CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 224	Date: OCTOBER 16, 2007
	Change Request 5043

Transmittal 201, dated May 11, 2007 is rescinded and replaced with Transmittal 224. The only change is in the manual text, the diagnosis codes were 6 characters and they were changed and corrected to 5 characters. All other information remains the same.

SUBJECT: Revise the Fiscal Intermediary Shared System (FISS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier

I. SUMMARY OF CHANGES: CMS will require all Medicare providers to have a NPI by May 23, 2007. For Medicare billing purposes, that number will replace all current identifiers at that time. The same number will be used by any provider that bills any third party for reimbursement of health care.

The CMS requires that the CERT PSCs implement the NPI in all applicable databases they maintain for use in the CERT effort. The CERT PSCs shall assume this work will take place over Fiscal Years 2006 and 2007.

NEW / REVISED MATERIAL
EFFECTIVE DATE: DECEMBER 3, 2007
IMPLEMENTATION DATE: DECEMBER 3, 2007

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Exhibits/Exhibit 36.1/CERT File Descriptions For Part A Contractors and Standard Systems

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 224	Date: October 16, 2007	Change Request: 5043

Transmittal 201, dated May 11, 2007 is rescinded and replaced with Transmittal 224. The only change is in the manual text, the diagnosis codes were 6 characters and they were changed and corrected to 5 characters. All other information remains the same.

SUBJECT: Revise the Fiscal Intermediary Shared System (FISS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier

Effective Date: December 3, 2007
Implementation Date: December 3, 2007

I. GENERAL INFORMATION

A. Background: The Medicare Program Integrity Manual, Chapter 12 – Carrier, DMERC, FI and full Program Safeguard Contractor (PSC) Interaction with the Comprehensive Error Rate Testing Contractor, Section 12.3.3.1 - Providing Sample Information to the CERT Contractor requires:

"Requests for claim information will be transmitted in the format specified in the sampled claims transaction file section of Exhibits 36.1 (carriers and DMERCs) and 36.2 (FIs and RHHIs). The Associated Contractors (AC's) response must be made using NDM and the formats provided for the sampled claims resolution file in Exhibit 36.1 (carriers and DMERCs) and 36.2 (FIs and RHHIs). Full PSCs are not responsible for this task.

"The ACs/full PSCs must coordinate with the CERT contractor to provide the requested information for claims identified in the sample in an electronic format. The sampling module will reside on a server in the CMS Data Center (CMSDC). The ACs/full PSCs will use the sampling module at the CMSDC.

"The ACs/full PSCs must submit a file daily to the CERT contractor (via CONNECT: Direct) containing information on claims entered during the day. Estimated claim volume is 2000 claims/cluster/year.

"The ACs/full PSCs must respond to the CERT contractor within 5 working days of receipt of the request from the CERT contractor. If the AC/full PSC receives a request for a claim that is no longer in the system or a claim that needed to be replaced, the AC/full PSC must provide a legitimate reason and send appropriate documents to the CERT contractor. In the case that a claim is requested for a patient that does not exist, the AC/full PSC should contact the provider."

The CMS will require all Medicare providers to have a National Provider Identifier (NPI) by May 23, 2007. For Medicare billing purposes, that number will replace all current identifiers at that time. The same number will be used by any provider that bills any third party for reimbursement of health care.

The CMS requires that the CERT PSCs implement the NPI in all applicable databases they maintain for use in the CERT effort. The CERT PSCs shall assume this work will take place over Fiscal Years 2006 and 2007.

B. Policy: The PIM, Chapter 12 – Carrier, DMERC, FI, and full PSC Interaction with the Comprehensive Error Rate Testing Contractor, Section 12.3.3.1 – requires that an AC/full PSC provide all information on claims in the CERT sample at the line level.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5043.1	The FISS maintainer shall modify the FISS system module to provide data in the format specified in the Medicare Program Integrity Manual Exhibit 36.1.							X				
5043.1.1	The FISS maintainer shall insure that the following changes already identified in Exhibit 36.1 are made as well as the other changes included in Exhibit 36.1							X				
5043.1.1.1	When an original claim has been subsequently adjusted and the adjustment claim(s) is/are included in the sampled claims resolution file, populate the original claim control number field in the sample claims resolution file with the original claim's DCN for all the adjustment claim(s).							X				
5043.1.1.2	Systematically assign a resolution code of 'INACT' for all claims with a status of 'I' in the sampled claims resolution file.							X				
5043.2	Contractor data centers shall implement, operate, and maintain the shared system changes specified in requirement 5043.1 and provided by shared system maintainers.	X		X			X	X				
5043.3	Contractors shall insure that their data centers have correctly implemented and are providing CERT files in the format required by this change request.	X		X			X					

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

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

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

V. CONTACTS

Pre-Implementation Contact(s): John Stewart (410) 786-1189 john.stewart@cms.hhs.gov
Post-Implementation Contact(s): John Stewart (410) 786-1189 john.stewart@cms.hhs.gov

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

Exhibit 36.1 - CERT File Descriptions For Part A Contractors and Standard Systems

(Rev. 224; Issued: 10-16-07; Effective/Implementation: 13-03-07)

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

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 = FI only
R = RHHI only or both FI and RHHI
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

Claims Universe File				
Claims Universe Claim Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Beneficiary State	X(2)	147	148	Spaces
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

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 UB-92 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 UB-92 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)
http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states 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)
http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states 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

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 = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

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

Claims 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

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 = FI only
R = RHHI only or both FI and RHHI
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

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

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 = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

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

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

DATA ELEMENT DETAIL

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

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

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

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

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

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	“2”
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Record Number	9(1)	9	9	Zero
Mode of Entry Indicator	X(1)	10	10	Space
Original Claim Control Number	X(23)	11	33	Spaces
Internal Control Number	X(23)	34	56	Spaces
Beneficiary HICN	X(12)	57	68	Spaces
Beneficiary Last Name	X(20)	69	88	Spaces
Beneficiary First Name	X(10)	89	98	Spaces
Beneficiary Middle Initial	X(1)	99	99	Spaces
Beneficiary Date of Birth	X(8)	100	107	Spaces
Beneficiary Gender	X(1)	108	108	Spaces
Billing Provider Number	X(9)	109	117	Spaces
Attending Physician UPIN	X(6)	118	123	Spaces
Claim Paid Amount	9(8)V99	124	133	Zeroes
Claim ANSI Reason Code 1	X(8)	134	141	Spaces
Claim ANSI Reason Code 2	X(8)	142	149	Spaces
Claim ANSI Reason Code 3	X(8)	150	157	Spaces
Claim ANSI Reason Code 4	X(8)	158	165	Spaces
Claim ANSI Reason Code 5	X(8)	166	173	Spaces
Claim ANSI Reason Code 6	X(8)	174	181	Spaces
Claim ANSI Reason Code 7	X(8)	182	189	Spaces
Statement covers From Date	X(8)	190	197	Spaces
Statement covers Thru Date	X(8)	198	205	Spaces
Claim Entry Date	X(8)	206	213	Spaces
Claim Adjudicated Date	X(8)	214	221	Spaces
Condition Code 1	X(2)	222	223	Spaces
Condition Code 2	X(2)	224	225	Spaces
Condition Code 3	X(2)	226	227	Spaces
Condition Code 4	X(2)	228	229	Spaces
Condition Code 5	X(2)	230	231	Spaces
Condition Code 6	X(2)	232	233	Spaces
Condition Code 7	X(2)	234	235	Spaces
Condition Code 8	X(2)	236	237	Spaces
Condition Code 9	X(2)	238	239	Spaces
Condition Code 10	X(2)	240	241	Spaces
Condition Code 11	X(2)	242	243	Spaces
Condition Code 12	X(2)	244	245	Spaces
Condition Code 13	X(2)	246	247	Spaces
Condition Code 14	X(2)	248	249	Spaces
Condition Code 15	X(2)	250	251	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Condition Code 16	X(2)	252	253	Spaces
Condition Code 17	X(2)	254	255	Spaces
Condition Code 18	X(2)	256	257	Spaces
Condition Code 19	X(2)	258	259	Spaces
Condition Code 20	X(2)	260	261	Spaces
Condition Code 21	X(2)	262	263	Spaces
Condition Code 22	X(2)	264	265	Spaces
Condition Code 23	X(2)	266	267	Spaces
Condition Code 24	X(2)	268	269	Spaces
Condition Code 25	X(2)	270	271	Spaces
Condition Code 26	X(2)	272	273	Spaces
Condition Code 27	X(2)	274	275	Spaces
Condition Code 28	X(2)	276	277	Spaces
Condition Code 29	X(2)	278	279	Spaces
Condition Code 30	X(2)	280	281	Spaces
Type of Bill	X(3)	282	284	Spaces
Principal Diagnosis Code	X(5)	285	289	Spaces
Other Diagnosis Code 1	X(5)	290	294	Spaces
Other Diagnosis Code 2	X(5)	295	299	Spaces
Other Diagnosis Code 3	X(5)	300	304	Spaces
Other Diagnosis Code 4	X(5)	305	309	Spaces
Other Diagnosis Code 5	X(5)	310	314	Spaces
Other Diagnosis Code 6	X(5)	315	319	Spaces
Other Diagnosis Code 7	X(5)	320	324	Spaces
Other Diagnosis Code 8	X(5)	325	329	Spaces
Principal Procedure	X(4)	330	333	Spaces
Principal Procedure Date	X(6)	334	339	Spaces
Other Procedure 1	X(4)	340	343	Spaces
Other Procedure 1 Date	X(6)	344	349	Spaces
Other Procedure 2	X(4)	350	353	Spaces
Other Procedure 2 Date	X(6)	354	359	Spaces
Other Procedure 3	X(4)	360	363	Spaces
Other Procedure 3 Date	X(6)	364	369	Spaces
Other Procedure 4	X(4)	370	373	Spaces
Other Procedure 4 Date	X(6)	374	379	Spaces
Other Procedure 5	X(4)	380	383	Spaces
Other Procedure 5 Date	X(6)	384	389	Spaces
Claim Demonstration Identification Number	9(2)	390	391	Zeroes
PPS Indicator	X(1)	392	392	Spaces
Action Code	X(1)	393	393	Spaces
Patient Status	X(2)	394	395	Spaces
Billing Provider NPI	X(10)	396	405	Spaces
Claim Provider Taxonomy Code	X(25)	406	430	Spaces
Medical Record Number	X(17)	431	447	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Patient Control Number	X(20)	448	467	Spaces
Attending Physician NPI	X(10)	468	477	Spaces
Attending Physician Last Name	X(16)	478	493	Spaces
Attending Physician First Name	X(8)	494	501	Spaces
Attending Physician Middle Initial	X(1)	502	502	Spaces
Operating Physician UPIN	X(6)	503	508	Spaces
Operating Physician NPI	X(10)	509	518	Spaces
Operating Physician Last Name	X(16)	519	534	Spaces
Operating Physician First Name	X(8)	535	542	Spaces
Operating Physician Middle Initial	X(1)	543	543	Spaces
Other Physician UPIN	X(6)	544	549	Spaces
Other Physician NPI	X(10)	550	559	Spaces
Other Physician Last Name	X(16)	560	575	Spaces
Other Physician First Name	X(8)	576	583	Spaces
Other Physician Middle Initial	X(1)	584	584	Spaces
Date of Admission	X(8)	585	592	Spaces
Type of Admission	X(1)	593	593	Spaces
Source of Admission	X(1)	594	594	Spaces
DRG	X(3)	595	597	Spaces
Occurrence Code 1	X(2)	598	599	Spaces
Occurrence Code 1 Date	X(8)	600	607	Spaces
Occurrence Code 2	X(2)	608	609	Spaces
Occurrence Code 2 Date	X(8)	610	617	Spaces
Occurrence Code 3	X(2)	618	619	Spaces
Occurrence Code 3 Date	X(8)	620	627	Spaces
Occurrence Code 4	X(2)	628	629	Spaces
Occurrence Code 4 Date	X(8)	630	637	Spaces
Occurrence Code 5	X(2)	638	639	Spaces
Occurrence Code 5 Date	X(8)	640	647	Spaces
Occurrence Code 6	X(2)	648	649	Spaces
Occurrence Code 6 Date	X(8)	650	657	Spaces
Occurrence Code 7	X(2)	658	659	Spaces
Occurrence Code 7 Date	X(8)	660	667	Spaces
Occurrence Code 8	X(2)	668	669	Spaces
Occurrence Code 8 Date	X(8)	670	677	Spaces
Occurrence Code 9	X(2)	678	679	Spaces
Occurrence Code 9 Date	X(8)	680	687	Spaces
Occurrence Code 10	X(2)	688	689	Spaces
Occurrence Code 10 Date	X(8)	690	697	Spaces
Occurrence Code 11	X(2)	698	699	Spaces
Occurrence Code 11 Date	X(8)	700	707	Spaces
Occurrence Code 12	X(2)	708	709	Spaces
Occurrence Code 12 Date	X(8)	710	717	Spaces
Occurrence Code 13	X(2)	718	719	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Occurrence Code 13 Date	X(8)	720	727	Spaces
Occurrence Code 14	X(2)	728	729	Spaces
Occurrence Code 14 Date	X(8)	730	737	Spaces
Occurrence Code 15	X(2)	738	739	Spaces
Occurrence Code 15 Date	X(8)	740	747	Spaces
Occurrence Code 16	X(2)	748	749	Spaces
Occurrence Code 16 Date	X(8)	750	757	Spaces
Occurrence Code 17	X(2)	758	759	Spaces
Occurrence Code 17 Date	X(8)	760	767	Spaces
Occurrence Code 18	X(2)	768	769	Spaces
Occurrence Code 18 Date	X(8)	770	777	Spaces
Occurrence Code 19	X(2)	778	779	Spaces
Occurrence Code 19 Date	X(8)	780	787	Spaces
Occurrence Code 20	X(2)	788	789	Spaces
Occurrence Code 20 Date	X(8)	790	797	Spaces
Occurrence Code 21	X(2)	798	799	Spaces
Occurrence Code 21 Date	X(8)	800	807	Spaces
Occurrence Code 22	X(2)	808	809	Spaces
Occurrence Code 22 Date	X(8)	810	817	Spaces
Occurrence Code 23	X(2)	818	819	Spaces
Occurrence Code 23 Date	X(8)	820	827	Spaces
Occurrence Code 24	X(2)	828	829	Spaces
Occurrence Code 24 Date	X(8)	830	837	Spaces
Occurrence Code 25	X(2)	838	839	Spaces
Occurrence Code 25 Date	X(8)	840	847	Spaces
Occurrence Code 26	X(2)	848	849	Spaces
Occurrence Code 26 Date	X(8)	850	857	Spaces
Occurrence Code 27	X(2)	858	859	Spaces
Occurrence Code 27 Date	X(8)	860	867	Spaces
Occurrence Code 28	X(2)	868	869	Spaces
Occurrence Code 28 Date	X(8)	870	877	Spaces
Occurrence Code 29	X(2)	878	879	Spaces
Occurrence Code 29 Date	X(8)	880	887	Spaces
Occurrence Code 30	X(2)	888	889	Spaces
Occurrence Code 30 Date	X(8)	890	897	Spaces
Value Code 1	X(2)	898	899	Spaces
Value Amount 1	9(8)V99	900	909	Zeroes
Value Code 2	X(2)	910	911	Spaces
Value Amount 2	9(8)V99	912	921	Zeroes
Value Code 3	X(2)	922	923	Spaces
Value Amount 3	9(8)V99	924	933	Zeroes
Value Code 4	X(2)	934	935	Spaces
Value Amount 4	9(8)V99	936	945	Zeroes
Value Code 5	X(2)	946	947	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Value Amount 5	9(8)V99	948	957	Zeroes
Value Code 6	X(2)	958	959	Spaces
Value Amount 6	9(8)V99	960	969	Zeroes
Value Code 7	X(2)	970	971	Spaces
Value Amount 7	9(8)V99	972	981	Zeroes
Value Code 8	X(2)	982	983	Spaces
Value Amount 8	9(8)V99	984	993	Zeroes
Value Code 9	X(2)	994	995	Spaces
Value Amount 9	9(8)V99	996	1005	Zeroes
Value Code 10	X(2)	1006	1007	Spaces
Value Amount 10	9(8)V99	1008	1017	Zeroes
Value Code 11	X(2)	1018	1019	Spaces
Value Amount 11	9(8)V99	1020	1029	Zeroes
Value Code 12	X(2)	1030	1031	Spaces
Value Amount 12	9(8)V99	1032	1041	Zeroes
Value Code 13	X(2)	1042	1043	Spaces
Value Amount 13	9(8)V99	1044	1053	Zeroes
Value Code 14	X(2)	1054	1055	Spaces
Value Amount 14	9(8)V99	1056	1065	Zeroes
Value Code 15	X(2)	1066	1067	Spaces
Value Amount 15	9(8)V99	1068	1077	Zeroes
Value Code 16	X(2)	1078	1079	Spaces
Value Amount 16	9(8)V99	1080	1089	Zeroes
Value Code 17	X(2)	1090	1091	Spaces
Value Amount 17	9(8)V99	1092	1101	Zeroes
Value Code 18	X(2)	1102	1103	Spaces
Value Amount 18	9(8)V99	1104	1113	Zeroes
Value Code 19	X(2)	1114	1115	Spaces
Value Amount 19	9(8)V99	1116	1125	Zeroes
Value Code 20	X(2)	1126	1127	Spaces
Value Amount 20	9(8)V99	1128	1137	Zeroes
Value Code 21	X(2)	1138	1139	Spaces
Value Amount 21	9(8)V99	1140	1149	Zeroes
Value Code 22	X(2)	1150	1151	Spaces
Value Amount 22	9(8)V99	1152	1161	Zeroes
Value Code 23	X(2)	1162	1163	Spaces
Value Amount 23	9(8)V99	1164	1173	Zeroes
Value Code 24	X(2)	1174	1175	Spaces
Value Amount 24	9(8)V99	1176	1185	Zeroes
Value Code 25	X(2)	1186	1187	Spaces
Value Amount 25	9(8)V99	1188	1197	Zeroes
Value Code 26	X(2)	1198	1199	Spaces
Value Amount 26	9(8)V99	1200	1209	Zeroes
Value Code 27	X(2)	1210	1211	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Value Amount 27	9(8)V99	1212	1221	Zeroes
Value Code 28	X(2)	1222	1223	Spaces
Value Amount 28	9(8)V99	1224	1233	Zeroes
Value Code 29	X(2)	1234	1235	Spaces
Value Amount 29	9(8)V99	1236	1245	Zeroes
Value Code 30	X(2)	1246	1247	Spaces
Value Amount 30	9(8)V99	1248	1257	Zeroes
Value Code 31	X(2)	1258	1259	Spaces
Value Amount 31	9(8)V99	1260	1269	Zeroes
Value Code 32	X(2)	1270	1271	Spaces
Value Amount 32	9(8)V99	1272	1281	Zeroes
Value Code 33	X(2)	1282	1283	Spaces
Value Amount 33	9(8)V99	1284	1293	Zeroes
Value Code 34	X(2)	1294	1295	Spaces
Value Amount 34	9(8)V99	1296	1305	Zeroes
Value Code 35	X(2)	1306	1307	Spaces
Value Amount 35	9(8)V99	1308	1317	Zeroes
Value Code 36	X(2)	1318	1319	Spaces
Value Amount 36	9(8)V99	1320	1329	Zeroes
Claim Final Allowed Amount	9(8)V99	1330	1339	Zeroes
Claim Deductible Amount	9(8)V99	1340	1349	Zeroes
Claim State	X(2)	1350	1351	Spaces
Claim Zip Code	X(9)	1352	1360	Spaces
Beneficiary State	X(2)	1361	1362	Spaces
Beneficiary Zip Code	X(9)	1363	1371	Spaces
Total Line Item Count	9(3)	1372	1374	Zeroes
Record Line Item Count	9(3)	1375	1377	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 **100** times for the Record (depending on Record Line Item Count)				
From and Thru values relate to the 1st line item				
Field Name	**Picture**			**Initialization**
Revenue center code	X(4)	1378	1381	Spaces
SNF-RUG-III code	X(3)	1382	1384	Spaces
APC adjustment code	X(5)	1385	1389	Spaces
HCPCS Procedure Code	X(5)	1390	1394	Spaces
HCPCS Modifier 1	X(2)	1395	1396	Spaces
HCPCS Modifier 2	X(2)	1397	1398	Spaces
HCPCS Modifier 3	X(2)	1399	1400	Spaces
HCPCS Modifier 4	X(2)	1401	1402	Spaces
HCPCS Modifier 5	X(2)	1403	1404	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Line Item Date	X(8)	1405	1412	Spaces
Line Submitted Charge	9(8)V99	1413	1422	Zeroes
Line Medicare Initial Allowed Charge	9(8)V99	1423	1432	Zeroes
ANSI Reason Code 1	X(8)	1433	1440	Spaces
ANSI Reason Code 2	X(8)	1441	1448	Spaces
ANSI Reason Code 3	X(8)	1449	1456	Spaces
ANSI Reason Code 4	X(8)	1457	1464	Spaces
ANSI Reason Code 5	X(8)	1465	1472	Spaces
ANSI Reason Code 6	X(8)	1473	1480	Spaces
ANSI Reason Code 7	X(8)	1481	1488	Spaces
ANSI Reason Code 8	X(8)	1489	1496	Spaces
ANSI Reason Code 9	X(8)	1497	1504	Spaces
ANSI Reason Code 10	X(8)	1505	1512	Spaces
ANSI Reason Code 11	X(8)	1513	1520	Spaces
ANSI Reason Code 12	X(8)	1521	1528	Spaces
ANSI Reason Code 13	X(8)	1529	1536	Spaces
ANSI Reason Code 14	X(8)	1537	1544	Spaces
Manual Medical Review Indicator	X(1)	1545	1545	Spaces
Resolution Code	X(5)	1546	1550	Spaces
Line Final Allowed Charge	9(8)V99	1551	1560	Zeroes
Line Cash Deductible	9(8)V99	1561	1570	Zeroes
Special Action Code/Override Code	X(1)	1571	1571	Zeroes
Units	9(7)	1572	1578	Zeroes
Filler	X(25)	1579	1603	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

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

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

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
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 five records.
Validation: Must be between 1 and 5
Remarks: None
Requirement: Required

Data Element: Mode of Entry Indicator

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

Data Element: Original Claim Control Number

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

Data Element: Internal Control Number

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

Data Element: Beneficiary HICN

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

Data Element: Beneficiary Last Name

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

Data Element: Beneficiary First Name

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

Data Element: Beneficiary Middle Initial

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

Data Element: Beneficiary Date of Birth

Definition: Birth date of the beneficiary
Validation: Must be a valid date
Remarks: CCYYMMDD on which the beneficiary was born
Requirement: Required

Data Element: Beneficiary Gender

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

Data Element: Billing Provider Number

Definition: First nine characters of number used to identify the billing/pricing provider or supplier

Validation: Must be present
If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the first line of the claim

Remarks: N/A

Requirement: Required for all claims

Data Element: Attending Physician UPIN

Definition: The UPIN submitted on the claim used to identify the physician that is responsible for coordinating the care of the patient while in the facility.

Validation: N/A

Remarks: Left justify

Requirement: Required when available on claim record.

Data Element: Claim Paid Amount

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

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Claim ANSI Reason Code 1
Claim ANSI Reason Code 2
Claim ANSI Reason Code 3
Claim ANSI Reason Code 4
Claim ANSI Reason Code 5
Claim ANSI Reason Code 6
Claim ANSI Reason Code 7

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

Validation: Must be valid American National Standards Institute (ANSI) Ambulatory Surgical Center (ASC) claim adjustment code and applicable group code.

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
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 listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Remarks: N/A
Requirement: Required if there is a condition code for the bill.

Data Element: Type of Bill
Definition: A code indicating the specific type of bill (hospital, inpatient, SNF, outpatient, adjustments, voids, etc.).
This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Remarks: N/A
Requirement: Required

Data Element: Principal Diagnosis
Definition: The ICD-9-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-9-CM diagnosis code

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

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

Data Element: Other Diagnosis Code 1
Other Diagnosis Code 2
Other Diagnosis Code 3
Other Diagnosis Code 4
Other Diagnosis Code 5
Other Diagnosis Code 6
Other Diagnosis Code 7
Other Diagnosis Code 8
Definition: The ICD-9-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-9-CM diagnosis code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS

approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.

- Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable.

Remarks: Report the full ICD-9-CM codes for up to eight 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: Principal Procedure and Date

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

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

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

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

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

Requirement: Required for inpatient claims.

Data Element: Other Procedure and Date 1
Other Procedure and Date 2
Other Procedure and Date 3
Other Procedure and Date 4
Other Procedure and Date 5

Definition: The ICD-9-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-9-CM procedure code

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

Remarks: The date applicable to the procedure is shown numerically as MM-DD-YY in the "date" portion.

Requirement: Required if on claim record.

Data Element: Claim Demonstration Identification Number

Definition: The number assigned to identify a demonstration project.

Validation: Must be numeric or zeroes

Remarks: 01-RUGS
02-HHA
03-TELEMED
04-UMWA
05-CHOICES
06-CABG
07-COE
08-MPPP
15-ESRD
30-LUNG
31-VA
37-MMCD
38-ENCOUNTER
39-CENTRALIZED BILLING PPV & FLU
40-INDIAN HEALTH SERVICE

Requirement: Required if available on claim record

Data Element: PPS Indicator

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

Validation: 0 = Not PPS
1 = PPS

Remarks: N/A

Requirement: Required

Data Element: Action Code

Definition: Indicator identifying the type of action requested by the intermediary to be taken on an institutional claim.

Validation: Must be a valid action code as listed in http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf

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 UB-92 Data Set

Remarks:

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care.
03	Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). See Code 61 below.
04	Discharged/transferred to an ICF
05	Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/05). Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of institutions.
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05).
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider To be DISCONTINUED effective 10/1/05.
*09	Admitted as an inpatient to this hospital
10-19	Reserved for National Assignment
20	Expired (or did not recover - Religious Non Medical Health Care Patient)
21-29	Reserved for National Assignment
30	Still patient or expected to return for outpatient services
31-39	Reserved for National Assignment
40	Expired at home (Hospice claims only)
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
43	Discharged/transferred to a Federal hospital (effective for discharges after October 1, 2003) Usage Note: Applies to discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.
44-49	Reserved for national assignment
50	Discharged/transferred to Hospice – home
51	Discharged/transferred to Hospice - medical facility
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to a hospital based Medicare approved swing bed.
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital

Code	Structure
63	Discharged/transferred to long term care hospitals
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66-70	Reserved for national assignment
71	Discharged/transferred to another institution for outpatient services (discontinued effective October 1, 2003)
72	Discharged/transferred to this institution for outpatient services (discontinued effective October 1, 2003)
73-99	Reserved for national assignment

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: Attending Physician First Name
Definition: First name (Given Name) of the attending physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Attending Physician Middle Initial
Definition: Middle Initial of the attending physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Operating Physician UPIN
Definition: The UPIN submitted on the claim used to identify the physician identification numbers associated with the physician who performed the principal procedure.
Validation: N/A
Remarks: Left justify
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: Operating Physician First Name
Definition: First name (Given Name) of the operating physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Operating Physician Middle Initial
Definition: Middle Initial of the operating physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Other Physician UPIN

Definition: The UPIN submitted on the claim used to identify other physician associated with the claim.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Other Physician NPI

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

Data Element: Other Physician Last Name

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

Data Element: Other Physician First Name

Definition: First name (Given Name) of the other physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Other Physician Middle Initial

Definition: Middle Initial of the other physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Date of Admission

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

Data Element: Type of Admission

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

1 Emergency - The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2 Urgent- The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.

3 Elective - The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
4 Newborn - Use of this code necessitates the use of a Special Source of Admission codes.
5 Trauma Center - Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.
6-8 - Reserved for National Assignment
9 Information Not Available – Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or verified by the American College of Surgeons and involving a trauma activation.

Requirement: Required on inpatient claims only.

Data Element: Source of Admission

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

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

Code Structure (For Emergency, Elective, or Other Type of Admission):

1	Physician Referral	**Inpatient**: The patient was admitted to this facility upon the recommendation of their personal physician. **Outpatient:** The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral).
2	Clinic Referral	**Inpatient:** The patient was admitted to this facility upon the recommendation of this facility's clinic physician. **Outpatient:** The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.
3	HMO Referral	**Inpatient:** The patient was admitted to this facility upon the recommendation of a HMO physician. **Outpatient:** The patient was referred to this facility for outpatient or referenced diagnostic services by a HMO physician.
4	Transfer from a Hospital	**Inpatient:** The patient was admitted to this facility as a transfer from an acute care facility where they were an inpatient **Outpatient:** The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.
5	Transfer from a SNF	**Inpatient:** The patient was admitted to this facility as a transfer from a SNF where they were an inpatient. **Outpatient:** The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where they are an inpatient.
6	Transfer from Another Health Care Facility	I**npatient**: The patient was admitted to this facility from a health care facility other than an acute care facility or SNF. This includes transfers from nursing homes, long term care facilities and SNF patients that are at a non-skilled level of care.

		Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where they are an inpatient.
7	Emergency Room	**Inpatient:** The patient was admitted to this facility upon the recommendation of this facility's emergency room physician. **Outpatient:** The patient received services in this facility's emergency department.
8	Court/Law Enforcement	**Inpatient:** The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. **Outpatient:** The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information Not Available	**Inpatient:** The means by which the patient was admitted to this facility is not known. **Outpatient:** For Medicare outpatient bills, this is not a valid code.
A	Transfer from a Critical Access Hospital (CAH)	I**npatient**: The patient was admitted to this facility as a transfer from a CAH where they were an inpatient. **Outpatient:** The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH were the patient is an inpatient.
B	Transfer From Another Home Health Agency	The patient was admitted to this home health agency as a transfer from another home health agency
C	Readmission to Same Home Health Agency	The patient was readmitted to this home health agency within the same home health episode period.
D-Z		Reserved for national assignment.

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
Occurrence Code and Date 2
Occurrence Code and Date 3
Occurrence Code and Date 4

Occurrence Code and Date 5
Occurrence Code and Date 6
Occurrence Code and Date 7
Occurrence Code and Date 8
Occurrence Code and Date 9
Occurrence Code and Date 10
Occurrence Code and Date 11
Occurrence Code and Date 12
Occurrence Code and Date 13
Occurrence Code and Date 14
Occurrence Code and Date 15
Occurrence Code and Date 16
Occurrence Code and Date 17
Occurrence Code and Date 18
Occurrence Code and Date 19
Occurrence Code and Date 20
Occurrence Code and Date 21
Occurrence Code and Date 22
Occurrence Code and Date 23
Occurrence Code and Date 24
Occurrence Code and Date 25
Occurrence Code and Date 26
Occurrence Code and Date 27
Occurrence Code and Date 28
Occurrence Code and Date 29
Occurrence Code and Date 30

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

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

Remarks:

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

Requirement: Required if available on claim record

Data Element: Value Codes and Amounts 1
Value Codes and Amounts 2
Value Codes and Amounts 3
Value Codes and Amounts 4
Value Codes and Amounts 5
Value Codes and Amounts 6
Value Codes and Amounts 7
Value Codes and Amounts 8
Value Codes and Amounts 9
Value Codes and Amounts 10
Value Codes and Amounts 11
Value Codes and Amounts 12
Value Codes and Amounts 13
Value Codes and Amounts 14

Value Codes and Amounts 15
Value Codes and Amounts 16
Value Codes and Amounts 17
Value Codes and Amounts 18
Value Codes and Amounts 19
Value Codes and Amounts 20
Value Codes and Amounts 21
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Value Codes and Amounts 26
Value Codes and Amounts 27
Value Codes and Amounts 28
Value Codes and Amounts 29
Value Codes and Amounts 30
Value Codes and Amounts 31
Value Codes and Amounts 32
Value Codes and Amounts 33
Value Codes and Amounts 34
Value Codes and Amounts 35
Value Codes and Amounts 36

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

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

Remarks:

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

Requirement: Required if available on claim record

Data Element: Claim Final Allowed Amount

Definition: Final Allowed Amount for this claim.

Validation: N/A

Remarks: The Gross Allowed charges on the claim. This represents the amount paid to the provider plus any beneficiary responsibility (co-pay and deductible)

Requirement: Required.

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

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

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

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

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

Data Element: 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 UB-92 Data Set
Remarks:
Include an entry for revenue code ‘0001’

Requirement: Required

Data Element: SNF-RUG-III Code

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

Validation: N/A

Remarks: N/A

Requirement: Required for SNF inpatient bills

Data Element: APC Adjustment Code

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

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

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

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

Validation: N/A

Remarks: Left justify the APC Adjustment Code

Requirement: Required if present on claim record

Data Element: HCPCS Procedure Code or HIPPS Code

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

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

Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs

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

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

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

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

Requirement: Required if present on claim record

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

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

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

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

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

Data Elementals Reason Code 1
ANSI Reason Code 2
ANSI Reason Code 3
ANSI Reason Code 4

ANSI Reason Code 5
ANSI Reason Code 6
ANSI Reason Code 7
ANSI Reason Code 8
ANSI Reason Code 9
ANSI Reason Code 10
ANSI Reason Code 11
ANSI Reason Code 12
ANSI Reason Code 13
ANSI Reason Code 14

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

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

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

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

Data Element: Manual Medical Review Indicator

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

Validation: Must be 'Y' or 'N'

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

Requirement: Required

Data Element: Resolution Code

Definition: Code indicating how the contractor resolved the line.

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

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

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

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

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

Remarks:

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

Requirement: **Required**

Data Element: Final Allowed Charge

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

Data Element: Cash Deductible

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

Data Element: Special Action/Override Code

Definition: Code used to identify special actions taken in determining payment of this line item.
Validation: Must be valid

0-Both deductible Action Code and coinsurance apply Override Code (1)
1-Deductible does not apply
2-Coinsurance does not apply
3-Neither deductible nor coinsurance apply
4-No charge or unites associated with this Revenue Center Code. (Used when multiple HCPCS codes are used for a single Revenue Center Code).
5-RHC or CORF Psychiatric the following alpha codes may be used for MSP processing, and only coded on the total charges line item Revenue Center Code equals 001
M-Override Code EGHP
N-Overrode Code Non EGHP

Remarks: N/A
Requirement: Required

Data Element: Units

Definition: The total number of services or time periods provided for the line item.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Filler

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

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

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
Remarks: N/A
Requirement: Required

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

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

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

DATA ELEMENT DETAIL

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

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

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

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

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

Provider Address File				
Provider Address Detail Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	Spaces
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Sequence Number	X(1)	9	9	Spaces
Provider Number	X(15)	10	24	Spaces
Provider Name	X(25)	25	49	Spaces
Provider Address 1	X(25)	50	74	Spaces
Provider Address 2	X(25)	75	99	Spaces
Provider City	X(15)	100	114	Spaces
Provider State Code	X(2)	115	116	Spaces
Provider Zip Code	X(9)	117	125	Spaces
Provider Phone Number	X(10)	126	135	Spaces
Provider Phone Number Extension	X(10)	136	145	Spaces
Provider FAX Number	X(10)	146	155	Spaces
Provider Type	X(1)	156	156	Spaces
Provider Address Type	9(3)	157	159	1
Provider E-mail Address	X(75)	160	234	Spaces
Provider Federal Tax number or EIN	9(10)	235	244	Zeroes
Filler	X(51)	245	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

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
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file

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

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

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

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

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

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

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

Data Element: Provider State Code

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

Data Element: Provider Zip Code

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

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

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

Data Element: Provider Phone Number

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

Data Element: Provider Phone Number Extension

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

Data Element: Provider Fax Number

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

Data Element: Provider Type

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

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

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

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

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

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

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

Data Element: Filler

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

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

DATA ELEMENT DETAIL

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

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

Data Element: Record Version Code
Definition: The code indicating the record version of the 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 = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

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