CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal: 1100	**Date: June 28, 2012**
	Change Request 7807

Transmittal 1072 dated April 26, 2012 is being rescinded and replaced by Transmittal 1100 , dated June 28, 2012, to update the CR to include the claim level rendering and referring physician information in addition to the line level originally included. There are no other changes in this change request. All other information remains the same.

SUBJECT: Fiscal Intermediary Shared System (FISS) System Enhancement for Including Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) and Name Information in the Comprehensive Error Rate Testing (CERT) Resolution Record

I. SUMMARY OF CHANGES:

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: October 1, 2012

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 Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 1100	Date: June 28, 2012	Change Request: 7807

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SUBJECT: Fiscal Intermediary Shared System (FISS) System Enhancement for Including Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) and Name Information in the Comprehensive Error Rate Testing (CERT) Resolution Record

Effective Date: January 1, 2012

Implementation Date: October 1, 2012

I. GENERAL INFORMATION

A. Background: Medicare needs to identify primary physicians/practitioners of service not only for use in standard claims transactions, but also for review, fraud detection, and planning purposes. In order to accomplish this, we must be able to determine the rendering physician/practitioner for each inpatient/outpatient service billed to Medicare and store this information in our databases that serve as the source for data analysis. Prior to the implementation of the 5010 version of the 837 I, this information could only be collected at the claim level in the other provider field. CMS can begin collecting this information at the line level following the implementation of the 5010 version of the 837 I. To perform needed data analysis, it is critical that FISS be able to associate physician/practitioner identifying information with each line item on institutional claims, and be able to forward that information to the CWF.

With the implementation of the 837 I version 5010A2 format, loop 2310C was redefined to 'Other Operating Physician' and, thus, not appropriate for usage for PCIP reporting. For providers using the 837 I 5010A2 format, effective January 1, 2012, the correct loop for reporting physician NPI information is loop 2310D, 'Rendering Provider'.

With the implementation of the electronic claim 837 I version 5010A2 format the field for "other physician" is mapped to three possible physician identifying fields. For hospice agencies reporting the physician certifying the terminal illness using the electronic claim 837 I version 5010A2 format this information should be reported in the 2310F loop. The Medicare standard system is required to process the 2310F loop for all outpatient claims.

This instruction implements enhancements to the FISS to furnish claim referring physician and claim and line level rendering physician/practitioner information to the CERT when billed on version 5010 of the 837 I.

The implementation of this CR is dependent on the business requirements of CRs 7578, 7686, and 7755.

B. Policy: Upon implementation of this instruction, providers submitting a combined claim, that is claims that include both facility and professional components, need to report the rendering physician or other practitioner at the line level if it differs from the rendering physician/practitioner reported at the claim level. Affected Medicare providers are Critical Access Hospitals billing under Method II, Federally Qualified Health Centers, and Rural Health Clinics.

For the 5010 version of the 837 I, FISS shall accept rendering physician/practitioner information at the line level (loop 2420C).

Upon implementation of this instruction, providers shall use the 837 I version 5010A2, 'Rendering Provider' field (loop 2310D). The 'Rendering Provider' field on the 837 I must be populated by the eligible primary care practitioner's NPI in order for the primary care services to qualify for the incentive bonus. Providers using the Fiscal Intermediary Shared System (FISS) shall utilize the 'Rendering Physician' field in FISS to report the NPI information. There are no other changes in this change request. All other information remains the same.

Hospices report the physician certifying the terminal illness on the claim when different than the attending physician in the referring physician 2310F loop of the 837 I version 5010A2.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7807.1	FISS shall forward line level rendering physician/practitioner information to the CERT.						X				CERT
7807.1.1	FISS shall populate the existing service line Rendering Physician NPI in the CERT Resolution Record with the new FISS service line fields created in CR 7578, excluding the new Physician Specialty Code field.						X				CERT
7807.1.2	FISS shall populate the existing Rendering Physician Last Name field in the CERT Resolution Record with the service line rendering physician/practitioner name information obtained from the service line Loop 2420C of the 5010 version of the 837 I, if present.						X				CERT
7807.1.3	FISS shall include the Physician Specialty Code for rendering physician/practitioners at the line level of the CERT Resolution Record.						X				CERT
7807.1.3.1	FISS shall reduce the number size of the line level filler by 2 characters.						X				CERT
7807.1.3.2	FISS shall add a new Physician Specialty Code field for rendering physician/practitioners at the line level of the CERT Resolution Record.						X				CERT
7807.2	In order to avoid confusion with the field names required in CR 7686, the "Other Physician" fields in the CERT resolution record shall be renamed "Claim Rendering Physician".						X				CERT
7807.3	FISS shall forward the claim level rendering physician/practitioner information to the CERT.						X				CERT
7807.3.1	FISS shall populate the renamed field "Claim Rendering Physician NPI" with the claim level rendering physician/practitioner NPI obtained from in loop 2310D						X				CERT

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	from the 837 I version 5010A2										
7807.3.2	FISS shall populate the renamed field "Claim Rendering Physician Last Name" in the CERT Resolution Record with the claim level rendering physician/practitioner last name obtained from in loop 2310D from the 837 I version 5010A2						X				CERT
7807.3.3	FISS shall add a new Claim Rendering Physician Specialty Code field for rendering physician/practitioners at the claim level of the CERT Resolution Record.						X				CERT
7807.3.4	FISS shall remove the Physician Specialty Code to the Claim Rendering Physician Specialty Code field at the claim level of the CERT resolution Record, when available in the internal claim record. DO NOT populate this element if it does not already exist in the internal claim record.						X				CERT
7807.4	FISS shall forward the claim level referring physician information to the CERT using information mapped from loop 2310F from the 837 I version 5010A2 to the newly created referring physician fields.						X				CERT
7807.4.1	FISS shall add a new Referring Physician NPI field for referring physician at the claim level of the CERT Resolution Record.						X				CERT
7807.4.2	FISS shall add a new Referring Physician Last Name field for referring physician at the claim level of the CERT Resolution Record.						X				CERT
7807.4.3	FISS shall add a new Referring Physician Specialty Code field for referring physician at the claim level of the CERT Resolution Record.						X				CERT
7807.4.4	FISS shall move the Physician Specialty Code to the Referring Physician Specialty Code field at the claim level of the CERT Resolution Record, when available in the internal claim record—DO NOT populate this element if it does not already exist in the internal claim record.						X				CERT
7807.5	FISS shall reduce the number size of the claim level filler by 30 characters (reduce from 50 to 20).						X				CERT
7807.6	FISS shall begin using Record Version Code D in the resolution file only with the implementation of this instruction.						X				CERT

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
7807.1.1	CMS required FISS to retain service line level rendering physician NPI in CR 7578
7807.1.2	CMS required FISS to extract service line level rendering physician information from the service line Loop 2420C of the 5010 version of the 837 I, if present with CR 7578
7807.1.3	CMS required FISS to extract service line level rendering physician specialty information from PECOS, retain that information in the internal claim record and submit that information to CWF, if present, with CR 7578
7807.7.3.1	The size of the line level filler field was reduced in order to offset the addition of the provider specialty field and retain the same record length.
7807.2	CMS required FISS to rename the other physician field in CR 7686
7807.3	CMS required FISS to retain claim level rendering physician information in CR 7686
7807.3.1 and 7807.3.2	CMS required FISS to map the information in loop 2310D from the 837 I version 5010A2 to the newly created Rendering Physician fields in the internal claim record.
7807.4	CMS required FISS to retain claim level rendering physician information in CR 7755
7807.4	CMS required FISS to map the information in loop 2310F from the 837 I version 5010A2 to the newly created referring physician fields.
7807.5	In order to offset the addition of the claim level fields and retain the same record length, the size of the claim level filler field has been reduced.
7807.6	For tracking purposed and version control, version D will be implemented to accommodate the revised format.

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

V. CONTACTS

Pre-Implementation Contact(s): Wendy Chesser, Wendy.Chesser@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs,*:

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

Section B: *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.

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
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = 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(60)	69	128	Spaces
Beneficiary First Name	X(35)	129	163	Spaces
Beneficiary Middle Initial	X(1)	164	164	Spaces
Beneficiary Date of Birth	X(8)	165	172	Spaces
Beneficiary Gender	X(1)	173	173	Spaces
Billing Provider Number	X(9)	174	182	Spaces
Attending Physician UPIN	X(6)	183	188	Spaces
Claim Paid Amount	S9(8)V99	189	198	Zeroes
Claim ANSI Reason Code 1	X(8)	199	206	Spaces
Claim ANSI Reason Code 2	X(8)	207	214	Spaces
Claim ANSI Reason Code 3	X(8)	215	222	Spaces
Claim ANSI Reason Code 4	X(8)	223	230	Spaces
Claim ANSI Reason Code 5	X(8)	231	238	Spaces
Claim ANSI Reason Code 6	X(8)	239	246	Spaces
Claim ANSI Reason Code 7	X(8)	247	254	Spaces
Statement covers From Date	X(8)	255	262	Spaces
Statement covers Thru Date	X(8)	263	270	Spaces
Claim Entry Date	X(8)	271	278	Spaces
Claim Adjudicated Date	X(8)	279	286	Spaces
Condition Code 1	X(3)	287	289	Spaces
Condition Code 2	X(3)	290	292	Spaces
Condition Code 3	X(3)	293	295	Spaces
Condition Code 4	X(3)	296	298	Spaces
Condition Code 5	X(3)	299	301	Spaces
Condition Code 6	X(3)	302	304	Spaces
Condition Code 7	X(3)	305	307	Spaces
Condition Code 8	X(3)	308	310	Spaces
Condition Code 9	X(3)	311	313	Spaces
Condition Code 10	X(3)	314	316	Spaces
Condition Code 11	X(3)	317	319	Spaces
Condition Code 12	X(3)	320	322	Spaces
Condition Code 13	X(3)	323	325	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Condition Code 14	X(3)	326	328	Spaces
Condition Code 15	X(3)	329	331	Spaces
Condition Code 16	X(3)	332	334	Spaces
Condition Code 17	X(3)	335	337	Spaces
Condition Code 18	X(3)	338	340	Spaces
Condition Code 19	X(3)	341	343	Spaces
Condition Code 20	X(3)	344	346	Spaces
Condition Code 21	X(3)	347	349	Spaces
Condition Code 22	X(3)	350	352	Spaces
Condition Code 23	X(3)	353	355	Spaces
Condition Code 24	X(3)	356	358	Spaces
Condition Code 25	X(3)	359	361	Spaces
Condition Code 26	X(3)	362	364	Spaces
Condition Code 27	X(3)	365	367	Spaces
Condition Code 28	X(3)	368	370	Spaces
Condition Code 29	X(3)	371	373	Spaces
Condition Code 30	X(3)	374	376	Spaces
Type of Bill	X(3)	377	379	Spaces
Principal Diagnosis Code	X(7)	380	386	Spaces
Other Diagnosis Code 1	X(7)	387	393	Spaces
Other Diagnosis Code 2	X(7)	394	400	Spaces
Other Diagnosis Code 3	X(7)	401	407	Spaces
Other Diagnosis Code 4	X(7)	408	414	Spaces
Other Diagnosis Code 5	X(7)	415	421	Spaces
Other Diagnosis Code 6	X(7)	422	428	Spaces
Other Diagnosis Code 7	X(7)	429	435	Spaces
Other Diagnosis Code 8	X(7)	436	442	Spaces
Other Diagnosis Code 9	X(7)	443	449	Spaces
Other Diagnosis Code 10	X(7)	450	456	Spaces
Other Diagnosis Code 11	X(7)	457	463	Spaces
Other Diagnosis Code 12	X(7)	464	470	Spaces
Other Diagnosis Code 13	X(7)	471	477	Spaces
Other Diagnosis Code 14	X(7)	478	484	Spaces
Other Diagnosis Code 15	X(7)	485	491	Spaces
Other Diagnosis Code 16	X(7)	492	498	Spaces
Other Diagnosis Code 17	X(7)	499	505	Spaces
Other Diagnosis Code 18	X(7)	506	512	Spaces
Other Diagnosis Code 19	X(7)	513	519	Spaces
Other Diagnosis Code 20	X(7)	520	526	Spaces
Other Diagnosis Code 21	X(7)	527	533	Spaces
Other Diagnosis Code 22	X(7)	534	540	Spaces
Other Diagnosis Code 23	X(7)	541	547	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Diagnosis Code 24	X(7)	548	554	Spaces
Principal Diagnosis Code Version Indicator Code	X(1)	555	555	Spaces
Other Diagnosis Code 1 Version Indicator Code	X(1)	556	556	Spaces
Other Diagnosis Code 2 Version Indicator Code	X(1)	557	557	Spaces
Other Diagnosis Code 3 Version Indicator Code	X(1)	558	558	Spaces
Other Diagnosis Code 4 Version Indicator Code	X(1)	559	559	Spaces
Other Diagnosis Code 5 Version Indicator Code	X(1)	560	560	Spaces
Other Diagnosis Code 6 Version Indicator Code	X(1)	561	561	Spaces
Other Diagnosis Code 7 Version Indicator Code	X(1)	562	562	Spaces
Other Diagnosis Code 8 Version Indicator Code	X(1)	563	563	Spaces
Other Diagnosis Code 9 Version Indicator Code	X(1)	564	564	Spaces
Other Diagnosis Code 10 Version Indicator Code	X(1)	565	565	Spaces
Other Diagnosis Code 11 Version Indicator Code	X(1)	566	566	Spaces
Other Diagnosis Code 12 Version Indicator Code	X(1)	567	567	Spaces
Other Diagnosis Code 13 Version Indicator Code	X(1)	568	568	Spaces
Other Diagnosis Code 14 Version Indicator Code	X(1)	569	569	Spaces
Other Diagnosis Code 15 Version Indicator Code	X(1)	570	570	Spaces
Other Diagnosis Code 16 Version Indicator Code	X(1)	571	571	Spaces
Other Diagnosis Code 17 Version Indicator Code	X(1)	572	572	Spaces
Other Diagnosis Code 18 Version Indicator Code	X(1)	573	573	Spaces
Other Diagnosis Code 19 Version Indicator Code	X(1)	574	574	Spaces
Other Diagnosis Code 20 Version Indicator Code	X(1)	575	575	Spaces
Other Diagnosis Code 21 Version Indicator Code	X(1)	576	576	Spaces
Other Diagnosis Code 22 Version Indicator Code	X(1)	577	577	Spaces
Other Diagnosis Code 23 Version Indicator Code	X(1)	578	578	Spaces
Other Diagnosis Code 24 Version Indicator Code	X(1)	579	579	Spaces
Principal Procedure	X(7)	580	586	Spaces
Principal Procedure Date	X(8)	587	594	Spaces
Other Procedure 1	X(7)	595	601	Spaces
Other Procedure 1 Date	X(8)	602	609	Spaces
Other Procedure 2	X(7)	610	616	Spaces
Other Procedure 2 Date	X(8)	617	624	Spaces
Other Procedure 3	X(7)	625	631	Spaces
Other Procedure 3 Date	X(8)	632	639	Spaces
Other Procedure 4	X(7)	640	646	Spaces
Other Procedure 4 Date	X(8)	647	654	Spaces
Other Procedure 5	X(7)	655	661	Spaces
Other Procedure 5 Date	X(8)	662	669	Spaces
Other Procedure 6	X(7)	670	676	Spaces
Other Procedure 6 Date	X(8)	677	684	Spaces
Other Procedure 7	X(7)	685	691	Spaces
Other Procedure 7 Date	X(8)	692	699	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Procedure 8	X(7)	700	706	Spaces
Other Procedure 8 Date	X(8)	707	714	Spaces
Other Procedure 9	X(7)	715	721	Spaces
Other Procedure 9 Date	X(8)	722	729	Spaces
Other Procedure 10	X(7)	730	736	Spaces
Other Procedure 10 Date	X(8)	737	744	Spaces
Other Procedure 11	X(7)	745	751	Spaces
Other Procedure 11 Date	X(8)	752	759	Spaces
Other Procedure 12	X(7)	760	766	Spaces
Other Procedure 12 Date	X(8)	767	774	Spaces
Other Procedure 13	X(7)	775	781	Spaces
Other Procedure 13 Date	X(8)	782	789	Spaces
Other Procedure 14	X(7)	790	796	Spaces
Other Procedure 14 Date	X(8)	797	804	Spaces
Other Procedure 15	X(7)	805	811	Spaces
Other Procedure 15 Date	X(8)	812	819	Spaces
Other Procedure 16	X(7)	820	826	Spaces
Other Procedure 16 Date	X(8)	827	834	Spaces
Other Procedure 17	X(7)	835	841	Spaces
Other Procedure 17 Date	X(8)	842	849	Spaces
Other Procedure 18	X(7)	850	856	Spaces
Other Procedure 18 Date	X(8)	857	864	Spaces
Other Procedure 19	X(7)	865	871	Spaces
Other Procedure 19 Date	X(8)	872	879	Spaces
Other Procedure 20	X(7)	880	886	Spaces
Other Procedure 20 Date	X(8)	887	894	Spaces
Other Procedure 21	X(7)	895	901	Spaces
Other Procedure 21 Date	X(8)	902	909	Spaces
Other Procedure 22	X(7)	910	916	Spaces
Other Procedure 22 Date	X(8)	917	924	Spaces
Other Procedure 23	X(7)	925	931	Spaces
Other Procedure 23 Date	X(8)	932	939	Spaces
Other Procedure 24	X(7)	940	946	Spaces
Other Procedure 24 Date	X(8)	947	954	Spaces
Principal Procedure Version Indicator Code	X(1)	955	955	Spaces
Other Procedure 1 Version Indicator Code	X(1)	956	956	Spaces
Other Procedure 2 Version Indicator Code	X(1)	957	957	Spaces
Other Procedure 3 Version Indicator Code	X(1)	958	958	Spaces
Other Procedure 4 Version Indicator Code	X(1)	959	959	Spaces
Other Procedure 5 Version Indicator Code	X(1)	960	960	Spaces
Other Procedure 6 Version Indicator Code	X(1)	961	961	Spaces
Other Procedure 7 Version Indicator Code	X(1)	962	962	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Other Procedure 8 Version Indicator Code	X(1)	963	963	Spaces
Other Procedure 9 Version Indicator Code	X(1)	964	964	Spaces
Other Procedure 10 Version Indicator Code	X(1)	965	965	Spaces
Other Procedure 11 Version Indicator Code	X(1)	966	966	Spaces
Other Procedure 12 Version Indicator Code	X(1)	967	967	Spaces
Other Procedure 13 Version Indicator Code	X(1)	968	968	Spaces
Other Procedure 14 Version Indicator Code	X(1)	969	969	Spaces
Other Procedure 15 Version Indicator Code	X(1)	970	970	Spaces
Other Procedure 16 Version Indicator Code	X(1)	971	971	Spaces
Other Procedure 17 Version Indicator Code	X(1)	972	972	Spaces
Other Procedure 18 Version Indicator Code	X(1)	973	973	Spaces
Other Procedure 19 Version Indicator Code	X(1)	974	974	Spaces
Other Procedure 20 Version Indicator Code	X(1)	975	975	Spaces
Other Procedure 21 Version Indicator Code	X(1)	976	976	Spaces
Other Procedure 22 Version Indicator Code	X(1)	977	977	Spaces
Other Procedure 23 Version Indicator Code	X(1)	978	978	Spaces
Other Procedure 24 Version Indicator Code	X(1)	979	979	Spaces
Claim Demonstration Identification Number	9(2)	980	981	Zeroes
PPS Indicator	X(1)	982	982	Spaces
Action Code	X(1)	983	983	Spaces
Patient Status	X(2)	984	985	Spaces
Billing Provider NPI	X(10)	986	995	Spaces
Claim Provider Taxonomy Code	X(25)	996	1020	Spaces
Medical Record Number	X(17)	1021	1037	Spaces
Patient Control Number	X(20)	1038	1057	Spaces
Attending Physician NPI	X(10)	1058	1067	Spaces
Attending Physician Last Name	X(16)	1068	1083	Spaces
Operating Physician NPI	X(10)	1084	1093	Spaces
Operating Physician Last Name	X(16)	1094	1109	Spaces
Claim Rendering Physician NPI	X(10)	1110	1119	Spaces
Claim Rendering Physician Last Name	X(16)	1120	1135	Spaces
Date of Admission	X(8)	1136	1143	Spaces
Type of Admission	X(1)	1144	1144	Spaces
Source of Admission	X(1)	1145	1145	Spaces
DRG	X(3)	1146	1148	Spaces
Occurrence Code 1	X(2)	1149	1150	Spaces
Occurrence Code 1 Date	X(8)	1151	1158	Spaces
Occurrence Code 2	X(2)	1159	1160	Spaces
Occurrence Code 2 Date	X(8)	1161	1168	Spaces
Occurrence Code 3	X(2)	1169	1170	Spaces
Occurrence Code 3 Date	X(8)	1171	1178	Spaces
Occurrence Code 4	X(2)	1179	1180	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Occurrence Code 4 Date	X(8)	1181	1188	Spaces
Occurrence Code 5	X(2)	1189	1190	Spaces
Occurrence Code 5 Date	X(8)	1191	1198	Spaces
Occurrence Code 6	X(2)	1199	1200	Spaces
Occurrence Code 6 Date	X(8)	1201	1208	Spaces
Occurrence Code 7	X(2)	1209	1210	Spaces
Occurrence Code 7 Date	X(8)	1211	1218	Spaces
Occurrence Code 8	X(2)	1219	1220	Spaces
Occurrence Code 8 Date	X(8)	1221	1228	Spaces
Occurrence Code 9	X(2)	1229	1230	Spaces
Occurrence Code 9 Date	X(8)	1231	1238	Spaces
Occurrence Code 10	X(2)	1239	1240	Spaces
Occurrence Code 10 Date	X(8)	1241	1248	Spaces
Occurrence Code 11	X(2)	1249	1250	Spaces
Occurrence Code 11 Date	X(8)	1251	1258	Spaces
Occurrence Code 12	X(2)	1259	1260	Spaces
Occurrence Code 12 Date	X(8)	1261	1268	Spaces
Occurrence Code 13	X(2)	1269	1270	Spaces
Occurrence Code 13 Date	X(8)	1271	1278	Spaces
Occurrence Code 14	X(2)	1279	1280	Spaces
Occurrence Code 14 Date	X(8)	1281	1288	Spaces
Occurrence Code 15	X(2)	1289	1290	Spaces
Occurrence Code 15 Date	X(8)	1291	1298	Spaces
Occurrence Code 16	X(2)	1299	1300	Spaces
Occurrence Code 16 Date	X(8)	1301	1308	Spaces
Occurrence Code 17	X(2)	1309	1310	Spaces
Occurrence Code 17 Date	X(8)	1311	1318	Spaces
Occurrence Code 18	X(2)	1319	1320	Spaces
Occurrence Code 18 Date	X(8)	1321	1328	Spaces
Occurrence Code 19	X(2)	1329	1330	Spaces
Occurrence Code 19 Date	X(8)	1331	1338	Spaces
Occurrence Code 20	X(2)	1339	1340	Spaces
Occurrence Code 20 Date	X(8)	1341	1348	Spaces
Occurrence Code 21	X(2)	1349	1350	Spaces
Occurrence Code 21 Date	X(8)	1351	1358	Spaces
Occurrence Code 22	X(2)	1359	1360	Spaces
Occurrence Code 22 Date	X(8)	1361	1368	Spaces
Occurrence Code 23	X(2)	1369	1370	Spaces
Occurrence Code 23 Date	X(8)	1371	1378	Spaces
Occurrence Code 24	X(2)	1379	1380	Spaces
Occurrence Code 24 Date	X(8)	1381	1388	Spaces
Occurrence Code 25	X(2)	1389	1390	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Occurrence Code 25 Date	X(8)	1391	1398	Spaces
Occurrence Code 26	X(2)	1399	1400	Spaces
Occurrence Code 26 Date	X(8)	1401	1408	Spaces
Occurrence Code 27	X(2)	1409	1410	Spaces
Occurrence Code 27 Date	X(8)	1411	1418	Spaces
Occurrence Code 28	X(2)	1419	1420	Spaces
Occurrence Code 28 Date	X(8)	1421	1428	Spaces
Occurrence Code 29	X(2)	1429	1430	Spaces
Occurrence Code 29 Date	X(8)	1431	1438	Spaces
Occurrence Code 30	X(2)	1439	1440	Spaces
Occurrence Code 30 Date	X(8)	1441	1448	Spaces
Value Code 1	X(2)	1449	1450	Spaces
Value Amount 1	S9(8)V99	1451	1460	Zeroes
Value Code 2	X(2)	1461	1462	Spaces
Value Amount 2	S9(8)V99	1463	1472	Zeroes
Value Code 3	X(2)	1473	1474	Spaces
Value Amount 3	S9(8)V99	1475	1484	Zeroes
Value Code 4	X(2)	1485	1486	Spaces
Value Amount 4	S9(8)V99	1487	1496	Zeroes
Value Code 5	X(2)	1497	1498	Spaces
Value Amount 5	S9(8)V99	1499	1508	Zeroes
Value Code 6	X(2)	1509	1510	Spaces
Value Amount 6	S9(8)V99	1511	1520	Zeroes
Value Code 7	X(2)	1521	1522	Spaces
Value Amount 7	S9(8)V99	1523	1532	Zeroes
Value Code 8	X(2)	1533	1534	Spaces
Value Amount 8	S9(8)V99	1535	1544	Zeroes
Value Code 9	X(2)	1545	1546	Spaces
Value Amount 9	S9(8)V99	1547	1556	Zeroes
Value Code 10	X(2)	1557	1558	Spaces
Value Amount 10	S9(8)V99	1559	1568	Zeroes
Value Code 11	X(2)	1569	1570	Spaces
Value Amount 11	S9(8)V99	1571	1580	Zeroes
Value Code 12	X(2)	1581	1582	Spaces
Value Amount 12	S9(8)V99	1583	1592	Zeroes
Value Code 13	X(2)	1593	1594	Spaces
Value Amount 13	S9(8)V99	1595	1604	Zeroes
Value Code 14	X(2)	1605	1606	Spaces
Value Amount 14	S9(8)V99	1607	1616	Zeroes
Value Code 15	X(2)	1617	1618	Spaces
Value Amount 15	S9(8)V99	1619	1628	Zeroes
Value Code 16	X(2)	1629	1630	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Value Amount 16	S9(8)V99	1631	1640	Zeroes
Value Code 17	X(2)	1641	1642	Spaces
Value Amount 17	S9(8)V99	1643	1652	Zeroes
Value Code 18	X(2)	1653	1654	Spaces
Value Amount 18	S9(8)V99	1655	1664	Zeroes
Value Code 19	X(2)	1665	1666	Spaces
Value Amount 19	S9(8)V99	1667	1676	Zeroes
Value Code 20	X(2)	1677	1678	Spaces
Value Amount 20	S9(8)V99	1679	1688	Zeroes
Value Code 21	X(2)	1689	1690	Spaces
Value Amount 21	S9(8)V99	1691	1700	Zeroes
Value Code 22	X(2)	1701	1702	Spaces
Value Amount 22	S9(8)V99	1703	1712	Zeroes
Value Code 23	X(2)	1713	1714	Spaces
Value Amount 23	S9(8)V99	1715	1724	Zeroes
Value Code 24	X(2)	1725	1726	Spaces
Value Amount 24	S9(8)V99	1727	1736	Zeroes
Value Code 25	X(2)	1737	1738	Spaces
Value Amount 25	S9(8)V99	1739	1748	Zeroes
Value Code 26	X(2)	1749	1750	Spaces
Value Amount 26	S9(8)V99	1751	1760	Zeroes
Value Code 27	X(2)	1761	1762	Spaces
Value Amount 27	S9(8)V99	1763	1772	Zeroes
Value Code 28	X(2)	1773	1774	Spaces
Value Amount 28	S9(8)V99	1775	1784	Zeroes
Value Code 29	X(2)	1785	1786	Spaces
Value Amount 29	S9(8)V99	1787	1796	Zeroes
Value Code 30	X(2)	1797	1798	Spaces
Value Amount 30	S9(8)V99	1799	1808	Zeroes
Value Code 31	X(2)	1809	1810	Spaces
Value Amount 31	S9(8)V99	1811	1820	Zeroes
Value Code 32	X(2)	1821	1822	Spaces
Value Amount 32	S9(8)V99	1823	1832	Zeroes
Value Code 33	X(2)	1833	1834	Spaces
Value Amount 33	S9(8)V99	1835	1844	Zeroes
Value Code 34	X(2)	1845	1846	Spaces
Value Amount 34	S9(8)V99	1847	1856	Zeroes
Value Code 35	X(2)	1857	1858	Spaces
Value Amount 35	S9(8)V99	1859	1868	Zeroes
Value Code 36	X(2)	1869	1870	Spaces
Value Amount 36	S9(8)V99	1871	1880	Zeroes
Claim Final Allowed Amount	S9(8)V99	1881	1890	Zeroes

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Claim Deductible Amount	S9(8)V99	1891	1900	Zeroes
Claim State	X(2)	1901	1902	Spaces
Claim Zip Code	X(9)	1903	1911	Spaces
Beneficiary State	X(2)	1912	1913	Spaces
Beneficiary Zip Code	X(9)	1914	1922	Spaces
Claim PWK	X(60)	1923	1982	Spaces
Patient Reason for Visit 1	X(7)	1983	1989	Spaces
Patient Reason for Visit 2	X(7)	1990	1996	Spaces
Patient Reason for Visit 3	X(7)	1997	2003	Spaces
Patient Reason for Visit 2 Version Indicator Code	X(1)	2004	2004	Spaces
Patient Reason for Visit 1 Version Indicator Code	X(1)	2005	2005	Spaces
Patient Reason for Visit 3 Version Indicator Code	X(1)	2006	2006	Spaces
Present on Admission/External Cause of Injury Indicator	X(37)	2007	2043	Spaces
External Cause of Injury 1	X(7)	2044	2050	Spaces
External Cause of Injury 2	X(7)	2051	2057	Spaces
External Cause of Injury 3	X(7)	2058	2064	Spaces
External Cause of Injury 4	X(7)	2065	2071	Spaces
External Cause of Injury 5	X(7)	2072	2078	Spaces
External Cause of Injury 6	X(7)	2079	2085	Spaces
External Cause of Injury 7	X(7)	2086	2092	Spaces
External Cause of Injury 8	X(7)	2093	2099	Spaces
External Cause of Injury 9	X(7)	2100	2106	Spaces
External Cause of Injury 10	X(7)	2107	2113	Spaces
External Cause of Injury 11	X(7)	2114	2120	Spaces
External Cause of Injury 12	X(7)	2121	2127	Spaces
External Cause of Injury 1 Version Indicator Code	X(1)	2128	2128	Spaces
External Cause of Injury 2 Version Indicator Code	X(1)	2129	2129	Spaces
External Cause of Injury 3 Version Indicator Code	X(1)	2130	2130	Spaces
External Cause of Injury 4 Version Indicator Code	X(1)	2131	2131	Spaces
External Cause of Injury 5 Version Indicator Code	X(1)	2132	2132	Spaces
External Cause of Injury 6 Version Indicator Code	X(1)	2133	2133	Spaces
External Cause of Injury 7 Version Indicator Code	X(1)	2134	2134	Spaces
External Cause of Injury 8 Version Indicator Code	X(1)	2135	2135	Spaces
External Cause of Injury 9 Version Indicator Code	X(1)	2136	2136	Spaces
External Cause of Injury 10 Version Indicator Code	X(1)	2137	2137	Spaces
External Cause of Injury 11 Version Indicator Code	X(1)	2138	2138	Spaces
External Cause of Injury 12 Version Indicator Code	X(1)	2139	2139	Spaces
Service Facility Zip Code	X(9)	2140	2148	Spaces
RAC adjustment indicator	X(1)	2149	2149	Spaces
Split/Adjustment Indicator	9(2)	2150	2151	Spaces
Referring Physician NPI	X(10)	2152	2161	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Referring Physician Last Name	X(16)	2162	2177	Spaces
Referring Physician Specialty	X(2)	2178	2179	Spaces
Claim Rendering Physician Specialty	X(2)	2180	2181	Spaces
Filler	X(20)	2182	2201	Spaces
Total Line Item Count	9(3)	2202	2204	Zeroes
Record Line Item Count	9(3)	2205	2207	Zeroes
Line Item group: The following group of fields occurs from 1 to 450 times for the claim (depending on Total Line Item Count) and 1 to **75** times for the Record (depending on Record Line Item Count)				
From and Thru values relate to the 1st line item				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Revenue center code	X(4)	2208	2211	Spaces
SNF-RUG-III code	X(3)	2212	2214	Spaces
APC adjustment code	X(5)	2215	2219	Spaces
HCPCS Procedure Code	X(5)	2220	2224	Spaces
HCPCS Modifier 1	X(2)	2225	2226	Spaces
HCPCS Modifier 2	X(2)	2227	2228	Spaces
HCPCS Modifier 3	X(2)	2229	2230	Spaces
HCPCS Modifier 4	X(2)	2231	2232	Spaces
HCPCS Modifier 5	X(2)	2233	2234	Spaces
Line Item Date	X(8)	2235	2242	Spaces
Line Submitted Charge	S9(8)V99	2243	2252	Zeroes
Line Medicare Initial Allowed Charge	S9(8)V99	2253	2262	Zeroes
ANSI Reason Code 1	X(8)	2263	2270	Spaces
ANSI Reason Code 2	X(8)	2271	2278	Spaces
ANSI Reason Code 3	X(8)	2279	2286	Spaces
ANSI Reason Code 4	X(8)	2287	2294	Spaces
ANSI Reason Code 5	X(8)	2295	2302	Spaces
ANSI Reason Code 6	X(8)	2303	2310	Spaces
ANSI Reason Code 7	X(8)	2311	2318	Spaces
ANSI Reason Code 8	X(8)	2319	2326	Spaces
ANSI Reason Code 9	X(8)	2327	2334	Spaces
ANSI Reason Code 10	X(8)	2335	2342	Spaces
ANSI Reason Code 11	X(8)	2343	2350	Spaces
ANSI Reason Code 12	X(8)	2351	2358	Spaces
ANSI Reason Code 13	X(8)	2359	2366	Spaces
ANSI Reason Code 14	X(8)	2367	2374	Spaces
Manual Medical Review Indicator	X(1)	2375	2375	Spaces
Resolution Code	X(5)	2376	2380	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Line Final Allowed Charge	S9(8)V99	2381	2390	Zeroes
Line Cash Deductible	S9(8)V99	2391	2400	Zeroes
Special Action Code/Override Code	X(1)	2401	2401	Zeroes
Units	S9(7)v999	2402	2411	Zeroes
Rendering Physician NPI	X(10)	2412	2421	Spaces
Rendering Physician Last Name	X(25)	2422	2446	Spaces
National Drug Code (NDC) field	X(11)	2447	2457	Spaces
National Drug Code (NDC) Quantity	S9(7)v999	2458	2467	Spaces
National Drug Code (NDC) Quantity Qualifier	X(2)	2468	2469	Spaces
Line PWK	X(60)	2470	2529	Spaces
Line Rendering Physician specialty	X(2)	2530	2531	Spaces
Filler	X(23)	2532	2554	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

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

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

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

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.

Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

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

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

Data Element: Original Claim Control Number
Definition: The Claim Control Number the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the 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: MMDDCCYY on which the beneficiary was born
Requirement: Required

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

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

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

Data Element: Claim Paid Amount
Definition: Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the 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 1-7
Definition: Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed
Validation: Must be valid American National Standards Institute (ANSI) Ambulatory Surgical Center (ASC) claim adjustment code and applicable group code.
Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code
Requirement: Report all ANSI reason codes on the bill

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

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

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

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

Data Element: Condition Code 1-30
Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Remarks: This field is left justified and blank filled. Requirement: Required if there is a condition code for the bill.

Data Element: Type of Bill
Definition: A code indicating the specific type of bill (hospital, inpatient, SNF, outpatient, adjustments, voids, etc.).
This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code

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

Data Element: Principal Diagnosis
Definition: The ICD--CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only ICD--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--CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD--CM diagnoses codes, including all seven 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: Principal Diagnosis Version Indicator Code
Definition: The diagnosis version code identifying the version of ICD diagnosis code submitted.
Validation:

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

Remarks: With the exception of claims submitted by ambulance suppliers (specialty
Requirement: Principal Diagnosis Version Code 1 is required for ALL claims.

Data Element: Other Diagnosis Code 1-24
Definition: The ICD-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be present during treatment
Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only ICD-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-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including all seven digits where applicable.

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

Data Element: Other Diagnosis Version Indicator Code 1-24

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

Validation:

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

Remarks:

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

Data Element: Principal Procedure and Date

Definition: The ICD-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 CCYYMMDD in the "date" portion.

Requirement: Required for inpatient claims.

Data Element: Principal Procedure Version Indicator Code

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

Validation:

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

Remarks:

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

Data Element: Other Procedure and Date 1-24

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

Validation: Must be a valid ICD-CM procedure code

- CMS accepts only ICD-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-CM Coordination and Maintenance Committee.

- The procedure code shown must be the full ICD-CM, Volume 3, procedure code, including all seven digits where applicable.

Remarks: The date applicable to the procedure is shown numerically as CCYYMMDD in the "date" portion.
Requirement: Required if on claim record.

Data Element: Other Procedure Code Version Indicator Code 1-24
Definition: The ICD-CM diagnosis version code identifying the version of procedure code submitted.
Validation:

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

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

Data Element: Claim Demonstration Identification Number
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks:
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
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:
Requirement: Required

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

Requirement: Required for providers using HIPAA standard transactions

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

Remarks: N/A
Requirement: Required when available.

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

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

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

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

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

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

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

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

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

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

Data Element: Source of Admission
Definition: The code indicating the means by which the beneficiary was admitted to the inpatient health care facility or SNF if the type of admission is (1) emergency, (2) urgent, or (3) elective.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Code Structure (For Emergency, Elective, or Other Type of Admission):
Requirement: Required when entered on the claim record.

Data Element: DRG (Diagnosis Related Group)
Definition: The code identifying the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
Validation: Must be valid per the DRG DEFINITIONS MANUAL
Remarks: N/A
Requirement: Required if available on the claim record

Data Element: Occurrence Code and Date 1-30
Definition: Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing

Manual, Chapter 25, Completing and Processing 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 1-36

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: Patient Reason for Visit 1-3

Definition: An ICD-9-CM code on the institutional claim indicating the beneficiary's reason for visit
Validation: Must be a valid ICD-CM diagnosis code

- CMS accepts only ICD-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-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including all seven digits where applicable.

Remarks: Report the full ICD-CM codes for up to 3 conditions responsible for the patient's visit.
Requirement: For OP claims, this field is populated for those claims that are required to process through OP PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services

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

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

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

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

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

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

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

Data Element: External Cause of Injury Diagnosis Codes 1-12
Definition: The ICD-CM code used to identify the external cause of injury, poisoning, or other adverse affect.
Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only ICD-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-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including all seven digits where applicable.

Remarks: Report the full ICD-CM codes for up to 12 conditions resulting from external causes.
Requirement: Required if available on the claim record.

Data Element: External Cause of Injury Version Indicator Code Codes 1-12
Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code identified as external cause of injury.
Validation:

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

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

Data Element: Service Facility Zip Code
Definition: Zip Code used to identify were the service was furnished.
Validation: Must be a valid Zip Code
Remarks:
Requirement: Required, if available on claim record.

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

Data Element: Split/Adjustment Indicator
Definition: Count of number of adjustments (with different DCNs) of the claim that are included in the resolution file.
Validation: '00' is used when only one DCN associated with the sampled claim is included in

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

- When the resolution file contains 2 DCNs related to a single claim, one of the records would contain a split/adjustment indicator of 01 and the second record would contain a split/adjustment indicator of 02.

This field is right justified and zero filled.

Remarks: This indicator does not apply when multiple records are submitted for a single claim record because of size restrictions.
CERT recognizes that Part A claims are not split. For Part A this field will identify adjustments only.

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

Data Element: Referring Physician NPI
Definition: NPI assigned to the Referring Physician—the physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
Validation: N/A
Remarks: Enter zeros if there is no referring physician
Requirement: Required when available on the claim record
NOTES:

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

Data Element: Referring Physician Last Name
Definition: Last name of the referring physician.
Validation: N/A
Remarks: Enter zeros if there is no referring/ordering provider
Requirement: Required when available on the claim record.

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

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

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

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

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

Data Element: Manual Medical Review Indicator
Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the 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.

Resolution Code	Description
DENAM	Denied after automated medical review
DENMR	Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMC	Denied for medical review reasons or for insufficient documentation medical necessity, manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DEO	Denied for non-medical reasons, other than denied as unprocessable.
RTP	Denied as unprocessable (return/reject)
REDAM	Reduced after medical review
REDMR	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
REDMC	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
REO	Reduced for non-medical review reasons.
INACT	Claim is inactive as identified by "I" Status

Requirement: **Required**

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

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

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

Data Element: Units
Definition: The total number of services or time periods provided for the line item.
Validation: N/A
Remarks: Zero filled to maintain the relative position of the decimal point.
The last three positions should contain the value to the right of the decimal in the number of services. Put a zero in the last three positions for whole numbers.

For example if the number of units is 10, this field would be filled as 0000010000
Requirement: Required

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

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

Data Element: National Drug Code (NDC) field
Definition: To be assigned at a later date.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

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

Data Element: National Drug Code (NDC) Quantity Qualifier
Definition: To be assigned at a later date.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

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

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

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

Exhibit 36.1

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)	10	10	'3'
Record Version Code	X(1)	11	11	Spaces
Contractor Type	X(1)	12	12	Spaces
Number of Claims	9(9)	13	21	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
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
Remarks: N/A
Requirement: Required

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