 7	X(8)	486	493	Spaces
ANSI Reason Code 8	X(8)	494	501	Spaces
ANSI Reason Code 9	X(8)	502	509	Spaces
ANSI Reason Code 10	X(8)	510	517	Spaces
ANSI Reason Code 11	X(8)	518	525	Spaces
ANSI Reason Code 12	X(8)	526	533	Spaces
ANSI Reason Code 13	X(8)	534	541	Spaces
ANSI Reason Code 14	X(8)	542	549	Spaces
Manual Medical Review Indicator	X(1)	550	550	Spaces
Resolution Code	X(5)	551	555	Spaces
Final Allowed Charge	9(7)v99	556	564	Zeroes
Units	9(4)	565	568	Zeroes
Filler	X(21)	569	589	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: **Contractor ID**

Definition: Contractor's CMS CROWD assigned number

Validation: Must be a valid CMS CROWD 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 Number**

Definition: The sequence number of the record. A claim may have up to three records

Validation: Must be between 1 and 3

Remarks: None

Requirement: Required

Data Element: **Claim Type**

Definition: Type of claim

Validation: Must be 'A' or 'R'

Where the **Type of Bill**, 1st position = 3, **Claim Type** should be 'R'.

Where the **Type of Bill**, 1st/2nd positions = 81 or 82, **Claim Type** should be 'R'.

All others will be **Claim Type** 'A'.

Remarks: A = Part A

R = RHHI only or both FI and RHHI

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 assigned to the claim in the universe file. This will be the number assigned by the Standard System to provide a crosswalk to pull all claims associated with the sample claim if a crosswalk is used for the claim.

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: **Internal Control Number**

Definition: Number currently assigned by the Standard System to uniquely identify the claim

Validation: N/A

Remarks: This number may be different from the Original Claim Control Number if the standard system has assigned a new Claims Control Number to an adjustment to the claims requested. The number assigned to the adjustment or the original claim control number if no adjustment has been made.

Requirement: Required

Data Element: **Beneficiary HICN**

Definition: Beneficiary's Health Insurance Claim Number

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: **Beneficiary Name**

Definition: Name of the beneficiary

Validation: N/A

Remarks: First, middle initial, and last names must be strung together to form a formatted name (e.g. John E Doe). If there are more than 30 characters, truncate the last name

Requirement: Required

Data Element: **Beneficiary Date of Birth**

Definition: Birth date of the beneficiary

Validation: N/A

Remarks: N/A

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 assigned by the Standard System to identify the billing/pricing provider or supplier
Validation: Must be present if claim contains the same billing/pricing provider number on all lines
Remarks: N/A
Requirement: Required for all claims containing the same billing/pricing provider on all lines

Data Element: **Attending Physician Number**

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

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 net amount paid after co-insurance and deductibles.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Claim ANSI Reason Code 1**
Claim ANSI Reason Code 2
Claim ANSI Reason Code 3
Claim ANSI Reason Code 4
Claim ANSI Reason Code 5
Claim ANSI Reason Code 6
Claim ANSI Reason Code 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. See Appendix _.
Remarks: Format is GGRRRRR 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 standard 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**

Condition Code 2

Condition Code 3

Condition Code 4

Condition Code 5

Condition Code 6

Condition Code 7

Condition Code 8

Condition Code 9

Condition Code 10

Condition Code 11

Condition Code 12

Condition Code 13

Condition Code 14

Condition Code 15

Condition Code 16

Condition Code 17

Condition Code 18

Condition Code 19

Condition Code 20

Condition Code 21

Condition Code 22

Condition Code 23

Condition Code 24

Condition Code 25

Condition Code 26

Condition Code 27

Condition Code 28

Condition Code 29

Condition Code 30

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

Validation: Must be a valid code as defined in the Intermediary Manual Part 3, Chapter IX - Processing - Reports - Records, Section 3871: MAGNETIC TAPE PROCESSING OF BILLS -- CODING STRUCTURES

Remarks: N/A

Requirement: Required if there is a condition code for the bill.

Data Element: Type of Bill

Definition: 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 bill type

In the first position, type of facility must be coded as one of the following:

- 1 = Hospital
- 2 = Skilled nursing facility (SNF)
- 3 = Home health agency (HHA)
- 4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
- 5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
- 6 = Intermediate care
- 7 = Clinic or hospital-based renal dialysis facility
- 8 = Special facility or ASC surgery
- 9 = Reserved

In the second position, facility type must be coded as follows:

For facility type code 1 thru 6, and 9

- 1 = Inpatient (including Part A)
- 2 = Hospital based or Inpatient (Part B only)
or home health visits under Part B
- 3 = Outpatient (HHA-A also)
- 4 = Other (Part B)
- 5 = Intermediate care - level I
- 6 = Intermediate care - level II
- 7 = Subacute Inpatient
(formerly Intermediate care - level III)
- 8 = Swing beds (used to indicate billing for
SNF level of care in a hospital with an
approved swing bed agreement)
- 9 = Reserved for national assignment

For facility type code 7

- 1 = Rural Health Clinic
- 2 = Hospital based or independent renal
dialysis facility
- 3 = Free-standing provider based federally
qualified health center
- 4 = Other Rehabilitation Facility (ORF) and
Community Mental Health Center (CMHC)
(eff 10/91 - 3/97); ORF only (eff. 4/97)
- 5 = Comprehensive Outpatient Rehabilitation Center
(CORF)
- 6 = Community Mental Health Center (CMHC) (eff 4/97)

7-8 = Reserved for national assignment
9 = Other

For facility type code 8

1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center in hospital
outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99)
formerly Rural primary care hospital
(eff. 10/94)
6-8 = Reserved for national use
9 = Other

The third position, sequence in episode, must be between 0 and 9

Remarks: N/A

Requirement: Required

Data Element: **Diagnosis Code 1**
Diagnosis Code 2
Diagnosis Code 3
Diagnosis Code 4
Diagnosis Code 5
Diagnosis Code 6
Diagnosis Code 7
Diagnosis Code 8
Diagnosis Code 9

Definition: Code identifying a diagnosed medical condition resulting in one or more items of service

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

Remarks: N/A

Requirement: Required

Data Element: **ICD9-CM Procedure Code 1**
ICD9-CM Procedure Code 2
ICD9-CM Procedure Code 3
ICD9-CM Procedure Code 4
ICD9-CM Procedure Code 5
ICD9-CM Procedure Code 6
ICD9-CM Procedure Code 7
ICD9-CM Procedure Code 8
ICD9-CM Procedure Code 9
ICD9-CM Procedure Code 10

Definition: Code identifying a service

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

Remarks: N/A

Requirement: Required if on bill

Data Element: **Claim Demonstration Identification Number**

Definition: The number assigned to identify a demonstration project.

Validation: Must be numeric or zeroes

Remarks: N/A

Requirement: Required only if carried 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
2 = Unable to determine/unknown

Remarks: N/A

Requirement: Required

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 - 150

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

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.

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

Data Element: **HCPCS Procedure Code**

Definition: The HCPCS/CPT-4 code that describes the service
Validation: Must be a valid HCPCS/CPT-4 code
Remarks: N/A
Requirement: Required if present on bill

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 standard system

Data Element: **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: **Medicare Initial Allowed Charge**
Definition: Amount Medicare allowed for the service or equipment before any reduction or denial
Validation: Must be a numeric value if the standard system can calculate the value, blanks if the standard system cannot calculate the value.
Remarks: N/A
Requirement: Required if the standard system can calculate the value. Enter blanks if the standard system cannot calculate the value

Data Element: **ANSI Reason Code 1**
ANSI Reason Code 2
ANSI Reason Code 3
ANSI Reason Code 4
ANSI Reason Code 5
ANSI Reason Code 6
ANSI Reason Code 7
ANSI Reason Code 8
ANSI Reason Code 9
ANSI Reason Code 10
ANSI Reason Code 11
ANSI Reason Code 12
ANSI Reason Code 13
ANSI Reason Code 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 GRRRRRRR where:
GG is the group code and RRRRRR is the adjustment reason code
Requirement: Report all ANSI Reason Codes included on the bill.

Data Element: **Complex 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 medical 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', 'N' or blank.

Remarks: Set to 'Y' if service was subjected to complex manual medical review, set to 'N' if service was subjected to routine manual medical review else leave blank.

Requirement: An entry is required if routine or complex medical review was performed on the line.

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 medical 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' or 'REO', 'DENAM', 'REDAM'

Remarks: APP = Approved as a valid submission
APPMR = Approved manually routine
APPMC = Approved manually complex
DENMR = Denied manually routine
DENMC = Denied manually complex
RTP = Denied as unprocessable (return/reject)
DEO = Denied for non-medical reasons, other than denied as unprocessable
REDMR = Reduced manually routine
REDMC = Reduced manually complex
REO = Reduced for non-medical review reasons

DENAM = Denied after automated medical review

REDAM = Reduced after medical review

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: **Units**

Definition: The total number of services or time periods provided for the line item.

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: **Filler**

Definition: Additional space -- use to be determined

Validation: N/A

Remarks: N/A

Requirement: Required

Sampled Claims Resolution File**Sampled 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'
Number of Claims	9(9)	7	15	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: **Number of Claims**

Definition: Number of sampled claim resolution records (not number of claims - there may be one to three records per claim) on this file (do not count header or trailer record)

Validation: Must be equal to the number of sampled claims resolution records on the file

Remarks: N/A

Requirement: Required

Provider Address File**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'
Contractor Type	X(1)	7	7	Spaces
File Date	X(8)	8	15	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: **Contractor Type**

Definition: Type of Medicare contractor(s) included in the file

Validation: Must be 'A' or 'R'

Where the **Type of Bill**, 1st position = 3, **Claim Type** should be 'R'.Where the **Type of Bill**, 1st/2nd positions = 81 or 82, **Claim Type** should be 'R'.All others will be **Claim Type** 'A'.

Remarks: A = FI only

R = RHHI only or both FI and RHHI

Requirement: Required

Data Element: **File Date**Definition: Date the *provider address file* was createdValidation: Must be a valid date not equal to a file date sent on any previous *provider address file*

Remarks: Format is CCYYMMDD

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'
Sequence Number	X(1)	7	7	Spaces
Provider Number	X(15)	8	22	Spaces
Provider Name	X(25)	23	47	Spaces
Provider Address 1	X(25)	48	72	Spaces
Provider Address 2	X(25)	73	97	Spaces
Provider City	X(15)	98	112	Spaces
Provider State Code	X(2)	113	114	Spaces
Provider Zip Code	X(9)	115	123	Spaces
Provider Phone Number	X(10)	124	133	Spaces
Provider FAX Number	X(10)	134	143	Spaces
Provider Type	X(1)	144	144	Spaces
Address Type	F(3)	145	147	1
Filler	X(22)	148	169	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: **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 the standard system to identify the billing/pricing provider or submitted on the claim to identify the attending physician

Validation: N/A

Remarks: Left justify

Requirement: Required

Data Element: **Provider Name**

Definition: Provider's name

Validation: N/A

Remarks: This is the payee name of the billing/pricing provider or attending physician
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 address1 of the billing/pricing provider or attending physician

Requirement: Required

Data Element: **Provider Address 2**

Definition: Second line of provider's address

Validation: N/A

Remarks: This is the address2 of the billing/pricing provider or attending physician

Requirement: Required if available

Data Element: **Provider City**

Definition: Provider's city name

Validation: N/A

Remarks: This is the city of the billing/pricing provider or attending physician

Requirement: Required if available

Data Element: **Provider State Code**

Definition: Provider's state code

Validation: Must be a valid state code

Remarks: This is the state of the billing/pricing provider or the attending physician

Requirement: Required if available

Data Element: **Provider Zip Code**

Definition: Provider's zip code

Validation: Must be a valid postal zip code

Remarks: This is the payee zip code of the billing/pricing provider or attending physician

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

Requirement: Required if available

Data Element: **Provider Phone Number**

Definition: Provider's phone number

Validation: Must be a valid phone number

Remarks: This is the phone number of the billing/pricing or attending physician. It will not be requested until the Spring of 2002

Requirement: Required

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 billing/pricing provider or attending physician

Requirement: Provide this information if available

Data Element: **Provider Type**

Definition: 1=Billing 2=Attending

Validation: Must be a 1 or a 2

Remarks: This field indicates whether the provider (whose name, address, and phone number are included in the record) billed the service or referred the beneficiary to the billing provider.

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)

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.

Requirement: Required

Data Element: **Filler**

Definition: Additional space -- use to be determined

Validation: N/A

Remarks: N/A

Requirement: Required

Provider Address File				
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'
Number of Records	S9(9)	7	15	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: **Number of Records**

Definition: Number of provider address records on this file (do not count header or trailer record)

Validation: Must be equal to the number of provider address records on the file

Remarks: N/A

Requirement: Required