CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2361	**Date: September 10, 2019**
	Change Request 11326

Transmittal 2349, dated August 9, 2019, is being rescinded and replaced by Transmittal 2361, dated, September 10, 2019, to update the implementation date and to revise elements of the file layout attachment. All other information remains the same.

SUBJECT: Solutions to the Medicare Administrative Contractor (MAC) Prepayment Review Reports

I. SUMMARY OF CHANGES: As a result of Change Requests (CR) 10414, 10460, and 10461, implemented April 1, 2019, various errors were reported; this CR will address each of those errors and provide solutions moving forward.

EFFECTIVE DATE: January 1, 2020 - Effective Date shall be based on Implementation Date and not Date of Service.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

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

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2361	Date: September 10, 2019	Change Request: 11326

Transmittal 2349, dated August 9, 2019, is being rescinded and replaced by Transmittal 2361, dated, September 10, 2019, to update the implementation date and to revise elements of the file layout attachment. All other information remains the same.

SUBJECT: Solutions to the Medicare Administrative Contractor (MAC) Prepayment Review Reports

EFFECTIVE DATE: January 1, 2020 - Effective Date shall be based on Implementation Date and not Date of Service.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

I. GENERAL INFORMATION

A. Background: As a result of Change Requests (CR) 10414, 10460, and 10461, implemented April 1, 2019, various errors were reported. The RAC Data Warehouse (RACDW) and the Shared Systems adapted to mitigate those errors, as appropriate. In order to provider clarity and ensure the most accurate capturing of MAC prepayment claims data, this CR will address each of those errors and provide solutions moving forward.

B. Policy: The nationwide Recovery Audit program was mandated under Division B, Title III, Section 302 of the Tax Relief and Healthcare Act of 2006.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11326.1	The contractor shall refer to the attached revised Non-RAC Claim Review File Format, including the Header Layout and the Claim Record Layout, for the list of data elements, valid values, and file format for the Prepayment Review File.	X	X	X	X		X	X		RAC Data Warehouse
11326.2	The contractor shall populate the Source Organization with one of the following options: JK, JL, JM, JJ, JN, J15, J8, J6, J5, J5N, JH, JF, JE, DA, DB, DC, DD, Z1, Z2, Z3, Z4, Z5, Z6, Z7, UPIC1, UPIC2, UPIC3, UPIC4, UPIC5, CERT, SMRC, OIG, PERM, QIO **NOTE:** The source organization is the organization that initiated the review or, for reviews tracked in the	X	X	X	X					RAC Data Warehouse

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	shared systems, entered the review into the system. **NOTE:** The UPIC mapping shall be as follows: UPIC1 = UPCMW UPIC2 = UPCW UPIC3 = UPCSW UPIC4 = UPCSE UPIC5 = UPCNE									
11326.2.1	The contractor shall confirm that the UPIC mapping described in BR 11326.2 has been in use; if not, the contractor shall use this mapping going forward and provide the previously used crosswalk to the RACDW via email to Ashley.Badami@cms.hhs.gov and Tony.Olivis@cms.hhs.gov no later than 10 business days after finalization of this CR.	X	X	X	X					RAC Data Warehouse
11326.2.2	The contractor shall update its edits to accept the new values for the Source Organization.					X				
11326.2.2.1	The contractor shall not assign a date parameter to the new values.					X				
11326.3	The contractor shall populate the Place of Service State Code and the Place of Service Zip Code fields using the Supplier State and Zip Code rather than the Beneficiary's State and Zip Code values.							X		
11326.4	The contractor shall populate the Place of Service State Code with the Pricing State Code if available, otherwise the Billing Provider State Code.						X			
11326.5	The contractors shall participate during the User Acceptance Testing (UAT) sessions to test the changes (December 2019).	X	X	X	X					RAC Data Warehouse
11326.5.1	The contractors shall use the following email addresses to report problems that arise (including error messages recieved from the RAC DW) pre- and post-implementation:	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• CMS contacts: Tony.Olivis@cms.hhs.gov, Ashley.Badami@cms.hhs.gov • KSI contacts: smikhaylenko@ksikoniag.com, helpdesk.RACDW@koniag.com									
11326.6	The contractors shall attend the following calls: • During the UAT period in December, up to 2 one-hour calls may be scheduled, by CMS, for all parties to discuss any testing issues that may occur. • Up to 3 one-hour calls shall be scheduled, by CMS, immediately following implementation in January 2020, to discuss any issues with implementation.	X	X	X	X	X	X	X		RAC Data Warehouse
11326.6.1	The contractor shall post the minutes of the meeting for their specific issues only discussed during the call within 2 business days of the meeting in eChimp.	X	X	X	X					
11326.6.1.1	The contractor shall provide their point of contacts (POCs) for the calls within 10 business days after the CR is released. **NOTE:** POCs shall be emailed to Ashley.Badami@cms.hhs.gov and Tony.Olivis@cms.hhs.gov	X	X	X	X	X	X	X		

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

VI. FUNDING

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

ATTACHMENTS: 1

Non-RAC Claim Review File Format

Last Modified Date: 8/23/2019

***Please note that all layouts detailed here pertain to the same claim file. The header is the first record in the file, followed by the claim records.**

***Contractors shall record blank spaces, on the Prepayment Review file layout in any field not available for prepayment.**

Header Layout

Field Name	Location	Length	Attributes	Sample	Valid Values and Notes
File Type	1	10	AN-10	CLAIM	Value: "Claim" Left justified, space fill
Filler	11	1	AN-1		Space fill
File Format Version	12	3	AN-3	001	Value: 001
Filler	15	1	AN -1		Space fill
Record Count	16	6	Num-6	000102	Number of records contained in file. Left justified, zero fill (in front of the actual count value) For example, if the record count is 102, then the correct value in this field should be 000102
Filler	22	1	AN-1		Space fill
Record Length	23	3	Num-3	371	371
Filler	26	1	AN -1		Space fill
Create Date	27	8	Num-8	20090617	File Creation Date Format = YYYYMMDD
Filler	35	7	AN -7		Space fill
Source System	42	5	AN-5		This field is necessary to identify the system producing the file. Allowed values are: • FISS • MCS • VMS • NONE (for files produced in-house by MACs/SMRC/ZPICs/UPICs, etc.)
Filler	47	325	AN-325		Space fill

Claim Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-A	R	Claim Record-C
Claim Type	2	2	1-A	R	NCH MQA Record Identification Code For Part A reviews: 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health Agency For Part B reviews: 6 = Carrier For DME reviews: 7 = Durable Medical Equipment
Place of Service State Code	3	4	2-A	S	State Codes (for example, ME, CA) Also allow FC for foreign country For DME claims this should be the Supplier's State Code For Part B claims this should be the pricing state code if present otherwise the billing provider state code.
Place of Service ZIP Code	5	9	5-AN	R	US Postal Code where service rendered. Allow 00000 if state is FC (foreign country) For DME claims this should be the Supplier's Zip Code
Ordering Provider State Code	10	11	2-AN	S Only allowed, but not required, for DME claims, must be empty otherwise	State Codes (for example, ME, CA) Also allow FC for foreign country

Ordering Provider Zip Code	12	16	5-AN	S Only allowed, but not required, for DME claims, must be empty otherwise	Allow 00000 if state is FC (foreign country)
Beneficiary Residence State Code	17	18	2-A	R for DME reviews Must be empty for Part A and B reviews	State Codes (for example, ME, CA) FC for foreign country
Beneficiary Residence ZIP Code	19	23	5-AN	R, for DME reviews Must be empty for Part A and B reviews	US Postal Code where service rendered. Allow 00000 if state is FC (foreign country)
Source Organization	24	28	5-AN	R	Organization that initiated the review or (for reviews tracked in the shared systems) entered the review into the shared system For prepayment this should be the indicator of the responsible contractor: JK, JL, JM, JJ, JN, J15, J8, J6, J5, J5N, JH, JF, JE, DA, DB, DC, DD, Z1, Z2, Z3, Z4, Z5, Z6, Z7, UPIC1, UPIC2, UPIC3, UPIC4, UPIC5, CERT, SMRC, OIG, PERM, QIO
MAC Jurisdiction	29	31	3-AN	R	Jurisdiction of the claim-processing MAC: only JK, JL, JM, JJ, JN, J15, J8, J6, J5, J5N, JH, JF, JE, DA, DB, DC, DD, are allowed

Contractor ID (Workload Number)	32	36	5-AN	R	Claims processing contractor ID number
Original Claim ID	37	59	23-AN	R	Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim • For Claim Type 1 through 5 - length must be equal to or greater than 14. • For Claim Type 6 - length must be 15. • For Claim Type 7 - length must be 14. Note – This is known to the SSMs as the Document Control Number (DCN).
Type of Bill	60	63	4-AN	R/S	* Required for Claim Type 1 - 5. Should be blank for Part B and DME claims
Provider Legacy Number	64	76	13-AN	S	Unique Provider Legacy Number of the provider that performed the service and filed the claim. For Part A claims this is the CCN. For Part B claims this is the PTAN. For DME claims this is the NSC.
Provider NPI	77	86	10-AN	R	Unique Provider NPI of the provider that performed the service and filed the claim For DME claims this should be the supplier NPI.

DME Ordering Provider NPI	87	96	10-AN	S	NPI of Provider that prescribed the supplies. Required for DME claims Should be left empty for Part A and Part B claims
Billed Claim Amount	97	106	10-AN	R, for pre-pay reviews Must be left blank for post-pay reviews	Billed amount on the claim submitted to CMS Only need for pre-pay reviews (for post-pay reviews Claim Paid Amount is collected instead) We will not allow decimal points. The last 2 characters will be assumed to be cents. I.e. 10000 will be interpreted as $100.00
Allowed Claim Amount	107	116	10-AN	S, for pre-pay reviews Must be left blank for post-pay reviews	Allowed amount on the claim submitted to CMS Only need for pre-pay reviews (for post-pay reviews Claim Paid Amount is collected instead) We will not allow decimal points. The last 2 characters will be assumed to be cents. I.e. 10000 will be interpreted as $100.00
Claim Received Date	117	124	8-AN	R, for pre-pay reviews Must be left blank for post-pay reviews	Date claim was billed YYYYMMDD (date claim was received in the SSMs). Only needed for pre-pay reviews (for post-pay reviews Claim Paid Date is collected instead).

Original Claim Paid Amount	125	134	10-AN	R, for post-pay reviews	Amount of original payment made from Medicare fund ex: 999999.99 Not applicable for prepayment reviews We will not allow decimal points. The last 2 characters will be assumed to be cents. I.e. 10000 will be interpreted as $100.00
Original Claim Paid Date	135	142	8-AN	R, for post-pay reviews	Date claim was paid YYYYMMDD Not applicable for pre-pay reviews
Statement Covers Period	143	146	4-AN	R/S	Length of Stay * Required for Claim Types 1 - Inpatient 2 - SNF 3 – Hospice Must be left blank for Part B and DME claims
Provider Type	147	148	2-AN	R	Type of Provider or Supplier Valid Values: 1 = Lab/Ambulance 2 = Outpatient Hospital 3 = Home Health (HHA) 4 = Hospice 5 = Professional Services (physician/non-physician practitioner) 6 = DME by Supplier 7 = Skilled Nursing (SNF) 8 = Inpatient Hospital 9 = Inpatient Rehabilitation (IRF) 10 = Critical Access Hospital (CAH) 11 = Long Term Care Hospital (LTCH) 12 = DME by Physician 13 = Ambulatory Surgery Center (ASC)

					14 = Other 15 = Inpatient Psychiatric Facility 16 = Outpatient Rehab Facility 17 = Comprehensive Outpatient Rehab Facility Note – VMS should only use 6 or 12.
CMS Provider Specialty Code	149	150	2-AN	S	CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files Must be left blank for Part A claims
Original Patient Discharge Status Code	151	152	2-AN	S	Original Patient Discharge Status Code Must be left blank for Part B and DME claims
Final Patient Discharge Status Code	153	154	2-AN	S	Final Patient Discharge Status Code Must be left blank for Part B and DME claims
HICN	155	169	15-AN	R	Beneficiary HIC Number
Medicare Beneficiary Identifier (MBI)	170	184	15-AN	S	Beneficiary MBI
Serial Claim Indicator	185	185	1-A	S	Allowed Values: • Y • N Only applicable to DME claims
Review Type	186	187	2-AN	R	Automated Review-AR Complex Review-CR Prepayment Review-PR All prepayment reviews should have this field set to PR
Review Status	188	189	2-AN	S	X – if the review was abandoned after the ADR was sent; Spaces otherwise
Adjusted Claim ID	190	212	23-AN	S*	* Required when a claim number is changed based on the review results.

Extrapolation Case ID	213	235	23-AN	S*	Extrapolation Case ID *Required for claims reviewed as part of extrapolation
Date Code A	236	237	2-AN	R*	Type of date: 02 Request for medical records (required) 03 Received provider's request for extension to submit records 04 New deadline for provider to submit records request for extension 05 Received medical records from provider 06 review contractor asks CMS for extension to complete review 07 New deadline for review contractor to complete review 08 Improper payment notification sent to provider 09 Request for discussion received from provider 10 Finding sent for re-adjudication 11 Readjudication compete, re-adjudicated claim received from the MAC 12 Demand letter sent. **(Once Date Code "12" has been uploaded, Demand Letter Amount is a required field on all subsequent uploads for this claim.)** 13 Claim closed 14 No findings letter sent 15 Technical Denial Determination Date

					20 Prepayment Review Claim Finalized (applicable to Prepayment Reviews only)
Date A	238	245	8-AN	R	Date format YYYYMMDD
Date Code B	246	247	2-AN	S	Type of date:
Date B	248	255	8-AN	S	Date format YYYYMMDD
Date Code C	256	257	2-AN	S	Type of date:
Date C	258	265	8-AN	S	Date format YYYYMMDD
Date Code D	266	267	2-AN	S	Type of date:
Date D	268	275	8-AN	S	Date format YYYYMMDD
Demand Letter Amount (or Savings Amount for prepayment reviews)	276	286	11-AN	S*	*Required when Date Code "12" comes in. Otherwise, it is an optional field. * Submit negative amounts for underpayments We will not allow decimal points. The last 2 characters will be assumed to be cents. I.e. 10000 will be interpreted as $100.00 **For post-pay reviews, Once Date Code "12" has been uploaded, Demand Letter Amount is a required field on all subsequent uploads for this claim.** For pre-pay reviews this Amount does not depend on presence or absence of any date code Note - Calculate as the difference between the allowed amount and the paid amount. Do not include co-pay, deductible, coinsurance, or network discount in calculation.

Overpayment/ Underpayment Indicator	287	288	2-AN	S	Overpayment/ Underpayment Indicator Values: • OP: Overpayment (Savings Amount > 0) • UP: Underpayment (Savings Amount < 0) • NA: No Finding (Savings Amount = 0) • blank: Review in progress (Savings Amount is empty) **Required for post-pay reviews when: Demand Letter Date (Date 12) or No Findings Letter Sent Date (Date 14) is not missing Required for pre-pay reviews when: Improper Payment Notification Date (Date 8) or No Findings Letter Sent Date (Date 14) is not missing.**
Initial Documentation Delivery Route (for documentation submitted in response to RA Request for Medical Record)	289	289	1-AN	S	Values: • 1: esMD • 2: fax • 3: mail paper record • 4: mail electronic records on a disk • 5: other May be blank for pre-pay reviews
Probe and Educate Round Number	290	290	1-AN	S	Can be left blank for pre-pay reviews Options: 1, 2, 3, or 4.
Review Topic Code 1	291	295	5-AN	S	MACs should use the CART codes
Review Topic Code 2	296	300	5-AN	S	MACs should use the CART codes
Review Topic Code 3	301	305	5-AN	S	MACs should use the CART codes

Review Topic Code 4	306	310	5-AN	S	MACs should use the CART codes
Review Topic Code 5	311	315	5-AN	S	MACs should use the CART codes
PIMR Activity Code	316	321	6-AN	S	This is required when the claim is “finalized” (has date 8 or 14)
Filler	322	371	50-AN		Space Fill

Claim Line Item Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes	
Record Type	1	1	1-AN	R	Line-L	
Line item number	2	4	3-AN	R	Claim line item number; 000 for institutional claims. If line number = 000, then no other lines are acceptable for that claim	
Original Diagnosis Code Version Indicator	5	5	1-AN	S	9 for ICD-9 or 0 for ICD-10;	For all fields capturing ‘Original’ and ‘Final’ values, the SSMs do not capture the ‘Original’ and ‘Final’ values separately in the system. Instead there is a single field, for example the Diagnosis Code Version Indicator, and if there is a change to the value in that field it simply overlays the previous value. SSMs will still be able to populate the ‘Original’ and ‘Final’ values on the prepayment review report. When the claim is first included on the report,

						the value that is current at that time will be listed in the 'Original' field on the report. When the claim is finalized, the value that is current at that time will be listed in the 'Final' field on the report. FISS and MCS capture principal diagnosis code at the claim header level. VMS captures at the line level. FISS and MCS should just repeat the same code for every line. The same comment applies to all other fields in the layout which may be captured on the claim level by some of the shared systems but RACDW needs to track on the line level.
Original Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	6	12	7-AN	S	Original ICD-9 or ICD-10. Decimal point(.) is not allowed.	
Final Diagnosis Code Version Indicator	13	13	1-AN	S	9 for ICD-9 or 0 for ICD-10;	
Final Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	14	20	7-AN	S	Final diagnosis code after audit. Decimal point(.) is not allowed.	
Original DRG	21	23	3-AN	S	Original DRG on claim. It must be	

					three digit numbers. Line 000 only Must be left blank for Part B and DME claims	
Final DRG	24	26	3-AN	S	Final DRG after audit. It must be three digit numbers. Line 000 only Must be left blank for Part B and DME claims	
Original ICD Procedure Code	27	33	7-AN	S	Original ICD9/ICD10 Procedure Code on reviewed claim. Decimal point(.) is not allowed. Must be left blank for Part B and DME claims	
Final ICD Procedure Code	34	40	7-AN	S	Final ICD9/ICD10 Procedure Code after audit. Decimal point(.) is not allowed. Must be left blank for Part B and DME claims	
Original OPPS code for outpatient hospitals (APCs)	41	45	5-AN	S	Original HOPPS code for outpatient hospitals (APCs) Must be left blank for Part B and DME claims	
Final OPPS code for outpatient hospitals (APCs)	46	50	5-AN	S	Final HOPPS code for outpatient hospitals (APCs) Must be left blank for Part B and DME claims	
Original HIPPS code for SNFs (RUG/AIs)	51	55	5-AN	S	Original HIPPS code for SNFs (RUG/AIs) Must be left blank for Part B and DME claims	
Final HIPPS code for SNFs (RUG/AIs)	56	60	5-AN	S	Final HIPPS code for SNFs (RUG/AIs) Must be left blank for Part B and DME claims	
Original HIPPS code for HHAs (HHRGs)	61	65	5-AN	S	Original HIPPS code for HHAs (HHRGs)	

					Must be left blank for Part B and DME claims	
Final HIPPS code for HHAs (HHRGs)	66	70	5-AN	S	Final HIPPS code for HHAs (HHRGs) Must be left blank for Part B and DME claims	
Original HIPPS code for IRFs (CMG/RICs)	71	75	5-AN	S	Original HIPPS code for IRFs (CMG/RICs) Must be left blank for Part B and DME claims	
Final HIPPS code for IRFs (CMG/RICs)	76	80	5-AN	S	Final HIPPS code for IRFs (CMG/RICs) Must be left blank for Part B and DME claims	
Original Level of Care code for hospice claims	81	85	5-AN	S	Original Level of Care code for hospice claims This field may be left blank if not tracked by the shared systems, however it will be retained in case if it is available for post-payment reviews.	
Final Level of Care code for hospice claims	86	90	5-AN	S	Final Level of Care code for hospice claims This field may be left blank if not tracked by the shared systems, however it will be retained in case if it is available for post-payment reviews	
Original HCPCS	91	95	5-AN	S	Original HCPCS on claim. Not generally used for inpatient claims (exceptions do exist)	
Final HCPCS	96	100	5-AN	S	Final HCPCS after audit. Not generally used for inpatient claims	

Original Units of Service	101	106	6-AN	S	Original units of service on claim	
Final Units of Service	107	112	6-AN	S	Final units of service on claims	
Denial Reason Code 1	113	118	6-AN	S	Reason claim/line considered overpaid/underpaid. If claim-level denial, list denial reason on line level and repeat in necessary.	
Denial Reason Code 2	119	124	6-AN	S		
Denial Reason Code 3	125	130	6-AN	S		
Denial Reason Code 4	131	136	6-AN	S		
Denial Reason Code 5	137	142	6-AN	S		
POS (Place of Service) code	143	144	2-AN	S	Should be blank for Part A claims.	
PC/TC (Professional Component/Technical Component) Indicator	145	145	1-AN	S	Should be blank for DME claims	
Modifier 1	146	147	2-AN	S		
Modifier 2	148	149	2-AN	S		
Modifier 3	150	151	2-AN	S		
Modifier 4	152	153	2-AN	S		
Modifier 5	154	155	2-AN	S		
Revenue Code	156	159	4-AN	S	Should be blank for Part B and DME claims	
Date of Service Start	160	167	8-AN	R	Date service started/performed YYYYMMDD	
Date of Service End	168	175	8-AN	R	Date service ended YYYYMMDD	
Filler	176	371	196-AN	R	Spaces	

Change Log

Date	Field	Change
7/5/2019	Place of Service State Code	Changed to situational
7/5/2019	Source Organization	Acceptable options updated to include all MACs.
7/5/2019	MAC Jurisdiction	Acceptable options updated to include all MACs.
7/5/2019	Probe and Educate Round Number	Acceptable options updated to include 1-4.
7/10/2019	Place of Service State Code	Added: For Part B claims this should be the pricing state code if present otherwise the billing provider state code.

8/23/2019	Original Diagnosis Code Version Indicator	Changed from “Required” to “Situational.”
8/23/2019	Original Principal Diagnosis Code (institutional) or line- specific Diagnosis Code (non-institutional)	Changed from “Required” to “Situational.”