

<b>CMS Manual System</b>	Department of Health & Human Services (DHHS)
<b>Pub 100-08 Medicare Program Integrity</b>	Centers for Medicare & Medicaid Services (CMS)
<b>Transmittal 209</b>	<b>Date: JUNE 12, 2007</b>
	<b>Change Request 5044</b>

**NOTE: Transmittal 197, dated April 6, 2007 is rescinded and replaced with Transmittal 209, dated June 12, 2007. Corrections In Exhibit 36.2 Are: Changed all signed fields to unsigned, corrected starting and ending positions to conform to field lengths, and made all date formats CCYYMMDD. All other information remains the same.**

**SUBJECT: Revise the VIPS Medicare System (VMS) and Medicare Contractor System (MCS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier**

**I. SUMMARY OF CHANGES:** The PIM, Chapter 12 - Carrier, DMERC, FI, and full PSC Interaction With the Comprehensive Error Rate Testing Contractor, Section 12.3.3.1, requires that an AC/full PSC provide all information on claims in the CERT sample at the line level.

**NEW/REVISED MATERIAL**

**EFFECTIVE DATE\*: JULY 1, 2007 (VMS)**

**OCTOBER 1, 2007 (MCS)**

**IMPLEMENTATION DATE: VMS SHALL IMPLEMENT ON JULY 2, 2007**

**MCS SHALL IMPLEMENT ON OCTOBER 1, 2007**

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

**II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)**

**R=REVISED, N=NEW, D=DELETED**

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	Exhibit 36.2/CERT Formats for Carrier and DMERC Standard Systems

**III. FUNDING:**

**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

**IV. ATTACHMENTS:**

**Business Requirements  
Manual Instruction**

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

# Attachment – Business Requirements

Pub. 100-08	Transmittal: 209	Date: June 12, 2007	Change Request: 5044
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**NOTE: Transmittal 197, dated April 6, 2007 is rescinded and replaced with Transmittal 209, dated June 12, 2007. Corrections In Exhibit 36.2 Are: Changed all signed fields to unsigned, corrected starting and ending positions to conform to field lengths, and made all date formats CCYYMMDD. All other information remains the same.**

**SUBJECT: Revise the VIPS Medicare System (VMS) and Medicare Contractor System (MCS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier**

**EFFECTIVE DATE: July 1, 2007 (VMS)**

***October 1, 2007 (MCS)***

**IMPLEMENTATION DATE: VMS shall implement on July 2, 2007**

**MCS shall implement on *October 1, 2007***

## **I. GENERAL INFORMATION**

**A. Background:** The Medicare Program Integrity Manual, Chapter 12, Section 12.3.3.1, Providing Sample Information to the CERT Contractor requires:

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

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

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

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

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

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

**B. Policy:** The PIM, Chapter 12, section 12.3.3.1 requires that an AC/full PSC provide all information on claims in the CERT sample at the line level.

## II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B  M A C	D M M A C	F I	C A R R I E R	D M R C	R H H I	Shared-System Maintainers				O T H E R
								F I S S	M C S	V M S	C W F	
5044.1	The MCS and VMS maintainers shall modify the MCS and VMS system modules to provide data in the format specified in the Medicare Program Integrity Manual, Exhibits/Exhibit 36.2.								X	X		
5044.2	Contractor data centers shall implement, operate, and maintain the shared system changes specified in requirement 5044.1 and provided by shared system maintainers.	X	X		X	X			X	X		D M E R C P S C s
5044.3	Contractors shall insure that their data centers have correctly implemented and are providing CERT files in the formats required by this OTN.	X	X		X	X						D M E R C P S C s

## III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B  M A C	D M M A C	F I	C A R R I E R	D M R C	R H H I	Shared-System Maintainers				O T H E R
								F I S S	M C S	V M S	C W F	
	None											

## IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
NA	NA

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

N/A

## V. CONTACTS

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

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

## VI. FUNDING

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

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

### ***B. For Medicare Administrative Contractors (MAC), use the following statement:***

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

## Exhibit 36.2 – CERT Formats for Carrier and DMERC Standard Systems

*(Rev. 209; Issued: 06-12-07; Effective: 07-01-07; Implementation: 07-02-07)*

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

### DATA ELEMENT DETAIL

#### Data Element: Contractor ID

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

#### Data Element: Record Type

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

#### Data Element: Record Version Code

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

#### Data Element: Contractor Type

Definition: Type of Medicare Contractor  
 Validation: Must be 'B' or 'D'  
 Remarks: B = Part B  
 D = DMERC  
 Requirement: Required

#### Data Element: Universe Date

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

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

Requirement: Required

Claims Universe File				
Claims Universe Claim Detail Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(15)	9	23	Spaces
Beneficiary HICN	X(12)	24	35	Spaces
Billing Provider Number	X(15)	36	50	Spaces
Billing Provider NPI	X(10)	51	60	Spaces
Claim Submitted Charge Amount	9(7)v99	61	69	Zeroes
Claim Demonstration Number	X(2)	70	71	Spaces
Claim State	X(2)	72	73	Spaces
Beneficiary State	X(2)	74	75	Spaces
Billing Provider Specialty	X(2)	76	77	Spaces
Line Item Count	9(2)	78	79	Zeroes
Line Item group: The following group of Fields occurs from 1 to 52 Times (depending on Line Item Count).				

From and Thru values relate to the 1st line item

Performing Provider Number	X(15)	80	94	Spaces
Performing Provider Specialty	X(2)	95	96	Spaces
HCPCS Procedure Code	X(5)	97	101	Spaces
From Date of Service	X(8)	102	109	Spaces
To Date of Service	X(8)	110	117	Spaces
Line Submitted Charge	9(7)v99	118	126	Zeroes
Performing Provider NPI	X(10)	127	136	Spaces

## DATA ELEMENT DETAIL

### Claim Header Fields

#### **Data Element: Contractor ID**

Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

**Data Element: Record Type**

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

**Data Element: Record Version Code**

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

**Data Element: Contractor Type**

Definition: Type of Medicare Contractor  
Validation: Must be 'B' or 'D'  
Remarks: B = Part B  
D = DMERC  
Requirement: Required

**Data Element: Claim Control Number**

Definition: Number assigned by the shared system to uniquely identify the claim  
Validation: N/A  
Remarks: N/A  
Requirement: Required

**Data Element: Beneficiary HICN**

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

**Data Element: Billing Provider Number**

Definition: Number assigned by the NSC or Carrier to identify the billing/pricing provider or supplier  
Validation: NA  
Remarks: Must be present. Use the same requirements as for Item 33 in HCFA 1500.

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

Requirement: Required

**Data Element: Billing Provider NPI**

Definition: NPI assigned to the Billing Provider.

Validation: N/A

Remarks: N/A.

Requirement: Required as available. This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

**Data Element: Claim Submitted Charge Amount**

Definition: The total submitted charges on the claim (the sum of line item submitted charges).

Validation: N/A

Remarks: N/A

Requirement: Required

**Data Element: Claim Demonstration Number**

Definition: Also known as Claim Demonstration Identification Number. The number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

Validation: Must be a Valid Demo ID

Remarks: N/A

Requirement: Required when available on claim.

**Data Element: Claim State**

Definition: State abbreviation identifying the state in which the service is furnished

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)

[http://www.usps.com/ncsc/lookups/usps\\_abbreviations.html#states](http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states)

Remarks: When services on a single claim are furnished in multiple states, enter the state identifier for the first detail line.

Requirement: Required

**Data Element: Beneficiary State**

Definition: State abbreviation identifying the state in which the beneficiary resides.

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)

[http://www.usps.com/ncsc/lookups/usps\\_abbreviations.html#states](http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states)

Remarks: N/A

Requirement: Required, when available

**Data Element: Billing Provider Specialty**

Definition: Code indicating the primary specialty of the Billing provider or supplier

Validation: N/A

Remarks: N/A

Requirement: Required

**Data Element: Line Item Count**

Definition: Number indicating number of service lines on the claim

Validation: Must be a number 01 – 52

Remarks: N/A

Requirement: Required

**Claim Line Item Fields**

**Data Element: Performing Provider Number**

Definition: Number assigned by the NSC or Carrier to identify the provider who performed the service or the supplier who supplied the medical equipment

Validation: N/A

Remarks: Enter the PIN of the performing provider. When several different providers of service or suppliers are billing on the same claim, show the individual PIN in the corresponding line item.

Requirement: Required

**Data Element: Performing Provider Specialty**

Definition: Code indicating the primary specialty of the performing provider or supplier

Validation: N/A

Remarks: N/A

Requirement: Required

**Data Element: HCPCS Procedure Code**

Definition: The HCPCS/CPT-4 code that describes the service

Validation: N/A

Remarks: N/A

Requirement: Required

**Data Element: From Date of Service**

Definition: The date the service was initiated

Validation: Must be a valid date less than or equal to To Date of Service

Remarks: Format is **CCYYMMDD**

Requirement: Required

**Data Element: To Date of Service**

Definition: The date the service ended

Validation: Must be a valid date greater than or equal to From Date of Service

Remarks: Format is **CCYYMMDD**

Requirement: Required

**Data Element: Line Submitted Charge**

Definition: Actual charge submitted by the provider or supplier for the service or equipment

Validation: N/A

Remarks: N/A

Requirement: Required

**Data Element: Performing Provider NPI**

Definition: NPI assigned to the Performing Provider.

Validation: N/A

Remarks: N/A.

Requirement: Required as available. This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

**Claims Universe File**

**Claims Universe Trailer Record (one record per file)**

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeroes

#### DATA ELEMENT DETAIL

##### Data Element: Contractor ID

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

##### Data Element: Record Type

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

##### Data Element: Record Version Code

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

##### Data Element: Contractor Type

Definition: Type of Medicare Contractor  
Validation: Must be 'B' or 'D'  
Remarks: B = Part B  
D = DMERC  
Requirement: Required

##### Data Element: Number of Claims

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

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

**DATA ELEMENT DETAIL**

**Data Element: Contractor ID**

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

**Data Element: Record Type**

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

**Data Element: Record Version Code**

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

**Data Element: Contractor Type**

Definition: Type of Medicare Contractor  
Validation: Must be 'B' or 'D'  
Remarks: B = Part B  
D = DMERC  
Requirement: Required

**Data Element: Transaction Date**

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

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

**DATA ELEMENT DETAIL**

**Data Element: Contractor ID**

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

**Data Element: Record Type**

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

**Data Element: Record Version Code**

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

**Data Element: Contractor Type**

Definition: Type of Medicare Contractor  
 Validation: Must be 'B' or 'D'  
 Remarks: B = Part B  
 D = DMERC  
 Requirement: Required

**Data Element: Claim Control Number**

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

**Data Element: Beneficiary HICN**

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

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

**DATA ELEMENT DETAIL**

**Data Element: Contractor ID**

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

**Data Element: Record Type**

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

**Data Element: Record Version Code**

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

**Data Element: Contractor Type**

Definition: Type of Medicare Contractor  
 Validation: Must be ‘B’ or ‘D’  
 Remarks: B = Part B  
 D = DMERC  
 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

<b>Claims Resolution File</b>				
<b>Claims Resolution Header Record (one record per file)</b>				
<b>Field Name</b>	<b>Picture</b>	<b>From</b>	<b>Thru</b>	<b>Initialization</b>
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 7/1/2007 did not contain this field.  
 Codes:  
 B = Record Format as of 7/1/2007  
 Remarks: N/A  
 Requirement: Required

**Data Element: Contractor Type**

Definition: Type of Medicare Contractor  
 Validation: Must be 'B' or 'D'  
 Remarks: B = Part B  
 D = DMERC  
 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

<b>Sampled Claims Resolution File</b>				
<b>Sampled Claims Resolution Detail Record (one record per claim)</b>				
<b>Field Name</b>	<b>Picture</b>	<b>From</b>	<b>Thru</b>	<b>Initialization</b>
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	
Assignment Indicator	X(1)	9	9	Spaces
Mode of Entry Indicator	X(1)	10	10	Spaces
Original Claim Control Number	X(15)	11	25	Spaces
Claim Control Number	X(15)	26	40	Spaces
Beneficiary HICN	X(12)	41	52	Spaces
Beneficiary Last Name	X(20)	53	72	Spaces
Beneficiary First Name	X(10)	73	82	Spaces
Beneficiary Middle Initial	X(1)	83	83	Spaces
Beneficiary Date Of Birth	X(8)	84	91	Spaces
Billing Provider Number	X(15)	92	106	Spaces
Referring/Ordering UPIN	X(6)	107	112	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	Picture	From	Thru	Initialization
Claim Allowed Amount	9(7)v99	113	121	Zeroes
Claim ANSI Reason Code 1	X(8)	122	129	Spaces
Claim ANSI Reason Code 2	X(8)	130	137	Spaces
Claim ANSI Reason Code 3	X(8)	138	145	Spaces
Claim Entry Date	X(8)	146	153	Spaces
Claim Adjudicated Date	X(8)	154	161	Spaces
Beneficiary Gender	X(1)	162	162	Spaces
Billing Provider NPI	X(10)	163	172	Spaces
Referring/Ordering Provider NPI	X(10)	173	182	Spaces
Claim Paid Amount	9(7)v99	183	191	Zeroes
Beneficiary Paid Amount	9(7)v99	192	200	Zeroes
Claim Diagnosis Code 1	X(5)	201	205	Spaces
Claim Diagnosis Code 2	X(5)	206	210	Spaces
Claim Diagnosis Code 3	X(5)	211	215	Spaces
Claim Diagnosis Code 4	X(5)	216	220	Spaces
Claim Diagnosis Code 5	X(5)	221	225	Spaces
Claim Diagnosis Code 6	X(5)	226	230	Spaces
Claim Diagnosis Code 7	X(5)	231	235	Spaces
Claim Diagnosis Code 8	X(5)	236	240	Spaces
Claim Zip Code	X(5)	241	245	Spaces
Claim Pricing State	X(2)	246	247	Spaces
Beneficiary Zip Code	X(5)	248	252	Spaces
Beneficiary State	X(2)	253	254	Spaces
Claim Demonstration Number	X(2)	255	256	Spaces

Line Item Count	9(2)	257	258	Zeroes
Line Item group: The following group of fields occurs from 1 to 52 times (Depending on Line Item Count).				

From and Thru values relate to the 1st line item

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	Picture	From	Thru	Initialization
Performing Provider Number	X(15)	259	273	Spaces
Performing Provider Specialty	X(2)	274	275	Spaces
HCPCS Procedure Code	X(5)	276	280	Spaces
HCPCS Modifier 1	X(2)	281	282	Spaces
HCPCS Modifier 2	X(2)	283	284	Spaces
HCPCS Modifier 3	X(2)	285	286	Spaces
HCPCS Modifier 4	X(2)	287	288	Spaces

Number of Services	999v9	289	292	Zeroes
Service From Date	X(8)	293	300	Spaces
Service To Date	X(8)	301	308	Spaces
Place of Service	X(2)	309	310	Spaces
Type of Service	X(1)	311	311	Spaces
Diagnosis Code	X(5)	312	316	Spaces
CMN Control Number	X(15)	317	331	Spaces
Line Submitted Charge	9(7)v99	332	340	Zeroes
Line Medicare Initial Allowed Charge	9(7)v99	341	349	Zeroes
ANSI Reason Code 1	X(8)	350	357	Spaces
ANSI Reason Code 2	X(8)	358	365	Spaces
ANSI Reason Code 3	X(8)	366	373	Spaces
ANSI Reason Code 4	X(8)	374	381	Spaces
ANSI Reason Code 5	X(8)	382	389	Spaces
ANSI Reason Code 6	X(8)	390	397	Spaces
ANSI Reason Code 7	X(8)	398	405	Spaces
Manual Medical Review Indicator	X(1)	406	406	Space
Resolution Code	X(5)	407	411	Spaces
Line Final Allowed Charge	9(7)v99	412	420	Zeroes
Performing Provider NPI	X(10)	421	430	Spaces
Performing Provider UPIN	X(6)	431	436	Spaces
Miles/Time/Units/Services Indicator Code	X(1)	437	437	Spaces
Line Deductible Applied	9(7)v99	438	446	Zeroes
Line Co-Insurance	9(7)V99	447	455	Zeroes
Line Paid Amount	9(7)v99	456	464	Zeroes
Line MSP Code	X(1)	465	465	Spaces
Line MSP Paid Amount	9(7)v99	466	474	Zeroes
Line Pricing Locality	X(2)	475	476	Spaces
Line Zip Code	X(5)	477	481	Spaces
Line Pricing State Code	X(2)	482	483	Spaces
Filler	X(25)	484	508	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 7/1/2007 did not contain this field.  
Codes:  
B = Record Format as of 7/1/2007  
Remarks: N/A  
Requirement: Required

**Data Element: Contractor Type**

Definition: Type of Medicare Contractor  
Validation: Must be 'B' or 'D'  
Remarks: B = Part B  
D = DMERC  
Requirement: Required

**Data Element: Assignment Indicator**

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

**Data Element: Mode of Entry Indicator**

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

**Data Element: Original Claim Control Number**

Definition: The Claim Control Number the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the 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: Must match the Claim Control Number identified in the Sampled Claims Transaction File.  
Remarks: N/A  
Requirement: Required

**Data Element: Claim Control Number**

Definition: Number assigned by the shared system to uniquely identify the claim  
Validation: N/A  
Remarks: N/A  
Requirement: Required

**Data Element: Beneficiary HICN**

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

**Data Element: Beneficiary Last Name**

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

**Data Element: Beneficiary First Name**

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

**Data Element: Beneficiary Middle Initial**

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

**Data Element: Beneficiary Date of Birth**

Definition: Date on which beneficiary was born.  
Validation: Must be a valid date  
Remarks: **CCYYMMDD** on which the beneficiary was born  
Requirement: Required

**Data Element: Billing Provider Number**

Definition: Number assigned by the NSC or Carrier to identify the billing/pricing provider or supplier.  
Validation: Must be present. Use the same requirements as for Item 33 in HCFA 1500.

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

Remarks: N/A  
Requirement: **Required**

**Data Element: Referring/Ordering UPIN**

Definition: UPIN assigned to identify the referring/ordering provider.  
Validation: N/A  
Remarks: Enter zeros if there is no referring/ordering provider

- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

- **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient

Requirement: Required when available on the claim record.

**Data Element: Claim Allowed Amount**

Definition: Final Allowed Amount for this claim.

Validation: N/A

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

Requirement: Required.

**Data Element: Claim ANSI Reason Code 1  
Claim ANSI Reason Code 2  
Claim ANSI Reason Code 3**

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

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

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

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

**Data Element: Claim Entry Date**

Definition: Date claim entered the shared claim processing system

Validation: Must be a valid date

Remarks: Format must be CCYYMMDD

Requirement: Required

**Data Element: Claim Adjudicated Date**

Definition: Date claim completed adjudication

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

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

Requirement: Required

**Data Element: Beneficiary Gender**

Definition: Gender of the Beneficiary.

Validation: M=Male

F=Female

U=Unknown

Remarks: N/A

Requirement: Required

**Data Element: Billing Provider NPI**

Definition: NPI assigned to the Billing Provider.

Validation: N/A

Remarks: N/A.

Requirement: Required when available. This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

**Data Element: Referring/Ordering Provider NPI**

Definition: NPI assigned to the Referring/Ordering Provider.  
Validation: N/A  
Remarks: Enter zeros if there is no referring/ordering provider

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

Requirement: Required when available on the claim record.

**Data Element: Claim Paid Amount**

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

**Data Element: Beneficiary Paid Amount**

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

**Data Element: Claim Diagnosis Code 1**  
**Claim Diagnosis Code 2**  
**Claim Diagnosis Code 3**  
**Claim Diagnosis Code 4**  
**Claim Diagnosis Code 5**  
**Claim Diagnosis Code 6**  
**Claim Diagnosis Code 7**  
**Claim Diagnosis Code 8**

**Definition:** The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided

**Validation:** Must be a valid ICD-9-CM diagnosis code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable

**Remarks:** With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures. Since this is a required field, resolution records for claims billed by Ambulance suppliers and independent clinical laboratories must include the following filler information when the diagnosis is not otherwise available:

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

**Requirement:** Claim Diagnosis 1 is required for ALL claims. Claim diagnosis codes 2-8 should be submitted if contained on the claim record.

**Data Element: Claim Zip Code**

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

**Validation:** Must be a valid Zip Code

**Remarks:** For DMERC Claims use the zip code for beneficiary residence.  
For Carrier Claims, use the zip code identified in item 32 of the HCFA 1500, except in the listed situations.

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

Requirement: Required.

Data Element: Claim Pricing State

Definition: State where services were furnished.

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) [http://www.usps.com/ncsc/lookups/usps\\_abbreviations.html#states](http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states)

Remarks: Furnish the state associated with the Claim Zip Code.

Requirement: Required.

**Data Element: Beneficiary Zip Code**

Definition: Zip Code associated with the beneficiary residence.

Validation: Must be a valid Zip Code

Remarks: Use the zip code for beneficiary residence.

Requirement: Required.

**Data Element: Beneficiary State**

Definition: State abbreviation identifying the state in which the beneficiary resides.

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)

[http://www.usps.com/ncsc/lookups/usps\\_abbreviations.html#states](http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states)

Remarks: N/A

Requirement: Required

**Data Element: Claim Demonstration Number**

Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

Validation: Must be a Valid Demo ID

Remarks: N/A

Requirement: Required when available on claim.

**Data Element: Line Item Count**

Definition: Number indicating number of service lines on the claim

Validation: Must be a number 01 – 52

Remarks: N/A

Requirement: Required

**Claim Line Item Fields**

**Data Element: Performing Provider Number**

Definition: Number assigned by the shared system to identify the provider who performed the service or the supplier who supplied the medical equipment

Validation: N/A

Remarks: N/A

Requirement: Required

**Data Element: Performing Provider Specialty**

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

**Data Element: HCPCS Procedure Code**

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

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

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

**Data Element: Number of Services**

Definition: The number of service rendered in days or units  
Validation: N/A  
Remarks: The last position should contain the value to the right of the decimal in the number of services. Put a zero in the last position for whole numbers.  
Requirement: Required

**Data Element: Service from Date**

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

**Data Element: Service to Date**

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

**Data Element: Place of Service**

Definition: Code that identifies where the service was performed  
Validation: N/A  
Remarks: Must be a value in the range of 00 99  
Requirement: Required

**Data Element: Type of Service**

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

**Data Element: Diagnosis Code**

Definition: Code identifying a diagnosed medical condition resulting in the line item service  
Validation: Must be a valid ICD-9-CM diagnosis code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures. Since this is a required field, resolution records for claims billed by Ambulance suppliers and independent clinical laboratories must include the following filler information when the diagnosis is not otherwise available:

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

Requirement: Required

**Data Element: CMN Control Number**

Definition: Number assigned by the shared system to uniquely identify a Certificate of Medical Necessity  
Validation: N/A  
Remarks: Enter a zero if no number is assigned  
Requirement: Required on DMERC claims

**Data Element: Line Submitted Charge**

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

**Data Element: Line Medicare Initial Allowed Charge**

Definition: Amount Medicare allowed for the service or equipment before any reduction or denial

Validation: N/A

Remarks: This charge is the lower of the fee schedule or billed amount (i.e., Submitted Charge), except for those services (e.g., ASC) that are always paid at the fee schedule amount even if it is higher than the Submitted Charge. If there is no fee schedule amount, then insert the Submitted Charge.

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

Requirement: Required

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

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

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

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

Requirement: ANSI Reason Code 1 must be present on all claims with resolutions of 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC', or 'REO', 'APPAM', 'DENAM', 'REDAM'.

**Data Element: Manual Medical Review Indicator**

Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the 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. .

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 medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. Review requiring use of the 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', 'DELET', or 'TRANS',

Remarks:

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

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

Requirement: Required

**Data Element: Line Final Allowed Charge**

Definition: Final Amount allowed for this service or equipment after any reduction or denial

Validation: N/A

Remarks: This represents the contractor's value of the service/item gross of co-pays and deductibles

Requirement: Required

**Data Element: Performing Provider NPI**

Definition: NPI assigned to the Performing Provider.

Validation: N/A

Remarks: N/A.

Requirement: This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

**Data Element: Performing Provider UPIN**

Definition: Unique Physician Identifier Number (UPIN) that identifies the physician supplier actually performing/providing the service.

Validation: N/A

Remarks: N/A.

Requirement: Required, **when available**.

**Data Element: Miles/Time/Units/Services Indicator**

Definition: Code indicating the units associated with services needing unit reporting on the line item for the carrier claim.

Validation: Must be a valid Indicator as identified in IOM 10.4 ch26 10.10

- 0 - No allowed services
- 1- Ambulance transportation miles
- 2- Anesthesia Time Units
- 3 - Services
- 4- Oxygen units
- 5- Units of Blood

Remarks: N/A

Requirement: Required

**Data Element: Line Deductible Applied**

Definition: Amount of deductible applied for this service or equipment

Validation: N/A

Remarks: N/A

Requirement: Required

**Data Element: Line Co-Insurance Amount**

Definition: Amount of co-insurance due for this service or equipment

Validation: N/A

Remarks: N/A

Requirement: Required

**Data Element: Line Paid Amount**

Definition: Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim

Validation: N/A

Remarks: This represents the contractor's value of the claim after co-pays and deductibles

Requirement: Required

**Data Element: Line MSP Code**

Definition: Code indicating primary payor for services on this line item

- Validation: A-Working Aged  
B-ESRD  
D-No-Fault  
E-Workers' Compensation  
F-Federal (Public Health)  
G-Disabled  
H-Black Lung  
I-Veterans  
L-Liability

Remarks: N/A

Requirement: Required , **when contained on the claim record.**

**Data Element: Line MSP Paid Amount**

Definition: The amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or tertiary).

Validation: N/A

Remarks: Amount paid by Primary Payer

Requirement: Required, **when contained on the claim record.**

**Data Element: Line Pricing Locality**

Definition: Code denoting the carrier-specific locality used for pricing this claim.

Validation: Must be a valid pricing locality

- Enter '00' for claims priced at a statewide locality.

Requirement: Required.

**Data Element: Line Zip Code**

Definition: Zip Code used to determine claim pricing locality.

Validation: Must be a valid Zip Code

Remarks: For DMERC Claims use the zip code for beneficiary residence.  
For Carrier Claims, use the zip code identified in item 32 of the HCFA 1500, unless the service was furnished in the patient's home. If the service was furnished in the patient's home, use the zip code from the patient's home address.

Requirement: Required.

**Data Element: Line Pricing State**

Definition: State where services were furnished.

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)  
[http://www.usps.com/ncsc/lookups/usps\\_abbreviations.html#states](http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states)

Remarks: Furnish the state associated with the **Line Zip Code**.

Requirement: Required.

**Data Element: Filler**

Definition: Additional space TBD

Validation: N/A

Remarks: N/A

Requirement: None

Claims Resolution File				
Claims Resolution Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	<b>17</b>	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 7/1/2007 did not contain this field.  
 Codes:  
 B = Record Format as of 7/1/2007  
 Remarks: N/A  
 Requirement: Required

**Data Element: Contractor Type**

Definition: Type of Medicare Contractor  
 Validation: Must be 'B' or 'D'  
 Remarks: B = Part B  
 D = DMERC  
 Requirement: Required

**Data Element: Number of Claims**

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

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

**DATA ELEMENT DETAIL**

**Data Element: Contractor ID**

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

**Data Element: Record Type**

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

**Data Element: Record Version Code**

Definition: The code indicating the record version of the Claim Provider Address file

Validation: Claim Provider Address files prior to 7/1/2007 did not contain this field.

Codes:

B = Record Format as of 7/1/2007

Remarks: N/A

Requirement: Required

**Data Element: Contractor Type**

Definition: Type of Medicare Contractor

Validation: Must be 'B' or 'D'

Remarks: B = Part B

D = DMERC

Requirement: Required

**Data Element: Provider Address Date**

Definition: Date the Provider Address File was created.

Validation: Must be a valid date not equal to a Provider Address date sent on any previous claims Provider Address file

Remarks: Format is CCYYMMDD. May use shared system batch processing date

Requirement: Required

<b>Provider Address File</b>				
<b>Provider Address Detail Record</b>				
<b>Field Name</b>	<b>Picture</b>	<b>From</b>	<b>Thru</b>	<b>Initialization</b>
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Number/NPI	X(15)	9	23	Spaces
Provider Name	X(25)	24	48	Spaces
Provider Address 1	X(25)	49	73	Spaces
Provider Address 2	X(25)	74	98	Spaces
Provider City	X(15)	99	113	Spaces
Provider State Code	X(2)	114	115	Spaces
Provider Zip Code	X(9)	116	124	Spaces
Provider Phone Number	X(10)	125	134	Spaces
Provider Phone Number Extension	X(10)	135	144	Spaces
Provider Fax Number	X(10)	145	154	Spaces
Provider Type	X(2)	155	156	Spaces
<b>Provider Address Order</b>	<b>X(2)</b>	<b>157</b>	<b>158</b>	<b>Spaces</b>
Provider Address Type	9(3)	159	161	Zero
Provider E-mail Address	X(75)	162	236	Spaces
Provider Federal Tax number or EIN	9(10)	237	246	Zeroes
Provider Taxonomy Code	9(10)	247	256	Zeroes
Provider License Number	X(16)	257	272	Spaces
Provider License State	X(2)	273	274	Spaces
Filler	X(25)	275	299	Spaces

## DATA ELEMENT DETAIL

### **Data Element: Contractor ID**

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

### **Data Element: Record Type**

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

### **Data Element: Record Version Code**

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

### **Data Element: Contractor Type**

Definition: Type of Medicare Contractor  
Validation: Must be 'B' or 'D'  
Remarks: B = Part B  
D = DMERC  
Requirement: Required

### **Data Element: Provider Number/NPI**

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

### **Data Element: Provider Name**

Definition: Provider's name  
Validation: N/A  
Remarks: This is the name of the provider  
The provider name must be formatted into a business name for mailing (e.g. Roger A Smith M.D. or Medical Associates, Inc.).  
Requirement: Required

### **Data Element: Provider Address 1**

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

### **Data Element: Provider Address 2**

Definition: 2nd line of provider's address

Validation: N/A  
Remarks: This is the address2 of the provider  
Requirement: Required if available

**Data Element: Provider City**

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

**Data Element: Provider State Code**

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

**Data Element: Provider Zip Code**

Definition: Provider's zip code  
Validation: Must be a valid postal zip code  
Remarks: This is the zip code of the provider's address. Provide 9-digit zip code if available, otherwise provide 5-digit zip code  
Requirement: Required

**Data Element: Provider Phone Number**

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

**Data Element: Provider Phone Number Extension**

Definition: Provider's telephone number Extension  
Validation: Must be a valid telephone number  
Remarks: This is the phone number  
Requirement: None

**Data Element: Provider Fax Number**

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

**Data Element: Provider Type**

Definition: 1=billing/pricing provider number (Assigned by carrier or NSC)  
2= referring/ordering provider (UPIN)  
3=Performing/rendering provider (Assigned by carrier or NSC)  
4=Entity is both billing/pricing and performing/rendering provider  
5=Entity is both referring/ordering and performing/rendering provider  
6=Entity is all (billing/pricing AND referring/ordering AND performing/rendering provider)  
7=billing/pricing provider number (NPI)  
8= referring/ordering provider (NPI)

- 9=Performing/rendering provider (NPI)**
- 10=Entity is both billing/pricing and performing/rendering provider (NPI)**
- 11=Entity is both referring/ordering and performing/rendering provider (NPI)**
- 12=Entity is all (billing/pricing AND referring/ordering AND performing/rendering provider) (NPI)**

Validation: Must be a valid provider type  
 Remarks: This field indicates for which provider number associated with a sampled claim the address information is furnished.  
 Requirement: Required

**Data Element: Address Order**

Definition: The order in which the records of provider addresses for the provider are entered into the provider address file detailed record. This field in combination with the Contractor ID, Provider number, and Provider Type will make each record in the file unique.

Validation: Must be a valid number between 01 and 99  
 Remarks: This field indicated the order in which records containing the addresses for a provider are entered into the detail file. For instance, if there are three addresses for a provider, the record for the first address for that provider will contain an '01' in this field; and the record for the second address for that provider will contain a '02' in this field.

Requirement: Required

**Data Element: Provider Address Type**

Definition: The type of Provider Address furnished.  
 Validation: 1 = Practice Address (MCS)  
                   Provider address (VMS)  
                   2 = Pay To Address (MCS)  
                   Payee Address (VMS)  
                   3 = Billing Address (VMS)  
                   4 = Correspondence Address  
                   5 = Medical Record Address

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

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

Requirement: Required

**Data Element: Provider E-Mail Address**

Definition: Provider’s e-mail address  
Validation: Must be a valid e-mail address  
Remarks: N/A  
Requirement: Required if available

**Data Element: Provider Federal Tax Number or EIN**

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

**Data Element: Provider Taxonomy Code**

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

**Data Element: Provider License Number**

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

**Data Element: Provider License State**

Definition: Identify the state that issued the providers professional business license  
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)  
[http://www.usps.com/ncsc/lookups/usps\\_abbreviations.html#states](http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states)  
Remarks: N/A  
Requirement: Required if available

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

<b>Claims Provider Address File</b>				
<b>Claims Provider Address Trailer Record (one record per file)</b>				
<b>Field Name</b>	<b>Picture</b>	<b>From</b>	<b>Thru</b>	<b>Initialization</b>
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces

Claims Provider Address File				
Claims Provider Address Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor Type	X(1)	8	8	Spaces
Number of Records	9(9)	9	17	Zeroes

#### DATA ELEMENT DETAIL

##### Data Element: Contractor ID

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

##### Data Element: Record Type

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

##### Data Element: Record Version Code

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

##### Data Element: Contractor Type

Definition: Type of Medicare Contractor  
Validation: Must be 'B' or 'D'  
Remarks: B = Part B  
D = DMERC  
Requirement: Required

##### Data Element: Number of Records

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