CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 660	**Date: June 29, 2016**
	Change Request 9238

Transmittal 637, dated February 5, 2016, is being rescinded and replaced by Transmittal 660, dated June 29, 2016, to update the responsibility section of the following requirements in the Business Requirements Table: 9238.6, 9238.6.1, 9238.6.1.1, 9238.6.2, 9238.6.3. All other information remains the same.

SUBJECT: Comprehensive Error Rate Testing (CERT) program Treatment of Claims in the Prior Authorization Model

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Exhibits section of Pub. 100-08, informing the Shared System Maintainers (SSMs) of new data elements that need to be sent.

EFFECTIVE DATE: July 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 2016

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Exhibits/36 - Overview of the CERT Process
R	Exhibits/36.1 - CERT Formats for A/B MAC (A) MACS and Shared Systems

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC

Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 660	Date: June 29, 2016	Change Request: 9238

Transmittal 637, dated February 5, 2016, is being rescinded and replaced by Transmittal 660, dated June 29, 2016, to update the responsibility section of the following requirements in the Business Requirements Table: 9238.6, 9238.6.1, 9238.6.1.1, 9238.6.2, 9238.6.3. All other information remains the same.

SUBJECT: Comprehensive Error Rate Testing (CERT) program Treatment of Claims in the Prior Authorization Model

EFFECTIVE DATE: July 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 2016

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services provided instruction to the CERT Contractor on conducting limited reviews of claims with an existing affirmed prior authorization. In order to accommodate these instructions, data elements identifying claims with affirmed prior authorizations must be submitted to the CERT contractor.

B. Policy: There are no statutory or regulatory policies that impact the change being made by this CR.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9238.1	The SSMs shall include all demonstration numbers on all claims paid under a demonstration (this is a universal requirement					X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	and should already be in place).									
9238.1.1	The first demonstration number populated in the claim data shall be sent to CERT in the resolution file in the current data element "***Claim Demonstration Number***".					X	X	X		
9238.1.2	The remaining demonstration numbers populated in the claim data shall be sent to CERT in the resolution file in new data elements ***"Claim Demonstration Identification Number 2-4***".					X	X	X		
9238.2	The SSMs shall populate the new data element "***Prior Authorization Program Indicator***" in the CERT resolution file					X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	for each claim line containing services subject to prior authorization in a state covered by the Prior Authorization (PA) project.									
9238.2.1	The SSMs shall add this field to the claim record in order for it to be moved to the CERT record.					X		X		
9238.2.2	The SSMs shall populate the new data element "***Prior Authorization Program Indicator***" in the CERT resolution file on the first claim detail line for claims reviewed at the claim level for each claim containing services subject to prior authorization in a state covered by the Prior Authorization (PA) project.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9238.3	The SSM shall populate the new data element "***Unique Tracking Number (UTN)***" in the CERT resolution file when a UTN is present in the claim processing system.					X	X	X		
9238.4	The SSM shall populate the new data element "***Prior Authorization Affirmed Indicator***" in the CERT Resolution file for each claim line containing services subject to prior authorization in a state covered by a PA Project.					X	X	X		
9238.4.1	When the claim line subject to prior authorization is denied/rejected/ or returned to the provider, the SSM shall					X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	populate the "***Prior Authorization Affirmed Indicator***" with "N", indicating that the Prior Authorization was not affirmed.									
9238.4.2	When the claim line subject to prior authorization is subjected to prepayment complex medical review, the SSM shall populate the "***Prior Authorization Affirmed Indicator***" with "N", indicating that the Prior Authorization was not affirmed.					X	X	X		
9238.4.3	When the claim line subject to prior authorization (contains both PA program indicator and UTN) is paid without being subjected to prepayment					X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	complex medical review, the SSM shall populate the "***Prior Authorization Affirmed Indicator***" with "Y", indicating that the Prior Authorization was affirmed.									
9238.5	The SSM shall not populate the "***Prior Authorization Affirmed Indicator***" on claim lines that are not subject to Prior Authorization.					X	X	X		
9238.6	The MAC must enter the necessary data to allow the SSM to identify each line of service the MAC subjects to complex manual medical review. The MAC shall manually enter this indicator on the claim.	X		X						

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9238.6.1	When the MAC receives documentation and performs complex manual medical review on one or more specific lines of service for that claim, the MAC shall enter Y in the claim line detail complex manual medical review indicator for each line of complex manual medical review.	X		X						
9238.6.1.1	When the MAC receives documentation and performs complex manual medical review on one or more specific lines of service for claims where the decision is at a claim level (i.e., inpatient hospital), the MAC shall enter Y in the claim line detail complex	X		X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	manual medical review indicator for the first line of the claim.									
9238.6.2	When the MAC performs routine manual medical review on one or more specific lines of service for that claim, the MAC shall enter N in the claim line manual medical review indicator for each line of routine manual medical review	X		X						
9238.6.3	When the MAC does not perform complex or routine manual medical review and/or the system performs automated medical review on any line of service, the MAC shall leave the line level manual medical review	X		X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	indicator blank.									
9238.6.4	When the DME MAC performs a complex medical review for a claim line where no prior authorization is obtained, a complex medical review PIMR code must be associated with that claim line so the CERT medical review indicator filed will be set to "Y".				X					
9238.6.5	The Part B MACs shall ensure that medical review related edits and audits are set up appropriately so that this field will be populated correctly.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Sarah Bochenick, 410-786-2882 or sarah.bochenick@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Exhibit 36- Overview of the CERT Process

(Rev.660, Issued: 06-29-16, Effective: 07-01-16, Implementation:07-05-16)

The CERT process begins at the MAC processing site where claims that have entered the standard claims processing system on a given day are extracted to create a Claims Universe File. This file is transmitted each day to the CERT Operations Center, where it is routed through a random sampling process. Claims that are selected as part of the sample are downloaded to the Sampled Claims Database. This database holds all sampled claims from all MACs. Periodically, sampled claim key data are extracted from the Sampled Claims Database to create a Sampled Claims Transaction File. This file is transmitted back to the MAC and matched to the MAC's claims history and provider files. A Sampled Claims Resolution File, a Claims History Replica File, and a Provider Address file are created automatically by the MAC and transmitted to the CERT Operations Center. They are used to update the Sampled Claims database with claim resolutions and provider addresses; the Claims History Replica records are added to a database for future analysis.

Software applications at the CERT Operations Center are used to review, track, and report on the sampled claims. Periodically, the CERT contractor requests the MAC to provide information supporting decisions on denied/reduced claims or claim line items and claims that have been subject to their medical review processes. The CERT contractor also sends reports identifying incorrect claim payment to the appropriate MAC for follow-up. MACs then report on their agreement and disagreement with CERT decisions, status of overpayment collections, and status of claims that go through the appeals process.

EXHIBIT 36.1 - CERT Formats for A/B MAC (A) MACS and Shared Systems
(Rev.660, Issued: 06-29-16, Effective: 07-01-16, Implementation: 07-05-16)

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

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

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

Data Element: Universe Date

Definition:	Date the universe of claims entered the shared system
Validation:	Must be a valid date not equal to a universe date sent on any previous claims universe file
Remarks:	Format is CCYYMMDD. May use shared system batch processing date; however the Universe Date must not equal the universe date on any previous claims universe file.
Requirement:	Required

Claims Universe File				
Claims Universe Claim Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	“2”
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Internal Control Number	X(23)	9	31	Spaces
Beneficiary HICN	X(12)	32	43	Spaces
Billing Provider Number	X(9)	44	52	Spaces
Billing Provider NPI	X(10)	53	62	Spaces
Type of Bill	X(3)	63	65	Spaces
Claim From Date	X (8)	66	73	Spaces
Claim Through Date	X (8)	74	81	Spaces
Condition Code 1	X (2)	82	83	Spaces
Condition Code 2	X (2)	84	85	Spaces
Condition Code 3	X (2)	86	87	Spaces
Condition Code 4	X (2)	88	89	Spaces
Condition Code 5	X (2)	90	91	Spaces
Condition Code 6	X (2)	92	93	Spaces
Condition Code 7	X (2)	94	95	Spaces
Condition Code 8	X (2)	96	97	Spaces
Condition Code 9	X (2)	98	99	Spaces
Condition Code 10	X (2)	100	101	Spaces
Condition Code 11	X (2)	102	103	Spaces
Condition Code 12	X (2)	104	105	Spaces
Condition Code 13	X (2)	106	107	Spaces
Condition Code 14	X (2)	108	109	Spaces
Condition Code 15	X (2)	110	111	Spaces
Condition Code 16	X (2)	112	113	Spaces
Condition Code 17	X (2)	114	115	Spaces
Condition Code 18	X (2)	116	117	Spaces
Condition Code 19	X (2)	118	119	Spaces
Condition Code 20	X (2)	120	121	Spaces
Condition Code 21	X (2)	122	123	Spaces
Condition Code 22	X (2)	124	125	Spaces
Condition Code 23	X (2)	126	127	Spaces
Condition Code 24	X (2)	128	129	Spaces
Condition Code 25	X (2)	130	131	Spaces
Condition Code 26	X (2)	132	133	Spaces
Condition Code 27	X (2)	134	135	Spaces
Condition Code 28	X (2)	136	137	Spaces
Condition Code 29	X (2)	138	139	Spaces
Condition Code 30	X (2)	140	141	Spaces
Claim Demonstration Number	X(2)	142	143	Spaces
PPS Indicator Code	X(1)	144	144	Spaces
Claim State	X(2)	145	146	Spaces
Beneficiary State	X(2)	147	148	Spaces

Claims Universe File				
Claims Universe Claim Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Claim Total Charge Amount	9(8)V99	149	158	Zeroes
Revenue Code Count	9(3)	159	161	Zero
Revenue Code group:				

The following group of fields occurs from 1 to 450 times (depending on Revenue Code Count)				

From and Thru values relate to the 1st line item				
Revenue Center Code	X(4)	162	165	Spaces
HCPCS	X(5)	166	170	Spaces
Revenue Center Total Charge	9(8)V99	171	180	Zeroes

DATA ELEMENT DETAIL

Claim (Header) Fields

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

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

Data Element: Contractor Type

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

Data Element: Internal Control Number

Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: Billing Provider Number

Definition: First nine characters of number assigned by Medicare to identify the billing/pricing provider or supplier.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Billing Provider NPI

Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required by May 23, 2007 for claims using HIPAA standard Transactions

Data Element: Type of Bill

Definition: Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks: N/A
Requirement: Required

Data Element: Claim from Date

Definition: The first day on the billing statement covering services rendered to the beneficiary
Validation: Must be a valid date
Remarks: Format is CCYYMMDD
Requirement: Required

Data Element: Claim through Date

Definition: The last day on the billing statement covering services rendered to the beneficiary
Validation: Must be a valid date
Remarks: Format is CCYYMMDD
Requirement: Required

Data Element: Condition Code 1
Condition Code 2
Condition Code 3
Condition Code 4
Condition Code 5
Condition Code 6
Condition Code 7
Condition Code 8
Condition Code 9
Condition Code 10
Condition Code 11
Condition Code 12
Condition Code 13
Condition Code 14
Condition Code 15
Condition Code 16
Condition Code 17
Condition Code 18
Condition Code 19
Condition Code 20
Condition Code 21
Condition Code 22
Condition Code 23
Condition Code 24
Condition Code 25
Condition Code 26
Condition Code 27
Condition Code 28
Condition Code 29
Condition Code 30

Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing
Validation: Must be a valid code as defined in the Claims Processing Manual (pub 100-4) chapter 25 (Completing and Processing CMS-1450 Data Set)
Remarks: N/A
Requirement: Required if claim has a condition code

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

Data Element: PPS Indicator Code alias Claim PPS Indicator Code

Definition: The code indicating whether (1) the claim is Prospective Payment System (PPS), (2) Unknown or (0) not PPS.
Validation: 0 = Not PPS
1 = PPS
2 = Unknown
Remarks: N/A
Requirement: Required

Data Element: Claim State
Definition: 2 character abbreviation identifying the state in which the service is furnished
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) or blank
Remarks: N/A
Requirement: Required if on claim record

Data Element: Beneficiary State
Definition: 2 character abbreviation designating the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) or blank
Remarks: N/A
Requirement: Required if on claim record

Data Element: Claim Total Charge Amount
Definition: The total charges for all services included on the institutional claim
Validation: N/A
Remarks: This field should contain the same amount as revenue center code 0001/total charges.
Requirement: Required

Data Element: Revenue Code Count
Definition: Number indicating number of revenue code lines on the claim. Include line 1 in the count
Validation: Must be a number 01 – 450
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: Revenue Code

Definition: Code assigned to each cost center for which a charge is billed
Validation: Must be a valid National Uniform Billing Committee (NUBC) approved code
Remarks: Include an entry for revenue code '0001'
Requirement: Required

Data Element: HCPCS Procedure Code or HIPPS Code

Definition: The HCPCS/CPT-4 code that describes the service or Health Insurance PPS (HIPPS) code
Validation: Must be a valid HCPCS/CPT-4 code
Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs

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

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

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

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

Requirement: Required if present on bill

Data Element: Revenue Center Total Charge

Definition: The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided
Validation: N/A
Remarks: N/A
Requirement: Required

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

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

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

Data Element: Number of Claims

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

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

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

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

Data Element: Transaction Date

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

Sampled Claims Transaction File				
Sampled Claims Transaction File Detail Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(23)	9	31	Spaces
Beneficiary HICN	X(12)	32	43	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

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

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

Data Element: Claim Control Number

Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: Reflects the Claim Control Number selected from the Claim Universe file in the sampling process.
Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: Reflects the Beneficiary HICN on the claim record selected from the Claim Universe file in the sampling process.

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

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

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

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

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
Remarks: N/A
Requirement: Required

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

Data Element: Resolution Date

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

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	“2”
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Record Number	9(1)	9	9	Zero
Mode of Entry Indicator	X(1)	10	10	Space
Original Claim Control Number	X(23)	11	33	Spaces
Internal Control Number	X(23)	34	56	Spaces
Beneficiary HICN	X(12)	57	68	Spaces
Beneficiary Last Name	X(60)	69	128	Spaces
Beneficiary First Name	X(35)	129	163	Spaces
Beneficiary Middle Initial	X(1)	164	164	Spaces
Beneficiary Date of Birth	X(8)	165	172	Spaces
Beneficiary Gender	X(1)	173	173	Spaces
Billing Provider Number	X(9)	174	182	Spaces
Attending Physician UPIN	X(6)	183	188	Spaces
Claim Paid Amount	S9(8)V99	189	198	Zeroes
Claim ANSI Reason Code 1	X(8)	199	206	Spaces
Claim ANSI Reason Code 2	X(8)	207	214	Spaces
Claim ANSI Reason Code 3	X(8)	215	222	Spaces
Claim ANSI Reason Code 4	X(8)	223	230	Spaces
Claim ANSI Reason Code 5	X(8)	231	238	Spaces
Claim ANSI Reason Code 6	X(8)	239	246	Spaces
Claim ANSI Reason Code 7	X(8)	247	254	Spaces
Statement covers From Date	X(8)	255	262	Spaces
Statement covers Thru Date	X(8)	263	270	Spaces
Claim Entry Date	X(8)	271	278	Spaces
Claim Adjudicated Date	X(8)	279	286	Spaces
Condition Code 1	X(3)	287	289	Spaces
Condition Code 2	X(3)	290	292	Spaces
Condition Code 3	X(3)	293	295	Spaces
Condition Code 4	X(3)	296	298	Spaces
Condition Code 5	X(3)	299	301	Spaces
Condition Code 6	X(3)	302	304	Spaces
Condition Code 7	X(3)	305	307	Spaces
Condition Code 8	X(3)	308	310	Spaces
Condition Code 9	X(3)	311	313	Spaces
Condition Code 10	X(3)	314	316	Spaces
Condition Code 11	X(3)	317	319	Spaces
Condition Code 12	X(3)	320	322	Spaces
Condition Code 13	X(3)	323	325	Spaces
Condition Code 14	X(3)	326	328	Spaces
Condition Code 15	X(3)	329	331	Spaces
Condition Code 16	X(3)	332	334	Spaces
Condition Code 17	X(3)	335	337	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Condition Code 18	X(3)	338	340	Spaces
Condition Code 19	X(3)	341	343	Spaces
Condition Code 20	X(3)	344	346	Spaces
Condition Code 21	X(3)	347	349	Spaces
Condition Code 22	X(3)	350	352	Spaces
Condition Code 23	X(3)	353	355	Spaces
Condition Code 24	X(3)	356	358	Spaces
Condition Code 25	X(3)	359	361	Spaces
Condition Code 26	X(3)	362	364	Spaces
Condition Code 27	X(3)	365	367	Spaces
Condition Code 28	X(3)	368	370	Spaces
Condition Code 29	X(3)	371	373	Spaces
Condition Code 30	X(3)	374	376	Spaces
Type of Bill	X(3)	377	379	Spaces
Principal Diagnosis Code	X(7)	380	386	Spaces
Other Diagnosis Code 1	X(7)	387	393	Spaces
Other Diagnosis Code 2	X(7)	394	400	Spaces
Other Diagnosis Code 3	X(7)	401	407	Spaces
Other Diagnosis Code 4	X(7)	408	414	Spaces
Other Diagnosis Code 5	X(7)	415	421	Spaces
Other Diagnosis Code 6	X(7)	422	428	Spaces
Other Diagnosis Code 7	X(7)	429	435	Spaces
Other Diagnosis Code 8	X(7)	436	442	Spaces
Other Diagnosis Code 9	X(7)	443	449	Spaces
Other Diagnosis Code 10	X(7)	450	456	Spaces
Other Diagnosis Code 11	X(7)	457	463	Spaces
Other Diagnosis Code 12	X(7)	464	470	Spaces
Other Diagnosis Code 13	X(7)	471	477	Spaces
Other Diagnosis Code 14	X(7)	478	484	Spaces
Other Diagnosis Code 15	X(7)	485	491	Spaces
Other Diagnosis Code 16	X(7)	492	498	Spaces
Other Diagnosis Code 17	X(7)	499	505	Spaces
Other Diagnosis Code 18	X(7)	506	512	Spaces
Other Diagnosis Code 19	X(7)	513	519	Spaces
Other Diagnosis Code 20	X(7)	520	526	Spaces
Other Diagnosis Code 21	X(7)	527	533	Spaces
Other Diagnosis Code 22	X(7)	534	540	Spaces
Other Diagnosis Code 23	X(7)	541	547	Spaces
Other Diagnosis Code 24	X(7)	548	554	Spaces
Principal Diagnosis Code Version Indicator Code	X(1)	555	555	Spaces
Other Diagnosis Code 1 Version Indicator Code	X(1)	556	556	Spaces
Other Diagnosis Code 2 Version Indicator Code	X(1)	557	557	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Diagnosis Code 3 Version Indicator Code	X(1)	558	558	Spaces
Other Diagnosis Code 4 Version Indicator Code	X(1)	559	559	Spaces
Other Diagnosis Code 5 Version Indicator Code	X(1)	560	560	Spaces
Other Diagnosis Code 6 Version Indicator Code	X(1)	561	561	Spaces
Other Diagnosis Code 7 Version Indicator Code	X(1)	562	562	Spaces
Other Diagnosis Code 8 Version Indicator Code	X(1)	563	563	Spaces
Other Diagnosis Code 9 Version Indicator Code	X(1)	564	564	Spaces
Other Diagnosis Code 10 Version Indicator Code	X(1)	565	565	Spaces
Other Diagnosis Code 11 Version Indicator Code	X(1)	566	566	Spaces
Other Diagnosis Code 12 Version Indicator Code	X(1)	567	567	Spaces
Other Diagnosis Code 13 Version Indicator Code	X(1)	568	568	Spaces
Other Diagnosis Code 14 Version Indicator Code	X(1)	569	569	Spaces
Other Diagnosis Code 15 Version Indicator Code	X(1)	570	570	Spaces
Other Diagnosis Code 16 Version Indicator Code	X(1)	571	571	Spaces
Other Diagnosis Code 17 Version Indicator Code	X(1)	572	572	Spaces
Other Diagnosis Code 18 Version Indicator Code	X(1)	573	573	Spaces
Other Diagnosis Code 19 Version Indicator Code	X(1)	574	574	Spaces
Other Diagnosis Code 20 Version Indicator Code	X(1)	575	575	Spaces
Other Diagnosis Code 21 Version Indicator Code	X(1)	576	576	Spaces
Other Diagnosis Code 22 Version Indicator Code	X(1)	577	577	Spaces
Other Diagnosis Code 23 Version Indicator Code	X(1)	578	578	Spaces
Other Diagnosis Code 24 Version Indicator Code	X(1)	579	579	Spaces
Principal Procedure	X(7)	580	586	Spaces
Principal Procedure Date	X(8)	587	594	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Procedure 1	X(7)	595	601	Spaces
Other Procedure 1 Date	X(8)	602	609	Spaces
Other Procedure 2	X(7)	610	616	Spaces
Other Procedure 2 Date	X(8)	617	624	Spaces
Other Procedure 3	X(7)	625	631	Spaces
Other Procedure 3 Date	X(8)	632	639	Spaces
Other Procedure 4	X(7)	640	646	Spaces
Other Procedure 4 Date	X(8)	647	654	Spaces
Other Procedure 5	X(7)	655	661	Spaces
Other Procedure 5 Date	X(8)	662	669	Spaces
Other Procedure 6	X(7)	670	676	Spaces
Other Procedure 6 Date	X(8)	677	684	Spaces
Other Procedure 7	X(7)	685	691	Spaces
Other Procedure 7 Date	X(8)	692	699	Spaces
Other Procedure 8	X(7)	700	706	Spaces
Other Procedure 8 Date	X(8)	707	714	Spaces
Other Procedure 9	X(7)	715	721	Spaces
Other Procedure 9 Date	X(8)	722	729	Spaces
Other Procedure 10	X(7)	730	736	Spaces
Other Procedure 10 Date	X(8)	737	744	Spaces
Other Procedure 11	X(7)	745	751	Spaces
Other Procedure 11 Date	X(8)	752	759	Spaces
Other Procedure 12	X(7)	760	766	Spaces
Other Procedure 12 Date	X(8)	767	774	Spaces
Other Procedure 13	X(7)	775	781	Spaces
Other Procedure 13 Date	X(8)	782	789	Spaces
Other Procedure 14	X(7)	790	796	Spaces
Other Procedure 14 Date	X(8)	797	804	Spaces
Other Procedure 15	X(7)	805	811	Spaces
Other Procedure 15 Date	X(8)	812	819	Spaces
Other Procedure 16	X(7)	820	826	Spaces
Other Procedure 16 Date	X(8)	827	834	Spaces
Other Procedure 17	X(7)	835	841	Spaces
Other Procedure 17 Date	X(8)	842	849	Spaces
Other Procedure 18	X(7)	850	856	Spaces
Other Procedure 18 Date	X(8)	857	864	Spaces
Other Procedure 19	X(7)	865	871	Spaces
Other Procedure 19 Date	X(8)	872	879	Spaces
Other Procedure 20	X(7)	880	886	Spaces
Other Procedure 20 Date	X(8)	887	894	Spaces
Other Procedure 21	X(7)	895	901	Spaces
Other Procedure 21 Date	X(8)	902	909	Spaces
Other Procedure 22	X(7)	910	916	Spaces
Other Procedure 22 Date	X(8)	917	924	Spaces
Other Procedure 23	X(7)	925	931	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Procedure 23 Date	X(8)	932	939	Spaces
Other Procedure 24	X(7)	940	946	Spaces
Other Procedure 24 Date	X(8)	947	954	Spaces
Principal Procedure Version Indicator Code	X(1)	955	955	Spaces
Other Procedure 1 Version Indicator Code	X(1)	956	956	Spaces
Other Procedure 2 Version Indicator Code	X(1)	957	957	Spaces
Other Procedure 3 Version Indicator Code	X(1)	958	958	Spaces
Other Procedure 4 Version Indicator Code	X(1)	959	959	Spaces
Other Procedure 5 Version Indicator Code	X(1)	960	960	Spaces
Other Procedure 6 Version Indicator Code	X(1)	961	961	Spaces
Other Procedure 7 Version Indicator Code	X(1)	962	962	Spaces
Other Procedure 8 Version Indicator Code	X(1)	963	963	Spaces
Other Procedure 9 Version Indicator Code	X(1)	964	964	Spaces
Other Procedure 10 Version Indicator Code	X(1)	965	965	Spaces
Other Procedure 11 Version Indicator Code	X(1)	966	966	Spaces
Other Procedure 12 Version Indicator Code	X(1)	967	967	Spaces
Other Procedure 13 Version Indicator Code	X(1)	968	968	Spaces
Other Procedure 14 Version Indicator Code	X(1)	969	969	Spaces
Other Procedure 15 Version Indicator Code	X(1)	970	970	Spaces
Other Procedure 16 Version Indicator Code	X(1)	971	971	Spaces
Other Procedure 17 Version Indicator Code	X(1)	972	972	Spaces
Other Procedure 18 Version Indicator Code	X(1)	973	973	Spaces
Other Procedure 19 Version Indicator Code	X(1)	974	974	Spaces
Other Procedure 20 Version Indicator Code	X(1)	975	975	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Procedure 21 Version Indicator Code	X(1)	976	976	Spaces
Other Procedure 22 Version Indicator Code	X(1)	977	977	Spaces
Other Procedure 23 Version Indicator Code	X(1)	978	978	Spaces
Other Procedure 24 Version Indicator Code	X(1)	979	979	Spaces
Claim Demonstration Identification Number	9(2)	980	981	Zeroes
PPS Indicator	X(1)	982	982	Spaces
Action Code	X(1)	983	983	Spaces
Patient Status	X(2)	984	985	Spaces
Billing Provider NPI	X(10)	986	995	Spaces
Claim Provider Taxonomy Code	X(25)	996	1020	Spaces
Medical Record Number	X(17)	1021	1037	Spaces
Patient Control Number	X(20)	1038	1057	Spaces
Attending Physician NPI	X(10)	1058	1067	Spaces
Attending Physician Last Name	X(16)	1068	1083	Spaces
Operating Physician NPI	X(10)	1084	1093	Spaces
Operating Physician Last Name	X(16)	1094	1109	Spaces
Claim Rendering Physician NPI	X(10)	1110	1119	Spaces
Claim Rendering Physician Last Name	X(16)	1120	1135	Spaces
Date of Admission	X(8)	1136	1143	Spaces
Type of Admission	X(1)	1144	1144	Spaces
Source of Admission	X(1)	1145	1145	Spaces
DRG	X(3)	1146	1148	Spaces
Occurrence Code 1	X(2)	1149	1150	Spaces
Occurrence Code 1 Date	X(8)	1151	1158	Spaces
Occurrence Code 2	X(2)	1159	1160	Spaces
Occurrence Code 2 Date	X(8)	1161	1168	Spaces
Occurrence Code 3	X(2)	1169	1170	Spaces
Occurrence Code 3 Date	X(8)	1171	1178	Spaces
Occurrence Code 4	X(2)	1179	1180	Spaces
Occurrence Code 4 Date	X(8)	1181	1188	Spaces
Occurrence Code 5	X(2)	1189	1190	Spaces
Occurrence Code 5 Date	X(8)	1191	1198	Spaces
Occurrence Code 6	X(2)	1199	1200	Spaces
Occurrence Code 6 Date	X(8)	1201	1208	Spaces
Occurrence Code 7	X(2)	1209	1210	Spaces
Occurrence Code 7 Date	X(8)	1211	1218	Spaces
Occurrence Code 8	X(2)	1219	1220	Spaces
Occurrence Code 8 Date	X(8)	1221	1228	Spaces
Occurrence Code 9	X(2)	1231	1230	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Occurrence Code 9 Date	X(8)	1231	1238	Spaces
Occurrence Code 10	X(2)	1239	1240	Spaces
Occurrence Code 10 Date	X(8)	1241	1248	Spaces
Occurrence Code 11	X(2)	1249	1250	Spaces
Occurrence Code 11 Date	X(8)	1251	1258	Spaces
Occurrence Code 12	X(2)	1259	1260	Spaces
Occurrence Code 12 Date	X(8)	1261	1268	Spaces
Occurrence Code 13	X(2)	1269	1270	Spaces
Occurrence Code 13 Date	X(8)	1271	1278	Spaces
Occurrence Code 14	X(2)	1279	1280	Spaces
Occurrence Code 14 Date	X(8)	1281	1288	Spaces
Occurrence Code 15	X(2)	1289	1290	Spaces
Occurrence Code 15 Date	X(8)	1291	1298	Spaces
Occurrence Code 16	X(2)	1299	1300	Spaces
Occurrence Code 16 Date	X(8)	1301	1308	Spaces
Occurrence Code 17	X(2)	1309	1310	Spaces
Occurrence Code 17 Date	X(8)	1311	1318	Spaces
Occurrence Code 18	X(2)	1319	1320	Spaces
Occurrence Code 18 Date	X(8)	1321	1328	Spaces
Occurrence Code 19	X(2)	1329	1330	Spaces
Occurrence Code 19 Date	X(8)	1331	1338	Spaces
Occurrence Code 20	X(2)	1339	1340	Spaces
Occurrence Code 20 Date	X(8)	1341	1348	Spaces
Occurrence Code 21	X(2)	1349	1350	Spaces
Occurrence Code 21 Date	X(8)	1351	1358	Spaces
Occurrence Code 22	X(2)	1359	1360	Spaces
Occurrence Code 22 Date	X(8)	1361	1368	Spaces
Occurrence Code 23	X(2)	1369	1370	Spaces
Occurrence Code 23 Date	X(8)	1371	1378	Spaces
Occurrence Code 24	X(2)	1379	1380	Spaces
Occurrence Code 24 Date	X(8)	1381	1388	Spaces
Occurrence Code 25	X(2)	1389	1390	Spaces
Occurrence Code 25 Date	X(8)	1391	1398	Spaces
Occurrence Code 26	X(2)	1399	1400	Spaces
Occurrence Code 26 Date	X(8)	1401	1408	Spaces
Occurrence Code 27	X(2)	1409	1410	Spaces
Occurrence Code 27 Date	X(8)	1411	1418	Spaces
Occurrence Code 28	X(2)	1419	1420	Spaces
Occurrence Code 28 Date	X(8)	1421	1428	Spaces
Occurrence Code 29	X(2)	1429	1430	Spaces
Occurrence Code 29 Date	X(8)	1431	1438	Spaces
Occurrence Code 30	X(2)	1439	1440	Spaces
Occurrence Code 30 Date	X(8)	1441	1448	Spaces
Value Code 1	X(2)	1449	1450	Spaces
Value Amount 1	S9(8)V99	1451	1460	Zeroes

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Value Code 2	X(2)	1461	1462	Spaces
Value Amount 2	S9(8)V99	1463	1472	Zeroes
Value Code 3	X(2)	1473	1474	Spaces
Value Amount 3	S9(8)V99	1475	1484	Zeroes
Value Code 4	X(2)	1485	1486	Spaces
Value Amount 4	S9(8)V99	1487	1496	Zeroes
Value Code 5	X(2)	1497	1498	Spaces
Value Amount 5	S9(8)V99	1499	1508	Zeroes
Value Code 6	X(2)	1509	1510	Spaces
Value Amount 6	S9(8)V99	1511	1520	Zeroes
Value Code 7	X(2)	1521	1522	Spaces
Value Amount 7	S9(8)V99	1523	1532	Zeroes
Value Code 8	X(2)	1533	1534	Spaces
Value Amount 8	S9(8)V99	1535	1544	Zeroes
Value Code 9	X(2)	1545	1546	Spaces
Value Amount 9	S9(8)V99	1547	1556	Zeroes
Value Code 10	X(2)	1557	1558	Spaces
Value Amount 10	S9(8)V99	1559	1568	Zeroes
Value Code 11	X(2)	1569	1570	Spaces
Value Amount 11	S9(8)V99	1571	1580	Zeroes
Value Code 12	X(2)	1581	1582	Spaces
Value Amount 12	S9(8)V99	1583	1592	Zeroes
Value Code 13	X(2)	1593	1594	Spaces
Value Amount 13	S9(8)V99	1595	1604	Zeroes
Value Code 14	X(2)	1605	1606	Spaces
Value Amount 14	S9(8)V99	1607	1616	Zeroes
Value Code 15	X(2)	1617	1618	Spaces
Value Amount 15	S9(8)V99	1619	1628	Zeroes
Value Code 16	X(2)	1629	1630	Spaces
Value Amount 16	S9(8)V99	1631	1640	Zeroes
Value Code 17	X(2)	1641	1642	Spaces
Value Amount 17	S9(8)V99	1643	1652	Zeroes
Value Code 18	X(2)	1653	1654	Spaces
Value Amount 18	S9(8)V99	1655	1664	Zeroes
Value Code 19	X(2)	1665	1666	Spaces
Value Amount 19	S9(8)V99	1667	1676	Zeroes
Value Code 20	X(2)	1677	1678	Spaces
Value Amount 20	S9(8)V99	1679	1688	Zeroes
Value Code 21	X(2)	1689	1690	Spaces
Value Amount 21	S9(8)V99	1691	1700	Zeroes
Value Code 22	X(2)	1701	1702	Spaces
Value Amount 22	S9(8)V99	1703	1712	Zeroes
Value Code 23	X(2)	1713	1714	Spaces
Value Amount 23	S9(8)V99	1715	1724	Zeroes
Value Code 24	X(2)	1725	1726	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Value Amount 24	S9(8)V99	1727	1736	Zeroes
Value Code 25	X(2)	1737	1738	Spaces
Value Amount 25	S9(8)V99	1739	1748	Zeroes
Value Code 26	X(2)	1749	1750	Spaces
Value Amount 26	S9(8)V99	1751	1760	Zeroes
Value Code 27	X(2)	1761	1762	Spaces
Value Amount 27	S9(8)V99	1763	1772	Zeroes
Value Code 28	X(2)	1773	1774	Spaces
Value Amount 28	S9(8)V99	1775	1784	Zeroes
Value Code 29	X(2)	1785	1786	Spaces
Value Amount 29	S9(8)V99	1787	1796	Zeroes
Value Code 30	X(2)	1797	1798	Spaces
Value Amount 30	S9(8)V99	1799	1808	Zeroes
Value Code 31	X(2)	1809	1810	Spaces
Value Amount 31	S9(8)V99	1811	1820	Zeroes
Value Code 32	X(2)	1821	1822	Spaces
Value Amount 32	S9(8)V99	1823	1832	Zeroes
Value Code 33	X(2)	1833	1834	Spaces
Value Amount 33	S9(8)V99	1835	1844	Zeroes
Value Code 34	X(2)	1845	1846	Spaces
Value Amount 34	S9(8)V99	1847	1856	Zeroes
Value Code 35	X(2)	1857	1858	Spaces
Value Amount 35	S9(8)V99	1859	1868	Zeroes
Value Code 36	X(2)	1869	1870	Spaces
Value Amount 36	S9(8)V99	1871	1880	Zeroes
Claim Final Allowed Amount	S9(8)V99	1881	1890	Zeroes
Claim Deductible Amount	S9(8)V99	1891	1900	Zeroes
Claim State	X(2)	1901	1902	Spaces
Claim Zip Code	X(9)	1903	1911	Spaces
Beneficiary State	X(2)	1912	1913	Spaces
Beneficiary Zip Code	X(9)	1914	1922	Spaces
Claim PWK	X(60)	1923	1982	Spaces
Patient Reason for Visit 1	X(7)	1983	1989	Spaces
Patient Reason for Visit 2	X(7)	1990	1996	Spaces
Patient Reason for Visit 3	X(7)	1997	2003	Spaces
Patient Reason for Visit 1 Version Indicator Code	X(1)	2004	2004	Spaces
Patient Reason for Visit 2 Version Indicator Code	X(1)	2005	2005	Spaces
Patient Reason for Visit 3 Version Indicator Code	X(1)	2006	2006	Spaces
Present on Admission/External Cause of Injury Indicator	X(37)	2007	2043	Spaces
External Cause of Injury 1	X(7)	2044	2050	Spaces
External Cause of Injury 2	X(7)	2051	2057	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
External Cause of Injury 3	X(7)	2058	2064	Spaces
External Cause of Injury 4	X(7)	2065	2071	Spaces
External Cause of Injury 5	X(7)	2072	2078	Spaces
External Cause of Injury 6	X(7)	2079	2085	Spaces
External Cause of Injury 7	X(7)	2086	2092	Spaces
External Cause of Injury 8	X(7)	2093	2099	Spaces
External Cause of Injury 9	X(7)	2100	2106	Spaces
External Cause of Injury 10	X(7)	2107	2113	Spaces
External Cause of Injury 11	X(7)	2114	2120	Spaces
External Cause of Injury 12	X(7)	2121	2127	Spaces
External Cause of Injury 1 Version Indicator Code	X(1)	2128	2128	Spaces
External Cause of Injury 2 Version Indicator Code	X(1)	2129	2129	Spaces
External Cause of Injury 3 Version Indicator Code	X(1)	2130	2130	Spaces
External Cause of Injury 4 Version Indicator Code	X(1)	2131	2131	Spaces
External Cause of Injury 5 Version Indicator Code	X(1)	2132	2132	Spaces
External Cause of Injury 6 Version Indicator Code	X(1)	2133	2133	Spaces
External Cause of Injury 7 Version Indicator Code	X(1)	2134	2134	Spaces
External Cause of Injury 8 Version Indicator Code	X(1)	2135	2135	Spaces
External Cause of Injury 9 Version Indicator Code	X(1)	2136	2136	Spaces
External Cause of Injury 10 Version Indicator Code	X(1)	2137	2137	Spaces
External Cause of Injury 11 Version Indicator Code	X(1)	2138	2138	Spaces
External Cause of Injury 12 Version Indicator Code	X(1)	2139	2139	Spaces
Service Facility Zip Code	X(9)	2140	2148	Spaces
RAC adjustment indicator	X(1)	2149	2149	Spaces
Split/Adjustment Indicator	9(2)	2150	2151	Spaces
Referring Physician NPI	X(10)	2152	2161	Spaces
Referring Physician Last Name	X(16)	2162	2177	Spaces
Referring Physician Specialty	X(2)	2178	2179	Spaces
Claim Rendering Physician Specialty	X(2)	2180	2181	Spaces
Overpay Indicator	X(1)	2182	2182	Spaces
Overpay Code	X(3)	2183	2185	Spaces
Claim Demonstration Identification Number 2	***X(2)***	***2186***	***2187***	***Spaces***

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Claim Demonstration Identification Number 3	***X(2)***	***2188***	***2189***	***Spaces***
Claim Demonstration Identification Number 4	***X(2)***	***2190***	***2191***	***Spaces***
Filler	***X(10)***	***2192***	***2201***	Spaces
Total Line Item Count	9(3)	***2202***	***2204***	Zeroes
Record Line Item Count	9(3)	***2205***	***2207***	Zeroes
Line Item group: The following group of fields occurs from 1 to 450 times for the claim (depending on Total Line Item Count) and 1 to **75** times for the Record (depending on Record Line Item Count)				
From and Thru values relate to the 1st line item				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Revenue center code	X(4)	2208	2211	Spaces
SNF-RUG-III code	X(3)	2212	2214	Spaces
APC adjustment code	X(5)	2215	2219	Spaces
HCPCS Procedure Code	X(5)	2220	2224	Spaces
HCPCS Modifier 1	X(2)	2225	2226	Spaces
HCPCS Modifier 2	X(2)	2227	2228	Spaces
HCPCS Modifier 3	X(2)	2229	2230	Spaces
HCPCS Modifier 4	X(2)	2231	2232	Spaces
HCPCS Modifier 5	X(2)	2233	2234	Spaces
Line Item Date	X(8)	2235	2242	Spaces
Line Submitted Charge	S9(8)V99	2243	2252	Zeroes
Line Medicare Initial Allowed Charge	S9(8)V99	2253	2262	Zeroes
ANSI Reason Code 1	X(8)	2263	2270	Spaces
ANSI Reason Code 2	X(8)	2271	2278	Spaces
ANSI Reason Code 3	X(8)	2279	2286	Spaces
ANSI Reason Code 4	X(8)	2287	2294	Spaces
ANSI Reason Code 5	X(8)	2295	2302	Spaces
ANSI Reason Code 6	X(8)	2303	2310	Spaces
ANSI Reason Code 7	X(8)	2311	2318	Spaces
ANSI Reason Code 8	X(8)	2319	2326	Spaces
ANSI Reason Code 9	X(8)	2327	2334	Spaces
ANSI Reason Code 10	X(8)	2335	2342	Spaces
ANSI Reason Code 11	X(8)	2343	2350	Spaces
ANSI Reason Code 12	X(8)	2351	2358	Spaces
ANSI Reason Code 13	X(8)	2359	2366	Spaces
ANSI Reason Code 14	X(8)	2367	2374	Spaces
Manual Medical Review Indicator	X(1)	2375	2375	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Resolution Code	X(5)	2376	2380	Spaces
Line Final Allowed Charge	S9(8)V99	2381	2390	Zeroes
Line Cash Deductible	S9(8)V99	2391	2400	Zeroes
Special Action Code/Override Code	X(1)	2401	2401	Zeroes
Units	S9(7)v999	2402	2411	Zeroes
Rendering Physician NPI	X(10)	2412	2421	Spaces
Rendering Physician Last Name	X(25)	2422	2446	Spaces
National Drug Code (NDC) field	X(11)	2447	2457	Spaces
National Drug Code (NDC) Quantity	S9(7)v999	2458	2467	Spaces
National Drug Code (NDC) Quantity Qualifier	X(2)	2468	2469	Spaces
Line PWK	X(60)	2470	2529	Spaces
Line Rendering Physician specialty	X(2)	2530	2531	Spaces
Prior Authorization Program Indicator	***X(4)***	***2532***	***2535***	***Spaces***
Unique Tracking Number (UTN)	***X(14)***	***2536***	***2549***	***Spaces***
Prior Authorization Affirmed Indicator	***X(1)***	***2550***	***2550***	***Spaces***
Filler	***X(4)***	***2551***	2554	Spaces

DATA ELEMENT DETAIL

Claim (Header) Fields

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
Remarks: N/A
Requirement: Required

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

Data Element: Record Number

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

Data Element: Mode of Entry Indicator

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

Data Element: Original Claim Control Number

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

Data Element: Internal Control Number

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

Data Element: Beneficiary HICN

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

Data Element: Beneficiary Last Name

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

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

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

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

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

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

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

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

Data Element: Claim ANSI Reason Code 1-7

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

Data Element: Statement Covers from Date
Definition: The beginning date of the statement
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Statement Covers thru Date
Definition: The ending date of the statement
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

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

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

Data Element: Condition Code 1-30
Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set
Remarks: This field is left justified and blank filled.
Requirement: Required if there is a condition code for the bill.

Data Element: Type of Bill
Definition: A code indicating the specific type of bill (hospital, inpatient, SNF, outpatient, adjustments, voids, etc.).
This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as “frequency” code
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set
Remarks: N/A
Requirement: Required

Data Element: Principal Diagnosis

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

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

- CMS accepts only CMS approved ICD--CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD--CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD--CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable

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

Requirement: Required

Data Element: Principal Diagnosis Version Indicator Code

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

Validation:

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

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

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

Data Element: Other Diagnosis Code 1-24

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

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

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable.

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

Requirement: Required if available on the claim record.

Data Element: Other Diagnosis Version Indicator Code 1-24

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

Validation:

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

Remarks:

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

Data Element: Principal Procedure and Date

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

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

- CMS accepts only CMS approved ICD--CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD--CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD--CM, Volume 3, procedure code, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM).

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

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

Requirement: Required for inpatient claims.

Data Element: Principal Procedure Version Indicator Code

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

Validation:

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

Remarks:

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

Data Element: Other Procedure and Date 1-24

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

Validation: Must be a valid ICD-CM procedure code

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD-CM, Volume 3, procedure code, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM).

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

Requirement: Required if on claim record.

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

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

Validation:

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

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

Data Element: Claim Demonstration Identification Number
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks: ***This field contains the value from the first populated demonstration field.***
Requirement: ***Required for all claims involved in a demonstration project***

Data Element: PPS Indicator
Definition: The code indicating whether (1) the claim is Prospective Payment System (PPS) or (0) not PPS.
Validation: 0 = Not PPS
1 = PPS
Remarks: N/A
Requirement: Required

Data Element: Action Code
Definition: Indicator identifying the type of action requested by the intermediary to be taken on an institutional claim.
Validation: Must be a valid action code.
1 = Original debit action (includes non-adjustment RTI correction items) – it will always be a 1 in regular bills.
2 = Cancel by credit adjustment – used only in credit/debit pairs (under HHPPS, updates the RAP).
3 = Secondary debit adjustment - used only in credit/debit pairs (under HHPPS, would be the final claim or an adjustment on a LUPA).
4 = Cancel only adjustment (under HHPPS, RAP/final claim/LUPA).
5 = Force action code 3
6 = Force action code 2
8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present
9 = Payment requested (used on bills that replace previously-submitted benefits-refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment code.)
Remarks: N/A
Requirement: Required

Data Element: Patient Status
Definition: This code indicates the patient’s status as of the “Through” date of the billing period.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set
Remarks:
Requirement: Required

Data Element: Billing Provider NPI

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

Data Element: Claim Provider Taxonomy Code

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

Remarks: N/A
Requirement: Required when available.

Data Element: Medical Record Number

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

Data Element: Patient Control Number

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

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

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

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

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

Data Element: Claim Rendering Physician NPI
Definition: NPI assigned to the claim rendering physician (mapped from 2310D from the 837I version 5010A2)
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Claim Rendering Physician Last Name
Definition: Last Name (Surname) of the claim rendering physician (mapped from 2310D from the 837I version 5010A2)
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

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

Data Element: Type of Admission

Definition: The code indicating the type and priority of an inpatient admission associated with the service on an intermediary claim.

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set Code Structure:

Requirement: Required on inpatient claims only.

Data Element: Source of Admission

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

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set Code Structure (For Emergency, Elective, or Other Type of Admission):

Requirement: Required when entered on the claim record.

Data Element: DRG (Diagnosis Related Group)

Definition: The code identifying the diagnostic related group to which a hospital claim belongs for prospective payment purposes.

Validation: Must be valid per the DRG DEFINITIONS MANUAL

Remarks: N/A

Requirement: Required if available on the claim record

Data Element: Occurrence Code and Date 1-30

Definition: Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown.

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set

Remarks:

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

Requirement: Required if available on claim record

Data Element: Value Codes and Amounts 1-36

Definition: Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim.

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set

Remarks:

- The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00).
- Negative amounts are not allowed except in the last entry.
- Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter.
- Some values are reported as cents, so refer to specific codes for instructions.

- If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence.
- Use the first line before the second, etc.

Requirement: Required if available on claim record

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

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

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

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

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

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

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

Data Element: Patient Reason for Visit 1-3
Definition: An ICD--CM code on the institutional claim indicating the beneficiary's reason for visit

Validation: Must be a valid ICD-CM diagnosis code

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable.

Remarks: Report the full ICD-CM codes for up to 3 conditions responsible for the patient's visit.

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

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

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

Validation:

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

Remarks:

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

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

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

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

Remarks: N/A

Requirement: Required

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

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

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

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable.

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

Requirement: Required if available on the claim record.

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

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

Validation:

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

Remarks:

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

Data Element: Service Facility Zip Code

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

Validation: Must be a valid Zip Code

Remarks:

Requirement: Required, if available on claim record.

Data Element: RAC Adjustment Indicator

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

Validation: 'R' identifies a RAC-requested adjustment

Remarks: N/A

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

Data Element: Split/Adjustment Indicator

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

Validation: '0' is used when only one DCN associated with the sampled claim is included in the resolution file.

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

- When the resolution file contains 2 DCNs related to a single claim, one of the records would contain a split/adjustment indicator of 1 and the second record would contain a split/adjustment indicator of 2.

.

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

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

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

Data Element: Referring Physician NPI

Definition: NPI assigned to the Referring Physician—the physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Validation: N/A

Remarks: Enter zeros if there is no referring physician

Requirement: Required when available on the claim record

NOTES:

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

Data Element: Referring Physician Last Name

Definition: Last name of the referring physician.

Validation: N/A

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

Requirement: Required when available on the claim record.

Data Element: Referring Physician Specialty

Definition: Code indicating the primary specialty of the referring physician.

Validation: N/A

Remarks: Enter zeros if the referring physician specialty is not available

Requirement: Required when available on the claim record.

Data Element: Claim Rendering Physician Specialty

Definition: Code indicating the primary specialty of the claim rendering physician.

Validation: N/A

Remarks: Enter zeros if the rendering physician specialty is not available

Requirement: Required when available on the claim record.

Data Element: Overpay Indicator

Definition: Code indicating whether or not an overpayment exists on an OIG or ZPIC tracked adjustment claims.

Validation:

- Y indicates an overpayment exists on an OIG or ZPIC claim
- N indicates an overpayment does not exist on an OIG or ZPIC claim
- Default value is blank for claims that are not OIG or ZPIC tracked claims.

Remarks: This field is populated only when there is a value present in the FSSCIDRP-OVERPAY-CODE field

Requirement: Required when available on the claim record.

Data Element: Overpay Code

Definition: Code that identifies an overpayment on an OIG or ZPIC tracked adjustment claim.

Validation: Any of the user-defined values present in the online parm PRMOIGAA, PRMOIG00 through PRMOIG20 records.

Remarks: This field is populated only when the claim is an OIG or ZPIC tracked adjustment claim.

Requirement: Required when available on the claim record.

Data Element: Claim Demonstration Identification Number 2
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks: This field contains the value from the second populated demonstration field.
Requirement: Required when available on the claim

Data Element: Claim Demonstration Identification Number 3
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks: This field contains the value from the third populated demonstration field.
Requirement: Required when available on the claim

Data Element: Claim Demonstration Identification Number 4
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks: This field contains the value from the fourth populated demonstration field.
Requirement: Required when available on the claim

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

Data Element: Total Line Item Count
Definition: Number indicating number of service lines on the claim
Validation: Must be a number 001 - 450
Remarks: N/A
Requirement: Required

Data Element: Record Line Item Count
Definition: Number indicating number of service lines on this record
Validation: Must be a number 001 - 100
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: Revenue Center Code
Definition: Code assigned to each cost center for which a charge is billed
Validation: Must be a valid NUBC-approved code
Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set
Remarks:
Include an entry for revenue code ‘0001’
Requirement: Required

Data Element: SNF-RUG-III Code

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

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

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

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

The HIPPS code identifies (1) the three case-mix dimensions of the Home Health Resource Group (HHRG) system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, is the basis of payment for each episode.
Validation: N/A
Remarks: Left justify the APC Adjustment Code
Requirement: Required if present on claim record

Data Element: HCPCS Procedure Code or HIPPS Code
Definition: The HCPCS/CPT-4 code that describes the service or Health Insurance PPS (HIPPS) code
Validation: Must be a valid HCPCS/CPT-4 or HIPPS code
Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs

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

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

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies

whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

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

Requirement: Required if present on claim record

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

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

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

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

Data Element: Line Medicare Initial Allowed Charge
Definition: Amount Medicare allowed for the service or equipment before any reduction or denial
Validation: Must be a numeric value.
Remarks: This is a required field. Use the value in FISS field FSSCPDCL-REV-COV-CHRG-AMT to populate this field (per CMS Change Request 3912)
Requirement: Required

Data Element: ANSI Reason Code 1-14
Definition: Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed
Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes
Remarks: Format is GGRRRRRR where: G is the group code and RRRRRR is the adjustment reason code
Requirement: Report all ANSI Reason Codes included on the bill.

Data Element: Manual Medical Review Indicator

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

Validation: Must be 'Y' or 'N'

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

Requirement: Required

Data Element: Resolution Code

Definition: Code indicating how the MAC resolved the line.

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

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the MAC's internal documentation, such as claims history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

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

pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

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

Remarks:

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

Requirement: **Required**

Data Element: Final Allowed Charge

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

Data Element: Cash Deductible

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

Data Element: Special Action/Override Code

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

Data Element: Units

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

Data Element: Rendering Physician NPI

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

Data Element: Rendering Physician Last Name

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

Data Element: National Drug Code (NDC) field

Definition: To be assigned at a later date.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: National Drug Code (NDC) Quantity Qualifier

Definition: To be assigned at a later date.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: National Drug Code (NDC) Quantity

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

Data Element: PWK Filler

Definition: PWK space -- use to be determined
Validation: N/A
Remarks: N/A

Requirement: Required when available on claim

Data Element: Rendering Physician Specialty
Definition: Code indicating the primary specialty of the rendering physician.
Validation: N/A
Remarks: Enter zeros if the rendering physician specialty is not available
Requirement: Required when available on the claim record.

Data Element: Prior Authorization Program Indicator
Definition: Prior Authorization Program Indicator issued by CMS to identify to which PA program the service belongs
Validation:
- ***Four character alphanumeric***
- ***The first character identifies the line of business***
  - ***A for Part A,***
  - ***B for Part B,***
  - ***D for DME,***
  - ***H for Home Health and Hospice***
- ***Followed by a three digit number.***

Remarks: N/A
Requirement: Required for claims containing services subject to a prior authorization program.

Data Element: Unique Tracking Number (UTN)
Definition: Unique Tracking Number (UTN) assigned to the prior authorization request for the service or item.
Validation: UTN shall be 14 characters and use the following format:
- ***First two characters = MAC identifier (e.g. RR for Railroad, 0F for Jurisdiction F, 05 for Jurisdiction 5, etc.)***
- ***Third character = line of business (e.g. A for Part A, B for Part B, D for DME, H for Home Health and Hospice)***
- ***Remaining numerical characters = a unique sequence number assigned by the Shared System***

Remarks: N/A
Requirement: Required for claims containing services covered by an affirmed prior authorization.

Data Element: Prior Auth Affirmed
Definition: Code to identify if the prior authorization for the service(s) on this line was affirmed
Validation:
- ***Y indicates the prior authorization was affirmed***
- ***N indicates the prior authorization was not affirmed***
- ***Default value is blank for claims that are not part of prior authorization demonstration.***

Remarks: N/A
Requirement: Required for claims containing services subject to prior authorization in the state where the service was furnished.

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

Remarks: N/A
Requirement: Required

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
Remarks: N/A
Requirement: Required

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

Data Element: Number of Claims

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

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

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

Data Element: Record Type

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

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

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

Data Element: Provider Address Date

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

Provider Address File				
Provider Address Detail Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	Spaces
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Sequence Number	X(1)	9	9	Spaces
Provider Number	X(15)	10	24	Spaces
Provider Name	X(60)	25	84	Spaces
Provider Address 1	X(25)	85	109	Spaces
Provider Address 2	X(25)	110	134	Spaces
Provider City	X(15)	135	149	Spaces
Provider State Code	X(2)	150	151	Spaces
Provider Zip Code	X(9)	152	160	Spaces
Provider Phone Number	X(10)	161	170	Spaces
Provider Phone Number Extension	X(10)	171	180	Spaces
Provider FAX Number	X(10)	181	190	Spaces
Provider Type	X(1)	191	191	Spaces
Provider Address Type	9(3)	192	194	1
Provider E-mail Address	X(75)	195	269	Spaces
Provider Federal Tax number or EIN	9(10)	270	279	Zeroes
Filler	X(16)	280	295	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012

Remarks: N/A
Requirement: Required

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

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

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

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

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

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

Data Element: Provider City
Definition: Provider's city name
Validation: N/A

Remarks: This is the city of the provider number
Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

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

Data Element: Provider Zip Code
Definition: Provider's zip code
Validation: Must be a valid postal zip code
Remarks: This is the zip code associated with the address furnished for the provider number identified in this record.
- Provide 9-digit zip code if available, otherwise provide 5-digit zip code

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

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

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

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

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

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

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

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

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

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

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

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

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
Remarks: N/A
Requirement: Required

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

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

Exhibit 36.2 – CERT Formats for A/B MACs (B) and DME MACs and Shared Systems

(Rev.:, Issued:, Effective: , Implementation:)

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor

Validation: Must be ‘B’ or ‘D’
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Universe Date
Definition: Date the universe of claims entered the shared system
Validation: Must be a valid date not equal to a universe date sent on any previous claims universe file
Remarks: Format is CCYYMMDD.

- Shared System logic may use shared system batch processing date as long as the date is not equal to the universe date sent on any previous claims universe file.

Requirement: Required

Claims Universe File				
Claims Universe Claim Detail Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(15)	9	23	Spaces
Beneficiary HICN	X(12)	24	35	Spaces
Billing Provider Number	X(15)	36	50	Spaces
Billing Provider NPI	X(10)	51	60	Spaces
Claim Submitted Charge Amount	S9(7)v99	61	69	Zeroes
Claim Demonstration Number	X(2)	70	71	Spaces
Claim State	X(2)	72	73	Spaces
Beneficiary State	X(2)	74	75	Spaces
Billing Provider Specialty	X(2)	76	77	Spaces
Line Item Count	9(2)	78	79	Zeroes
Line Item group: The following group of Fields occurs from 1 to 52 Times (depending on Line Item Count).				
From and Thru values relate to the 1st line item				
Performing Provider Number	X(15)	80	94	Spaces
Performing Provider Specialty	X(2)	95	96	Spaces
HCPCS Procedure Code	X(5)	97	101	Spaces
From Date of Service	X(8)	102	109	Spaces
To Date of Service	X(8)	110	117	Spaces
Line Submitted Charge	S9(7)v99	118	126	Zeroes
Performing Provider NPI	X(10)	127	136	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Claim Control Number
Definition: Number assigned by the shared system to uniquely identify the claim
Validation: The required format for the Claim Control Number is different for each claim type
DME: must be 15 digits with a leading 1 as filler
Part B: must be 15 digits, with two leading zeros as filler.
Remarks: N/A
Requirement: Required

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

Data Element: Billing Provider Number
Definition: Number assigned by the National Supplier Clearinghouse (NSC) or MAC to identify the billing/pricing provider or supplier
Validation: NA
Remarks: Must be present. Use the same requirements as for Item 33 in HCFA 1500.

- Enter the PIN, for the performing provider of service/supplier who is **not** a member of a group practice.
- Enter the group PIN, for the performing provider of service/supplier who is a member of a group practice.
- Suppliers billing the DME MAC will use the National Supplier Clearinghouse (NSC) number in this item.

- If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the performing provider on the first line of the claim.

Requirement: Required

Data Element: Billing Provider NPI
Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required.

Data Element: Claim Submitted Charge Amount
Definition: The total submitted charges on the claim (the sum of line item submitted charges).
Validation: N/A
Remarks: N/A
Requirement: Required

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

Data Element: Claim State
Definition: State abbreviation identifying the state in which the service is furnished
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)
Remarks: When services on a single claim are furnished in multiple states, enter the state identifier for the first detail line.
Requirement: Required for <u>all</u> Part B Claims. For DME claims, required if available.

Data Element: Beneficiary State
Definition: State abbreviation identifying the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)
Remarks: N/A
Requirement: Required, when available

Data Element: Billing Provider Specialty
Definition: Code indicating the primary specialty of the Billing provider or supplier
Validation: N/A
Remarks: N/A
Requirement: Required

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

Requirement: Required

Claim Line Item Fields

Data Element: Performing Provider Number
Definition: Number assigned by the NSC or MAC to identify the provider who performed the service or the supplier who supplied the medical equipment
Validation: N/A
Remarks: Enter the PIN of the performing provider. When several different providers of service or suppliers are billing on the same claim, show the individual PIN in the corresponding line item.
Requirement: Required

Data Element: Performing Provider Specialty
Definition: Code indicating the primary specialty of the performing provider or supplier
Validation: N/A
Remarks: N/A
Requirement: Required

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

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

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

Data Element: Line Submitted Charge
Definition: Actual charge submitted by the provider or supplier for the service or equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Performing Provider NPI
Definition: NPI assigned to the Performing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required.

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

Sampled Claims Transaction File				
Sampled Claims Transaction File Detail Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(15)	9	23	Spaces
Beneficiary HICN	X(12)	24	35	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Claim Control Number
Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: Reflects the Claim Control Number selected from the Claim Universe file in the sampling process.
Requirement: Required

Data Element: Beneficiary HICN

Definition:	Beneficiary's Health Insurance Claim Number
Validation:	N/A
Remarks:	Reflects the Beneficiary HICN on the claim record selected from the Claim Universe file in the sampling process.

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

DATA ELEMENT DETAIL

Data Element:Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 7/1/2016
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

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

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Claim Diagnosis Code 7	X(7)	314	320	Spaces
Claim Diagnosis Code 7Version Indicator Code	X(1)	321	321	Spaces
Claim Diagnosis Code 8	X(7)	322	328	Spaces
Claim Diagnosis Code 8Version Indicator Code	X(1)	329	329	Spaces
Claim Diagnosis Code 9	X(7)	330	336	Spaces
Claim Diagnosis Code 9Version Indicator Code	X(1)	337	337	Spaces
Claim Diagnosis Code 10	X(7)	338	344	Spaces
Claim Diagnosis Code 10Version Indicator Code	X(1)	345	345	Spaces
Claim Diagnosis Code 11	X(7)	346	352	Spaces
Claim Diagnosis Code 11Version Indicator Code	X(1)	353	353	Spaces
Claim Diagnosis Code 12	X(7)	354	360	Spaces
Claim Diagnosis Code 12Version Indicator Code	X(1)	361	361	Spaces
Claim Zip Code	X(9)	362	370	Spaces
Claim Pricing State	X(2)	371	372	Spaces
Beneficiary Zip Code	X(9)	373	381	Spaces
Beneficiary State	X(2)	382	383	Spaces
Claim Demonstration Number	X(2)	384	385	Spaces
RAC Adjustment Indicator	X(1)	386	386	Spaces
Split/Adjustment Indicator	X(2)	387	388	Spaces
Facility NPI	X(10)	389	398	Spaces
Claim PWK	X(60)	399	458	Spaces
Claim Demonstration Identification Number2	***X(2)***	***459***	***460***	***Spaces***
Claim Demonstration Identification Number3	***X(2)***	***461***	***462***	***Spaces***
Claim Demonstration Identification Number4	***X(2)***	***463***	***464***	***Spaces***
Line Item Count	9(2)	***465***	***466***	Zeroes
Filler	***X(44)***	***467***	***510***	Spaces
Line Item group: The following group of fields occurs from 1 to 13 times (Depending on Line Item Count).				

From and Thru values relate to the 1st line item

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Performing Provider Number	X(15)	511	525	Spaces
Performing Provider Specialty	X(2)	526	527	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
HCPCS Procedure Code	X(5)	528	532	Spaces
HCPCS Modifier 1	X(2)	533	534	Spaces
HCPCS Modifier 2	X(2)	535	536	Spaces
HCPCS Modifier 3	X(2)	537	538	Spaces
HCPCS Modifier 4	X(2)	539	540	Spaces
Number of Services	S9(7)v999	541	550	Zeroes
Service From Date	X(8)	551	558	Spaces
Service To Date	X(8)	559	566	Spaces
Place of Service	X(2)	567	568	Spaces
Type of Service	X(1)	569	569	Spaces
Diagnosis Code	X(7)	570	576	Spaces
Line Diagnosis Code Version Indicator Code	X(1)	577	577	Spaces
CMN Control Number	X(15)	578	592	Spaces
Line Submitted Charge	S9(7)v99	593	601	Zeroes
Line Medicare Initial Allowed Charge	S9(7)v99	602	610	Zeroes
ANSI Reason Code 1	X(8)	611	618	Spaces
ANSI Reason Code 2	X(8)	619	626	Spaces
ANSI Reason Code 3	X(8)	627	634	Spaces
ANSI Reason Code 4	X(8)	635	642	Spaces
ANSI Reason Code 5	X(8)	643	650	Spaces
ANSI Reason Code 6	X(8)	651	658	Spaces
ANSI Reason Code 7	X(8)	659	666	Spaces
Manual Medical Review Indicator	X(1)	667	667	Space
Resolution Code	X(5)	668	672	Spaces
Line Final Allowed Charge	S9(7)v99	673	681	Zeroes
Performing Provider NPI	X(10)	682	691	Spaces
Performing Provider UPIN	X(6)	692	697	Spaces
Miles/Time/Units/Services Indicator Code	X(1)	698	698	Spaces
Line Deductible Applied	S9(7)v99	699	707	Zeroes
Line Co-Insurance	S9(7)V99	708	716	Zeroes
Line Paid Amount	S9(7)v99	717	725	Zeroes
Line MSP Code	X(1)	726	726	Spaces
Line MSP Paid Amount	S9(7)v99	727	735	Zeroes
Line Pricing Locality	X(2)	736	737	Spaces
Line Zip Code	X(9)	738	746	Spaces
Line Pricing State Code	X(2)	747	748	Spaces
Ambulance Point of Pick up Zip Code	X(9)	749	757	Spaces
Ambulance Point of Drop Off Zip Code	X(9)	758	766	Spaces
Line PWK	X(60)	767	826	Spaces
Prior Authorization Program Indicator	***X(4)***	***827***	***830***	***Spaces***

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Unique Tracking Number (UTN)	***X(14)***	***831***	***844***	***Spaces***
Prior Authorization Affirmed Indicator	***X(1)***	***845***	***845***	***Spaces***
Filler	***X(6)***	***846***	***851***	***Spaces***

DATA ELEMENT DETAIL

Claim (Header) Fields

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 7/1/2016
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

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

Data Element: Original Claim Control Number

Definition: The Claim Control Number the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the MAC or shared system changed the claim control number during processing, enter the number the shared system used to look up the number needed to pull all records associated with the sample claim.

Validation: Must match the Claim Control Number identified in the Sampled Claims Transaction File.

Remarks: N/A

Requirement: Required

Data Element: Claim Control Number

Definition: Number assigned by the shared system to uniquely identify the claim

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Beneficiary Last Name

Definition: Last Name (Surname) of the beneficiary

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Beneficiary First Name

Definition: First (Given) Name of the beneficiary

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Beneficiary Middle Initial

Definition: First letter from Beneficiary Middle Name

Validation: N/A

Remarks: N/A

Requirement: Required when available

Data Element: Beneficiary Date of Birth

Definition: Date on which beneficiary was born.

Validation: Must be a valid date

Remarks: MMDDCCYY on which the beneficiary was born

Requirement: Required

Data Element: Billing Provider Number

Definition: Number assigned by the National Supplier Clearinghouse (NSC) or MAC to identify the billing/pricing provider or supplier.

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

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

Remarks: N/A

Requirement: **Required**

Data Element: Referring/Ordering UPIN

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

Validation: N/A

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

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

Requirement: Required when available on the claim record.

Data Element: Claim Allowed Amount

Definition: Final Allowed Amount for this claim.

Validation: N/A

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

Requirement: Required.

Data Element: Claim ANSI Reason Code 1-3

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

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

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

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

Data Element: Claim Entry Date

Definition: Date claim entered the shared claim processing system

Validation: Must be a valid date

Remarks: Format must be CCYYMMDD

Requirement: Required

Data Element: Claim Adjudicated Date

Definition: Date claim completed adjudication

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

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

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

Data Element: Billing Provider NPI
Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required

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

Requirement: Required when available on the claim record.

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

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

Data Element: Claim Diagnosis Code 1-12
Definition: The ICD-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided
Validation: Must be a valid ICD-CM diagnosis code
- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.

- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable

Remarks:

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

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

Data Element: Claim Diagnosis Version Indicator Code 1-12

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

Validation:

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

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

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

Data Element: Claim Zip Code

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

Validation: Must be a valid Zip Code

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

Remarks: For DME MAC Claims use the zip code for beneficiary residence.
For Part B Claims, use the zip code identified in item 32 of the HCFA 1500, except in the listed situations.

- For ambulance services, identify the zip code where the patient was picked up.

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

Requirement: Required.

Data Element: Claim Pricing State
Definition: State where services were furnished.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)
Remarks: Furnish the state associated with the Claim Zip Code.
Requirement: Required.

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

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

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

Data Element: Beneficiary State
Definition: State abbreviation identifying the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)
Remarks: N/A
Requirement: Required

Data Element: Claim Demonstration Number
Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID
Remarks: ***Must be populated with the value from the first populated demonstration number on the claim.***
Requirement: ***Required on every claim processed under a CMS demonstration project.***

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

Data Element: Split/Adjustment Indicator
Definition: Count of number of splits/replicates/adjustments (with different claim control numbers (ICN/CCN)) of the sampled claim that are included in the

resolution file.

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

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

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

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

Data Element: Facility NPI

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

Data Element: PWK

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

Data Element: Claim Demonstration Number 2

Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID
Remarks: ***Must be populated with the value from the second populated demonstration number on the claim.***
Requirement: ***Required when present on claim.***

Data Element: Claim Demonstration Number 3

Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID
Remarks: ***Must be populated with the value from the third populated demonstration number on the claim.***
Requirement: ***Required when present on claim.***

Data Element: Claim Demonstration Number 4

Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID
Remarks: ***Must be populated with the value from the fourth populated demonstration number on the claim.***
Requirement: ***Required when present on claim***

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

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

Claim Line Item Fields

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

Data Element: Performing Provider Specialty
Definition: Code indicating the primary specialty of the performing provider or supplier
Validation: Must be a valid Provider Specialty per IOM 10.4 ch26 10.8
Remarks: N/A
Requirement: Required

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

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

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

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

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

Data Element: Place of Service
Definition: Code that identifies where the service was performed

Validation: N/A
Remarks: Must be a value in the range of 00-99
Requirement: Required

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

Data Element: Diagnosis Code
Definition: Code identifying a diagnosed medical condition resulting in the line item service
Validation: Must be a valid ICD-CM diagnosis code

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable

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

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

Requirement: Required

Data Element: Line Diagnosis Code Version Indicator Code
Definition: The ICD--CM diagnosis version code identifying the version of diagnosis code submitted.
Validation:

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

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures.
Requirement: Diagnosis Version Code is required for ALL lines, except those billed by ambulance and independent clinical laboratory suppliers.

Data Element: CMN Control Number
Definition: Number assigned by the shared system to uniquely identify a Certificate of Medical Necessity
Validation: N/A

Remarks: Enter a zero if no number is assigned
Requirement: Required on DME claims

Data Element: Line Submitted Charge
Definition: Actual charge submitted by the provider or supplier for the service or equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Line Medicare Initial Allowed Charge
Definition: Amount Medicare allowed for the service or equipment before any reduction or denial
Validation: N/A
Remarks: This charge is the lower of the fee schedule or billed amount (i.e., Submitted Charge), except for those services (e.g., ASC) that are always paid at the fee schedule amount even if it is higher than the Submitted Charge. If there is no fee schedule amount, then insert the Submitted Charge.

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

Requirement: Required

Data Element: ANSI Reason Code 1-7
Definition: Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed
Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes
Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code
Requirement: ANSI Reason Code 1 must be present on all claims with resolutions of 'DENMR', 'DENMC' ,'DEO', 'RTP', 'REDMR', 'REDMC', or 'REO','APPAM','DENAM','REDAM'.

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

Data Element: Resolution Code

Definition: Code indicating how the MAC resolved the line.

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

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the MAC's internal documentation, such as claims history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

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

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

Remarks:

Resolution Code	Description
APP	Approved as a valid submission without manual medical review.
APPAM	Approved after automated medical review
APPMR	Approved after manual medical review routine
APPMC	Approved after manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.
DENAM	Denied after automated medical review
DENMR	Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMC	Denied for medical review reasons or for insufficient documentation medical necessity, manual medical review complex. If this codes is selected, set the Manual Medial

Resolution Code	Description
	Review Indicator to 'Y.'
DEO	Denied for non-medical reasons, other than denied as unprocessable.
RTP	Denied as unprocessable (return/reject)
REDAM	Reduced after medical review
REDMR	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
REDMC	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
REO	Reduced for non-medical review reasons.
DELET	Claim deleted from processing system—AC maintains record of claim on system
TRANS	Claim was originally submitted to the wrong contractor and has been transferred to the contractor with jurisdiction.

Requirement: Required

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

Data Element: Performing Provider NPI
Definition: NPI assigned to the Performing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required for providers that use HIPPA standard transactions.

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

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

5- Units of Blood
Remarks: N/A
Requirement: Required

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

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

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

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

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

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

Requirement: Required.

Data Element: Line Zip Code

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

Data Element: Line Pricing State
Definition: State where services were furnished.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)
Remarks: Furnish the state associated with the Line Zip Code.
Requirement: Required.

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

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

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

Data Element: Prior Authorization Program Indicator
Definition: Prior Authorization Program Indicator issued by CMS to identify to which PA program the service belongs
Validation:
- ***Four character alphanumeric***
- ***The first character identifies the line of business***
  - ***A for Part A,***
  - ***B for Part B,***
  - ***D for DME,***
  - ***H for Home Health and Hospice***
- ***Followed by a three digit number.***

Remarks: ***N/A***
Requirement: ***Required for claims containing services subject to a prior authorization program.***

Data Element: ***Unique Tracking Number (UTN)***
Definition: ***Unique Tracking Number (UTN) assigned to the prior authorization request for the service or item.***
Validation: ***For Prior Authorization Claims/services the UTN shall be 14 characters and use the following format:***

- ***First two characters = MAC identifier (e.g. RR for Railroad, 0F for Jurisdiction F, 05 for Jurisdiction 5, etc.)***
- ***Third character = line of business (e.g. A for Part A, B for Part B, D for DME, H for Home Health and Hospice)***
- ***Remaining numerical characters = a unique sequence number assigned by the Shared System***

For claims/services in the PMD Prior Authorization Project, the UTN shall be 14 characters and use the following format:

- ***First character = DME MAC identifier (e.g. A for Jurisdiction A, B for Jurisdiction B, etc.)***
- ***Second and third characters = 00 (zero and zero)***
- ***Remaining characters = a unique sequence number assigned by the Shared System***

Remarks: ***N/A***
Requirement: ***Required for claims containing services covered by an affirmed prior authorization.***

Data Element: ***Prior Auth Affirmed***
Definition: ***Code to identify if the prior authorization for the service(s) on this line was affirmed***
Validation:

- ***Y indicates the prior authorization was affirmed***
- ***N indicates the prior authorization was not affirmed***
- ***Default value is blank for services that are not part of prior authorization demonstration.***

Remarks: ***N/A***
Requirement: ***Required for claims containing services subject to prior authorization in the state where the service was furnished.***

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

Claims Resolution File				
Claims Resolution Trailer Record (one record per file)				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	1617	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 7/1/2016
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor’s CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be ‘B’ or ‘D’
Remarks: B = A/B MAC (B)
D = DME MAC

Requirement: Required

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

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

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

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

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

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

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

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

Data Element: Provider Phone Number Extension
Definition: Provider's telephone number Extension

Validation: Must be a valid telephone number
Remarks: This is the phone number
Requirement: None

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

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

Data Element: Address Order
Definition: The order in which the records of provider addresses for the provider are entered into the provider address file detailed record. This field in combination with the Contractor ID, Provider number, and Provider Type will make each record in the file unique.
Validation: Must be a valid number between 01 and 99
Remarks: This field indicated the order in which records containing the addresses for a provider are entered into the detail file. For instance, if there are three addresses for a provider, the record for the first address for that provider with contain an '01' in this field; and the record for the second address for that provider will contain a '02' in this field.
Requirement: Required

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

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

Requirement: Required

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

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

Data Element: Provider Taxonomy Code
Definition: The non-medical data code set used to classify health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute Accredited Standards Committee health care transaction.
Validation: Must be present
Remarks: If multiple taxonomy codes are available, furnish the first one listed.
Requirement: Required if available

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

Data Element: Provider License State
Definition: Identify the state that issued the providers professional business license
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)
Remarks: N/A
Requirement: Required if available

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

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

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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