Centers for Medicare & Medicaid Services
CMS Target Life Cycle (TLC)

Accountable Care Organization – Operational System (ACO-OS)

Claim and Claim Line Feed (CCLF) Information Packet (IP)

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1 Overview

The purpose of this Information Packet (IP) is to describe the content and basic operations of the Claim and Claim Line Feed (CCLF) files sent to Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program, Vermont All-Payer ACO Model (VTAPM), End-Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs) participating in the Comprehensive ESRD Care (CEC) Model[1], the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model, Kidney Care Choices (KCC) Model, and Primary Care First (PCF) Model. For the purpose of this document, the term "ACO" will be used to refer to REACH ACOs, KCC Entities, PCF Practices, and Shared Savings Program ACOs.

KCC has two options based on provider participation: Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC). CCLFs for KCF or CKCC Entities are distinguished based on the filename as listed in the Section 4.2.

The Centers for Medicare & Medicaid Services (CMS) gathers a data feed for certain beneficiaries, according to data sharing preferences as determined by each Medicare ACO program and model in compliance with appropriate Health Insurance Portability and Accountability Act (HIPAA) regulation to share their claims data with the ACO. For the appropriate beneficiaries, the data feed provided to the ACO includes claims for all services covered by Part A (Hospital Insurance) and Part B (Supplemental Medical Insurance) that were provided and processed during the prior month. Claims data also include prescriptions covered by a Prescription Drug Program in which the beneficiary is enrolled. Medicare Claims are submitted by a broad range of facilities (institutional providers), professionals, and suppliers, including hospitals (both inpatient and outpatient claims); physicians; home health agencies (HHA); skilled nursing facilities (SNFs); hospices; and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers. Some of these provide services that are covered by Part A and/or Part B (e.g., hospitals and SNFs); others provide services that are covered only by Part B.

Medicare Administrative Contractors (MACs) are responsible for processing Medicare claims. Different payment methods and claims processing systems are used depending upon the type of facility where services are received. For example, the inpatient prospective payment system (IPPS) is used to price acute hospital inpatient services, the Physician Fee Schedule is used to price physician office visits, and the outpatient prospective payment system (OPPS) is used to price outpatient services received in an outpatient setting. Medicare claims processing entities are responsible for following the rules of the various payment systems and pricing the claims.

To comply with the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the Medicare Beneficiary Identifier (MBI) will be accepted on claims, and the Health Information Claim Number (HICN) value will no longer be displayed. CMS will include blanks for the HICN, Beneficiary Equitable Beneficiary Identification Code (BIC) HICN, and Beneficiary Railroad Board Number (RRB) fields in CCLFs generated effective January 1, 2020, onwards.

[1] The CEC Model ended on March 31, 2021. No CCLFs were distributed after this date.

The data files that ACOs receive monthly consist of five Part A files, three Part B files, one Part D file, one beneficiary demographics file, one beneficiary MBI cross-reference file, and one summary statistics file. These files are described in Section 2: Structure and Content. In addition to receiving monthly CCLFs, REACH, Shared Savings Program, and VTAPM ACOs should expect to receive CCLFs for the three-month claims run-out period for claims paid for the prior Performance Year (PY).

- Shared Savings Program ACOs receive CCLFs for the three-month claims run-out period from 2019 onward.
- For VTAPM ACOs, the Initial Alignment Report (Report 1-1) and the Report on Excluded Beneficiaries (Report 1-2) provide identifying information (including names and contact information) for each of the ACO's prospectively aligned beneficiaries.
- For Shared Savings Program ACOs, the Assignment List Report provided routinely by CMS during a PY includes beneficiary identifiable information on each of the ACO's assigned population.
- For ACO REACH and KCC Models, the Beneficiary Alignment Report includes the identifying information for aligned beneficiaries.
- These reports are important sources of information used in conjunction with the data contained in these CCLF Reports.

Beginning in October 2018, the CCLF filenames for the Shared Savings Program ACOs were updated to include the PY Identifier to indicate the specific PY for which the data are being shared with ACOs. Additionally, the file will include a "PY" in the filename. The filenames are provided in Appendix B: CCLF File Layouts.

The term "claim" refers to a bill that is submitted by a provider for services rendered to a Medicare beneficiary over a period of time. A single claim can be associated with multiple services provided on one or more dates. Individual services are reported on the claim form as separate claim lines. Some data files will be at the claim level, and some will be at the line level.

This document includes the following appendices:

- Appendix A: Alcohol and Substance Abuse Code Tables
- Appendix B: CCLF File Layouts
- Appendix C: Zip File Instructions

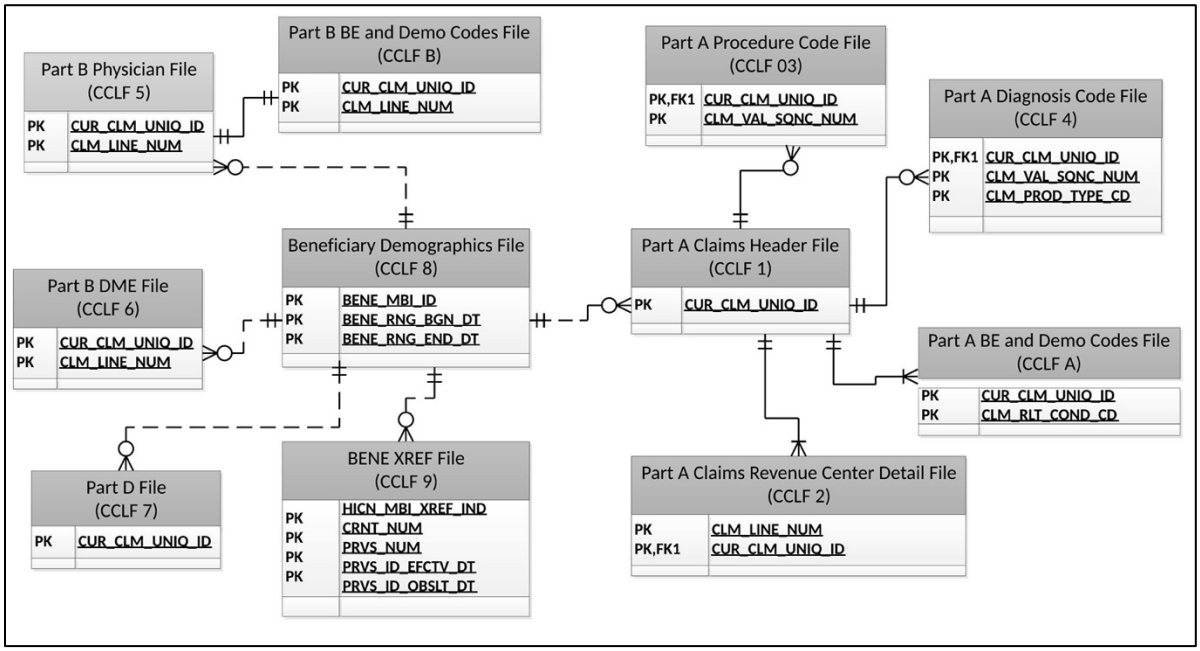
2 Structure and Content

This section provides a brief set of directions for users to begin utilizing the CCLFs.

2.1 High-Level Relationships among the Claim Files

Figure 1 shows, at a very high level, the relationships among the 11 files that the ACOs receive.

Figure 1: Entity Relationship Diagram



The Beneficiary Demographics File is the starting point of Figure 1. The file contains information, such as Primary Key (PK) and variables, to assist an ACO in identifying a record from the Beneficiary Demographics File. A record in a given file (i.e., a row from the file) can be uniquely identified using a PK; that is, a PK consists of exactly enough information to uniquely identify a row from a file. Depending upon the nature/structure of a data file, a PK can consist of multiple variables. For the Beneficiary Demographics File, the PK consists of BENE_MBI_ID, BENE_RNG_BGN_DT, and BENE_RNG_END_DT. Using these three fields, a record can be identified in the Beneficiary Demographics File.

A PK with a singular value is a PK that can be identified by just one column in a table. The PK for the Part A claims header is CUR_CLM_UNIQ_ID. Each row in this file can be identified by just one column value. Each claim header is uniquely identified by a different CUR_CLM_UNIQ_ID value.

The Foreign Key (FK) signals that the variable is used as a PK in another file. For example, BENE_MBI_ID is an FK in the Part D File, signaling that it is a PK in another file (i.e., the Beneficiary Demographics File).

Starting with January 2022, the relationship between Part A Claims Header File (CCLF1) and Part A Benefit Enhancement and Demo Codes File (CCLFA) has changed to one-to-one or many. Prior to January 2022, the relationship between CCLF1 and CCLFA was one-to-one.

2.1.1 Defining Relationships between Files

In Figure 1, the lines connecting the files define the relationships between the files (i.e., entities). There are two types of relationships in the diagram:

- **Zero-to-many:** A dotted line (which means optional relationship) that ends in a circle with three lines indicates that the entity closest to symbol represents "zero, one, or many" attributes for the relationship. An example of this relationship is the line connecting the Beneficiary Demographics File and the Part B Physician File. This means that there is one and only one row in the Beneficiary Demographic Files that can be associated with zero, one, or many rows in the Part B Physician File.
- **One-to-many:** A solid line (that indicates a mandatory relationship) that splits into three lines indicates a one-to-many relationship. An example of this relationship is the line connecting the Part A Claims Header File and the Part A Claims Revenue Center Detail File. This means that only one row in the Part A Claims Header File must be associated with at least one row or can be associated with many rows from the Part A Claims Revenue Center Detail File.

2.2 Part A Claims Data

Part A claim data files contain claims submitted by facilities such as hospitals, SNFs, HHAs, rehabilitation facilities, and dialysis facilities. These files are referred to as institutional or facility files. The Part A claims file contains claims for services that are covered under Part A as well as claims for some services that are covered under Part B of Medicare. An example of a Part B-covered service appearing in the Part A file would be a visit to the emergency department of an acute care hospital that did not result in an admission. In this situation, the hospital would file a Part A claim form for a Part B-covered service. As a result, the Part B covered service would be included in the Part A claim record.

2.2.1 Part A Claims Header File

The Part A Claims Header File (CCLF1) contains summary claims from HHAs, SNFs, acute care hospitals (inpatient and outpatient claims), and hospice facilities. This file is at the summary claim level and does NOT contain line-item information. From this file, an ACO can obtain beneficiary-level spending on facility services (overall, by diagnostic related group [DRG], or by principal diagnosis), the national provider identifier (NPI) corresponding to the provider and/or facility associated with the claim, and the MBI. This file can also be used to calculate the proportion of services (as measured by payment amount) rendered to an ACO's beneficiaries that are provided by the ACO versus non-ACO providers.

Institutional providers are identified in the Part A Claims Header File by both the facility NPI (FAC_PRVDR_NPI_NUM) and the older Online Survey Certification and Reporting System (OSCAR) number (also referred to as the CMS Certification Number or CCN). Data describing the individual or organization identified by the NPI may be obtained from the National Plan and Provider Enumeration System (NPPES).

The Part A Claims Header File also provides the NPI of the attending, operating, and other provider.

The International Classification of Diseases (ICD) Version Indicator can be found in the Claim Header File. This indicator is a single character denotation of whether the code received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data.

For information on the Part A Claims Header File layout, refer to Table 14: Part A Claims Header File.

2.2.2 Part A Claim Revenue Center Detail File

The Part A Claims Revenue Center Detail File (CCLF2) contains line-item level detail for each claim from the Part A Claims Header File. This file contains code from the healthcare common procedure coding system (HCPCS) for each service received as well as the date the service was received. For outpatient claims, the file contains the payment amount and allowed charge amount for individual services. The file can be used to ascertain the proportion of an ACO's beneficiaries who received a particular service.

For information on the Part A Claim Revenue Center Detail File layout, refer to Table 15: Part A Claims Revenue Center Detail File.

2.2.3 Part A Procedure Code File

The Part A Procedure Code File (CCLF3) contains detailed information regarding the claims from the Part A Claims Header File, such as the type of surgical procedure performed and the date it was performed. This file can be used in conjunction with the Part A Claims Header File to identify and compare surgical procedures that are associated with a given principal diagnosis for both ACO and non-ACO providers. For example, a beneficiary diagnosed with X is more likely to receive surgical procedure Y from an ACO provider, whereas surgical procedure Z is more likely to be performed by a non-ACO provider.

The ICD Version Indicator can be found in the Part A Procedure Code File. This indicator is a single character denotation of whether the code received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data. For information on the Part A Procedure Code File layout, refer to Table 16: Part A Procedure Code File.

2.2.4 Part A Diagnosis Code File

The Part A Diagnosis Code File (CCLF4) contains the diagnosis code for the principal diagnosis as well as all secondary diagnoses that correspond with a given claim from the Part A Claims Header File. For a given claim, the associated secondary diagnoses can be distinguished from one another using the variables CLM_VAL_SQNC_NUM and CLM_PROD_TYPE_CD. This file can be used in conjunction with the Part A Claims Header File to identify secondary diagnoses that are associated with a given principal diagnosis.

The ICD Version Indicator can be found in the Part A Diagnosis Code File. This indicator is a single character denotation of whether the code received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data.

For information on the Part A Diagnosis Code File layout, refer to Table 17: Part A Diagnosis Code File.

2.2.5 Part B Claims Data

The following subsections provide information on the Part B Claim Data Files.

2.2.6 Part B Physician File

The Part B Physician File (CCLF5) contains information on services delivered by physicians, practitioners, and suppliers. The file contains both claim-level and line-level information. At the claim level, the file contains date of service, MBI, HICN (will be blank starting January 2020),

header level diagnosis code, disposition code, and type of claim (DMEPOS or non-DMEPOS). At the line level, the file contains provider specialty, date of service, HCPCS code, HCPCS modifier code, payment amount, allowed charge amount, line-level diagnosis code (i.e., the "pointer" to the header level diagnosis), units of service, primary payer, provider Taxpayer Identification Number (TIN), and rendering NPI number. This information allows you to identify the proportion of total Part B services (or a particular type of Part B service) being supplied to your beneficiaries by the ACO versus non-ACO providers.

The ICD Version Indicator is found in the Part B Physician File. This indicator is a single character denotation of whether the code received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data.

For information on the Part B Physician File layout, refer to Table 18: Part B Physicians File.

2.2.7 Part B DME File

The Part B DME File (CCLF6) consists of claim-line records but includes both claim-level and line-level information. Claim-level information includes date of service, disposition code, and type of claim submitted (DMEPOS versus non-DMEPOS). Line-level information includes date of service, HCPCS code, payment amount, allowed charge amount, ordering NPI number, and "paid to" NPI number.

For information on the Part B DME File layout, refer to Table 19: Part B DME File.

2.3 Part D Claims Data

The Part D File (CCLF7) contains prescription drug information at the beneficiary level. Some of the data elements in this file include the National Drug Code (NDC), quantity dispensed, days supplied, prescribing provider ID, service provider ID, and patient payment amount.

For information on the Part D Claims Data File layout, refer to Table 20: Part D File.

2.4 Beneficiary Data

The following subsections provide information on the beneficiary data files.

2.4.1 Beneficiary Demographics File

The Beneficiary Demographics file (CCLF8) contains the list of beneficiaries for whom the ACO is qualified to receive claims data. For Shared Savings Program ACOs, this is limited to beneficiaries who have consented to share their claims information and have not been excluded by CMS. For Shared Savings Program ACOs with preliminary prospective assignment with retrospective reconciliation (Track 1, Track 2, or BASIC or ENHANCED ACOs who have chosen preliminary prospective assignment with retrospective reconciliation), the CCLF8 file includes beneficiaries who are voluntarily aligned or have had a qualifying primary care visit with the specific ACO within the past 12 months. For Shared Savings Program ACOs with prospective assignment (Track 3, Track 1+, or BASIC or ENHANCED ACOs who have chosen prospective assignment), the CCLF8 includes beneficiaries present on an ACO's current prospective assignment list. These beneficiaries could have been assigned because of the assignment visit plurality methodology or because the beneficiary voluntarily aligned with an ACO's participating provider. The CCLFs are sent to Shared Savings Program ACOs for a beneficiary (with a current data sharing preference of Opt-in and not excluded by CMS) who died prior to the Shared Savings Program ACO's agreement date.

The Monthly Claims data for a beneficiary aligned to a VTAPM ACO are suppressed (not sent) after a quarterly check, regardless of the beneficiary's data sharing preference, when the beneficiary's paid claims for any services are associated with a terminated and/or removed provider and that beneficiary has no paid claims with any other currently active providers of the VTAPM ACO within the last 12 months.

Claims data for a beneficiary, with a data sharing preference of Opt-in, are resumed (included within the CCLFs) with the aligned VTAPM ACO when there is at least one paid claim for services within the last 12 months with a currently active provider. Even if a beneficiary's status is reflected as "resumed" in the Monthly Beneficiary Data Sharing Status file, that beneficiary's claims are not included in the CCLFs if the beneficiary opts out of sharing claims data.

For VTAPM historical CCLFs are not impacted by the Suppression/Resumption process.

For VTAPM, the historical CCLFs are generated for newly aligned beneficiaries with a Claims-Through Date within the 36-month period prior to the PY. Newly aligned beneficiaries are those who are aligned to an ACO in the current PY but not in the previous PY. All the beneficiaries who are aligned to an ACO in the prior PY are not considered as newly aligned beneficiaries and they are not included in the historical CCLFs. Historical CCLFs are generated at the beginning of the PY in the month of January. In the month of January, the ACOs receive two sets of CCLFs: monthly and historical.

For the Shared Savings Program, the historical claims data are defined as beneficiary data available to a Shared Savings Program ACO 36-month period prior to their agreement start date.

CMS will make 36 months of historical claims available if a beneficiary is newly assigned to the ACO. The Shared Savings Program shares historical claims data at the beneficiary level under the following conditions:

- The beneficiary consents to sharing data.
- The beneficiary is newly assigned/assignable or voluntarily aligned to the ACO.
- The ACO is receiving claims data for the first time.

Detailed claims data reports provided to VTAPM ACOs do not include data for beneficiaries who have opted out of data sharing with the ACO. Substance abuse data are shared with ACOs for only those beneficiaries who have opted into this specific type of data sharing.

During a PY, ACO REACH Entities will receive historical claims going back 36 months prior to their PY for the newly aligned beneficiary who has not opted out of data sharing or whose data are not otherwise suppressed. Please note that during a Direct Contracting Entity's first performance year, all beneficiaries are considered newly aligned.

For PCF, the Practices will receive the following historical and monthly CCLFs:

- Historical claims going back 36 months prior to the beneficiary alignment start date (always the first day of the month) for the newly aligned beneficiary who consents to share the data.
- Monthly claims going back 36 months and loaded in the reporting month for the beneficiary who consents to share the data, and who is not newly aligned.

For KCC Model, the CKCC and KCF Entities will receive following historical and monthly CCLFs for the IP:

- Historical claims during the IP going back 12 months prior to their agreement start date for a newly aligned beneficiary who consents to share the data and has not been suppressed.
- Monthly claims during the IP going back 12 months prior to their agreement start date and loaded in the quarter for a beneficiary who has not opted out to share the data, and who is not newly aligned and not suppressed. Therefore, monthly claims are sent quarterly during the IP.

For KCC Model, the CKCC and KCF Entities will receive following historical and monthly CCLFs for the PY:

- Historical claims going back 36 months prior to their PY for the newly aligned beneficiary who has not opted out of data sharing and has not been suppressed. **Note:** *KCC Entities will receive historical claims for all beneficiaries in the first file of the PY1.*
- Monthly claims going back 36 months prior to their PY and loaded in the reporting month for the beneficiary who has not opted out of data sharing, and who is not newly aligned and has not been suppressed.

Note: *For Shared Savings Program, ACO REACH, and KCC Models, the Monthly and historical claims are combined and delivered in a single set of CCLFs.*

For the IP, the historical and monthly claims data for a KCC beneficiary aligned to an Entity are suppressed (not sent) after a check, regardless of the beneficiary's data sharing preference, when the beneficiary's claims are not associated with an active provider within the last 6 months.

Note: *For ACO REACH, PCF, and KCC Models, additional requirements regarding receiving HIPAA-protected data are available in the Participation Agreement for the model. The Participation Agreement is the agreement between CMS and Entity or Practice to participate in the model.*

This file contains the beneficiary's current MBI, HICN (will be blank starting January 2020), first/middle/last name, ZIP code, date of birth, sex, race, age, Medicare Status Code, dual eligibility status, hospice begin/end dates, and date of death if a decedent.

The Beneficiary Demographics File may contain multiple rows for the same beneficiary. This is because the beneficiary may have services with varying BENE_RNG_BGN_DT and BENE_RNG_END_DT dates. In this case, each row will have its own relationship to the rows of the CCLF 1, CCLF5, CCLF6, and CCLF7. This is represented in Figure 1: Entity Relationship Diagram as each row in the Beneficiary Demographics File has an association with zero or many rows of each of the four other CCLF files.

For information on the Beneficiary Demographics File layout, refer to Table 21: Beneficiary Demographics File.

2.4.2 Beneficiary Cross-Reference (XREF) File

The Beneficiary cross-reference (XREF) File (referred to as the "Beneficiary XREF File" or CCLF9) is produced to capture the list of beneficiaries who have at least one MBI change and have not opted out of data sharing, as described in Section 2.4.1 above. The beneficiary's current number, which constitutes the most recent MBI, and any previous MBI(s) and start/end dates, can be used to identify the historical claims that should be linked to the new beneficiary number or vice versa. The MBI can change if initiated by the beneficiary due to multiple reasons

like fraud or identity theft. Any claims submitted after the MBI change occurs will carry the new or most recent MBI.

For information on the Beneficiary XREF File layout, refer to Table 22: Beneficiary XREF File.

2.5 Part A Claims Benefit Enhancement and Demonstration Codes File

The Part A Claims Benefit Enhancement (BE) and Demonstration Codes File (CCLFA) are only available for ACO REACH, KCC, PCF, Shared Savings Program, and VTAPM ACOs. CCLFA contains BE code and Medicare Demonstration Special Processing Numbers associated with Part A claims, Population-Based Payment (PBP)/ All-Inclusive Population-Based Payment (AIPBP) Part A reduction amounts, and PBP/AIPBP Part A inclusion amounts. The file contains a row for each unique claim that is processed with one or more of the following BEs: PBP, AIPBP, SNF 3-Day Waiver, Telehealth, and/or Post Discharge Home Visit. All BE code present for each claim displays in the file. Additionally, the file displays all available Medicare Demonstration Special Processing Numbers for each Part A claim; up to five numbers are available. To view more information for each claim in CCLFA, such as claim amounts, please use the Current Claim Unique ID to map to CCLF1.

For VTAPM ACOs, PBP is a payment mechanism where a percentage of payments to the Providers are withheld from the Medicare fee-for-service (FFS) payments. The projected total amount withheld from Providers is then distributed to VTAPM ACOs monthly through per-beneficiary, per-month (PBPM) payments.

AIPBP is a payment mechanism where all (100%) of payments to Providers are withheld from the FFS payments. CMS makes a monthly AIPBP payment to VTAPM ACOs, with which NGACO and VTAPM ACOs are responsible for paying claims for VTAPM Providers receiving 100% reduced FFS payments.

For those Providers who have entered into an agreement with a VTAPM ACO to participate in the PBP/AIPBP mechanism, the Medicare Part A PBP/AIPBP Reduction Amount and PBP/AIPBP Inclusion Amount are provided in CCLFA. The PBP/AIPBP Inclusion Amount is the amount that would have been paid in the absence of a PBP/AIPBP reduction. PBP/AIPBP data are derived directly from the Integrated Data Repository (IDR) and are only available at the header-level for Part A claims. For information on Part B PBP/AIPBP data, please refer to Section 2.2.6, Part B Physician File.

2.6 Part B Claims Benefit Enhancement and Demonstration Codes File

The Part B Claims BE and Demonstration Codes File (CCLFB) are only available for ACO REACH, KCC, PCF, Shared Savings Program, VTAPM ACOs. CCLF B contains BE code and Medicare Demonstration Special Processing Numbers associated with Part B claim lines, PBP/AIPBP Part B reduction amounts, and PBP/AIPBP Part B inclusion amounts. The file contains a row for each unique claim line that is processed with one or more of the following BEs: PBP, AIPBP, SNF 3-Day Waiver, Telehealth, and/or Post Discharge Home Visit. All BE code present for each claim line displays in the file. Additionally, the file displays all available Medicare Demonstration Special Processing Numbers for each Part B claim line; up to five numbers will be available. To view more information for each claim line in CCLFB, such as claim amounts, please use the Current Claim Unique ID and Claim Line Number to map to CCLF5.

For those Providers who have entered into an agreement with a VTAPM ACO to participate in the PBP/AIPBP payment mechanism, the Medicare Part B PBP/AIPBP Reduction Amount and PBP/AIPBP Inclusion Amount are provided in CCLFB. The PBP/AIPBP Inclusion Amount is the amount that would have been paid in the absence of a PBP/AIPBP reduction. PBP/AIPBP data

are derived directly from the IDR and are available at the claim line-level for Part B claims. For information on Part A PBP/AIPBP data, please refer to Section 2.2.1, Part A Claims Header File.

2.7 Summary Statistics Data

The Summary Statistics File (CCLF0) contains the record count for each of the 11 CCLF files. This file can be used to verify the receipt of all of a file's records. This file is implemented for ACO REACH, KCC, PCF, Shared Savings Program, and VTAPM ACOs.

The file is delivered to the user as a pipe-delimited text file, which can be downloaded into a Microsoft Excel spreadsheet, as shown in Table 1.

Note: *The total record count varies each month for the files in Table 1.*

Table 1: Summary Statistics File in Microsoft Excel Spreadsheet Format

File Number	File Description	Total Record Count	Record Length
CCLF1	Part A Claims Header File	xxxxxxxxx	xxx
CCLF2	Part A Claims Revenue Center Detail File	xxxxxxxxx	xxx
CCLF3	Part A Procedure Code File	xxxxxxxxx	xxx
CCLF4	Part A Diagnosis Code File	xxxxxxxxx	xxx
CCLF5	Part B Physicians File	xxxxxxxxx	xxx
CCLF6	Part B DME File	xxxxxxxxx	xxx
CCLF7	Part D File	xxxxxxxxx	xxx
CCLF8	Beneficiary Demographics File	xxxxxxxxx	xxx
CCLF9	BENE XREF File	xxxxxxxxx	xxx
CCLFA	Part A BE and Demo Codes File	xxxxxxxxx	xxx
CCLFB	Part B BE and Demo Codes File	xxxxxxxxx	xxx
CCLF0	Summary Statistics Header Record	xxxxxxxxx	xxx

For information on the Summary Statistics Header Record and Summary Statistics Detail Record File layouts, refer to Table 25: Summary Statistics Header Record and Table 26: Summary Statistics Detail Records.

2.8 NPI and OSCAR Data Sources

From January 2022 onward, CCLF1-CCLF6 files contain two fields for each NPI and OSCAR element. The NPI and OSCAR fields are not duplicative and sourced from two different systems: PECOS and claims processing systems. ACOs are welcome to use either the PECOS

sourced field or the claims sourced field for their internal claims processing. Appendix B: CCLF File Layouts provides a description of both fields.

3 Limitations and Cautions

This section describes limitations and cautions for ACOs to consider when using the CCLF.

3.1 Matching MBIs

A beneficiary's MBI is unique to that beneficiary but may change over time. CCLFs 1 through 9, A, and B, as they are provided each month, contain the beneficiary's most current MBI. When records from multiple months are being combined, the Beneficiary XREF File (CCLF9) can be used each month to cross reference records associated with the current MBI to records associated with previous MBIs.

The steps below detail instructions for merging CCLF data, and provide an example of merging data for the months of January and February of a particular PY:

1. Use the February Beneficiary XREF File to identify the current and previous MBI(s).
2. After identifying the previous MBIs in the February Beneficiary XREF File, locate the same previous MBIs in the January CCLF data.
3. Replace the previous MBIs in the January CCLF data with the current MBIs from the February CCLF data. The file will now have only one unique MBI per beneficiary across time (over January and February in this example).

3.2 Dropping Denied Claims

Depending on your use of the data for analysis, you may want to drop denied and corrected claims from the Part A and B CCLF data. For Part B Physician/DME claims, some individual line-items can be denied, whereas other line-items are not denied. Part B claims need to be dropped depending upon the value of the variable CLM_CARR_PMT_DNL_CD, and Part B line-items need to be dropped depending upon the value of the variable CLM_PRCSG_IND_CD. For Part A claims, the variable CLM_MDCR_NPMT_RSN_CD identifies claims that have been denied. Unlike Part B claims, Part A claims are either accepted in their entirety or denied in their entirety.

3.3 Part D Data Limitations

The Part D data file only includes records for beneficiaries who are enrolled in a Prescription Drug Plan (PDP). Many beneficiaries have Part D prescription drug coverage through an employer-sponsored retiree drug plan. Part D data does not include prescription data for these beneficiaries due to differences in the data that are required to be submitted by a PDP and a retiree drug plan. Furthermore, Part D data only reflect expenditures for filled prescriptions.

The Part D claims contained in the CCLF are "final action" claims, unlike the other claims-related files in the CCLF, which are debit/credit claims. In any given set of monthly CCLF files, only "final action" claims are contained in the Part D file. Furthermore, the Part D cancellation claims (i.e., delete claims) are always submitted with a $0 payment amount. As you create a claims record over time by combining many monthly CCLF data feeds for Part D claims, you will need to identify for any given set of Related Claims (i.e., claims that all represent the same event) the most recent claim and delete/ignore all of the previous related claims for that event. That is, you need to identify the "final action" claims.

Lastly, note that the NDC code is not populated for “delete” prescription drug events (PDEs); all cancellation claims in the Part D file have blank values for the NDC code field.

3.4 Claims Run-Out

Claims for services that are rendered towards the end of the PY are generally not processed until the beginning of the following PY. As a result, the IDR claim load date (CLM_IDR_LD_DT) and the Claim Through Date (CLM_THRU_DT) should be used to identify claims loaded at a later time for services rendered for the prior PY. ACO REACH, Shared Savings Program, and VTAPM ACOs receive the 3-months claims run-out files for the prior PY in the months of February through April of the next PY. *For example, ACOs received the 3-months claims run-out files for 2018 PY in the months of February to April 2019.*

Note: *Claims run-out period does not apply for the KCC Model.*

ACO REACH Entities will receive claims run-out files starting 2022. Monthly claims data do not include claims for services that have not yet been submitted to the MAC by the provider. Similarly, monthly claims data do not include claims that have been received by the MAC but are not fully processed at the time the claims feeds are generated.

Two variables are used to control claims run-out: CLM_THRU_DT and CLM_IDR_LD_DT.

- The CLM_THRU_DT is the last day on the billing statement that covers services rendered to the beneficiary.
- The CLM_IDR_LD_DT is the date the claim was loaded into the Integrated Data Repository (IDR), the CMS data warehouse or repository. The CLM_IDR_LD_DT is generally a Monday.

For a given claim, there is typically a time gap between the CLM_THRU_DT and the CLM_IDR_LD_DT. However, in some cases, a claim is “pended” (i.e., held back) and not loaded into the IDR immediately. As a result, some claims loaded into the IDR on a given Monday (from CLM_IDR_LD_DT) will include claims whose CLM_THRU_DT is weeks or in a small number of cases, months in the past. Therefore, to control claims run-out, both variables are needed. For example, to capture all of the claims rendered for a particular month that were loaded during the run-out period, you would use the CLM_THRU_DT with a date range from the beginning of the PY until the end of the PY, and an IDR_LD_DT for the given reporting month. For the given example, you would need to specify the following:

- CLM_IDR_LD_DT on or before March 31, 2016.
- CLM_THRU_DT for any month within CY2015.

3.5 Part A Header Expenditures vs Part A Revenue Center Expenditures

Both the Part A Header file (CCLF1) and the Part A Revenue Center file (CCLF2) contain a payment related field, entitled CLM_PMT_AMT and CLM_LINE_CVRD_PD_AMT, respectively. The revenue center payment amounts should only be relied on if they sum to the header level payment amount. If the revenue center level payment amounts do not sum to the header level payment amount, then the revenue center level payment amounts should be ignored. The reasons for the discrepancy between revenue center and header level payments are that some claims do not have revenue center level payments (e.g., inpatient claims which are paid at claim level using the DRG payment system), some claims are not required to report at the revenue center level (and thus sometimes yield inconsistent reporting at the revenue center level

compared to the header level), and for some claims the revenue center amounts reported were not actually those used for payment.

3.6 Date Fields

There are various date-related fields in the CCLF data files. In some instances, the date field is not required or is not available in the source. In these cases, that date field is commonly filled in with “1000-01-01” or “9999-12-31.” These dates should be treated as “missing” or “null” values. Also, note that line-level service dates on inpatient claims can fall outside of the time period of the header level from/thru dates.

3.7 Other Limitations/Cautions

The Medicare dataset supplied to you is a subset of the full set of Medicare data. The variables were chosen because they were deemed the most useful information for you.

The data do not reflect the use and expenditures for beneficiaries who have not given permission for their data to be shared with ACOs. In addition, substance abuse data are not shared when the beneficiary has opted out of substance abuse data sharing (Shared Savings Program, KCC and ACO REACH beneficiaries are always opted out). As a result, these data may not include 100% of the claims data for every beneficiary.

4 Updates in the CCLF Data Files

4.1 Latest Fields and Descriptive Text Changes to the Claims Line Feed

No changes have been made to this file since the last published version.

4.1.1 CCLF2 - Part A Revenue Center File

No changes have been made to this file since the last published version.

4.1.2 CCLF3 - Part A Procedure Code File

No changes have been made to this file since the last published version.

4.1.3 CCLF4 - Part A Diagnosis Code File

No changes have been made to this file since the last published version.

4.1.4 CCLF5 - Part B Physician File

No changes have been made to this file since the last published version.

4.1.5 CCLF6 - Part B DME File

No changes have been made to this file since the last published version.

4.1.6 CCLF7 - Part D File

No changes have been made to this file since the last published version.

4.1.7 CCLF8 - Beneficiary Demographics File

No changes have been made to this file since the last published version.

4.1.8 CCLF9 - Beneficiary Cross-Reference (XREF) File

No changes have been made to this file since the last published version.

4.1.9 CCLFA - Part A Claims Benefit Enhancement and Demonstration Codes File

No changes have been made to this file since the last published version.

4.1.10 CCLFB - Part B Claims Benefit Enhancement and Demonstration Codes File

No changes have been made to this file since the last published version.

4.1.11 CCLF0 - Summary Statistics File

No changes have been made to this file since the last published version.

4.2 File Naming Convention Changes to the Claims Line Feed

Beginning January 2020, all generated CCLFs will be packaged and zipped in a single zip file instead of individual zip files for each ACO each month. This single zip file applies to Shared Savings Program, VTAPM, ACO REACH, KCC, and PCF Models.

The file naming convention for Shared Savings Program ACOs' monthly CCLF will be P.A****.ACO.ZCY**.Dyymmdd.Thhmmsst. *For example, the file sent to Shared Savings Program ACOs for monthly CCLFs in 2020 will be P.A****.ACO.ZCY20.Dyymmdd.Thhmmsst. The "Y**" indicates the PY for which the data are shared with the ACOs.*

The file naming convention for Shared Savings Program runout CCLFs will be P.A****.ACO.ZCR**.Dyymmdd.Thhmmsst. *For example, the file for Shared Savings Program ACOs for the 2019 PY run outs in 2020 will be P.A****.ACO.ZCR19.Dyymmdd.Thhmmsst.*

The file naming convention for VTAPM ACOs' monthly CCLFs will be P.F***.ACO.ZCY**.Dyymmdd.Thhmmsst. *For example, the file sent to VTAPM ACOs for monthly CCLFs in 2020 will be P.F***.ACO.ZCY20.Dyymmdd.Thhmmsst. "Y**" indicates the PY for which the data are shared with the ACOs.*

The file naming convention for VTAPM runout CCLFs will be P.F***.ACO.ZCR**.Dyymmdd.Thhmmsst. *For example, the file sent to VTAPM ACOs for the 2019 PY run outs in 2020 will be P.F***.ACO.ZCR19.Dyymmdd.Thhmmsst.*

The file naming convention for REACH ACOs' monthly CCLFs will be P.D****.ACO.ZCY**.Dyymmdd.Thhmmsst. *For example, the file sent to* REACH ACOs' *in 2021 will be P.D****.ACO.ZCY21.Dyymmdd.Thhmmsst. "Y**" indicates the PY for which the data are shared with the ACOs.*

The file naming convention for ACO REACH runout CCLFs will be P.D****.ACO.ZCR**.Dyymmdd.Thhmmsst. *For example, the file sent to ACO REACH Entities for the 2021 PY run outs in 2022 will be P. D****.ACO.ZCR21.Dyymmdd.Thhmmsst.*

The file naming convention for KCC Entities' (KCF and CKCC options) monthly CCLFs will be as follows:

For KCF, the file naming convention is P.K****.ACO.ZCY**.Dyymmdd.Thhmmsst. *For example, the file sent to KCC Entities in 2021 will be P.K****.ACO.ZCY21.Dyymmdd.Thhmmsst. The "Y**" indicates the year for which the data are shared with the ACOs.*

For CKCC, the file naming convention is P.C****.ACO.ZCY**.Dyymmdd.Thhmmsst. *For example, the file sent to KCC Entities in 2021 will be P.C****.ACO.ZCY21.Dyymmdd.Thhmmsst. The "Y**" indicates the year for which the data are shared with the ACOs.*

For PCF, the file naming convention is P.P******.ACO.ZC**.Dyymmdd.Thhmmsst. *For example, the file sent to PCF Entities in 2021 will be P.P******.ACO.ZC21.Dyymmdd.Thhmmsst.*

Notes:

- *Run-out CCLFs files are not generated for KCC.*
- *The CCLF files will be delivered for the KCC,* ACO REACH*, and PCF models via Data Hub. Please refer to Appendix C: Zip File Instructions.*

Refer to Appendix B: CCLF File Layouts for the specific file naming convention for each program when a single file is unzipped to find individual CCLFs.

4.3 Description of the Additional Fields

Please refer to Appendix B: CCLF File Layouts for a complete description of each new field.

4.4 Debit/Credit Method & Identification of Cancellation/Adjustment Claims

Note: *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The HICN, BIC HICN, and RRB fields will be blank in CCLFs generated effective January 1, 2020, onwards.*

The Debit/Credit method gives a full account/history of the claims processed over time. This means that the universe of claims is included in the claims line feed, including adjustment and cancellation claims. The variable CLM_ADJSMT_TYPE_CD identifies which of the following categories that any individual claim falls into:

- CLM_ADJSMT_TYPE_CD= 0 signifies an Original Claim.
- CLM_ADJSMT_TYPE_CD= 1 signifies a Cancellation Claim.
- CLM_ADJSMT_TYPE_CD= 2 signifies an Adjustment Claim (claim that is an adjustment to an original claim).

5 Application Notes

The following subsections provide application notes.

5.1 Identification of Related Claims Using the Natural Key

5.1.1 Creation of the Most Recent MBI field (MR_MBI) for use in the Natural Key

A beneficiary can have changes in their MBI over time. The beneficiary XREF file (CCLF9) contains a complete history of MBIs ever used to identify a beneficiary, for beneficiaries who have had a change in their MBI over time. In other words, the XREF file (CCLF9) provides a crosswalk between all older MBIs and the most recent MBI for a beneficiary.

Suppose John Doe is enrolled into Medicare and has been assigned an MBI of "1EG4TE5MK73." Processed claims would use an MBI of "1EG4TE5MK73." Suppose that on

May 1, 2019, his MBI changes to “6U50TE7GG18.” Claims from May 2019 and later will get processed using his new MBI. CCLF files contain the MBI associated with the beneficiary at the time they are generated. In this example, “6U50TE7GG18” is the “most recent MBI.”

To identify and link related claims, a beneficiary’s MBI’s from previously received data files need to be mapped to the most recently received MBI. The user of the CCLF data files will need to create the following field:

Most Recent MBI field (MR_MBI): Replace the old MBI (in the previous datasets) with the current MBI (from the most recent set of CCLF data) using information from the beneficiary cross-reference file (CCLF9). After making the replacements, rename the MBI field to MR_MBI. The MR_MBI field is used as part of the Natural Key in section 5.1.2 below.

5.1.2 Natural Keys

“Related Claims” refers to all the claims associated with a single episode of service (i.e., event). This includes the original claim(s) and any corresponding cancellation and adjustment claims. A natural key allows you to identify/group Related Claims. The natural key for each of the files is as follows:

Part A Claim Header File/Revenue Center/Procedure/Diagnosis files:

- CLM_BLG_PRVDR_OSCAR_NUM
- CLM_FROM_DT
- CLM_THRU_DT
- Most Recent MBI (MR_MBI)

Part B Physician/DME files:

- CLM_CNTL_NUM
- Most Recent MBI (MR_MBI)

Part D File:

- CLM_LINE_FROM_DT, PRVDR_SRVC_ID_QLFYR_CD
- CLM_SRVC_PRVDR_GNRC_ID_NUM
- CLM_DSPNSNG_STUS_CD
- CLM_LINE_RX_SRVC_RFRNC_NUM
- CLM_LINE_RX_FILL_NUM

5.1.3 Example: Linking Related Claims in the Part A Header File Using the Natural Key

Suppose you are looking at a claim with CUR_CLM_UNIQ_ID=3589734591235. To identify all related claims, first find the values for the natural key that are associated with CUR_CLM_UNIQ_ID=3589734591235 (i.e., find the values for CLM_BLG_PRVDR_OSCAR_NUM, CLM_FROM_DT, CLM_THRU_DT, and MR _MBI (most recent MBI) when CUR_CLM_UNIQ_ID=3589734591235). Suppose that, for the claim in this example, the values for the natural key are as follows:

- CLM_BLG_PRVDR_OSCAR_NUM =654321
- CLM_FROM_DT= 07/01/12
- CLM_THRU_DT= 7/04/12
- MR_MBI (most recent MBI)= 6U50TE7GG18

Using these values for the natural key, we can now identify all claims in the Part A Header File that have the same values for the natural key. Suppose we obtain the following from Table 2:

Table 2: Part A Header File

CUR_CLM_UNIQ_ID	CLM_BLG_PRVDR_OSCAR_NUM	CLM_FROM_DT	CLM_THRU_DT	MR_MBI
2222222222222	654321	07/01/12	7/04/12	6U50TE7GG18
3589734591235	654321	07/01/12	7/04/12	6U50TE7GG18
1313274894021	654321	07/01/12	7/04/12	6U50TE7GG18
1111111111111	654321	07/01/12	7/04/12	6U50TE7GG18
3333333333333	654321	07/01/12	7/04/12	6U50TE7GG18

This group of claims consists of five records that are all related to one another. Specifically, they all involve a claim for services provided to a beneficiary by a single Part A provider during the time period July 1, 2012, through July 4, 2012. Further information is needed to distinguish among the claims and identify the “final action” claim(s). In this example, it will be useful to obtain information on the claim effective date and the claim adjustment type code. In Table 3, this additional information is added. (The Natural Key is dropped to reduce the number of columns displayed; however, one can assume that those columns shown in the above table are simply not displayed here).

Table 3: Claim Effective Date and the Claim Adjustment Type Code

ROW	BENE_MBI_ID	CUR_CLM_UNIQ_ID	CLM_EFCTV_DT	CLM_ADJSMT_TYPE_CD
1	5F27TE6KM28	2222222222222	07/30/12	0 (original claim)
2	5F27TE6KM28	3589734591235	08/01/12	1 (cancellation claim)
3	5F27TE6KM28	1313274894021	08/01/12	2 (adjustment claim)
4	6U50TE7GG18	1111111111111	08/07/12	1 (cancellation claim)
5	6U50TE7GG18	3333333333333	08/07/12	2 (adjustment claim)

In the above table, you will find that the record in Row 2 cancels the record in Row 1. Likewise, the record in Row 4 cancels the record in Row 3. The remaining record in Row 5 is the "final action" claim. Note that in this example, sorting by CLM_EFCTV_DT and then by CLM_ADJSMT_TYPE_CD, yields the final action claim as the last record in this sort. This is a unique example, and it is NOT always true that related claims sorted in this way will yield the "final action" claim(s). As detailed in Section 5.2 below, there is variation across the claims-related files (Part A, Part B, Part D) in the appropriate use of the variables CLM_EFCTV_DT and CLM_ADJSMT_TYPE_CD in distinguishing among related claims.

5.2 Occurrences of Related Claims in the Various Claims-Related Files

5.2.1 Related Claims in the Part A Header File

In the Part A Header File, you will find original claims, cancellation claims, and adjustment claims (i.e., claims with CLM_ADJSMT_TYPE_CD=0, 1, or 2 respectively). Related claims found in the Part A Header File may exhibit several patterns, including but not limited to the following:

1. An original claim with no other related claims
2. An adjustment claim with no other related claims
3. A set of related claims consisting of an original claim and a cancellation claim
4. A set of related claims including two original claims (and no other related claims)
5. A set of related claims including an original claim, a cancellation claim, and an adjustment claim

The timing of the processing of the related claims is not always straightforward. In all instances, an original claim will be processed before its corresponding adjustment and cancellation claim(s). In many instances, the cancellation claim is processed at the same time as the adjustment claim. However, in some instances, the cancellation claim is processed weeks (or even months) after the adjustment claim is processed. In other instances, the cancellation claim is processed weeks (or even months) before the adjustment claim. As a result, it is not always straightforward (or possible) to distinguish among all the beneficiary's related claims.

To identify the "final action" or "non-canceled" claims in a related set of claims, it is necessary to match each cancellation claim with one of the following:

1. An original claim
2. An adjustment claim

All original/cancellation and adjustment/cancellation matched pairs should be removed/ignored, yielding only final action claim(s). It is possible that there is more than one final action claim among a related set of claims.

In the event a Claim Through Date (CLM_THRU_DT) is submitted incorrectly and must be revised, the following will happen:

1. A cancellation claim will be generated identical to the original claim and will have the same incorrect through date.
2. An adjustment claim will be submitted with the correct Claim Through Date. In this instance, the natural key cannot be used to link the related claims together. When one of the fields of the natural key changes, the natural key is no longer useful in linking related claims together.

5.2.2 Related Claims in the Part B Physician File

In the Part B Physician File, you will find original claims and cancellation claims. You will not find any adjustment claims in these files. A variety of related claims are found in the Part B Physician File including (but not limited to) the following:

1. An original claim with no other related claims.
2. A set of related claims consisting of an original claim and a cancellation claim.
3. A set of related claims consisting of two original claims and one cancellation claim.
4. A set of related claims consisting of three original claims and two cancellation claims.

5.2.3 Related Claims in the Part B DME File

In the Part B DME File, you will find original claims and cancellation claims. You will not find any adjustment claims in these files. A variety of related claims are found in the Part B DME File including (but not limited to) the following:

1. An original claim with no other related claims.
2. A set of related claims consisting of one original claim and one cancellation claim.
3. A set of related claims consisting of two original claims and one cancellation claim.
4. A set of related claims consisting of three original claims and two cancellation claims.

5.2.4 Related Claims in the Part D File

In the Part D File, you will find original claims, cancellation claims, and adjustment claims. A variety of related claims are found in the Part D File, including (but not limited to) an original claim with no other related claims.

5.3 Calculating Beneficiary-Level Expenditures

5.3.1 Calculating Total Part A and B Expenditures

Calculating total expenditures for a beneficiary using debit/credit data is a conceptually simple process of adding up all the debit and credit amounts associated with the claims incurred by a beneficiary during a specific time period.

However, it is slightly more complicated for two reasons: First, the payment amounts on each record are not "signed" to indicate whether the payment amount is a payment to the provider or a recovery from the provider. Therefore, it is necessary to use the CLM_ADJSMT_TYPE_CD to determine whether to "add" or "subtract" the payment amount from the running total. Second, different MBIs may appear on the claims for a single beneficiary at different points in time.

To correctly "sign" the payment amounts as a payment to a provider, or a recovery from a provider, follow the steps below to identify beneficiary-level expenditures for Part A and Part B services:

1. Identify the canceled claims in the Part A Header file. These claims are identified by CLM_ADJSMT_TYPE_CD=1. Change the "sign" of the variable CLM_PMT_AMT for each of these cancellation claims (i.e., multiply the CLM_PMT_AMT by -1). For example, if on a given cancellation claim the value for CLM_PMT_AMT=$30.18, then change this to equal -$30.18.
2. Identify all the canceled records (line items) in the Part B Physician file. The canceled line items are identified by CLM_ADJSMT_TYPE_CD=1. Change the "sign" of the variable CLM_LINE_CVRD_PD_AMT for each of these canceled line items.
3. Identify all the canceled records (line items) in the Part B DME file. The canceled line items are identified by CLM_ADJSMT_TYPE_CD=1. Change the "sign" of the variable CLM_LINE_CVRD_PD_AMT for each of these canceled line items.

Note: *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The HICN, Beneficiary Equitable BIC HICN, and RRB fields will be blank in CCLFs generated effective January 1, 2020, onwards.*

To identify all claims incurred by a single beneficiary, regardless of changes in the beneficiary's MBI, follow the steps below:

1. Replace all old MBIs in the previous datasets (if any) with the current MBI using information from the Beneficiary XREF File (CCLF9).
2. For each current MBI (after making the changes from step 1), identify the Part A claims from the Part A Claims Header File. Identify total Part A Header level expenditures for each MBI after accounting for the potential "sign" changes in Step 1.
3. For each current MBI (after making the changes from step 1), identify the Part B Physician line-items. Identify the total Part B Physician expenditures (summing across line-items) for each MBI after accounting for the potential "sign" changes in Step 2.
4. For each current MBI (after making the changes from Step 1), identify the Part B DME line-items. Identify the total Part B DME expenditures (summing across line-items) for each MBI after accounting for the potential "sign" changes in Step 3.
5. Sum the values in 2, 3, and 4 above to get total Part A and B expenditures at the beneficiary-level (year-to-date or for whatever time period you prefer).

5.3.2 Example of Calculating Total Part A and Part B Expenditures

1. Starting from your initial assignment list (or Initial Alignment Report, depending on the Medicare ACO program you participate in), suppose you have a beneficiary with a current MBI of 6U50TE7GG18. Going to the Beneficiary XREF File, you find the beneficiary does not have any previous MBIs. The most recent BENE_MBI_ID would be "6U50TE7GG18."
2. For this beneficiary, suppose you finds claims in the Part A Header File and the Part B Physician File, but no claims in the Part B DME File.
3. Calculating total Part A Expenditures: The following table contains the full set of Part A Header Records for the beneficiary.

Table 4: Part A Header Records

CLM#	CCN	FROM	THRU	MR_MBI	PAID	ADJ_TYPE	EFCTV_DT
1	654321	07/01/12	07/08/12	6U50TE7GG18	$200	0	07/20/12
2	654321	07/01/12	07/08/12	6U50TE7GG18	$0	2	09/20/12
3	654321	07/01/12	07/08/12	6U50TE7GG18	$200	1	08/07/12
4	654321	07/01/12	07/08/12	6U50TE7GG18	$210	2	09/20/12
5	654321	07/01/12	07/08/12	6U50TE7GG18	$0	2	08/07/12
6	654321	07/01/12	07/08/12	6U50TE7GG18	$0	1	10/07/12
7	654321	08/20/12	08/29/12	6U50TE7GG18	$50	0	09/20/12

Many of the variables' names were shortened to make the table fit better. The following contains a list of the variables' names that were changed, with their "new" names in parentheses: CUR_CLM_UNIQ_ID (CLM#), CLM_BLG_PRVDR_OSCAR_NUM (CCN), CLM_FROM_DT (FROM), CLM_THRU_DT (THRU), CLM_PMT_AMT (PAID), CLM_ADJSMT_TYPE_CD (ADJ_TYPE), and CLM_EFCTV_DT (EFCTV_DT).

Changing the sign for CLM_PMT_AMT on all cancellation claims (i.e., those claims with CLM_ADJSMT_TYPE_CD=1) yields the following:

Table 5: Part A Header Records

CLM#	CCN	FROM	THRU	MR_MBI	PAID	ADJ_TYPE	EFCTV_DT
1	654321	07/01/12	07/08/12	6U50TE7GG18	$200	0	07/20/12
2	654321	07/01/12	07/08/12	6U50TE7GG18	$0	2	09/20/12
3	654321	07/01/12	07/08/12	6U50TE7GG18	-$200	1	08/07/12
4	654321	07/01/12	07/08/12	6U50TE7GG18	$210	2	09/20/12

CLM#	CCN	FROM	THRU	MR_MBI	PAID	ADJ_TYPE	EFCTV_DT
5	654321	07/01/12	07/08/12	6U50TE7GG18	$0	2	08/07/12
6	654321	07/01/12	07/08/12	6U50TE7GG18	-$0	1	10/07/12
7	654321	08/20/12	08/29/12	6U50TE7GG18	$50	0	09/20/12

Summing across the values of the variable CLM_PMT_AMT yields: $200 + $0 + -$200 +$210 + $0 + -$0 + $50=$260. Note that Claim #3 (i.e., claim where CLM#=3) cancels Claim #1. It is unclear which claim (Claim #2 or Claim #5) that Claim #6 is canceling. However, if there are any data elements contained in the claims line feed that vary between Claim #2 and Claim #5, then these data elements could potentially be used to identify which claim is being canceled by Claim #6. This may not always be possible, and hence you will not know which claim (#2 or #5) should be canceled; you will simply need to pick one in this case. Lastly, note that Claims #1-#6 are a set of Related Claims (i.e., they all have the same natural key), whereas Claim #7 is a separate un-related claim.

For utilization measurement purposes, you may want to identify the claims that represent the most recent (i.e., final action) data. In this instance, this would include three Part A claims: Claim #4, Claim #7 and either Claim #2 or Claim #5, but not both.

4. Calculating Part B Physician Expenditures: The following table contains the full set of Part B Physician records for the beneficiary:

Table 6: Part B Line-Item Records

CLM#	LINE_NUM	CNTL_NUM	MR_MBI	PAID	ADJ_TYPE	EFCTV_DT
1	3	7	6U50TE7GG18	$0	1	09/02/12
1	1	7	6U50TE7GG18	$380	1	09/02/12
1	2	7	6U50TE7GG18	$227	1	09/02/12
2	1	7	6U50TE7GG18	$380	0	09/02/12
2	2	7	6U50TE7GG18	$227	0	09/02/12
2	3	7	6U50TE7GG18	$100	0	09/02/12
3	3	7	6U50TE7GG18	$0	0	08/15/12
3	1	7	6U50TE7GG18	$380	0	08/15/12
3	2	7	6U50TE7GG18	$227	0	08/15/12

Some variables have been renamed in a similar fashion as in the Part A Header record table from Part 3. The following additional variable renaming was done to conserve space in the table, where the “new” names are in parentheses: CLM_LINE_CVRD_PD_AMT (PAID), CLM_LINE_NUM (LINE_NUM), and CLM_CNTL_NUM (CNTL_NUM).

Changing the sign for CLM_LINE_CVRD_PD_AMT on all cancellation claims (i.e., those claims with CLM_ADJSMT_TYPE_CD=1) yields the following:

Table 7: Part B Line-Item Records

CLM#	LINE_ NUM	CNTL_NUM	MR_MBI	PAID	ADJ_TYPE	EFCTV_DT
1	3	7	6U50TE7GG18	-$0	1	09/02/12
1	1	7	6U50TE7GG18	-$380	1	09/02/12
1	2	7	6U50TE7GG18	-$227	1	09/02/12
2	1	7	6U50TE7GG18	$380	0	09/02/12
2	2	7	6U50TE7GG18	$227	0	09/02/12
2	3	7	6U50TE7GG18	$100	0	09/02/12
3	3	7	6U50TE7GG18	$0	0	08/15/12
3	1	7	6U50TE7GG18	$380	0	08/15/12
3	2	7	6U50TE7GG18	$227	0	08/15/12

Summing across the values of the variable CLM_LINE_CVRD_PD_AMT yields the following:

$0 + -$380 + -$227 + $380 + $227 + $100 + $0 + $380 + $227 = $100 + $380 + $227 = $707.

5. To calculate total Part A and B expenditures, sum the amount from steps 3 and 4. Total Part A and B expenditures=$260+$707=$967.

5.4 Part A vs Part B Claims

To identify the total expenditure incurred and paid under the Hospital Insurance (Part A) program and the Supplemental Medical Insurance (Part B) program, it is important to know that the Part A claims files will include Medicare provider payments for some services covered under both Part A and Part B.

To distinguish Part A claims that are covered and paid under the Hospital Insurance program from those covered under the Supplemental Medical Insurance program, you must use the Claim Facility Type Code and the Claim Service Classification Code.

All claims in the Part B physician and Part B DMEPOS files are covered under the Supplemental Medical Insurance program.

5.5 Identifying Sources of Care for the Assigned/Aligned Population

Follow the steps below to determine the percentage of care being provided by your ACO, as measured by number of Part A line items, for the beneficiaries included in your CCLF.

Note: *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN, Beneficiary Equitable BIC HICN, and RRB fields will be blank effective January 1, 2020. Use the Part A Claim Revenue Center Detail File to identify the number of line items for a beneficiary. Each row in this table represents a separate line item.*

1. Identify the rows in the file that correspond to each beneficiary (using the current BENE_MBI_ID). For a given beneficiary-claim combination, each row (line-item) can be distinguished by the claim line number (CLM_LINE_NUM). For a given claim (and its associated line items), the determination of who provided the service (ACO or non-ACO) provider can be determined by looking at the claim facility NPI (FAC_PRVDR_NPI_NUM) and the operating physician NPI (OPRTG_PRVDR_NPI_NUM) from the Part A Claims Header File.
2. Calculate the total line items for Part A services, line items for Part A services provided by the ACO, and line items for Part A services provided by non-ACO providers.

6 Combining Claims Data with Other Data Sources

The monthly claims data feed provides data on Medicare expenditures for services covered by Parts A, B, and D. It also provides a limited set of demographic variables for each beneficiary. Additional data sources that may be merged into the claims data are listed below.

6.1 Assignment/Alignment Report

For VTAPM ACOs, the Initial Alignment Report (Report 1-1) includes identifying information for each initially aligned beneficiary. The list of aligned beneficiary data is updated throughout the PY as beneficiaries lose eligibility for alignment. The schedule for the beneficiary eligibility verification for VTAPMVTAPM alignment eligibility is verified quarterly. The VTAPM data updates are reflected after each eligibility verification process in the Report 1-2 VTAPM Quarterly Report on Excluded Beneficiaries.

For Shared Savings Program ACOs, the Assignment Report includes identifying information for each beneficiary. These data are also updated each quarter.

For ACO REACH and KCC Models, the Beneficiary Alignment Report includes the identifying information for aligned beneficiaries.

These reports are the source of beneficiary identifying information for the claims data.

6.2 Provider Data

The claims data identifies providers by NPI (or in some cases the OSCAR number or CCN). Information to identify providers by name must be merged with the claims data. One source for this information is the public-use NPPES file.

7 Useful Resources

7.1 Useful Resources Regarding Medicare Claims Data

The Research Data Assistance Center (ResDAC) website is a useful source of information regarding Medicare claims data. The CMS Manual System, publication 100-04 Medicare Claims Processing Manual is a useful source of information regarding Carrier Payment Denial Codes. Other useful sources of information are the National Claims History zip file of reports and the ResDAC website.

For Shared Savings Program ACOs, the ACO-MS provides helpful resources like the Data Exchange User Guide and additional publicly available Shared Savings Program Data. The Data Exchange User Guide is available in the Knowledge Library section of the ACO-MS and provides information on the CCLF process for the ACOs based on their track or assignment type.

8 Best Practices for Protecting Beneficiary-Level Data

CMS takes protecting the data of millions of Medicare beneficiaries very seriously. It is important to ensure that necessary steps are taken to keep the data secure. By implementing the below listed best practices, we can all help to better protect beneficiary data:

1. Do not click on a link or attachment until you have talked to the sender or are expecting the attachment.
2. Never share your password.
3. Avoid sharing Personally Identifiable Information (PII), Protected Health Information (PHI), or sensitive data by email. If you must share, encrypt it, and do not send the password through email.
4. Never send work information to or from your personal account.
5. Forward suspicious email to your organization's IT administrator. If you believe Medicare beneficiary (or provider) data has been compromised, report the incident to the CMS IT Service Desk at 1-800-562-1963.

More information on CMS security, privacy guidance, and best practices are available at CMS Information Security Overview.

Appendix A: Alcohol and Substance Abuse Code Tables

The following tables contain codes for alcohol and substance abuse-related diagnoses, which CMS will exclude from Shared Savings Program Claims Line Feeds.

Codes for alcohol and substance abuse-related diagnoses will be excluded from Claims Line Feeds generated for VTAPM ACOs for beneficiaries who have not opted into Alcohol and Substance Abuse sharing with that VTAPM ACO.

Substance abuse codes in the following tables will be excluded from CCLFs for KCC, ACO REACH, and PCF ACOs.

Table 8: CMS/MS-DRGs

CMS/MS-DRG	Description
*CMS-DRG 522	Alcohol/drug abuse or dependence w rehabilitation therapy w/o CC
*CMS-DRG 523	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o CC
MS-DRG 895	Alcohol/drug abuse or dependence w rehabilitation therapy
MS-DRG 896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC
MS-DRG 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC

***NOTE:** Effective with discharges on and after October 1, 2007 (Fiscal Year (FY) 2008), CMS DRGs 522 and 523 were deleted and no longer associated with alcohol and substance abuse.

Table 9: CPT and HCPCS Codes

CPT Code	Description
0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (i.e., ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder
4320F	Patient counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence
G1028	Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal spray (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure

CPT Code	Description
G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes
G0137	Intensive outpatient services; minimum of nine services over a 7-contiguous day period, which can include individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; drugs and biologicals furnished for therapeutic purposes, excluding opioid agonist and antagonist medications that are FDA-approved for use in treatment of OUD or opioid antagonist medications for the emergency treatment of known or suspected opioid overdose; individualized activity therapies that are not primarily recreational or diversionary; family counseling (the primary purpose of which is treatment of the individual's condition); patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); diagnostic services (not including toxicology testing); (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure, if applicable).
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)
G2068	Medication assisted treatment, buprenorphine (oral): weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)
G2069	Medication assisted treatment, buprenorphine (injectable): weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)
G2070	Medication assisted treatment, buprenorphine (implant insertion): weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)
G2071	Medication assisted treatment, buprenorphine (implant removal): weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)

CPT Code	Description
G2072	Medication assisted treatment, buprenorphine (implant insertion and removal): weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)
G2073	Medication assisted treatment, naltrexone: weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)
G2074	Medication assisted treatment: weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)
G2075	Medication assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)
G2076	Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician or qualified personnel that includes preparation of a treatment plan including the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel (provision of the services by a Medicare-enrolled Opioid Treatment Program). List separately in addition to code for primary procedure.
G2077	Periodic assessment: assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a Medicare-enrolled Opioid Treatment Program). List separately in addition to code for primary procedure.
G2078	Take-home supply of methadone: up to 7 additional day supply (provision of the services by a Medicare-enrolled Opioid Treatment Program). List separately in addition to code for primary procedure.
G2079	Take-home supply of buprenorphine (oral): up to 7 additional day supply (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.
G2080	Each additional 30 minutes of counseling in a week of medication assisted treatment (provision of the services by a Medicare-enrolled Opioid Treatment Program). List separately in addition to code for primary procedure.
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month

CPT Code	Description
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)
G2172	All-inclusive payment for services related to highly coordinated and integrated opioid use disorder (OUD) treatment services furnished for the demonstration project
G2215	Take-home supply of nasal naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program)); List separately in addition to code for primary procedure
G2216	Take-home supply of injectable naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure
G9562	Patients who had a follow-up evaluation conducted at least every three months during opioid therapy
G9578	Documentation of signed opioid treatment agreement at least once during opioid therapy
G9584	Patient evaluated for risk of misuse of opiates by using a brief validated instrument (e.g., opioid risk tool, soapp-r) or patient interviewed at least once during opioid therapy
G9621	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling
H0005	Alcohol and/or drug services, group counseling by a clinician
H0006	Alcohol and/or drug services: case management
H0007	Alcohol and/or drug services: crisis intervention (outpatient)
H0008	Alcohol and/or drug services: sub-acute detox (hospital inpatient)
H0009	Alcohol and/or drug services: Acute detox (hospital inpatient)
H0010	Alcohol and/or drug services: Sub-acute detox (residential addiction program inpatient)

CPT Code	Description
H0011	Alcohol and/or drug services: acute detox (residential addiction program inpatient)
H0012	Alcohol and/or drug services: Sub-acute detox (residential addiction program outpatient)
H0013	Alcohol and/or drug services: acute detox (residential addiction program outpatient)
H0014	Alcohol and/or drug services: ambulatory detox
H0015	Alcohol and/or drug services: intensive outpatient
H0050	Alcohol and/or drug services: brief Intervention, per 15 minutes
99408	Alcohol and substance (other than tobacco) abuse structure screening (e.g., AUDIT, DAST) and brief intervention (SBI) services: 15-30 minutes
99409	Alcohol and substance (other than tobacco) abuse structure screening (e.g., AUDIT, DAST) and brief intervention (SBI) services: greater than 30 minutes
H0034	Alcohol and/or drug abuse halfway house services, per diem
H0047	Alcohol and/or Drug abuse services, not otherwise specified
H2035	Alcohol and/or drug treatment program, per hour
H2036	Alcohol and/or drug treatment program, per diem
H0020	Alcohol and/or drug services; methadone administration and/or service (provisions of the drug by a licensed program)
J0570	Buprenorphine implant 74.2 mg
M1034	Adults who have at least 180 days of continuous pharmacotherapy with a medication prescribed for oud without a gap of more than seven days
M1035	Adults who are deliberately phased out of medication assisted treatment (mat) prior to 180 days of continuous treatment
S9475	Ambulatory Setting substance abuse treatment or detoxification services per diem
T1006	Alcohol and/or substance abuse services, family/couple counseling
T1007	Alcohol and/or substance abuse services, treatment plan development and or modification

CPT Code	Description
T1008	Day Treatment for individual alcohol and/or substance abuse services
T1009	Child sitting services for children of individuals receiving alcohol and/or substance abuse services
T1010	Meals for individuals receiving alcohol and/or substance abuse services (when meals are not included in the program
T1011	Alcohol and/or substance abuse services not otherwise classified
T1012	Alcohol and/or substance abuse services, skill development
Q9991	Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
Q9992	Injection, buprenorphine extended-release (sublocade), greater than 100 mg

Table 10: ICD-9-CM Procedure Codes

ICD-9-CM Procedure Code	Description
94.45	Drug Addict Counseling
94.46	Alcoholism Counseling
94.53	Referral Alcohol Rehab
94.54	Referral for Drug Rehab
94.6	Alcohol and drug rehabilitation and detoxification
94.61	Alcohol rehabilitation
94.62	Alcohol detoxification
94.63	Alcohol rehabilitation and detoxification
94.64	Drug rehabilitation
94.65	Drug detoxification
94.66	Drug rehabilitation and detoxification
94.67	Combined alcohol and drug rehabilitation
94.68	Combined alcohol and drug detoxification
94.69	Combined alcohol and drug rehabilitation and detoxification

Table 11: ICD-9-CM Diagnosis Codes

ICD-9-CM Diagnosis Code	Description
291	Alcohol-induced mental disorders
291.0	Alcohol withdrawal delirium
291.1	Alcohol-induced persisting amnestic disorder
291.2	Alcohol-induced persisting dementia
291.3	Alcohol-induced psychotic disorder with hallucinations

ICD-9-CM Diagnosis Code	Description
291.4	Idiosyncratic alcohol intoxication
291.5	Alcohol-induced psychotic disorder with delusions
291.81	Alcohol withdrawal
291.82	Alcohol induced sleep disorders
291.89	Other alcohol-induced mental disorders
291.9	Unspecified alcohol-induced mental disorders
292	Drug-induced mental disorders
292.0	Drug withdrawal
292.1	Drug-induced psychotic disorders
292.11	Drug-induced psychotic disorder with delusions
292.12	Drug-induced psychotic disorder with hallucinations
292.2	Pathological drug intoxication
292.8	Other specified drug-induced mental disorders
292.81	Drug-induced delirium
292.82	Drug-induced persisting dementia
292.83	Drug-induced persisting amnestic disorder
292.84	Drug-induced mood disorder
292.85	Drug induced sleep disorders
292.89	Other specified drug-induced mental disorders
292.9	Unspecified drug-induced mental disorder
303	Alcohol dependence syndrome
303.0	Acute alcoholic intoxication
303.00	Acute alcoholic intoxication in alcoholism, unspecified

ICD-9-CM Diagnosis Code	Description
303.01	Acute alcoholic intoxication in alcoholism, continuous
303.02	Acute alcoholic intoxication in alcoholism, episodic
303.03	Acute alcoholic intoxication in alcoholism, in remission
303.9	Other and unspecified alcohol dependence
303.90	Other and unspecified alcohol dependence, unspecified
303.91	Other and unspecified alcohol dependence, continuous
303.92	Other and unspecified alcohol dependence, episodic
303.93	Other and unspecified alcohol dependence, in remission
304	Drug Dependence
304.0	Opioid type dependence
304.00	Opioid type dependence, unspecified
304.01	Opioid type dependence, continuous
304.02	Opioid type dependence, episodic
304.03	Opioid type dependence, in remission
304.1	Sedative, hypnotic, or anxiolytic dependence
304.10	Sedative, hypnotic, or anxiolytic dependence, unspecified
304.11	Sedative, hypnotic, or anxiolytic dependence, continuous
304.12	Sedative, hypnotic, or anxiolytic dependence, episodic
304.13	Sedative, hypnotic, or anxiolytic dependence, in remission
304.2	Cocaine dependence
304.20	Cocaine dependence, unspecified
304.21	Cocaine dependence, continuous
304.22	Cocaine dependence, episodic

ICD-9-CM Diagnosis Code	Description
304.23	Cocaine dependence, in remission
304.3	Cannabis dependence
304.30	Cannabis dependence, unspecified
304.31	Cannabis dependence, continuous
304.32	Cannabis dependence, episodic
304.33	Cannabis dependence, in remission
304.4	Amphetamine and other psychostimulant dependence
304.40	Amphetamine and other psychostimulant dependence, unspecified
304.41	Amphetamine and other psychostimulant dependence, continuous
304.42	Amphetamine and other psychostimulant dependence, episodic
304.43	Amphetamine and other psychostimulant dependence, in remission
304.5	Hallucinogen dependence
304.50	Hallucinogen dependence, unspecified
304.51	Hallucinogen dependence, continuous
304.52	Hallucinogen dependence, episodic
304.53	Hallucinogen dependence, in remission
304.6	Other specified drug dependence
304.60	Other specified drug dependence, unspecified
304.61	Other specified drug dependence, continuous
304.62	Other specified drug dependence, episodic
304.63	Other specified drug dependence, in remission
304.7	Combinations of opioid type drug with any other drug dependence
304.70	Combinations of opioid type drug with any other drug dependence, unspecified

ICD-9-CM Diagnosis Code	Description
304.71	Combinations of opioid type drug with any other drug dependence, continuous
304.72	Combinations of opioid type drug with any other drug dependence, episodic
304.73	Combinations of opioid type drug with any other drug dependence, in remission
304.8	Combinations of drug dependence excluding opioid type drug
304.80	Combinations of drug dependence excluding opioid type drug, unspecified
304.81	Combinations of drug dependence excluding opioid type drug, continuous
304.82	Combinations of drug dependence excluding opioid type drug, episodic
304.83	Combinations of drug dependence excluding opioid type drug, in remission
304.9	Unspecified drug dependence
304.90	Unspecified drug dependence, unspecified
304.91	Unspecified drug dependence, continuous
304.92	Unspecified drug dependence, episodic
304.93	Unspecified drug dependence, in remission
305	Nondependent abuse of drugs
305.0	Alcohol abuse
305.00	Alcohol abuse, unspecified
305.01	Alcohol abuse, continuous
305.02	Alcohol abuse, episodic
305.03	Alcohol abuse, in remission
305.2	Cannabis abuse
305.20	Cannabis abuse, unspecified
305.21	Cannabis abuse, continuous
305.22	Cannabis abuse, episodic

ICD-9-CM Diagnosis Code	Description
305.23	Cannabis abuse, in remission
305.3	Hallucinogen abuse
305.30	Hallucinogen abuse, unspecified
305.31	Hallucinogen abuse, continuous
305.32	Hallucinogen abuse, episodic
305.33	Hallucinogen abuse, in remission
305.4	Sedative, hypnotic, or anxiolytic abuse
305.40	Sedative, hypnotic, or anxiolytic abuse, unspecified
305.41	Sedative, hypnotic, or anxiolytic abuse, continuous
305.42	Sedative, hypnotic, or anxiolytic abuse, episodic
305.43	Sedative, hypnotic, or anxiolytic abuse, in remission
305.5	Opioid abuse
305.50	Opioid abuse, unspecified
305.51	Opioid abuse, continuous
305.52	Opioid abuse, episodic
305.53	Opioid abuse, in remission
305.6	Cocaine abuse
305.60	Cocaine abuse, unspecified
305.61	Cocaine abuse, continuous
305.62	Cocaine abuse, episodic
305.63	Cocaine abuse, in remission
305.7	Amphetamine or related acting sympathomimetic abuse
305.70	Amphetamine or related acting sympathomimetic abuse, unspecified

ICD-9-CM Diagnosis Code	Description
305.71	Amphetamine or related acting sympathomimetic abuse, continuous
305.72	Amphetamine or related acting sympathomimetic abuse, episodic
305.73	Amphetamine or related acting sympathomimetic abuse, in remission
305.8	Antidepressant type abuse
305.80	Antidepressant type abuse, unspecified
305.81	Antidepressant type abuse, continuous
305.82	Antidepressant type abuse, episodic
305.83	Antidepressant type abuse, in remission
305.9	Other, mixed, or unspecified drug abuse
305.90	Other, mixed, or unspecified drug abuse, unspecified
305.91	Other, mixed, or unspecified drug abuse, continuous
305.92	Other, mixed, or unspecified drug abuse, episodic
305.93	Other, mixed, or unspecified drug abuse, in remission
790.3	Excessive blood level of alcohol
V65.42	Counseling on substance use and abuse

Table 12: ICD-10-PCS Inpatient Procedure Codes

ICD-10-PCS Code	Description
HZ2ZZZZ	Detoxification Services for Substance Abuse Treatment
HZ30ZZZ	Individual Counseling for Substance Abuse Treatment, Cognitive
HZ31ZZZ	Individual Counseling for Substance Abuse Treatment, Behavioral
HZ32ZZZ	Individual Counseling for Substance Abuse Treatment, Cognitive-Behavioral
HZ33ZZZ	Individual Counseling for Substance Abuse Treatment, 12-Step
HZ34ZZZ	Individual Counseling for Substance Abuse Treatment, Interpersonal

ICD-10-PCS Code	Description
HZ35ZZZ	Individual Counseling for Substance Abuse Treatment, Vocational
HZ36ZZZ	Individual Counseling for Substance Abuse Treatment, Psychoeducational
HZ37ZZZ	Individual Counseling for Substance Abuse Treatment, Motivational Enhancement
HZ38ZZZ	Individual Counseling for Substance Abuse Treatment, Confrontational
HZ39ZZZ	Individual Counseling for Substance Abuse Treatment, Continuing Care
HZ3BZZZ	Individual Counseling for Substance Abuse Treatment, Spiritual
HZ40ZZZ	Group Counseling for Substance Abuse Treatment, Cognitive
HZ41ZZZ	Group Counseling for Substance Abuse Treatment, Behavioral
HZ42ZZZ	Group Counseling for Substance Abuse Treatment, Cognitive-Behavioral
HZ43ZZZ	Group Counseling for Substance Abuse Treatment, 12-Step
HZ44ZZZ	Group Counseling for Substance Abuse Treatment, Interpersonal
HZ45ZZZ	Group Counseling for Substance Abuse Treatment, Vocational
HZ46ZZZ	Group Counseling for Substance Abuse Treatment, Psychoeducation
HZ47ZZZ	Group Counseling for Substance Abuse Treatment, Motivational Enhancement
HZ48ZZZ	Group Counseling for Substance Abuse Treatment, Confrontational
HZ49ZZZ	Group Counseling for Substance Abuse Treatment, Continuing Care
HZ4BZZZ	Group Counseling for Substance Abuse Treatment, Spiritual
HZ50ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Cognitive
HZ51ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Behavioral
HZ52ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Cognitive-Behavioral
HZ53ZZZ	Individual Psychotherapy for Substance Abuse Treatment, 12-Step
HZ54ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Interpersonal

ICD-10-PCS Code	Description
HZ55ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Interactive
HZ56ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychoeducation
HZ57ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Motivational Enhancement
HZ58ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Confrontational
HZ59ZZZ	Individual Psychotherapy for Substance Abuse Treatment, Supportive
HZ5BZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychoanalysis
HZ5CZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychodynamic
HZ5DZZZ	Individual Psychotherapy for Substance Abuse Treatment, Psychophysiological
HZ63ZZZ	Family Counseling for Substance Abuse Treatment
HZ80ZZZ	Medication Management for Substance Abuse Treatment, Nicotine Replacement
HZ81ZZZ	Medication Management for Substance Abuse Treatment, Methadone Maintenance
HZ82ZZZ	Medication Management for Substance Abuse Treatment, Levo-alpha-acetyl-methadol (LAAM)
HZ83ZZZ	Medication Management for Substance Abuse Treatment, Antabuse
HZ84ZZZ	Medication Management for Substance Abuse Treatment, Naltrexone
HZ85ZZZ	Medication Management for Substance Abuse Treatment, Naloxone
HZ86ZZZ	Medication Management for Substance Abuse Treatment, Clonidine
HZ87ZZZ	Medication Management for Substance Abuse Treatment, Bupropion
HZ88ZZZ	Medication Management for Substance Abuse Treatment, Psychiatric Medication
HZ89ZZZ	Medication Management for Substance Abuse Treatment, Other Replacement Medication
HZ90ZZZ	Pharmacotherapy for Substance Abuse Treatment, Nicotine Replacement

ICD-10-PCS Code	Description
HZ91ZZZ	Pharmacotherapy for Substance Abuse Treatment, Methadone Maintenance
HZ92ZZZ	Pharmacotherapy for Substance Abuse Treatment, Levo-alpha-acetyl-methadol (LAAM)
HZ93ZZZ	Pharmacotherapy for Substance Abuse Treatment, Antabuse
HZ94ZZZ	Pharmacotherapy for Substance Abuse Treatment, Naltrexone
HZ95ZZZ	Pharmacotherapy for Substance Abuse Treatment, Naloxone
HZ96ZZZ	Pharmacotherapy for Substance Abuse Treatment, Clonidine
HZ97ZZZ	Pharmacotherapy for Substance Abuse Treatment, Bupropion
HZ98ZZZ	Pharmacotherapy for Substance Abuse Treatment, Psychiatric Medication
HZ99ZZZ	Pharmacotherapy for Substance Abuse Treatment, Other Replacement Medication

Table 13: ICD-10-CM Diagnosis Codes

ICD-10-CM Diagnosis Code	Description
F10.10	Alcohol abuse, uncomplicated
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.19	Alcohol abuse with unspecified alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.29	Alcohol dependence with unspecified alcohol-induced disorder
F10.94	Alcohol use, unspecified with alcohol-induced mood disorder
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder

ICD-10-CM Diagnosis Code	Description
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.129	Alcohol abuse with intoxication, unspecified
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium
F10.229	Alcohol dependence with intoxication, unspecified
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.239	Alcohol dependence with withdrawal, unspecified
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.280	Alcohol dependence with alcohol-induced anxiety disorder

ICD-10-CM Diagnosis Code	Description
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.920	Alcohol use, unspecified with intoxication, uncomplicated
F10.921	Alcohol use, unspecified with intoxication delirium
F10.929	Alcohol use, unspecified with intoxication, unspecified
F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
F10.959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F10.981	Alcohol use, unspecified with alcohol-induced sexual dysfunction
F10.982	Alcohol use, unspecified with alcohol-induced sleep disorder
F10.988	Alcohol use, unspecified with other alcohol-induced disorder
F11.10	Opioid abuse, uncomplicated
F11.14	Opioid abuse with opioid-induced mood disorder
F11.19	Opioid abuse with unspecified opioid-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.29	Opioid dependence with unspecified opioid-induced disorder
F11.90	Opioid use, unspecified, uncomplicated

ICD-10-CM Diagnosis Code	Description
F11.93	Opioid use, unspecified with withdrawal
F11.94	Opioid use, unspecified with opioid-induced mood disorder
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder
F11.120	Opioid abuse with intoxication, uncomplicated
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.129	Opioid abuse with intoxication, unspecified
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11.181	Opioid abuse with opioid-induced sexual dysfunction
F11.182	Opioid abuse with opioid-induced sleep disorder
F11.188	Opioid abuse with other opioid-induced disorder
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.229	Opioid dependence with intoxication, unspecified
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder

ICD-10-CM Diagnosis Code	Description
F11.920	Opioid use, unspecified with intoxication, uncomplicated
F11.921	Opioid use, unspecified with intoxication delirium
F11.922	Opioid use, unspecified with intoxication with perceptual disturbance
F11.929	Opioid use, unspecified with intoxication, unspecified
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11.981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11.982	Opioid use, unspecified with opioid-induced sleep disorder
F11.988	Opioid use, unspecified with other opioid-induced disorder
F12.10	Cannabis abuse, uncomplicated
F12.19	Cannabis abuse with unspecified cannabis-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission
F12.29	Cannabis dependence with unspecified cannabis-induced disorder
F12.90	Cannabis use, unspecified, uncomplicated
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder
F12.120	Cannabis abuse with intoxication, uncomplicated
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.129	Cannabis abuse with intoxication, unspecified
F12.150	Cannabis abuse with psychotic disorder with delusions

ICD-10-CM Diagnosis Code	Description
F12.151	Cannabis abuse with psychotic disorder with hallucinations
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.229	Cannabis dependence with intoxication, unspecified
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.920	Cannabis use, unspecified with intoxication, uncomplicated
F12.921	Cannabis use, unspecified with intoxication delirium
F12.922	Cannabis use, unspecified with intoxication with perceptual disturbance
F12.929	Cannabis use, unspecified with intoxication, unspecified
F12.950	Cannabis use, unspecified with psychotic disorder with delusions
F12.951	Cannabis use, unspecified with psychotic disorder with hallucinations
F12.959	Cannabis use, unspecified with psychotic disorder, unspecified
F12.980	Cannabis use, unspecified with anxiety disorder
F12.988	Cannabis use, unspecified with other cannabis-induced disorder
F13.10	Sedative, hypnotic, or anxiolytic abuse, uncomplicated

ICD-10-CM Diagnosis Code	Description
F13.14	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
F13.19	Sedative, hypnotic, or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.20	Sedative, hypnotic, or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic, or anxiolytic dependence, in remission
F13.24	Sedative, hypnotic, or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13.26	Sedative, hypnotic, or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.27	Sedative, hypnotic, or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.29	Sedative, hypnotic, or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.90	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13.94	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13.96	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.97	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.99	Sedative, hypnotic, or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.120	Sedative, hypnotic, or anxiolytic abuse with intoxication, uncomplicated
F13.121	Sedative, hypnotic, or anxiolytic abuse with intoxication delirium
F13.129	Sedative, hypnotic, or anxiolytic abuse with intoxication, unspecified
F13.150	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions

ICD-10-CM Diagnosis Code	Description
F13.151	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.159	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.181	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.182	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.188	Sedative, hypnotic, or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
F13.220	Sedative, hypnotic, or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic, or anxiolytic dependence with intoxication delirium
F13.229	Sedative, hypnotic, or anxiolytic dependence with intoxication, unspecified
F13.230	Sedative, hypnotic, or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic, or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic, or anxiolytic dependence with withdrawal with perceptual disturbance
F13.239	Sedative, hypnotic, or anxiolytic dependence with withdrawal, unspecified
F13.250	Sedative, hypnotic, or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.251	Sedative, hypnotic, or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.259	Sedative, hypnotic, or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.280	Sedative, hypnotic, or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder

ICD-10-CM Diagnosis Code	Description
F13.281	Sedative, hypnotic, or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.282	Sedative, hypnotic, or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.288	Sedative, hypnotic, or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F13.920	Sedative, hypnotic, or anxiolytic use, unspecified with intoxication, uncomplicated
F13.921	Sedative, hypnotic, or anxiolytic use, unspecified with intoxication delirium
F13.929	Sedative, hypnotic, or anxiolytic use, unspecified with intoxication, unspecified
F13.930	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal, uncomplicated
F13.931	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal delirium
F13.932	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13.939	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal, unspecified
F13.950	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.951	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.959	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.980	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.981	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.982	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder

ICD-10-CM Diagnosis Code	Description
F13.988	Sedative, hypnotic, or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.19	Cocaine abuse with unspecified cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.21	Cocaine dependence, in remission
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.29	Cocaine dependence with unspecified cocaine-induced disorder
F14.90	Cocaine use, unspecified, uncomplicated
F14.94	Cocaine use, unspecified with cocaine-induced mood disorder
F14.99	Cocaine use, unspecified with unspecified cocaine-induced disorder
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.121	Cocaine abuse with intoxication with delirium
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.129	Cocaine abuse with intoxication, unspecified
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
F14.182	Cocaine abuse with cocaine-induced sleep disorder
F14.188	Cocaine abuse with other cocaine-induced disorder

ICD-10-CM Diagnosis Code	Description
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.229	Cocaine dependence with intoxication, unspecified
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.920	Cocaine use, unspecified with intoxication, uncomplicated
F14.921	Cocaine use, unspecified with intoxication delirium
F14.922	Cocaine use, unspecified with intoxication with perceptual disturbance
F14.929	Cocaine use, unspecified with intoxication, unspecified
F14.950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14.951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14.959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14.980	Cocaine use, unspecified with cocaine-induced anxiety disorder
F14.981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14.982	Cocaine use, unspecified with cocaine-induced sleep disorder

ICD-10-CM Diagnosis Code	Description
F14.988	Cocaine use, unspecified with other cocaine-induced disorder
F15.10	Other stimulant abuse, uncomplicated
F15.14	Other stimulant abuse with stimulant-induced mood disorder
F15.19	Other stimulant abuse with unspecified stimulant-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder
F15.90	Other stimulant use, unspecified, uncomplicated
F15.93	Other stimulant use, unspecified with withdrawal
F15.94	Other stimulant use, unspecified with stimulant-induced mood disorder
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F15.120	Other stimulant abuse with intoxication, uncomplicated
F15.121	Other stimulant abuse with intoxication delirium
F15.122	Other stimulant abuse with intoxication with perceptual disturbance
F15.129	Other stimulant abuse with intoxication, unspecified
F15.150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15.151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction

ICD-10-CM Diagnosis Code	Description
F15.182	Other stimulant abuse with stimulant-induced sleep disorder
F15.188	Other stimulant abuse with other stimulant-induced disorder
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.229	Other stimulant dependence with intoxication, unspecified
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.920	Other stimulant use, unspecified with intoxication, uncomplicated
F15.921	Other stimulant use, unspecified with intoxication delirium
F15.922	Other stimulant use, unspecified with intoxication with perceptual disturbance
F15.929	Other stimulant use, unspecified with intoxication, unspecified
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15.951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15.959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified

ICD-10-CM Diagnosis Code	Description
F15.980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
F15.981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15.982	Other stimulant use, unspecified with stimulant-induced sleep disorder
F15.988	Other stimulant use, unspecified with other stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.19	Hallucinogen abuse with unspecified hallucinogen-induced disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F16.90	Hallucinogen use, unspecified, uncomplicated
F16.94	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F16.120	Hallucinogen abuse with intoxication, uncomplicated
F16.121	Hallucinogen abuse with intoxication with delirium
F16.122	Hallucinogen abuse with intoxication with perceptual disturbance
F16.129	Hallucinogen abuse with intoxication, unspecified
F16.150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16.151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified

ICD-10-CM Diagnosis Code	Description
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16.188	Hallucinogen abuse with other hallucinogen-induced disorder
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.221	Hallucinogen dependence with intoxication with delirium
F16.229	Hallucinogen dependence with intoxication, unspecified
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder
F16.920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16.921	Hallucinogen use, unspecified with intoxication with delirium
F16.929	Hallucinogen use, unspecified with intoxication, unspecified
F16.950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16.951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
F16.959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
F16.980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder

ICD-10-CM Diagnosis Code	Description
F16.983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F16.988	Hallucinogen use, unspecified with other hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated
F18.14	Inhalant abuse with inhalant-induced mood disorder
F18.17	Inhalant abuse with inhalant-induced dementia
F18.19	Inhalant abuse with unspecified inhalant-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.27	Inhalant dependence with inhalant-induced dementia
F18.29	Inhalant dependence with unspecified inhalant-induced disorder
F18.90	Inhalant use, unspecified, uncomplicated
F18.94	Inhalant use, unspecified with inhalant-induced mood disorder
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
F18.99	Inhalant use, unspecified with unspecified inhalant-induced disorder
F18.120	Inhalant abuse with intoxication, uncomplicated
F18.121	Inhalant abuse with intoxication delirium
F18.129	Inhalant abuse with intoxication, unspecified
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.188	Inhalant abuse with other inhalant-induced disorder

ICD-10-CM Diagnosis Code	Description
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.221	Inhalant dependence with intoxication delirium
F18.229	Inhalant dependence with intoxication, unspecified
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.920	Inhalant use, unspecified with intoxication, uncomplicated
F18.921	Inhalant use, unspecified with intoxication with delirium
F18.929	Inhalant use, unspecified with intoxication, unspecified
F18.950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18.951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18.959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
F18.980	Inhalant use, unspecified with inhalant-induced anxiety disorder
F18.988	Inhalant use, unspecified with other inhalant-induced disorder
F19.10	Other psychoactive substance abuse, uncomplicated
F19.14	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
F19.16	Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder

ICD-10-CM Diagnosis Code	Description
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.19	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F19.90	Other psychoactive substance use, unspecified, uncomplicated
F19.94	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
F19.96	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting amnestic disorder
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19.129	Other psychoactive substance abuse with intoxication, unspecified

ICD-10-CM Diagnosis Code	Description
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.229	Other psychoactive substance dependence with intoxication, unspecified
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.239	Other psychoactive substance dependence with withdrawal, unspecified
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations

ICD-10-CM Diagnosis Code	Description
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19.921	Other psychoactive substance use, unspecified with intoxication with delirium
F19.922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
F19.929	Other psychoactive substance use, unspecified with intoxication, unspecified
F19.930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
F19.931	Other psychoactive substance use, unspecified with withdrawal delirium
F19.932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
F19.939	Other psychoactive substance use, unspecified with withdrawal, unspecified
F19.950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
F19.951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19.959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified

ICD-10-CM Diagnosis Code	Description
F19.980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F19.981	Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction
F19.982	Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder
F19.988	Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder
F55.0	Abuse of antacids
F55.1	Abuse of herbal or folk remedies
F55.2	Abuse of laxatives
F55.3	Abuse of steroids or hormones
F55.4	Abuse of vitamins
F55.8	Abuse of other non-psychoactive substances
R78.0	Finding of alcohol in blood
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser

Appendix B: CCLF File Layouts

Starting January 2021 onward, the MFT mailbox will be retired and all the Shared Savings Program CCLF files will only be delivered to the Data Hub.

The CCLF files for the VTAPM models are delivered as binary zip files to the ACO mailbox. The file naming convention for the CCLFs sent to ACO mailbox as zip files in the single zip file starting January 2020, are listed in Section 4.2 File Naming Convention Changes to the Claims Line Feed.

ACO REACH and KCC Entities and PCF Practices will be able to access CCLFs and reports through the “Data Hub” in the 4 Innovation (4i) application. Data Hub can be located on the left-hand pane in the 4i application.

Following is the list of data elements present on the CCLF Files when the single file is unzipped. The file names for each individual CCLF file when unzipped are listed prior to each table.

Notes for all tables in this appendix:

- *Where applicable in the file layouts, a minus “-” in the beginning of the format description indicates that if the value is negative, the first character will display as “-.” For all other values, a blank will display as the first character.*
- *Fields where data are not available from the data source will be left blank.*
- *Data Fields marked with an I contain PII. Data Fields marked with an H contain PHI.*

Part A Claims Header File (CCLF1)

The filename convention for the Shared Savings Program in Table 14 is:

- For regular CCLFs: P.A****.ACO.ZC1Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC1R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 14 is:

- For monthly CCLFs: P.F***.ACO.ZC1Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC1R**.Dyymmdd.Thhmmsst

The filename convention for the ACO REACH Model in Table 14 is:

- For monthly CCLFs: P.D****.ACO.ZC1Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC1R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model Entities in Table 14 for KCF option Entities is P.K****.ACO.ZC1Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC1Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 14 is P.P******.ACO.ZC1Y**.Dyymmdd.Thhmmsst.

Note: *KCC does not generate run-out CCLFs.*

Table 14: Part A Claims Header File (CCLF1)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim. I H
2	PRVDR_OSCAR_NUM	Provider OSCAR Number	14	19	6	X(06)	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service. H
3	BENE_MBI_ID	Medicare Beneficiary Identifier	20	30	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary I H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	BENE_HIC_NUM	Beneficiary HIC Number	31	41	11	X(11)	Legacy Beneficiary HICN field[I] **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*
5	CLM_TYPE_CD	Claim Type Code	42	43	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs.[H] Claim type code include: 10 = HHA claim 20 = Non swing bed SNF claim 30 = Swing bed SNF claim 40 = Outpatient claim 50 = Hospice claim 60 = Inpatient claim 61 = Inpatient “Full-Encounter” claim

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
6	CLM_FROM_DT	Claim From Date	44	53	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. H Also known as “Statement Covers From Date.”
7	CLM_THRU_DT	Claim Thru Date	54	63	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. H Also known as the “Statement Covers Through Date.”

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLM_BILL_FAC_TYPE_CD	Claim Bill Facility Type Code	64	64	1	X(01)	The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). H Claim Facility Type Code include: 1 = Hospital 2 = SNF 3 = HHA 4 = Religious non-medical (hospital) 5 = Religious non-medical (extended care) 6 = Intermediate care 7 = Clinic or hospital-based renal dialysis facility 8 = Specialty facility or Ambulatory Surgical Center (ASC) surgery 9 = Reserved
9	CLM_BILL_CLSFCTN_CD	Claim Bill Classification Code	65	65	1	X(01)	The second digit of the type of bill (TOB2) is used to indicate with greater specificity where the service was provided (e.g., a department within a hospital). H Find Claim Service Classification Code at the ResDAC website.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	PRNCPL_DGNS_CD	Principal Diagnosis Code	66	72	7	X(07)	The ICD-9/10 diagnosis code identifies the beneficiary's principal illness or disability. H
11	ADMTG_DGNS_CD	Admitting Diagnosis Code	73	79	7	X(07)	The ICD-9/10 diagnosis code identifies the illness or disability for which the beneficiary was admitted. H
12	CLM_MDCR_NPMT_RSN_CD	Claim Medicare Non-Payment Reason Code	80	81	2	X(02)	Indicates the reason payment on an institutional claim is denied. Find Medicare Non-Payment Reason Code at the ResDAC website.
13	CLM_PMT_AMT	Claim Payment Amount	82	98	17	-9(13).99	Amount that Medicare paid on the claim. H
14	CLM_NCH_PRMRY_PYR_CD	Claim NCH Primary Payer Code	99	99	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer. H If this field is blank, Medicare is the primary payer for the beneficiary. Find NCH Primary Payer Code at the ResDAC website.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	PRVDR_FAC_FIPS_ST_CD	Federal Information Processing Standards (FIPS) State Code	100	101	2	X(02)	Identifies the state where the facility providing services is located.
16	BENE_PTNT_STUS_CD	Beneficiary Patient Status Code	102	103	2	X(02)	Indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home, another facility) or the circumstances of a discharge (e.g., against medical advice, or patient death). I H Find Patient Discharge Status Code at the ResDAC website.
17	DGNS_DRG_CD	Diagnosis Related Group Code	104	107	4	X(04)	Indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes. I H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18	CLM_OP_SRVC_TYPE_CD	Claim Outpatient Service Type Code	108	108	1	X(01)	A code reported by the provider that indicates the specific type of claim (Inpatient, Outpatient, etc.). I H Claim Outpatient Service Type Code include: 0 = Blank 1 = Emergency (The patient required immediate medical intervention because of severe life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room) 2 = Urgent (The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the available and suitable accommodation) 3 = Elective (The patient's condition permitted adequate time to schedule the availability of suitable accommodations)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18 CONTINUED							5 = Reserved 6 = Reserved 7 = Reserved 8 = Reserved 9 = Unknown (Information not available)
19	FAC_PRVDR_NPI_NUM	Facility Provider NPI Number	109	118	10	X(10)	Identifies the facility associated with the claim. Each facility is assigned its own unique NPI.
20	OPRTG_PRVDR_NPI_NUM	Operating Provider NPI Number	119	128	10	X(10)	Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI.
21	ATNDG_PRVDR_NPI_NUM	Attending Provider NPI Number	129	138	10	X(10)	Identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI.
22	OTHR_PRVDR_NPI_NUM	Other Provider NPI Number	139	148	10	X(10)	Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
23	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	149	150	2	X(02)	Indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Code include: 0 = Original Claim 1 = Cancellation Claim 2 = Adjustment claim
24	CLM_EFCTV_DT	Claim Effective Date	151	160	10	YYYY-MM-DD	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date. H
25	CLM_IDR_LD_DT	Claim IDR Load Date	161	170	10	YYYY-MM-DD	When the claim was loaded into the IDR.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
26	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	171	181	11	X(11)	Legacy Beneficiary Equitable BIC HICN Number. **Note**: *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, MBI will be accepted on claims, and the HICN value/ Beneficiary Equitable BIC HICN Number will no longer be displayed. The Beneficiary Equitable BIC HICN Number will be blank in CCLFs generated effective January 1, 2020, onwards.*
27	CLM_ADMSN_TYPE_CD	Claim Admission Type Code	182	183	2	X(2)	Indicates the type and priority of inpatient services. IH Claim Admission Type Code include: 0 = Blank 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma Center 6-8 = Reserved 9 = Unknown

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
28	CLM_ADMSN_SRC_CD	Claim Admission Source Code	184	185	2	X(2)	Indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility). Find Admission Source Code at the ResDAC website.
29	CLM_BILL_FREQ_CD	Claim Bill Frequency Code	186	186	1	X(1)	The third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Find Claim Frequency Code at the ResDAC website.
30	CLM_QUERY_CD	Claim Query Code	187	187	1	X(1)	Indicates the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator). Claim Query Code include: 0 = Credit adjustment 1 = Interim bill 2 = HHA benefits exhausted 3 = Final bill 4 = Discharge notice 5 = Debit adjustment

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
31	DGNS_PRCDR_ICD_IND	ICD Version Indicator	188	188	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than “9” or “0” in the source data.
32	CLM_MDCR_INSTNL_TOT_CHRG_AMT	Total Claim Charge Amount	189	203	15	-9(11).99	Effective with NCH Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.
33	CLM_MDCR_IP_PPS_CPTL_IME_AMT	Claim Capital Indirect Medical Education Amount	204	218	15	-9(11).99	The amount of the indirect medical education (IME) (reimbursable amount for teaching hospitals only; an added amount passed by Congress to augment normal Prospective Payment System [PPS] payments for teaching hospitals to compensate them for higher patient costs resulting from medical education programs for interns and residents) portion of the PPS payment for capital. **Note**: *Applicable for claim type = 60 and total calculated based on debit credit methodology.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
34	CLM_OPRTNL_IME_AMT	Claim Operational Indirect Medical Education Amount	219	240	22	-9(18).99	The indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry). **Note**: *Applicable for claim type = 60 and total calculated based on debit credit methodology.*
35	CLM_MDCR_IP_PPS_DSPRPRTNT_AMT	Claim Capital Disproportionate Amount	241	255	15	-9(11).99	Effective 3/2/92, the amount of disproportionate share (rate reflecting indigent population served) portion of the PPS payment for capital. [NCH] **Note**: *Applicable for claim type = 60 and total calculated based on debit credit methodology.*
36	CLM_HIPPS_UNCOMPD_CARE_AMT	Claim Health Insurance Prospective Payment System Uncompensated Care Amount	256	270	15	-9(11).99	This is a payment for DSH hospitals as part of Section 3133 of ACA. It represents the uncompensated care amount of the payment. **Note**: *Applicable for claim types = (10, 20, 30, 40, 50, 60) and total calculated based on debit credit methodology.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
37	CLM_OPRTNL_DSPRPRTNT_AMT	Claim Operational disproportionate Amount	271	292	22	-9(18).99	The disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry). **Note**: *Applicable for claim type = 60 and total calculated based on debit credit methodology.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
38	CLM_BLG_PRVDR_OSCAR_NUM	Claim Provider OSCAR number	293	312	20	x(20)	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 2 "Provider OSCAR Number" sourced from Provider Enrollment Change of Ownership System (PECOS).*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
39	CLM_BLG_PRVDR_NPI_NUM	Claim Facility Provider NPI Number	313	322	10	x(10)	Identifies the facility associated with the claim. Each facility is assigned its own unique NPI. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 19 "Facility Provider NPI Number" sourced from PECOS.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
40	CLM_OPRTG_PRVDR_NPI_NUM	Claim Operating Provider NPI Number	323	332	10	x(10)	Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 20 "Operating Provider NPI Number" sourced from PECOS*.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
41	CLM_ATNDG_PRVDR_NPI_NUM	Claim Attending Provider NPI Number	333	342	10	x(10)	Identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 21 "Attending Provider NPI Number" sourced from PECOS.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
42	CLM_OTHR_PRVDR_NPI_NUM	Claim Other Provider NPI Number	343	352	10	x(10)	Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 22 "Other Provider NPI Number" sourced from PECOS.*
43	CLM_CNTL_NUM	Claim Control Number	353	392	40	x(40)	An identifier assigned by the claim processor (i.e., MAC, Part D Plan, or Encounter Data Processing Contractor) to a claim.
44	CLM_ORG_CNTL_NUM	Claim Original Control Number	393	432	40	x(40)	A unique number assigned by the state's payment system that identifies an original claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
45	CLM_CNTRCTR_NUM	Claim Contractor Number	433	437	5	x(5)	A number assigned by CMS identifying a MAC authorized to process Medicare claims.

Part A Claims Revenue Center Detail File (CCLF2)

The filename convention for the Medicare Shared Savings Program in Table 15 is:

- For regular CCLFs: P.A****.ACO.ZC2Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC2R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 15 is:

- For monthly CCLFs: P.F***.ACO.ZC2Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC2R**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 15 is:

- For monthly CCLFs: P.D****.ACO.ZC2Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC2R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model Entities in Table 15 for KCF option Entities is P.K****.ACO.ZC2Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC2Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 15 is P.P******.ACO.ZC2Y**.Dyymmdd.Thhmmsst.

Table 15: Part A Claims Revenue Center Detail File (CCLF2)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim. I H
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line.
3	BENE_MBI_ID	Medicare Beneficiary Identifier	24	34	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary. I H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	BENE_HIC_NUM	Beneficiary HIC Number	35	45	11	X(11)	Legacy Beneficiary HICN field. **Note**: *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLM_TYPE_CD	Claim Type Code	46	47	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. H Claim type code include: 10 = HHA claim 20 = Non swing bed SNF claim 30 = Swing bed SNF claim 40 = Outpatient claim 50 = Hospice claim 60 = Inpatient claim 61 = Inpatient “Full-Encounter” claim
6	CLM_LINE_FROM_DT	Claim Line From Date	48	57	10	YYYY-MM-DD	The date the service associated with the line item began. H
7	CLM_LINE_THRU_DT	Claim Line Thru Date	58	67	10	YYYY-MM-DD	The date the service associated with the line item ended. H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLM_LINE_PROD_REV_CTR_CD	Product Revenue Center Code	68	71	4	X(04)	The number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Find Revenue Center Code at the ResDAC website. Revenue center code 0001 represents the total of all revenue centers included on the claim.
9	CLM_LINE_INSTNL_REV_CTR_DT	Claim Line Institutional Revenue Center Date	72	81	10	YYYY-MM-DD	The date that applies to the service associated with the Revenue Center code.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	CLM_LINE_HCPCS_CD	HCPCS Code	82	86	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary. **Note**: *Health Insurance Prospective Payment System (HIPPS) code may be available when the Product Revenue Center Code is "0022" (SNF Prospective Payment System).*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	87	97	11	X(11)	Legacy Beneficiary Equitable BIC HICN Number. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value/ Beneficiary Equitable BIC HICN Number will no longer be displayed. The Beneficiary Equitable BIC HICN Number will be blank in CCLFs generated effective January 1, 2020, onwards.*
12	PRVDR_OSCAR_NUM	Provider OSCAR Number	98	103	6	X(6)	A facility's Medicare/Medicaid identification number, also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services. H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLM_FROM_DT	Claim From Date	104	113	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. H Also known as the "Statement Covers From Date."
14	CLM_THRU_DT	Claim Thru Date	114	123	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. H Also known as the "Statement Covers Through Date."
15	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	124	147	24	-9(18).9999	Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units). H
16	CLM_LINE_CVRD_PD_AMT	Claim Line Covered Paid Amount	148	164	17	-9(13).99	The amount Medicare reimbursed the provider for covered services associated with the claim-line. H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	HCPCS_1_MDFR_CD	HCPCS First Modifier Code	165	166	2	X(2)	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H
18	HCPCS_2_MDFR_CD	HCPCS Second Modifier Code	167	168	2	X(2)	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H
19	HCPCS_3_MDFR_CD	HCPCS Third Modifier Code	169	170	2	X(2)	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
20	HCPCS_4_MDFR_CD	HCPCS Fourth Modifier Code	171	172	2	X(2)	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H
21	HCPCS_5_MDFR_CD	HCPCS Fifth Modifier Code	173	174	2	X(2)	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H
22	CLM_REV_APC_HIPPS_CD	Claim Revenue APC HIPPS Code	175	179	5	X(5)	APC group for outpatient claim type

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
23	CLM_FAC_PRVDR_OSCAR_NUM	Claim Facility Provider OSCAR Number	180	199	20	X(20)	A facility's Medicare/Medicaid identification number, also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 12 "Provider OSCAR Number" sourced from PECOS.*

Part A Procedure Code File (CCLF3)

The filename convention for the Medicare Shared Savings Program in Table 16 is:

- For regular CCLFs: P.A****.ACO.ZC3Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC3R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 16 is:

- For monthly CCLFs: P.F***.ACO.ZC3Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC3R**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 16 is:

- For monthly CCLFs: P.D****.ACO.ZC3Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC3R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 16 for KCF option Entities is P.K****.ACO.ZC3Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC3Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 16 is P.P******.ACO.ZC3Y**.Dyymmdd.Thhmmsst.

Table 16: Part A Procedure Code File (CCLF3)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim. IH
2	BENE_MBI_ID	Medicare Beneficiary Identifier	14	24	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary. IH

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
3	BENE_HIC_NUM	Beneficiary HIC Number	25	35	11	X(11)	Legacy Beneficiary HICN field. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	CLM_TYPE_CD	Claim Type Code	36	37	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. H Claim type code are: 10 = HHA claim 20 = Non swing bed SNF claim 30 = Swing bed SNF claim 40 = Outpatient claim 50 = Hospice claim 60 = Inpatient claim 61 = Inpatient “Full-Encounter” claim
5	CLM_VAL_SQNC_NUM	Claim Value Sequence Number	38	39	2	9(2)	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
6	CLM_PRCDR_CD	Procedure Code	40	46	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim. H
7	CLM_PRCDR_PRFRM_DT	Procedure Performed Date	47	56	10	YYYY-MM-DD	The date the indicated procedure was performed. H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	57	67	11	X(11)	Legacy Beneficiary Equitable BIC HICN Number. **Note**: *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value/ Beneficiary Equitable BIC HICN Number will no longer be displayed. The Beneficiary Equitable BIC HICN Number will be blank in CCLFs generated effective January 1, 2020, onwards.*
9	PRVDR_OSCAR_NUM	Provider OSCAR Number	68	73	6	X(6)	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services. H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	CLM_FROM_DT	Claim From Date	74	83	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. H Also known as “Statement Covers From Date.”
11	CLM_THRU_DT	Claim Thru Date	84	93	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. H Also known as the “Statement Covers Through Date.”
12	DGNS_PRCDR_ICD_IND	ICD Version Indicator	94	94	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than “9” or “0” in the source data.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLM_BLG_PRVDR_OSCAR_NUM	Claim Provider OSCAR Number	95	114	20	X(20)	A facility's Medicare/Medicaid identification number, also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 9 "Provider OSCAR Number" sourced from PECOS.*

Part A Diagnosis Code File (CCLF4)

The filename convention for the Medicare Shared Savings Program in Table 17 is:

- For regular CCLFs: P.A****.ACO.ZC4Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC4R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out.

The filename convention for the VTAPM Model in Table 17 is:

- For monthly CCLFs: P.F***.ACO.ZC4Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC4R**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 17 is:

- For monthly CCLFs: P.D****.ACO.ZC4Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC4R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 17 for KCF option Entities is P.K****.ACO.ZC4Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC4Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 17 is P.P******.ACO.ZC4Y**.Dyymmdd.Thhmmsst.

Table 17: Part A Diagnosis Code File (CCLF4)

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim. IH
2	BENE_MBI_ID	Medicare Beneficiary Identifier	14	24	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary. IH

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
3	BENE_HIC_NUM	Beneficiary HIC Number	25	35	11	X(11)	Legacy Beneficiary HICN field. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
4	CLM_TYPE_CD	Claim Type Code	36	37	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. H Claim type code include: 10 = HHA claim 20 = Non swing bed SNF claim 30 = Swing bed SNF claim 40 = Outpatient claim 50 = Hospice claim 60 = Inpatient claim 61 = Inpatient “Full-Encounter” claim
5	CLM_PROD_TYPE_CD	Claim Product Type Code	38	38	1	X(01)	Code classifying the diagnosis category. H Category codes include: E = Accident diagnosis code 1 = First diagnosis E code D = Other diagnosis code
6	CLM_VAL_SQNC_NUM	Claim Value Sequence Number	39	40	2	9(2)	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
7	CLM_DGNS_CD	Diagnosis Code	41	47	7	X(07)	The ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H
8	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	48	58	11	X(11)	Legacy Beneficiary Equitable BIC HICN Number. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims and the HICN value/ Beneficiary Equitable BIC HICN Number will no longer be displayed. The Beneficiary Equitable BIC HICN Number will be blank effective January 1, 2020.*
9	PRVDR_OSCAR_NUM	Provider OSCAR Number	59	64	6	X(6)	The OSCAR is a facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services. H

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
10	CLM_FROM_DT	Claim From Date	65	74	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. H Also known as the "Statement Covers From Date."
11	CLM_THRU_DT	Claim Thru Date	75	84	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. H Also known as the "Statement Covers Through Date."
12	CLM_POA_IND	Claim Present-on-Admission Indicator	85	91	7	X(7)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility. I H Find Present-on-Admission values at the ResDAC website.
13	DGNS_PRCDR_ICD_IND	ICD Version Indicator	92	92	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than "9" or "0" in the source data.

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
14	CLM_BLG_PRVDR_OSCAR_NUM	Claim Provider OSCAR Number	93	112	20	X(20)	A facility's Medicare/Medicaid identification number, also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 9 "Provider OSCAR Number" sourced from PECOS.*

Part B Physicians File (CCLF5)

The filename convention for the Medicare Shared Savings Program in Table 18 is:

- For regular CCLFs: P.A****.ACO.ZC5Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC5R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 18 is:

- For monthly CCLFs: P.F***.ACO.ZC5Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC5R**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 18 is:

- For monthly CCLFs: P.D****.ACO.ZC5Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC5R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 18 for KCF option Entities is P.K****.ACO.ZC5Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC5Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 18 is P.P******.ACO.ZC5Y**.Dyymmdd.Thhmmsst.

Table 18: Part B Physicians File (CCLF5)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim. IH
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line within a given claim.
3	BENE_MBI_ID	Medicare Beneficiary Identifier	24	34	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary. IH

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	BENE_HIC_NUM	Beneficiary HIC Number	35	45	11	X(11)	Legacy Beneficiary HICN field. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The HICN field will be blank effective January 1, 2020.*
5	CLM_TYPE_CD	Claim Type Code	46	47	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. H Claim type code include: 71 = RIC O local carrier non-DMEPOS claim 72 = RIC O local carrier DMEPOS claim
6	CLM_FROM_DT	Claim From Date	48	57	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. H Also known as the “Statement Covers From Date.”

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLM_THRU_DT	Claim Thru Date	58	67	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. H Also known as the “Statement Covers Through Date.”

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	RNDRG_PRVDR_TYPE_CD	Rendering Provider Type Code	68	70	3	X(03)	Indicates the type of provider who provided the service associated with this line item on the claim. Provider Type Code include: 0 = Clinics, groups, associations, partnerships, or other entities 1 = Physicians or suppliers reporting as solo practitioners 2 = Suppliers (other than sole proprietorship) 3 = Institutional provider 4 = Independent laboratories 5 = Clinics (multiple specialties) 6 = Groups (single specialty) 7 = Other entities 8 = Family Practice UI = UPIN Identification N2 = National Council for Prescription Drug Programs D = National Supplier Clearinghouse BP = PIN Individual

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8 CONTINUED							BG = PIN Group A = Online Survey, Certification and Reporting
9	RNDRG_PRVDR_FIPS_ST_CD	Rendering Provider FIPS State Code	71	72	2	X(02)	Identifies the state that the provider providing the service is located in.
10	CLM_PRVDR_SPCLTY_CD	Claim-Line Provider Specialty Code	73	74	2	X(02)	Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item. Find Provider Specialty Code at CMS.gov or the Research Data Assistance Center.
11	CLM_FED_TYPE_SRVC_CD	Claim Federal Type Service Code	75	75	1	X(01)	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Code are defined in the Medicare Carrier Manual. Find Types of Service Code at the ResDAC website.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
12	CLM_POS_CD	Claim Place of Service Code	76	77	2	X(02)	Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual. Find Place of Service Code at the ResDAC website.
13	CLM_LINE_FROM_DT	Claim Line From Date	78	87	10	YYYY-MM-DD	The date the service associated with the line item began.
14	CLM_LINE_THRU_DT	Claim Line Thru Date	88	97	10	YYYY-MM-DD	The date the service associated with the line item ended.
15	CLM_LINE_HCPCS_CD	HCPCS Code	98	102	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary. IH
16	CLM_LINE_CVRD_PD_AMT	Claim Line NCH Payment Amount	103	117	15	X(15)	The amount of payment made by Medicare on behalf of the beneficiary for the indicated service after deductible and coinsurance amounts have been paid.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLM_LINE_PRMRY_PYR_CD	Claim Primary Payer Code	118	118	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code. I H If this field is blank, Medicare is the primary payer for the beneficiary. Find Primary Payer Code at the ResDAC website.
18	CLM_LINE_DGNS_CD	Diagnosis Code	119	125	7	X(07)	The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability. I H
19	CLM_RNDRG_PRVDR_TAX_NUM	Claim Provider Tax Number	126	135	10	X(10)	The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service. I

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
20	RNDRG_PRVDR_NPI_NUM	Rendering Provider NPI Number	136	145	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI.
21	CLM_CARR_PMT_DNL_CD	Claim Carrier Payment Denial Code	146	147	2	X(02)	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied. Find Carrier Payment Denial Code at the ResDAC website. Additionally, the following code may be available: G = MSP Cost Avoided - Secondary Claims Investigation H = MSP Cost Avoided - Self Reports J = MSP Cost Avoided - 411.25 T = MSP Cost Avoided - IEQ contractor (eff. 7/96) X = MSP Cost Avoided - generic Y = MSP Cost Avoided - IRS/SSA data match project

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
22	CLM_PRCSG_IND_CD	Claim-Line Processing Indicator Code	148	149	2	X(02)	Indicates if the service indicated on the claim line was allowed or the reason it was denied. Find Processing Indicator Code at the ResDAC website. Additionally, the following code may be available: G = MSP Cost Avoided - Secondary Claims Investigation H = MSP Cost Avoided - Self Reports J = MSP Cost Avoided - 411.25 19 = MSP Cost Avoided - Worker's Compensation Set Aside 41 = MSP Cost Avoided - Next Generation Desktop

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
23	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	150	151	2	X(02)	Indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Code include: 0 = Original Claim 1 = Cancellation Claim 2 = Adjustment claim
24	CLM_EFCTV_DT	Claim Effective Date	152	161	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
25	CLM_IDR_LD_DT	Claim IDR Load Date	162	171	10	YYYY-MM-DD	When the claim was loaded into the IDR.
26	CLM_CNTL_NUM	Claim Control Number	172	211	40	X(40)	A unique number assigned to a claim by the Medicare carrier. This number allows CMS to associate each line item with its respective claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
27	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	212	222	11	X(11)	Legacy Beneficiary Equitable BIC HICN Number. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value/ Beneficiary Equitable BIC HICN Number will no longer be displayed. The Beneficiary Equitable BIC HICN Number will be blank effective January 1, 2020.*
28	CLM_LINE_ALOWD_CHRG_AMT	Claim Line Allowed Charges Amount	223	239	17	X(17)	The amount Medicare approved for payment to the provider.
29	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	240	263	24	-9(18).9999	Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
30	HCPCS_1_MDFR_CD	HCPCS First Modifier Code	264	265	2	X(2)	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H
31	HCPCS_2_MDFR_CD	HCPCS Second Modifier Code	266	267	2	X(2)	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H
32	HCPCS_3_MDFR_CD	HCPCS Third Modifier Code	268	269	2	X(2)	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H
33	HCPCS_4_MDFR_CD	HCPCS Fourth Modifier Code	270	271	2	X(2)	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
34	HCPCS_5_MDFR_CD	HCPCS Fifth Modifier Code	272	273	2	X(2)	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. H
35	CLM_DISP_CD	Claim Disposition Code	274	275	2	X(2)	Information regarding payment actions on the claim. Claim Disposition Code include: 01 = Debit accepted 02 = Debit accepted (automatic adjustment) 03 = Cancel accepted
36	CLM_DGNS_1_CD	Claim Diagnosis First Code	276	282	7	X(7)	The first of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H
37	CLM_DGNS_2_CD	Claim Diagnosis Second Code	283	289	7	X(7)	The second of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
38	CLM_DGNS_3_CD	Claim Diagnosis Third Code	290	296	7	X(7)	The third of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H
39	CLM_DGNS_4_CD	Claim Diagnosis Fourth Code	297	303	7	X(7)	The fourth of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H
40	CLM_DGNS_5_CD	Claim Diagnosis Fifth Code	304	310	7	X(7)	The fifth of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H
41	CLM_DGNS_6_CD	Claim Diagnosis Sixth Code	311	317	7	X(7)	The sixth of 12allowable ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H
42	CLM_DGNS_7_CD	Claim Diagnosis Seventh Code	318	324	7	X(7)	The seventh of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H
43	CLM_DGNS_8_CD	Claim Diagnosis Eighth Code	325	331	7	X(7)	The eighth of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
44	DGNS_PRCDR_ICD_IND	ICD Version Indicator	332	332	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than “9” or “0” in the source data.
45	CLM_DGNS_9_CD	Claim Diagnosis Ninth Code	333	339	7	X(7)	The ninth of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary’s illness or disability. IH
46	CLM_DGNS_10_CD	Claim Diagnosis Tenth Code	340	346	7	X(7)	The tenth of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary’s illness or disability. IH
47	CLM_DGNS_11_CD	Claim Diagnosis Eleventh Code	347	353	7	X(7)	The eleventh of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary’s illness or disability. IH
48	CLM_DGNS_12_CD	Claim Diagnosis Twelfth Code	354	360	7	X(7)	The twelfth of 12 allowable ICD-9/10 diagnosis code identifying the beneficiary’s illness or disability. IH
49	HCPCS_BETOS_CD	HCPCS BETOS Code	361	363	3	X(3)	A code representing a clinical category. The Berenson-Eggers Type of Service (BETOS) code.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
50	CLM_RNDRG_PRVDR_NPI_NUM	Claim Rendering Provider NPI Number	364	373	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 20 "Rendering Provider NPI Number" sourced from PECOS.*
51	CLM_RFRG_PRVDR_NPI_NUM	Claim Referring Provider NPI Number	374	383	10	X(10)	A number that identifies the provider that referred the service on the claim line. Each provider is assigned its own unique NPI.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
52	CLM_CNTRCTR_NUM	Claim contractor number	384	388	5	X(5)	A number assigned by CMS identifying a MAC authorized to process Medicare claims.

Part B DME File (CCLF6)

The filename convention for the Medicare Shared Savings Program in Table 19 is:

- For regular CCLFs: P.A****.ACO.ZC6Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC6R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 19 is:

- For monthly CCLFs: P.F***.ACO.ZC6Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC6R**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 19 is:

- For monthly CCLFs: P.D****.ACO.ZC6Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC6R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 19 for KCF option Entities is P.K****.ACO.ZC6Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC6Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 19 is P.P******.ACO.ZC6Y**.Dyymmdd.Thhmmsst.

Table 19: Part B DME File (CCLF6)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim. I H
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line.
3	BENE_MBI_ID	Medicare Beneficiary Identifier	24	34	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary. I H
4	BENE_HIC_NUM	Beneficiary HIC Number	35	45	11	X(11)	Legacy Beneficiary HICN field. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLM_TYPE_CD	Claim Type Code	46	47	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. H Claim type code include: 81 = RIC M DMERC non-DMEPOS claim 82 = RIC M DMERC DMEPOS claim
6	CLM_FROM_DT	Claim From Date	48	57	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. H Also known as the “Statement Covers From Date.”
7	CLM_THRU_DT	Claim Thru Date	58	67	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. H Also known as the “Statement Covers Through Date.”

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLM_FED_TYPE_SRVC_CD	Claim Federal Type Service Code	68	68	1	X(01)	Indicates the type of service (e.g., consultation, surgery), provided to the beneficiary. Types of Service Code are defined in the Medicare Carrier Manual. H Find Types of Service Code at the ResDAC website.
9	CLM_POS_CD	Claim Place of Service Code	69	70	2	X(02)	Indicates place where the indicated service was provided (e.g., ambulance, school). H Find Place of Service Code at the ResDAC website.
10	CLM_LINE_FROM_DT	Claim Line From Date	71	80	10	YYYY-MM-DD	The date the service associated with the line item began. H
11	CLM_LINE_THRU_DT	Claim Line Thru Date	81	90	10	YYYY-MM-DD	The date the service associated with the line item ended. H
12	CLM_LINE_HCPCS_CD	HCPCS Code	91	95	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary. H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLM_LINE_CVRD_PD_AMT	Claim Line NCH Payment Amount	96	110	15	-9(11).99	The amount of payment made by Medicare on behalf of the beneficiary for the indicated service after deductible and coinsurance amounts have been paid. H
14	CLM_PRMRY_PYR_CD	Claim Primary Payer Code	111	111	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code. If this field is blank, Medicare is the primary payer for the beneficiary. Find Primary Payer Code at the ResDAC website.
15	PAYTO_PRVDR_NPI_NUM	Pay-to Provider NPI Number	112	121	10	X(10)	A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	ORDRG_PRVDR_NPI_NUM	Ordering Provider NPI Number	122	131	10	X(10)	A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI.
17	CLM_CARR_PMT_DNL_CD	Claim Carrier Payment Denial Code	132	133	2	X(02)	Indicates to whom payment was made (e.g., physician, beneficiary) or if the claim was denied Find Carrier Payment Denial Code at the ResDAC website. Additionally, the following code may be available: G = Secondary Claims Investigation H = Self Reports J = 411.25 T = MSP Cost Avoided - IEQ contractor (eff. 7/96) X = MSP Cost Avoided - generic Y = MSP Cost Avoided - IRS/SSA data match project

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18	CLM_PRCSG_IND_CD	Claim Processing Indicator Code	134	135	2	X(02)	Indicates if the service indicated on the claim line was allowed or the reason it was denied. Find Processing Indicator Code at the ResDAC website. Additionally, the following code may be available: G = MSP Cost Avoided - Secondary Claims Investigation H = MSP Cost Avoided - Self Reports J = MSP Cost Avoided - 411.25 19 = MSP Cost Avoided - Worker's Compensation Set Aside 41 = MSP Cost Avoided - Next Generation Desktop

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
19	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	136	137	2	X(02)	Indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Code include: 0 = Original Claim 1 = Cancellation Claim 2 = Adjustment claim
20	CLM_EFCTV_DT	Claim Effective Date	138	147	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date. H
21	CLM_IDR_LD_DT	Claim IDR Load Date	148	157	10	YYYY-MM-DD	When the claim was loaded into the IDR.
22	CLM_CNTL_NUM	Claim Control Number	158	197	40	X(40)	A unique number assigned to a claim by the Medicare carrier. This number allows CMS to associate each line item with its respective claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
23	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	198	208	11	X(11)	Legacy Beneficiary Equitable BIC HICN Number. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value/ Beneficiary Equitable BIC HICN Number will no longer be displayed. The Beneficiary Equitable BIC HICN Number will be blank in CCLFs generated effective January 1, 2020, onwards.*
24	CLM_LINE_ALOWD_CHRG_AMT	Claim Line Allowed Charges Amount	209	225	17	-9(14).99	The amount Medicare approved for payment to the provider.
25	CLM_DISP_CD	Claim Disposition Code	226	227	2	X(2)	Contains information regarding payment actions on the claim. Claim Disposition Code include: 01 = Debit accepted 02 = Debit accepted (automatic adjustment) 03 = Cancel accepted

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
26	CLM_BLG_PRVDR_NPI_NUM	Claim Pay-to Provider NPI Number	228	237	10	X(10)	A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 15 "Pay-to Provider NPI Number" sourced from PECOS.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
27	CLM_RFRG_PRVDR_NPI_NUM	Claim Ordering Provider NPI Number	238	247	10	X(10)	A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI. **Notes:** • *From January 2022 onward, for Shared Savings Program, ACO REACH, KCC, VTAPM, and PCF models, this value is sourced from the Medicare claims processing system.* • *This field is included in addition to the Element 16 "Ordering Provider NPI Number" sourced from PECOS.*

Part D File (CCLF7)

The filename convention for the Medicare Shared Savings Program in Table 20 is:

- For regular CCLFs: P.A****.ACO.ZC7Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC7R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 20 is:

- For monthly CCLFs: P.F***.ACO.ZC7Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC7R**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 20 is:

- For monthly CCLFs: P.D****.ACO.ZC7Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC7R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 20 for KCF option Entities is P.K****.ACO.ZC7Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC7Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 20 is P.P******.ACO.ZC7Y**.Dyymmdd.Thhmmsst.

Table 20: Part D File (CCLF7)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim. I H
2	BENE_MBI_ID	Medicare Beneficiary Identifier	14	24	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary. I H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
3	BENE_HIC_NUM	Beneficiary HIC Number	25	35	11	X(11)	Legacy Beneficiary HICN field. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*
4	CLM_LINE_NDC_CD	NDC Code	36	46	11	X(11)	A universal unique product identifier for human drugs. H
5	CLM_TYPE_CD	Claim Type Code	47	48	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. H Claim type code include: 01 = Part D - Original without resubmitted PDE 02 = Part D - Adjusted PDE 03 = Part D - Deleted Claims 04 = Part D - Resubmitted PDE

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
6	CLM_LINE_FROM_DT	Claim Line From Date	49	58	10	YYYY-MM-DD	The date the service associated with the line item began (i.e., the date upon which the prescription was filled).
7	PRVDR_SRVC_ID_QLFYR_CD	Provider Service Identifier Qualifier Code	59	60	2	X(02)	Indicates the type of number used to identify the pharmacy providing the services: 01 = NPI Number 06 = Unique Physician Identification Number (UPIN) 07 = National Council for Prescription Drug Programs (NCPDP) Number 08 = State License Number 11 = TIN 99 = Other mandatory for Standard Data Format
8	CLM_SRVC_PRVDR_GNRC_ID_NUM	Claim Service Provider Generic ID Number	61	80	20	X(20)	The number associated with the indicated code in the Provider Service Identification Qualifier Code field.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLM_DSPNSNG_STUS_CD	Claim Dispensing Status Code	81	81	1	X(01)	Indicates the status of prescription fulfillment. Dispensing Code include: P = Partially filled C = Completely filled

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	CLM_DAW_PROD_SLCTN_CD	Claim Dispense as Written (DAW) Product Selection Code	82	82	1	X(01)	Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed. DAW Product Selection Code include: 0 = No product selection indicated 1 = Substitution not allowed by prescriber 2 = Substitution allowed – Patient requested that brand be dispensed 3 = Substitution allowed – Pharmacist selected product dispensed 4 = Substitution allowed – Generic not in stock 5 = Substitution allowed – Brand drug dispensed as generic 6 = Override 7 = Substitution not allowed – Brand drug mandated by law 8 = Substitution allowed – Generic drug not available in marketplace 9 = Other

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	83	106	24	-9(18).9999	Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units).
12	CLM_LINE_DAYS_SUPLY_QTY	Claim Line Days' Supply Quantity	107	115	9	9(09)	The number of days the supply of medication dispensed by the pharmacy will cover.
13	PRVDR_PRSBNG_ID_QLFYR_CD	Provider Prescribing ID Qualifier Code	116	117	2	X(02)	Indicates the type of number used to identify the prescribing provider: 01 = NPI Number 06 = UPIN 07 = NCPDP Number 08 = State License Number 11 = TIN 12 = DEA 99 = Other mandatory for Standard Data Format
14	CLM_PRSBNG_PRVDR_GNRC_ID_NUM	Claim Prescribing Provider Generic ID Number	118	137	20	X(20)	The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLM_LINE_BENE_PMT_AMT	Claim Line Beneficiary Payment Amount	138	150	13	-9(9).99	The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible, or other patient pay amounts). H
16	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	151	152	2	X(02)	Indicates whether the claim an original, cancellation, or adjustment claim. Claim Adjustment Type Code include: 0 = Original Claim 1 = Cancellation Claim 2 = Adjustment claim
17	CLM_EFCTV_DT	Claim Effective Date	153	162	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date. H
18	CLM_IDR_LD_DT	Claim IDR Load Date	163	172	10	YYYY-MM-DD	When the claim was loaded into the IDR.
19	CLM_LINE_RX_SRVC_RFRNC_NUM	Claim Line Prescription Service Reference Number	173	184	12	9(12)	Identifies a prescription dispensed by a particular service provider on a particular service date.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
20	CLM_LINE_RX_FILL_NUM	Claim Line Prescription Fill Number	185	193	9	X(09)	Assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	CLM_PHRMCY_SRVC_TYPE_CD	Claim Pharmacy Service Type Code	194	195	2	X(02)	A unique identifier of a type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy or when benefits are based upon the type of service performed. 1 = Community/Retail Pharmacy Services 2 = Compounding Pharmacy Services 3 = Home Infusion Therapy Provider Services 4 = Institutional Pharmacy Services 5 = Long Term Care Pharmacy Services 6 = Mail Order Pharmacy Services 7 = Managed Care Organization Pharmacy Services 8 = Specialty Care Pharmacy Services 99 = Other

Beneficiary Demographics File (CCLF8)

The filename convention for the Medicare Shared Savings Program in Table 21 is:

- For regular CCLFs: P.A****.ACO.ZC8Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC8R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 21 is:

- For monthly CCLFs: P.F***.ACO.ZC8Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC8R**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 21 is:

- For monthly CCLFs: P.D****.ACO.ZC8Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC8R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 21 for KCF option Entities is P.K****.ACO.ZC8Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC8Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 21 is P.P******.ACO.ZC8Y**.Dyymmdd.Thhmmsst.

Table 21: Beneficiary Demographics File (CCLF8)

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
1	BENE_MBI_ID	Medicare Beneficiary Identifier	1	11	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary. IH

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
2	BENE_HIC_NUM	Beneficiary HIC Number	12	22	11	X(11)	Legacy Beneficiary HICN field. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*
3	BENE_FIPS_STATE_CD	Beneficiary FIPS State Code	23	24	2	9(02)	Identifies the state where the beneficiary receiving services resides. IH
4	BENE_FIPS_CNTY_CD	Beneficiary FIPS County Code	25	27	3	9(03)	Identifies the county where the beneficiary receiving services resides. IH
5	BENE_ZIP_CD	Beneficiary ZIP Code	28	32	5	X(05)	The beneficiary's ZIP code as indicated in their Medicare enrollment record. IH
6	BENE_DOB	Beneficiary Date of Birth	33	42	10	YYYY-MM-DD	The month, day, and year of the beneficiary's birth. IH

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
7	BENE_SEX_CD	Beneficiary Sex Code	43	43	1	X(01)	The beneficiary's sex. IH Code includes: 1 = Male 2 = Female 0 = Unknown
8	BENE_RACE_CD	Beneficiary Race Code	44	44	1	X(01)	The beneficiary's race. IH Code includes: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = North American Native
9	BENE_AGE	Beneficiary Age	45	47	3	9(03)	The beneficiary's current age, as calculated by subtracting the beneficiary's date of birth from the current date. IH

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
10	BENE_MDCR_STUS_CD	Beneficiary Medicare Status Code	48	49	2	X(02)	Indicates the reason for a beneficiary's entitlement to Medicare benefits as of a particular date, broken down by the following categories: IH Old Age & Survivors Insurance (OASI), Disabled, and ESRD, and by appropriate combinations of these categories: 10 = Aged without ESRD 11 = Aged with ESRD 20 = Disabled without ESRD 21 = Disabled with ESRD 31 = ESRD only
11	BENE_DUAL_STUS_CD	Beneficiary Dual Status Code	50	51	2	X(02)	Identifies the most recent entitlement status of beneficiaries eligible for a program(s) in addition to Medicare (e.g., Medicaid). IH Find Dual Status Code at the ResDAC website.
12	BENE_DEATH_DT	Beneficiary Death Date	52	61	10	YYYY-MM-DD	The month, day, and year of a beneficiary's death. IH

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
13	BENE_RNG_BGN_DT	Date beneficiary enrolled in Hospice	62	71	10	YYYY-MM-DD	The date the beneficiary enrolled in Hospice. IH
14	BENE_RNG_END_DT	Date beneficiary ended Hospice	72	81	10	YYYY-MM-DD	The date the beneficiary is-enrolled in hospice. IH
15	BENE_1ST_NAME	Beneficiary First Name	82	111	30	X(30)	The first name of the beneficiary. IH
16	BENE_MIDL_NAME	Beneficiary Middle Name	112	126	15	X(15)	The middle name of the beneficiary. IH
17	BENE_LAST_NAME	Beneficiary Last Name	127	166	40	X(40)	The last name of the beneficiary. IH
18	BENE_ORGNL_ENTLMT_RSN_CD	Beneficiary Original Entitlement Reason Code	167	167	1	X(01)	The reason for the beneficiary's original entitlement to Medicare benefits. IH 0 = Old Age and Survivors Insurance (OASI) 1 = Disability Insurance Benefits (DIB) 2 = ESRD 3 = Both DIB and ESRD 4 = Unknown

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
19	BENE_ENTLMT_BUYIN_IND	Beneficiary Entitlement Buy-in Indicator	168	168	1	X(01)	Indicates for each month of the denominator reference year, the entitlement of the beneficiary to Medicare Part A, Medicare Part B, or Medicare Parts A and B both, as well as whether or not the beneficiary's state of residence was liable and paid for the beneficiary's Medicare Part B monthly premiums. IH 0 = Not Entitled 1 = Part A Only 2 = Part B Only 3 = Part A and Part B A = Part A, State Buy-In B = Part B, State Buy-In C = Parts A and B, State Buy-In
20	BENE_PART_A_ENRLMT_BGN_DT	Bene Entitlement Part A Begin Date	169	178	10	YYYY-MM-DD	The date that a beneficiary is entitled for Medicare Part A benefits.
21	BENE_PART_B_ENRLMT_BGN_DT	Bene Entitlement Part B Begin Date	179	188	10	YYYY-MM-DD	The date that a beneficiary is entitled for Medicare Part B benefits.

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
22	BENE_LINE_1_ADDR	Beneficiary Derived Mailing Line One Address	189	233	45	X(45)	The first line of the street address.
23	BENE_LINE_2_ADDR	Beneficiary Derived Mailing Line Two Address	234	278	45	X(45)	The second line of the street address.
24	BENE_LINE_3_ADDR	Beneficiary Derived Mailing Line Three Address	279	318	40	X(40)	The third line of the street address.
25	BENE_LINE_4_ADDR	Beneficiary Derived Mailing Line Four Address	319	358	40	X(40)	The fourth line of the street address.
26	BENE_LINE_5_ADDR	Beneficiary Derived Mailing Line Five Address	359	398	40	X(40)	The fifth line of the street address.
27	BENE_LINE_6_ADDR	Beneficiary Derived Mailing Line Six Address	399	438	40	X(40)	The sixth line of the street address.
28	GEO_ZIP_PLC_NAME	Beneficiary City	439	538	100	X(100)	The name of the city.

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
29	GEO_USPS_STATE_CD	Beneficiary State	539	540	2	X(2)	State code used by the United States Postal Service to identify a state.
30	GEO_ZIP5_CD	Beneficiary Zip Code	541	545	5	X(5)	The US Postal Service code that is associated with a geographical area.
31	GEO_ZIP4_CD	Beneficiary Zip Code Ext.	546	549	4	X(4)	A four-digit extension to a ZIP Code that represents a subdivision for mailing purposes of the ZIP Code.

Beneficiary XREF File (CCLF9)

The filename convention for the Medicare Shared Savings Program in Table 22 is:

- For regular CCLFs: P.A****.ACO.ZC9Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC9R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 22 is:

- For monthly CCLFs: P.F***.ACO.ZC9Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC9R**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 22 is:

- For monthly CCLFs: P.D****.ACO.ZC9Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC9R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 22 for KCF option Entities is P.K****.ACO.ZC9Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC9Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 22 is P.P******.ACO.ZC9Y**.Dyymmdd.Thhmmsst.

Table 22: Beneficiary XREF File (CCLF9)

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
1	HICN_MBI_XREF_IND…	HICN/MBI XREF Indicator…	1	1	1	X(1)	M = MBI **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*
2	CRNT_NUM	Current Beneficiary Identifier	2	12	11	X(11)	Current Beneficiary MBI will denote the MBI. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
3	PRVS_NUM	Previous Beneficiary Identifier	13	23	11	X(11)	Previous Beneficiary MBI. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The HICN field will be blank in CCLFs generated effective January 1, 2020, onwards.*
4	PRVS_ID_EFCTV_DT	Previous Identifier Effective Date	24	33	10	YYYY-MM-DD	The date the previous identifier became active.
5	PRVS_ID_OBSLT_DT	Previous Identifier Obsolete Date	34	43	10	YYYY-MM-DD	The date the previous identifier ceased to be active.
6	BENE_RRB_NUM	Beneficiary Railroad Board Number	44	55	12	X(12)	Legacy RRB number. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the Medicare Beneficiary Identifier (MBI) will be accepted on claims, and the HICN and RRB will no longer be displayed. These fields will be blank effective January 1, 2020, in CCLF files.*

Part A Claims Benefit Enhancement and Demonstration Code File (CCLFA)

The filename convention for the Medicare Shared Savings Program in Table 23 is:

- For regular CCLFs: P.A****.ACO.ZCAY**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZCAR**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 23 is:

- For monthly CCLFs: P.F***.ACO.ZCAY**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZCAR**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 23 is:

- For monthly CCLFs: P.D****.ACO.ZCAY**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZCAR**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 23 for KCF option Entities is P.K****.ACO.ZCAY**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZCAY**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model Practices in Table 23 is P.P******.ZCAY**.Dyymmdd.Thhmmsst.

Table 23: Part A Claims Benefit Enhancement and Demonstration Code File (CCLFA)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim. IH
2	BENE_MBI_ID	Medicare Beneficiary Identifier	14	24	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary. IH

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
3	BENE_HIC_NUM	Beneficiary HIC Number	25	35	11	X(11)	Legacy Beneficiary HICN field. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
4	CLM_TYPE_CD	Claim Type Code	36	37	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. H Claim type code include: 10 = HHA claim 20 = Non swing bed SNF claim 30 = Swing bed SNF claim 40 = Outpatient claim 50 = Hospice claim 60 = Inpatient claim 61 = Inpatient “Full-Encounter” claim
5	CLM_ACTV_CARE_FROM_DT	Claim Admission Date	38	47	10	YYYY-MM-DD	On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or Christian science sanatorium. I H

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
6	CLM_NGACO_PBPMT_SW	PBP Benefit Enhancement Indicator	48	48	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim is tied to a PBP benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*
7	CLM_NGACO_PDSCHRG_HCBS_SW	Post Discharge Home Visit Benefit Enhancement Indicator	49	49	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim is tied to a Post Discharge Home Visit benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLM_NGACO_SNF_WVR_SW	SNF 3-Day Waiver Benefit Enhancement Indicator	50	50	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim is tied to a SNF 3-Day Waiver benefit enhancement. Blank if no data are available. **Note:** *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*
9	CLM_NGACO_TLHLTH_SW	Telehealth Benefit Enhancement Indicator	51	51	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim is tied to a Telehealth benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	CLM_NGACO_CPTATN_SW	AIPBP Benefit Enhancement Indicator	52	52	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim is tied to an AIPBP benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*
11	CLM_DEMO_1ST_NUM	First Program Demonstration Number	53	54	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a first demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
12	CLM_DEMO_2ND_NUM	Second Program Demonstration Number	55	56	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a second demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.
13	CLM_DEMO_3RD_NUM	Third Program Demonstration Number	57	58	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a third demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
14	CLM_DEMO_4TH_NUM	Fourth Program Demonstration Number	59	60	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a fourth demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.
15	CLM_DEMO_5TH_NUM	Fifth Program Demonstration Number	61	62	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a fifth demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLM_PBP_INCLSN_AMT	PBP/AIPBP Inclusion Amount	63	81	19	-9(15).99	The amount that would have been paid in the absence of PBP/ AIPBP Reduction. The value for the PBP/AIPBP Inclusion Amount is derived from the table and column called “CMS_VIEW_CLM_PRD.CLM_VAL_AMT” when the value code within the field called “CLM_VAL_CD” equals “Q0.”
17	CLM_PBP_RDCTN_AMT	PBP/AIPBP Reduction Amount	82	100	19	-9(15).99	The PBP/AIPBP Reduction Amount withheld from payment to the Provider. The value for the PBP/AIPBP Reduction Amount is derived from the table and column called “CMS_VIEW_CLM_PRD.CLM_VAL_AMT” when the value code within the field called “CLM_VAL_CD” equals “Q1.”

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18	CLM_NGACO_CMG_WVR_SW	Care Management Home Visits	101	101	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim is tied to a Care Management Home Visits benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*
19	CLM_INSTNL_PER_DIEM_AMT	Claim Institutional Per Diem Amount	102	120	19	-9(15).99	The maximum amount a provider can be paid for each day of care.
20	CLM_MDCR_IP_BENE_DDCTBL_AMT	Claim Medicare Inpatient Beneficiary Deductible Amount	121	135	15	-9(11).99	The amount of the deductible the beneficiary paid for inpatient services, as originally submitted on the institutional claim.
21	CLM_MDCR_COINSRNC_AMT	Claim Medicare Coinsurance Amount	136	154	19	-9(15).99	An amount identifying the portion applied toward the coinsurance a beneficiary is responsible for.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
22	CLM_BLOOD_LBLTY_AMT	Claim Blood Liability Amount	155	169	15	-9(11).99	An amount identifying the portion of the blood deductible a beneficiary is liable for.
23	CLM_INSTNL_PRFNL_AMT	Claim Institutional Professional Amount	170	184	15	-9(11).99	For inpatient and outpatient claims, the amount of physician and other professional charges covered under Medicare Part B (e.g., if computing interim payment these charges are deducted)
24	CLM_NCVRD_CHRG_AMT	Claim Noncovered Charge Amount	185	203	19	-9(15).99	The charges for institutional long-term care are not reimbursable by the primary payer. The non-covered charges do not refer to charges not covered for any other service.
25	CLM_MDCR_DDCTBL_AMT	Claim Medicare Deductible Amount	204	222	19	-9(15).99	An amount identifying the portion applied toward the deductible a beneficiary is responsible for.
26	CLM_RLT_COND_CD	Claim Related Condition Code Periodic interim payments (PIP) - 62	223	224	2	X(2)	The code that indicates a condition relating to an institutional claim that may affect payer processing.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
27	CLM_OPRTNL_OUTLR_AMT	Operating Outlier Amount (DSH) -17	225	243	19	-9(15).99	Operating Outlier Amount (DSH)
28	CLM_MDCR_NEW_TECH_AMT	Medicare new technology add-on payment -77	244	262	19	-9(15).99	Medicare new technology add-on payment
29	CLM_ISLET_ISOLN_AMT	Islet Isolation Add-on payment amount - Q7	263	281	19	-9(15).99	Islet Isolation Add-on payment amount
30	CLM_SQSTRTN_RDCTN_AMT	Part A Sequestration reduction amounts - 73	282	300	19	-9(15).99	The payment to the provider will be reduced by the amount specified by CMS.
31	CLM_1_REV_CNTR_ANSI_RSN_CD	claim adjustment reason code (CARC)	301	303	3	X(3)	A Fiscal Intermediary Shared System (FISS) code identifying the type of adjustment being performed.
32	CLM_1_REV_CNTR_ANSI_GRP_CD	Claim Adjustment Segment (CAS) Group Code	304	305	2	X(2)	These codes categorize a payment adjustment.
33	CLM_MIPS_PMT_AMT	Capital MIPS payment costs	306	324	19	-9(15).99	Capital MIPS payment costs

Part B Claims Benefit Enhancement and Demonstration Code File (CCLFB)

The filename convention for the Medicare Shared Savings Program in Table 24 is:

- For regular CCLFs: P.A****.ACO.ZCBY**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZCBR**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 24 is:

- For monthly CCLFs: P.F***.ACO.ZCBY**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZCBR**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 24 is:

- For monthly CCLFs: P.D****.ACO.ZCBY**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZCBR**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 24 for KCF option Entities is P.K****.ACO.ZCBY**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZCBY**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 24 is P.P******.ACO.ZCBY**.Dyymmdd.Thhmmsst.

Table 24: Part B Claims Benefit Enhancement and Demonstration Code File (CCLFB)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim. IH
2	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line within a given claim.
3	BENE_MBI_ID	Medicare Beneficiary Identifier	24	34	11	X(11)	A Medicare Beneficiary Identifier assigned to a beneficiary. IH
4	BENE_HIC_NUM	Beneficiary HIC Number	35	45	11	X(11)	Legacy Beneficiary HICN field. **Note:** *To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The Beneficiary HIC Number will be blank in CCLFs generated effective January 1, 2020, onwards.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLM_TYPE_CD	Claim Type Code	46	47	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs Claim type code include: 71=RIC O local carrier non-DMEPOS claim 72=RIC O local carrier DMEPOS claim
6	CLM_LINE_NGACO_PBPMT_SW	PBP Benefit Enhancement Indicator	48	48	1	X(1)	A single character code of “Y” or “N” that indicates whether a particular claim line is tied to a PBP benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLM_LINE_NGACO_PDSCHRG_HCBS_SW	Post Discharge Home Visit Benefit Enhancement Indicator	49	49	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim line is tied to a Post Discharge Home Visit benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*
8	CLM_LINE_NGACO_SNF_WVR_SW	SNF 3-Day Waiver Benefit Enhancement Indicator	50	50	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim line is tied to a SNF 3-Day Waiver benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLM_LINE_NGACO_TLHLTH_SW	Telehealth Benefit Enhancement Indicator	51	51	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim line is tied to a Telehealth benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*
10	CLM_LINE_NGACO_CPTATN_SW	AIPBP Benefit Enhancement Indicator	52	52	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim line is tied to an AIPBP benefit enhancement. Blank if no data are available. **Note**: *This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLM_DEMO_1ST_NUM	First Program Demonstration Number	53	54	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a first demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.
12	CLM_DEMO_2ND_NUM	Second Program Demonstration Number	55	56	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a second demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLM_DEMO_3RD_NUM	Third Program Demonstration Number	57	58	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a third demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.
14	CLM_DEMO_4TH_NUM	Fourth Program Demonstration Number	59	60	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a fourth demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLM_DEMO_5TH_NUM	Fifth Program Demonstration Number	61	62	2	X(2)	Medicare Demonstration Special Processing Number (SPN). This is a fifth demonstration number. This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative.
16	CLM_PBP_INCLSN_AMT	PBP/AIPBP Inclusion Amount	63	77	15	-9(11).99	The amount that would have been paid in the absence of PBP/AIPBP Reduction. The value for the PBP/AIPBP Inclusion Amount is derived from the table and column called “CMS_VIEW_CLM_PRD.CLM_LINE_OTHR_APLD_AMT” when the value code within the field called “CLM_LINE_OTHR_APLD_CD” equals “J.”

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLM_PBP_RDCTN_AMT	PBP/AIPBP Reduction Amount	78	92	15	-9(11).99	The PBP/AIPBP Reduction Amount withheld from payment to the Provider. The value for the PBP/AIPBP Reduction Amount is derived from the table and column called "CMS_VIEW_CLM_PRD. CLM_LINE_OTHR_APLD_AMT" when the value code within the field called "CLM_LINE_OTHR_APLD_CD" equals "L."
18	CLM_NGACO_CMG_WVR_SW	Care Management Home Visits	93	93	1	X(1)	A single character code of "Y" or "N" that indicates whether a particular claim is tied to a Care Management Home Visits benefit enhancement. Blank if no data are available. ***Note**: This field was created for both NGACO and VTAPM models. NGACO sunset in 2022 but this field will continue to be used for the VTAPM model.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
19	CLM_MDCR_DDCTBL_AMT	Claim Medicare Deductible Amount	94	112	19	-9(15).99	Amount indicates the Medicare deductible amount billed to Medicaid for this service. The Medicare Deductible Amount does not necessarily reflect the amount actually paid.
20	CLM_SQSTRTN_RDCTN_AMT	Part B Sequestration reduction amounts	113	127	15	-9(11).99	The payment to the provider will be reduced by the amount specified by CMS. Only one period has been defined by CMS for a 2% reduction that began on 04/01/2013 as part of government sequestration.
21	CLM_LINE_CARR_HPSA_SCRCTY_CD	Claim Line Carrier Health Professional Shortage Area Scarcity Code	128	128	1	X(1)	A code used to track the Health Professional Shortage Area (HPSA) related bonus payments on Part B Professional claims

Summary Statistics Header Record (CCLF0)

The filename convention for the Medicare Shared Savings Program in Table 25 and Table 26 is:

- For regular CCLFs: P.A****ACO.ZC0Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.A****.ACO.ZC0R**.Dyymmdd.Thhmmsst, “R” instead of “Y” indicating run-out

The filename convention for the VTAPM Model in Table 25 and Table 26 is:

- For monthly CCLFs: P.F***.ACO.ZC0Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.F***.ACO.ZC0R**.Dyymmdd.Thhmmsst.

The filename convention for the ACO REACH Model in Table 25 is:

- For monthly CCLFs: P.D****.ACO.ZC0Y**.Dyymmdd.Thhmmsst.
- For run-out CCLFs: P.D****.ACO.ZC0R**.Dyymmdd.Thhmmsst.

The filename convention for the KCC Model in Table 25 for KCF option Entities is P.K****.ACO.ZC0Y**.Dyymmdd.Thhmmsst and for CKCC option Entities is P.C****.ACO.ZC0Y**.Dyymmdd.Thhmmsst.

The filename convention for the PCF Model in Table 25 and Table 26 is P.P******.ACO.ZC0Y**.Dyymmdd.Thhmmsst.

Table 25: Summary Statistics Header Record (CCLF0)

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
1	File Number Label	Title	1	13	13	X(13)	“File Number” This field will be left-justified and right-padded with spaces.
2	Delimiter	Delimiter	14	14	1	X(1)	“|”
3	File Description Label	Title	15	34	20	X(20)	“File Description” This field will be left-justified and right-padded with spaces.
4	Delimiter	Delimiter	35	35	1	X(1)	“|”

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
5	Total Records Count Label	Title	36	55	20	X(20)	"Total Records Count" This field will be left-justified and right-padded with spaces.
6	Delimiter	Delimiter	56	56	1	X(1)	"|"
7	Record Length Label	Title	57	69	13	X(13)	"Record Length" This field will be left-justified and right-padded with spaces.

Table 26: Summary Statistics Detail Records

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
1	File Type	Type of CCLF file	1	7	7	X(7)	Field will contain either "CCLF1," "CCLF2," "CCLF3," "CCLF4," "CCLF5," "CCLF6," "CCLF7," "CCLF8," "CCLF9," "CCLFA," or "CCLFB." This field will be left-justified and right-padded with spaces.
2	Delimiter	Delimiter	8	8	1	X(1)	"|"

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
3	File Name	Name of CCLF file	9	51	43	X(43)	For file CCLF1, this field will contain “Part A Claims Header File.” For file CCLF2, this field will contain “Part A Claims Revenue Center Detail File.” For file CCLF3, this field will contain “Part A Procedure Code File.” For file CCLF4, this field will contain “Part A Diagnosis Code File.” For file CCLF5, this field will contain “Part B Physicians File.” For file CCLF6, this field will contain “Part B DME File.” For file CCLF7, this field will contain “Part D File.” For file CCLF8, this field will contain “Beneficiary Demographics File.” For file CCLF9, this field will contain “BENE XREF File.” For file CCLFA, this field will contain “Part A BE and Demo Codes File.” For file CCLFB, this field will contain “Part B BE and Demo Codes File.” This field will be left-justified and right-padded with spaces.
4	Delimiter	Delimiter	52	52	1	X(1)	“|”

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
5	Number of records	Contains the number of records in the file	53	63	11	X(11)	This field will be right-justified and left-padded with spaces.
6	Delimiter	Delimiter	64	64	1	X(1)	“|”
7	Length of record	Contains the length of the record in the file.	65	69	5	X(5)	This field will be right-justified and left-padded with spaces.
8	Filler	Filler	70	70	1	X(1)	Blank

Appendix C: Zip File Instructions

ACO-MS Data Hub:

Starting September 28, 2020, the Shared Savings Program ACOs can access the Data Hub tab in ACO-MS to download the CCLF files. The CCLF files in the Data Hub will contain the .”zip” extension that allows for a download to the local drive. ACOs can use any MS Window-based zip utility to unzip the files.

MFT Mailbox:

Beginning September 28, 2020 through December 31, 2020, the Shared Savings Program ACOs will be able to access the CCLFs through the MFT mailbox in the SSP ACO Portal and Data Hub tab in ACO-MS parallelly. On December 31, 2020, the MFT mailbox and the SSP ACO Portal will be retired and the Data Hub will become the only delivery mechanism for the CCLF.

VTAPM ACOs will continue to access the CCLF files through the MFT mailbox to download the files. The ACOs must set the transfer mode from the default of ASCII to binary when downloading the zipped file. The CCLF files transfer as a binary zip file without any appended file extension (e.g., “zip”).

To extract the file from the transferred zip file, MS Window users will need to append the .”zip” extension to the filename to unzip the file using any Microsoft Windows-based zip utility. Unix/Linux users will need to use the unzip command to unzip the files.

4i Data Hub:

The KCC and ACO REACH Entities and PCF Practices can download the CCLFs from the 4i Data Hub. The Data Hub gives user access to sensitive program reports and CCLFs. Users can find the Data Hub feature on the left-hand pane of 4i application. The CCLF files in the 4i Data Hub will contain the .”zip” extension that allows for a download to the local drive. Entities can use any Microsoft Windows-based zip utility to unzip the files. Upon unzipping the CCLFs, the Entities can find the 12 individual CCLFs in their local drive. Entities can use the Notepad or Notepad++ utility to view the content of these individual CCLFs. For MAC users, please use TextEdit to open the files once they are unzipped.

Notices and Disclaimers

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Acronyms

Acronym	Description
4i	4 Innovation
ACO	Accountable Care Organization
ACO-MS	Accountable Care Organization – Management System
ACO-OS	Accountable Care Organization – Operational System
ACO REACH	Accountable Care Organization Realizing Equity, Access, and Community Health
AIPBP	All-Inclusive Population-Based Payment
ASC	Ambulatory Surgical Center
BE	Benefit Enhancement
BENE	Beneficiary
BIC	Beneficiary Identification Code
CAN	Claim Account Number
CCLF	Claim and Claim Line Feed
CCN	CMS Certification Number
CEC	Comprehensive ESRD Care
CKCC	Comprehensive Kidney Care Contracting
CMS	Centers for Medicare & Medicaid Services
DAW	Dispense As Written
DIB	Disability Insurance Benefits
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospital
EFT	Electronic File Transfer
EIN	Employer Identification Number
ESCO	ESRD Seamless Care Organization
ESRD	End-Stage Renal Disease

Acronym	Description
FFS	Fee-for-Service
FI	Fiscal Intermediaries
FIPS	Federal Information Processing Standards
FK	Foreign Key
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HICN	Health Insurance Claim Number
HIPPS	Health Insurance Prospective Payment System
ICD	International Classification of Diseases
IDR	Integrated Data Repository
IP	Information Packet
IPPS	Inpatient Prospective Payment System
KCC	Kidney Care Choices
KCF	Kidney Care First
MAC	Medicare Administrative Contractors
MBI	Medicare Beneficiary Identifier
MFT	Managed File Transfer
NCH	National Claims History
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NGACO	Next Generation Accountable Care Organization
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OASI	Old Age & Survivors Insurance
OPPS	Outpatient Prospective Payment System
OSCAR	Online Survey Certification and Reporting System
OUD	Opioid Use Disorder
PCF	Primary Care First

Acronym	Description
PBP	Population-Based Payment
PBPM	Per-beneficiary, per-month
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PHI	Protected Health Information
PII	Personally Identifiable Information
PK	Primary Key
RRB	Railroad Retirement Board
SNF	Skilled Nursing Facility
SPN	Special Processing Number
SSN	Social Security Number
TIN	Taxpayer Identification Number
UPIN	Unique Physician Identification Number
VTAPM	Vermont All-Payer Accountable Care Organization (ACO) Model
XLC	eXpedited Life Cycle
XREF	Cross-Reference

Glossary

Term	Definition
4i	The 4 Innovation (4i) system supports APM entities in the submission of applications and management of participation in an APM to improve the quality of care and reduce service costs. 4i is used by APM entities and Centers for Medicare and Medicaid Services/Center for Medicare and Medicaid Innovation (CMS/CMMI) to review and adjudicate applications to approve APM entity participation.
Accountable Care Organization	ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve.
Centers for Medicare & Medicaid Services	CMS is a Federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards.
Claims Run Out	Claims for services that are rendered towards the end of the PY (late arriving claims) are generally not processed until the beginning of the following PY referred to as Claims Run - Out period. The Claims Run-Out period is defined as January, February, and March following the end of a PY. The Claims Run-Out CCLF files are generated in February, March, and April following the end of a PY to include the claims loaded after the end of the PY.
Data Hub	Module in 4i and ACO-MS containing CCLFs, beneficiary exclusion files, and reports.
Electronic File Transfer	EFT is the act of transmitting files over a computer network or the Internet.
End-Stage Renal Disease	ESRD is an irreversible decline in kidney function that is severe enough to be fatal without dialysis or transplantation.
Healthcare Common Procedure Coding System	HCPCS is a set of health care procedure code based on the American Medical Association's Current Procedural Terminology (Commonly pronounced Hick-Picks).

Term	Definition
Integrated Data Repository	The IDR is a single source database system containing CMS beneficiary and claim data.
MBI	The MBI has 11 characters and consists of numbers and upper-case letters. Medicare beneficiaries will be assigned their own randomly-generated identifier.
New Medicare Card Project	The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new MBI will replace the SSN-based HICN on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status. After the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims, and the HICN value will no longer be displayed. The HICN field will be blank in CCLFs generated effective January 1, 2020 onwards.
New Medicare Card Transition Period	Transition period where either the HICN or the MBI, or both MBI and HICN can be used in ACO-OS data exchanges. The transition period will begin no earlier than April 1, 2018 and run through December 31, 2019.
Reporting Month	Reporting month is the calendar month for which the CCLFs will be produced.
Shared Savings Program	The Shared Savings Program promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Participating entities that meet quality and performance standards, referred to as Medicare ACOs, are eligible to receive payments for shared savings.
Suppress/Resume VTAPM CCLFs	Claims data for a beneficiary aligned to a VTAPM ACO will be suppressed (will not be sent) as part of the CCLFs after a quarterly check, regardless of the beneficiary's data sharing preference, when the beneficiary's paid claims for any services are associated with a terminated and/or removed provider and that beneficiary has no paid claims with any other currently active providers of the VTAPM ACO within the last 12 months. Claims data for a beneficiary, with data sharing preference of Opt-in, will be resumed (included within the CCLFs) with the aligned VTAPM ACO when there is at least one paid claim for any services within the last 12 months with a currently active provider.

Term	Definition
Suppress/Resume KCC CCLFs	Claims data for a beneficiary aligned to an Entity will be suppressed (will not be sent) as part of the CCLFs after a monthly check, regardless of the beneficiary's data sharing preference, when the beneficiary's claims (paid claims for any services and unpaid alignment qualifying claims) are not associated with an active provider within the last six months. Claims data for a currently-suppressed beneficiary, with data sharing preference of Opt-in, will be resumed (included within the CCLFs) with the aligned Entity when there is at least a (paid claim for any services or unpaid alignment qualifying claim) within the last six months with an active provider.

Record of Changes

Version	Date	Description of Change
1.0	03/07/2012	BIETL096_Pioneer_CCLF_IP_v1_0_F_20120307
2.0	11/06/12	In Table 3, Element 3 corrected the format to X(06) because Online Survey Certification and Report System (OSCAR) numbers contain both letters and numbers. Edited and renamed the document (removed the word “Pioneer,” etc.) so that it applies to the entire ACO program. Added additional Appendix to include Substance Abuse Codes. Added the AMA copyright disclaimer to Table 4 – CPT Codes. Added the Summary Statistics file. Updated Appendix B – File Layouts Updated Sections 2, 3, 4, and 5 to incorporate the change to the Debit/Credit version of the data feed. Additional Section: Section 7. Deleted extra space between section 5.4 and 5.5.
3.0	02/25/2013	Final baselined version by NG.
4.0	07/29/2013	March 2013: Revised to add new and additional fields and information as requested by CMS. Updated Appendix B for the March 2013 release. Updated and baselined versioning per customer’s request and added change records from Maricom. Updated and baselined versioning per CM/P3’s request and removed duplicate rows in Table 16. June 2013: Updated the “Description of Change” to be more descriptive of changes for the June 2013 release. Section 2.6: Addition of text stating the file will be sent to Shared Savings Program and Pioneer Part A Claims Revenue Center Detail File Addition of “CLM_LINE” to Claim Field Label element 7 and 9

Version	Date	Description of Change
4.0 Cont.	07/29/2013	Part B Physicians File Addition of “RNDRG” to Claim Field Label element 18 Finalized updates for the June 2013 release: Changes to section 2.1.1 based on comments from CM received on June 26, 2013. Minor edits to section 3.3 to improve readability. Changes to section 2.1.1 based on comments from CM received on July 17, 2013.
5.0	02/26/2014	Updated Section 2.5.2. Updated the format column of elements 23 and 24 in Appendix B, Table 6. Revised Section 2.5.2 Updated Provider Specialty Codes hyperlink for Element #9 in Table 10.
6.0	05/14/2014	Added Table 6: ICD-10-PCS Inpatient Procedure Codes. Added Table 7: ICD-10-CM Diagnosis Codes.
7.0	06/24/2014	Added additional Substance Abuse codes.
8.0	09/30/2014	Changes to the CCLF format effective October 2014. Updated based on the September 2014 release: Updated Table 9, Element #14-20. Updated Table 12, Element #28-42. Updated Table 14, Element #10-19. Added additional fields for Table 15: Beneficiary Demographics File. Updated based on customer. Updated Table 14, Element #12 added “DEA” in Claim Field Description. Updated Table 15, Elements #17 and #18. Highlighted changes in Appendix B: CCLF File Layouts, including Tables 9, 12, 14, and 15.
9.0	12/23/2014	Added Notices and Disclaimers. Updated Section 1. Updated the Format column in Tables 8, 9, 12, 13, 14, and 19. Update the Part B Physician File Table 18 Element 7 to include additional Provider Type Codes.

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10.0	07/17/2015	Reworded the two lead-in paragraphs in Appendix A: Alcohol and Substance Abuse Codes. Appendix A: Removed SA codes based on coordination with SAMHSA. Updated the following sections to include the ICD codes of 9, 10, and "U": 2.2.1, 2.2.3, 2.2.4, 2.3.1, and Appendix B: CCLF File Layouts. Updated Table 13: ICD-10-CM-Diagnosis Codes with the updated list of ICD9/10 codes. Updated Section 2.6.
11.0	08/28/2015	Updated Section 2.5.1 – Provided further information regarding the Beneficiary Demographics File. Updated Section 3.2 – Clarified blank vs. non-blank value of the variable CCLFs. Updated Section 4.0 and 4.1 – Revised text for clarity. Updated Section 5.2.1 – Provided further information regarding the Natural Keys. Updated typos on "BENE_EQTBL_BIC_HICN_NUM" where applicable. Added Section 8: Best Practices for Protecting Beneficiary-Level Data. Updated Appendix B – Added CCLF file number after each file name. Updated Acronyms List.

Version	Date	Description of Change
12.0	12/10/2015	NGACO Model is included in this version of the IP. Updated Overview. Revised Section 1 text based on Final Rule 2015 changes. Revised Section 2.6. Revised Appendix A Description. Appendix B CCLF File Layout – Updated the CCLF file name convention for Shared Savings Program, Pioneer and NGACO Programs that are sent to ACO Mailboxes. Updated Sections 2.1.1, 2.1.2, 2.5.1, 2.5.2, 2.6, 4.1, 4.2. Deleted the old field names that were part of previous published version of CCLF IP from Section 4.1. Added New field “DGNS_PRCDR_ICD_IND” in Section 4.1. Updated section 4.1.9 to state that no new fields were added to the file. Updated the Appendix B Start Position, End Position, Data Length Format and Comments for Table 23: Summary Statistics Header Record (CCLF0) and Table 24: Summary Statistics Detail Records. Updated Appendix B file layouts: Made corrections to several Claim Field Labels and Formats. Added note to Appendix B to describe the significance of a minus “-” in a file format.
13.0	12/17/2015	Updated: Section 2.5.1: Beneficiary Demographics File to include reference to claims data will not be shared on suppressed beneficiaries. Section 2.5.2: (CCLF9) clarify Current HICN for only what is in CCLF8 Glossary

Version	Date	Description of Change
14.0	03/15/2016	Updated: Overview Section 2.1.2 to clarify descriptive text for entity relationship. Section 2.5.1 to include text on CCLF sharing criteria with ACOs. Section 2.5.2 to reword Beneficiary XREF File description. Section 3.1 to update explanation of how to use the Beneficiary XREF File. Section 3.2 to clarify descriptive text for dropping denied claims. Section 6.1 to include references to reports. Sections 6.2 and 7.1 to update outdated links.
15.0	06/06/2016	Updated: Section 2.2.1 Part A Claims Header File to include Population-Based Payment information. Section 2.3.1 Part B Physicians File to include Population-Based Payment information. Table 14 to include Part A Population-Based Payment fields. Table 18 to include Part B Population-Based Payment fields. Section 2.5.1: Revised the Beneficiary Demographics File (CCLF8) description to describe the NGACO and Pioneer Suppression and Resumption logic for the sharing of beneficiary information based on the opt-out and opt-in rules. Table 18: Part B Physicians File (CCLF5) Claim Field Label was updated. Table 19: Part B DME File (CCLF6) Claim Field Label and Format were updated. ResDAC links in Appendix B: CCLF File Layouts. Added Sections 3.5 and 3.6. Glossary

Version	Date	Description of Change
16.0	07/20/2016	Updated: Section 2.2.1 Part A Claims Header File to include All-Inclusive Population-Based Payment information. Section 2.3.1 Part B Physicians File to include All-Inclusive Population-Based Payment information. Table 14 to include Part A All-Inclusive Population-Based Payment fields. Table 18 to include Part B All-Inclusive Population-Based Payment fields. Glossary
17.0	11/18/2016	Updated: Section 1 to include CEC alignment report information. Section 3.4 Claims run-out to include the latest IDR fields used for claims run-out reporting. Section 4 to capture the latest field changes. Section 6.1: Assignment/Alignment Report to include information about CEC alignment data. Section 7 and Appendix B, CCLF5, Element 20 to provide or update the Carrier Denial Codes link. Removed references to Pioneer Demonstration based on the Pioneer Model Close Out. Updated Section 7.1 to add a reference to Shared Savings Program SSP Data Exchange User Guide. Appendix A: Alcohol and Substance Abuse Code Tables for CEC substance abuse codes. Appendix B: CCLF File Layouts for CEC file naming convention. Acronyms

Version	Date	Description of Change
18.0	01/25/2017	Added: Section 2.6 Part A Claims Benefit Enhancement and Demonstration Codes File overview. Section 2.7 Part B Claims Benefit Enhancement and Demonstration Codes File overview. Table 23 Part A Benefit Enhancement and Demonstration Codes File. Table 24 Part B Benefit Enhancement and Demonstration Codes File. Updated: Section 2.2.1 Part A Claims Header File to move PBP/AIPBP information to section 2.6. Section 2.3.1 Part B Physician File to move PBP/AIPBP information to section 2.7. Table 1 Summary Statistics File in Microsoft Excel Spreadsheet Format to include CCLFs 10 and 11. Section 4 Fields in the CCLF Data Files for changes to CCLFs 1, 5, 10, and 11. Table 23 and Table 24 to remove mention of tildes (~) for document consistency. Table 26 Summary Statistics Detail Records for changes as a result of the introduction of CCLFs 10 and 11. Section 2.5.1 with CEC Suppression/Resumption check Moved PII/PHI notation to the Description column in the tables in “Appendix B – CCLF File Layouts.” Removed notes globally that CCLF 0 (Summary Statistics File) will only contain nine CCLFs for CEC. CEC ESCOs will receive all 11 CCLF file names in the CCLF 0 file. Updated Section 2.5.1 to explain how the newly aligned flag takes precedence over Suppression status for CEC monthly CCLF generation. Corrected Table 23 start and end positions. Glossary and Acronyms

Version	Date	Description of Change
19.0	06/02/2017	Updated: CCLF 5 and 6 to provide additional code definitions. CCLFs A and B to include “blank” as a valid value for benefit enhancements. Code field description for Element 20 in Table 18: Part B Physicians File (CCLF5).
20.0	08/14/2017	Added a note to CCLF2 file layout for the condition when HIPPS codes will display in the file.
21.0	12/11/2017	Revised Outpatient Service Type Codes in CCLF 1 based on an IDR data dictionary correction. Updated the CEC Suppression/Resumption determination criteria to include the unpaid CEC alignment qualifying claims. Updated description to field descriptions in CCLF 1 and 5, based on CMS feedback.
22.0	01/09/2018	Added a Medicare Beneficiary Identifier field to CCLFs 1-8, A, and B. Added an MBI/HICN indicator, current number, previous number, previous number effective date, and previous number obsolete date fields to CCLF 9. Removed Current HICN, Previous HICN, Previous HICN effective date, and previous HICN obsolete date fields from CCLF 9. Added a note to the Entity Relationship Diagram relating to the MBI. Added an example of when an MBI may change in section 2.5.2. Revised notes in Entity Relationship Diagram and sections 5.3 and 5.5. Revised wording in various sections based on CMS feedback.
23.0	04/19/2018	Updated Table 18: Part B Physicians File (CCLF5) Updated Section 2.5.1 Beneficiary Demographics File and Glossary for CEC Beneficiary Data sharing process to ‘Monthly’ from ‘Quarterly’. Added claims run-out text. Suppression resumption check is updated from quarterly to monthly.

Version	Date	Description of Change
24.0	07/30/2018	Updated filename convention for the Medicare Shared Savings Program for the following CCLFs: • CCLF1-9 • CCLF A-B • CCLF 0
25.0	11/16/2018	Updated filename convention for the Medicare Shared Savings Program for the following CCLFs: • CCLF1-9 • CCLF A-B • CCLF 0 Added New Fields to CCLF1, 2, 5, 8, A, B. Updated Section 4. Addition of Section 4.2. Added the Vermont All Payer Model (VTAPM) where applicable. Appendix B: Updated the filename convention for CEC and NGACO and added VTAPM.
26.0	03/08/2019	Updated Section 2.5.1 to include VTAPM Suppression/Resumption Section 4.2: Updated the example in File naming convention Appendix B: Updated the Part A and Part B Claims Benefit Enhancement and Demonstration Codes Files with Care Management Home Visits benefit enhancement. Section 2.5.1, added Historical CCLF definition to NGACO, VTAPM, Shared Savings program and CEC programs Updated the description of Claim Outpatient Service Type Code in Appendix B
27.0	05/31/2019	Updated CCLF file names Section 4.2, Appendix B • Added filename convention for Shared Savings Program run-out CCLFs Updated the NGACO Suppression process from Quarterly to Monthly 2.5.1 • Updated NGACO and VTAPM run-out file names.

Version	Date	Description of Change
28.0	11/20/2019	Added Note throughout: “To comply with MACRA of 2015, after the end of the New Medicare Card Transition Period in December 2019, only the MBI will be accepted on claims and the HICN value will no longer be displayed. The HICN/BIC/RRB fields will be blank in CCLFs effective January 1, 2020 onwards.” Updated Section 4.2 “Zip File Naming Convention Changes to the Claims Line Feed” to correct the CEC Zip filename. Updated the Section 4.4 heading to “Debit/Credit Methodology.” This copy replaces the 10/28/2019 copy of v28.0.
29.0	09/28/2020	Updated Section 4 Appendix B: Updated the Shared Savings Program New delivery mechanism Appendix C: Updated the zip file instructions for the Data Hub tab in ACO-MS
30.0	10/26/2020	Updated to include Direct Contracting and KCC Models.
31.0	12/23/2020	Updated Table 9: CPT and HCPCS Codes to include additional 29 alcohol and substance abuse codes.
32.0	03/01/2021	Updated to include PCF Model. Updated Appendix B ResDAC links.
33.0	11/04/2021	Removed references to CEC based on CEC Close Out. Replaced “Direct Contracting” references to “Global and Professional Direct Contracting (GPDC)” Added Substance Abuse Codes (G1028, G2215, G2216) to Appendix A. Appendix B: Updated CCLFs 1 to 6 and A, B with new elements
34.0	04/28/2022	Updated Figure 1 (Entity Relationship Diagram) and Section 2.1 (High-Level Relationships among the Claim Files) to show relationship change between CCLF1 & CCLFA. Global change to replace the “GPDC” with “GPDC/ACO REACH.”
35.0	06/06/2022	Added Section 2.8 “NPI and OSCAR Data Sources.”

Version	Date	Description of Change
36.0	12/08/2022	Appended CCLF1 with the following fields: • Claim Control Number • Claim Original Control Number • Claim Contractor Number Appended CCLF5 with: • Claim Contractor Number Updated the text for “GPDC” to “ACO REACH”
37.0	12/14/2023	Updated Appendix A Alcohol and Substance Abuse Code Tables to include the new code G0137 effective from Jan 1 2024.
38.0	02/02/2024	Following note was added in Appendix A Alcohol and Substance Abuse Codes Tables: ***Note:** Effective with discharges on and after October 1, 2007 (FY 2008), CMS DRGs 522 and 523 were deleted and no longer associated with alcohol and substance abuse.