

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1483	Date: March 31, 2015
	Change Request 8913

Transmittal 1462, dated February 6, 2015, is being rescinded and replaced by Transmittal 1483 dated March 31, 2015, to clarify the format of both the electronic report and file format discussed in this CR. All other information remains the same.

SUBJECT: Identifying “No Documentation” Medical Necessity Denials for Claims Flagged for Recovery Auditor Review

I. SUMMARY OF CHANGES: The purpose of this Change Request is to provide a Recovery Audit specific "No documentation" reason code for Medicare Administrative Contractors to append to prepayment claim denials.

EFFECTIVE DATE: July 1, 2015

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: July 6, 2015 - Define/Analyze and Design Application; October 5, 2015 - Hours for Code Development/Test and Alpha Testing

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	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

One Time Notification

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
8913.1.1.1	The VDC shall also send the file created in BR 8913.1 to the respective MAC.								VDC	
8913.1.2	Recovery Audit Contractors shall be prepared to receive the daily file as well as be prepared for testing phases with FISS, the STC and the MAC.	X				X			RACs	
8913.1.3	The Recovery Audit Contractor shall use the confirmed file format attached for the creation of the file in BR 8913.1, which includes the DCN, HIC, DOS, and Provider/NPI.					X				
8913.2	Contractors shall ensure that Reason Code 56900 has the following ANSI coding assigned: CARC 226, RARC N102, Group Code CO and Appeal Code MA01.	X								
8913.3	FISS shall create separate electronic monthly reports of all the automated claim denials for "No Documentation" being sent to the Recovery Auditor, sorted by Recovery Audit region. (Recovery Audit Regions A-D, 1-5).					X				
8913.3.1	Recovery Audit Contractors shall be prepared to receive the monthly reports as well as be prepared for testing phases with FISS, the STC and the MAC.	X				X			RACs	
8913.3.2	FISS shall use the confirmed report format attached for the creation of the report in BR 8913.3.					X				
8913.4	FISS shall add a claim level field on the claim record to store the PIMR Activity Code.					X				
8913.5	FISS shall display the new field on the on-line claim screen.					X				
8913.6	FISS shall move the value in the PIMR Activity Code field on the Reason Code File to the new field created in BR 8913.4.					X				
8913.7	The VDC shall send the monthly report created in BR 8913.3 to the Recovery Auditor to the appropriate Recovery Auditor region.								VDC	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Ashley Ford, 410-786-0828 or Ashley.Ford@cms.hhs.gov.

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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

ATTACHMENTS: 2

Daily File Copybook

01	RA	RC-CLM-OUTPUT-REC.	
	05	RAC-CLM-BDL-LETTER-CD OCCURS 10 TIMES	PIC X(05) VALUE SPACES.
	05	RAC-CLM-ADR-ORIG-REQ-DT-CYMD	PIC X(08) VALUE SPACES.
	05	RAC-CLM-DCN	PIC X(23) VALUE SPACES.
	05	RAC-CLM-MEDA-PROV-ID	PIC X(13) VALUE SPACES.
	05	RAC-CLM-NPI-NUMBER	PIC X(10) VALUE SPACES.
	05	RAC-CLM-PROV-NAME	PIC X(31) VALUE SPACES. increased from 23 to 31
	05	RAC-CLM-CARRIER-CD-ID	PIC X(05) VALUE SPACES.
	05	RAC-LOCALITY-CD-ID	PIC X(02) VALUE SPACES.
	05	RAC-CLM-STMT-COV-FROM-DT-CYMD	PIC X(08) VALUE SPACES.
	05	RAC-CLM-STMT-COV-TO-DT-CYMD	PIC X(08) VALUE SPACES.
	05	RAC-CLM-PAT-CNTRL-NO	PIC X(20) VALUE SPACES.
	05	RAC-CLM-HIC	PIC X(12) VALUE SPACES.
	05	RAC-CLM-BENE-LAST-NAME	PIC X(15) VALUE SPACES. increased from 13 to 15
	05	RAC-CLM-BENE-FIRST-NAME	PIC X(10) VALUE SPACES.
	05	RAC-CLM-BENE-DOB	PIC X(08) VALUE SPACES.
	05	RAC-CLM-BENE-SEX	PIC X(01) VALUE SPACES.
	05	RAC-CLM-INTERMEDIARY-NB	PIC X(05) VALUE SPACES.
	05	RAC-CLM-CLM-TYP-IND	PIC X(01) VALUE SPACES.
	05	RAC-CLM-TOTAL-CHARGE-AMOUNT	PIC 9(09)V99 VALUE ZEROS.
	05	RAC-CLM-PRINCIPLE-DIAG	PIC X(07) VALUE SPACES.
	05	RAC-CLM-DIAG-CD-2 OCCURS 25 TIMES.	
		10 RAC-CLM-DIAG-CD2-OTH	PIC X(07) VALUE SPACES.
	05	RAC-CLM-DIAG-POA-IND OCCURS 25 TIMES	PIC X(01) VALUE SPACES.
	05	RAC-CLM-EXT-INJURY-DIAG-CODE	PIC X(07) VALUE SPACES.
	05	RAC-CLM-PROC-CD OCCURS 25 TIMES	PIC X(07) VALUE SPACES.
	05	RAC-CLM-PROC-DT-CYMD OCCURS 25 TIMES	PIC X(08) VALUE SPACES.

05	RAC-CLM-COND-CD OCCURS 30 TIMES	PIC X(02) VALUE SPACES.
05	RAC-CLM-OCCUR-CD OCCURS 30 TIMES	PIC X(02) VALUE SPACES.
05	RAC-CLM-OCCUR-DT-CYMD OCCURS 30 TIMES	PIC X(08) VALUE SPACES.
05	RAC-CLM-OCCUR-SPAN-CD OCCURS 10 TIMES	PIC X(02) VALUE SPACES.
05	RAC-CLM-OCCUR-SPAN-FRM-DT-CYMD OCCURS 10 TIMES	PIC X(08) VALUE SPACES.
05	RAC-CLM-OCCUR-SPAN-TO-DT-CYMD OCCURS 10 TIMES	PIC X(08) VALUE SPACES.
05	RAC-CLM-VALUE-CODE-AMT OCCURS 36 TIMES	
	10 RAC-CLM-VAL-CD	PIC X(02) VALUE SPACES.
	10 RAC-CLM-VAL-AMT	PIC 9(07)V99 VALUE ZEROS.
05	RAC-CLM-DRG-CD	PIC X(03) VALUE SPACES.
05	RAC-CLM-BILL-TYP-CD	PIC X(03) VALUE SPACES.
05	RAC-CLM-PATIENT-STATUS	PIC X(02) VALUE SPACES.
05	RAC-CLM-ADM-SOURCE	PIC X(01) VALUE SPACES.
05	RAC-CLM-ORIG-PROV-REIMB	PIC 9(09)V99 VALUE ZERO.
05	RAC-CLM TREAT-AUTH-CD	PIC X(18) VALUE SPACES.
05	RAC-CLM-LINES-TOTAL	PIC 9(03) VALUE ZERO.
05	FILLER	PIC X(41) VALUE SPACES.
05	RAC-CLM-LINE-ITEMS OCCURS 100 TIMES.	
	10 RAC-CLM-REV-CD	PIC X(04) VALUE SPACES.
	10 RAC-CLM-HCPC-CD	PIC X(05) VALUE SPACES.
	10 RAC-CLM-HCPC-MODIFIERS	PIC X(10) VALUE SPACES.
	10 RAC-CLM-SERV-DT-CYMD	PIC X(08) VALUE SPACES.
	10 RAC-CLM-REV-TOT-CHRG-AMT	PIC 9(09)V99 VALUE ZERO.
	10 RAC-CLM-REV-NCOV-CHRG-AMT	PIC 9(09)V99 VALUE ZERO.
	10 RAC-CLM-PROV-REIMB-LINE	PIC 9(09)V99 VALUE ZERO.
	10 RAC-CLM-LINE-REASON	PIC X(05) VALUE SPACES.
	10 RAC-CLM-REV-UNITS-BILLED	PIC S9(09) VALUE ZERO.
	10 RAC-CLM-REV-SERV-UNIT-CNT	PIC S9(09) VALUE ZERO.
	10 RAC-CLM-IDE-NUMBER	PIC X(15) VALUE SPACES.
	10 RAC-CLM-APC-HCPCS-APC	PIC 9(05) VALUE ZERO.

10 RAC-CLM-LINE-OCE-FLAGS

15 RAC-CLM-APC-SERV-IND	PIC X(02) VALUE SPACES.
15 RAC-CLM-APC-PAYMENT-IND	PIC X(02) VALUE SPACES.
15 RAC-CLM-APC-DISC-FCTR	PIC X(01) VALUE SPACES.
15 RAC-CLM-APC-DEN-REJ	PIC X(01) VALUE SPACES.
15 RAC-CLM-APC-PKG-FLAG	PIC X(01) VALUE SPACES.
15 RAC-CLM-APC-PAY-ADJ-FLAG	PIC X(02) VALUE SPACES.
15 RAC-CLM-APC-TOB-INCL	PIC X(01) VALUE SPACES.
15 RAC-CLM-APC-ACTION-FLAG	PIC X(01) VALUE SPACES.
15 RAC-CLM-COMPOSITE-ADJ-FLAG	PIC X(02) VALUE SPACES.

Header Layout

Field Name	Location	Length	Attributes	Sample	Valid Values and Notes
File Type	1	10	AN-10	CLAIM	Value: "Claim" Left justified, space fill
Filler	11	1	AN-1		Space fill
File Format Version	12	3	AN-3	4	Value: 004
Filler	15	1	AN -1		Space fill
Record Count	16	6	Num-6	102	Number of records contained in file. Right justified, zero fill
Filler	22	1	AN-1		Space fill
Record Length	23	3	Num-3	128	128
Filler	26	1	AN -1		Space fill
Create Date	27	8	Num-8	20090617	File Creation Date Format = YYYYMMDD
Filler	35	7	AN -7		Space fill
Source ID	42	5	AN-5		Values = Contractor ID of the user who created the file. Left Justified

Filler	47	1	AN-1		Space fill
MAC Workload Number	48	5	Num- 5	12345	Workload Number
Filler	53	75	AN-1	R	Space fill
Text Delimiter	128	1	AN-1		Text Delimiter

Claim Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Claim Record-C
Claim Type	2	2	1-A	R	NCH MQA Record Identification Code 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health Agency 6 = DDE 7 = Professional
Out-of-Jurisdiction Flag	3	3	1-A	S	Use a space.
State Code for the provider	4	5	2-A	R	State Codes: ME, CA
Place of Service ZIP Code	6	10	5-AN	R	US Postal Code where service rendered.

Contractor ID	11	15	5-AN	R	Claims processing contractor ID number
Original Claim ID	16	38	23-AN	R	<p>Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim</p> <p>For Claim Type 1 through 5 - length must be equal to or greater than 14.</p> <p>For Claim Type 6 - length must be 15.</p> <p>For Claim Type 7 - length must be 14.</p>
Type of Bill	39	42	4-AN	R/S	* Required for Claim Type 1 - 5. (left justified)
Provider Legacy Number	43	55	13-AN	S	Unique Provider Legacy Number of the provider that performed the service and filed the claim.
Provider NPI	56	65	10-AN	R	Unique Provider NPI of the provider that performed the service and filed the claim
DME Ordering Provider NPI	66	75	10-AN	S	NPI of Provider that prescribed the supplies.
Filler	76	92	17-AN	Filler	Spaces
Date of Service Start (statement covers from date)	93	100	8-N	R	Date service started/performed YYYYMMDD
Date of Service End (statement covers thru date)	101	108	8-N	R	Date service ended YYYYMMDD
Provider Type	109	110	2-AN	R	Type of Provider or Supplier

Valid Values:

1 = Lab/Ambulance

2 = Outpatient Hospital

3 = Home Health (HHA)

4 = Hospice

5 = Professional Services (physician/non-physician practitioner)

6 = DME by Supplier

7 = Skilled Nursing (SNF)

8 = Inpatient Hospital

9 = Inpatient Rehabilitation (IRF)

10 = Critical Access Hospital (CAH)

11 = Long Term Care Hospital (LTCH)

12 = DME by Physician

13 = Ambulatory Surgery Center (ASC)

14 = Other

CMS Provider Specialty Code	111	112	2-AN	S	CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files
Review Type	113	114	2-AN	R	

					Pre-Payment Review-PR
Date Chosen for Prepayment Review	115	122	8-N	R	Date format YYYYMMDD (Date it goes to SB6000 or SB6001)
PIMR Activity Code	123	124	2-AN	R	XA-XD or X1-X5
Text Delimiter	125	125	1-an	Delimiter	Text delimiter

Claim Line Item Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Line-L
Line item number	2	4	3-AN	R	Claim line item number; 000 for institutional claims. If line number = 000, then no other lines are acceptable for that claim
Original Diagnosis Code Version Indicator	5	5	1-N	R	9 for ICD-9 or 0 for ICD-10;
Original Principal Diagnosis Code (institutional)	6	12	7-AN	R	Original ICD-9 or ICD-10. Decimal point(.) is not allowed.
Original DRG	13	15	3-AN	S	Original DRG on claim. It must be three digit numbers. Line 000 only
Original ICD Primary Procedure Code	16	22	7-AN	S	Original ICD9/ICD10 Procedure Code on RAC identified claim. Decimal point(.) is not allowed.

Original Non-DRG PPS/Hospice LOC Code	23	27	5-AN	S	Original HOPPS code for outpatient hospitals (APCs), HIPPS code for SNFs (RUG/Als), HHAs (HHRGs) or IRFs (CMG/RICs), or Level of Care code for hospice claims.
Original HCPCS	28	32	5-AN	S	Original HCPCS on claim. Not generally used for inpatient claims (exceptions do exist)
Original Units of Service	33	35	3-N	S	Original units of service on claim
Prior Authorization (PA) Program Indicator	36	39	4-AN	S	This field identifies the PA Program - change made by CR9017
Filler	40	124	85-AN	R	Spaces
Text Delimiter	125	125	1-AN		Text Delimiter