CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10110	**Date: May 8, 2020**
	Change Request 11731

SUBJECT: Implement Error Tracking into the Recovery Audit Contractor (RAC) Data Warehouse (RACDW) Non-RAC Prepayment File Layout

I. SUMMARY OF CHANGES: Tag the correction records included in automated files sent to the RACDW, so that the RACDW can verify when errors have been corrected. Improving error correction tracking and ensuring completeness of data stored in the RACDW.

EFFECTIVE DATE: October 1, 2020; January 1, 2021 - For Business Requirement #14 - For calls following implementation
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020; January 4, 2021 - For Business Requirement #14 - For calls following implementation

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	N/A

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

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 10110	Date: May 8, 2020	Change Request: 11731

SUBJECT: Implement Error Tracking into the Recovery Audit Contractor (RAC) Data Warehouse (RACDW) Non-RAC Prepayment File Layout

EFFECTIVE DATE: October 1, 2020; January 1, 2021 - For Business Requirement #14 - For calls following implementation
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I. GENERAL INFORMATION

A. Background: This Change Request (CR) is to implement error tracking into the RACDW Non- RAC prepayment file layout, as it is necessary for RACDW objectives. This CR will not change the delivery of the flat file. However, it will adjust the current file layout by adding identifying fields to the records included in automated files sent to the RACDW. These new fields, will allow the RACDW to verify automatically when the same record has been resent to correct a reported RACDW identified error. This enhancement will improve error correction tracking and ensure completeness of claims data stored within the RACDW.

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

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11731.1	The contractor shall follow the revised non-RAC prepayment file layout. The changes to the layout include: • File format version in the header changed from 001 to 002 • Record length in the header changed to 423 • The filler on the claim level is removed, and the filler on the line level is adjusted so that the line records are always 423 characters long • A required **record ID** field added to each record in the file (claim and line), with the exception of the header record. The record ID for each record in the file shall be unique within a file and shall be sequential, starting					X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	with 1. The header shall not be counted. For the purpose of calculating record ID, there shall be no distinction made between claim records and line records – all of them can use IDs from the same sequence. The format of the record ID field is numeric, and it can be up to 6 digits long. • A **correcting file name** field (90 characters long) added to each claim record in the file – line records won't have this field. This field shall be filled with blank spaces for all regular uploads. • A **correcting record ID** field (6 characters long) added to each claim record in the file – line records won't have this field. This field shall be filled with blank spaces for all regular uploads.									
11731.2	The contractor shall follow the revised non-RAC prepayment file layout for all manual uploads into the RACDW. The changes to the layout include: • File format version in the header changed from 001 to 002 • Record length in the header changed to 423 • A required **record ID** field added to each record in the file, with the exception of the header record • A **correcting file name** field added to each claim record in the file – line records won't have this field. This field shall be left blank for all system uploads, but will be used when the corrections to records that errored out are re-uploaded. • A **correcting record ID** field added to each claim record in the file – line records won't have this field. This field shall be left blank for all system uploads, but will be used when the corrections to records that errored out are re-uploaded.	X	X	X	X					
11731.3	The contractor shall use the required **record ID** field for each record in the file, which shall be unique within a file and shall be sequential, starting with 1. The header shall not be counted. For the purpose of	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	calculating record ID, there shall be no distinction made between claim records and line records – all of them can use IDs from the same sequence. The format of the record ID field is numeric, and it can be up to 6 digits long.									
11731.4	The contractor shall use an optional **correcting file name** field, which shall be left blank for all regular records, but shall be non-empty for the records intended to correct records that errored-out earlier. The format of the record ID field is alpha-numeric, and it can be up to 90 characters long (with the following 3 special characters also allowed: '#', '.', '-'). If not empty, the value shall be the name of the file that contained errored-out records, exactly as recorded by RACDW (including timestamps and .txt extension)	X	X	X	X					
11731.5	The contractor shall use an optional **correcting record ID** field, which shall be left blank for all system uploads, but shall be non-empty for the records intended to correct records that errored-out earlier. The format of the record ID field is numeric (if not blank), and it can be up to 6 digits long. If not empty, the value shall be the record ID of the claim record that errored out and is being corrected by the current file. Even if the error was due to a line-level validation failure, the correction record shall still refer to record ID of the claim that contained a faulty line.	X	X	X	X					
11731.6	The contractors shall participate during the User Acceptance Testing (UAT) sessions to test the changes (As scheduled by CMS).	X	X	X	X					VDC
11731.7	The contractors shall attend the following calls: • During the UAT period (as scheduled by CMS), up to 2 one-hour calls may be scheduled, by CMS, for all parties to discuss any testing issues that may occur.	X	X	X	X	X	X	X		VDC
11731.8	The contractor shall post the minutes of the meeting for their specific issues only discussed during the calls within 2 business days of the meeting in e-Chimp.	X	X	X	X					VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11731.9	The contractors shall use the following email addresses to report problems that arise (including error messages received from the RAC DW) pre- and post-implementation: • CMS contacts: Tony.Olivis@cms.hhs.gov, Ashley.Badami@cms.hhs.gov • KSI contacts: smikhaylenko@ksikoniag.com, helpdesk.RACDW@koniag.com	X	X	X	X					
11731.10	The contractor shall provide a list of point of contacts (POCs) within 3 business days after the CR is released, who are responsible for remediating errors and resending any files in case there is an error during transmission. • CMS contacts: Tony.Olivis@cms.hhs.gov, Ashley.Badami@cms.hhs.gov • KSI contacts: smikhaylenko@ksikoniag.com, helpdesk.RACDW@koniag.com	X	X	X	X					
11731.11	The contractor shall provide a list of point of contacts (POCs) for the calls/error reporting within 3 business days after the CR is released. • CMS contacts: Tony.Olivis@cms.hhs.gov, Ashley.Badami@cms.hhs.gov • KSI contacts: smikhaylenko@ksikoniag.com, helpdesk.RACDW@koniag.com .	X	X	X	X	X	X	X		
11731.12	The contractor shall be available to address and fix any file transmission, validation, or other issue discovered to ensure accuracy and timeliness of the data transmission, via email or conference call.	X	X	X	X					
11731.13	The contractor shall correct RACDW identified errors except the following:	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	12 =Claim is currently suppressed. Until further notice do not work on this claim 13 = Claim is permanently excluded from RAC review. Stop all work on this claim 170 = Claim cannot be saved because of errors in one or more of line item records 202 = Cannot add or save line record due to invalid or missing claim record 224 = Line record cannot be saved with errors in the other line item(s) of the same claim 296 = The claim is suppressed and updating fields used for suppression matching (Provider ID, NPI, Original Claim Paid Date/Claim Received Date, Service Start/End Date, Length of Stay/Statement Covers Period, Zip Code, Original ICD Code, Original DRG Code, and Original HCPCS Code) is not allowed 1733 = The claim review cannot be deleted with X since it does not exist in the system									
11731.14	The contractors shall attend the following calls: • Up to 3 one-hour calls shall be scheduled, by CMS, up to 30 days immediately following implementation of the CR, to discuss any issues with implementation.	X	X	X	X	X	X	X		VDC

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Tony Olivis, 410-786-7545 or Tony.Olivis@cms.hhs.gov , Ashley Badami, 410-786-0828 or Ashley.Badami@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 1

Non-RAC Claim Review File Format

Last Modified Date: 3/25/2020

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

Header Layout

Field Name	Location	Length	Attributes	Sample	Valid Values and Notes
File Type	1	10	AN-10	CLAIM	Value: "Claim" Left justified, space fill
Filler	11	1	AN-1		Space fill
File Format Version	12	3	AN-3	002	Value: 002
Filler	15	1	AN -1		Space fill
Record Count	16	6	Num-6	000102	Number of records contained in file. Left justified, zero fill (in front of the actual count value) For example, if the record count is 102, then the correct value in this field should be 000102
Filler	22	1	AN-1		Space fill
Record Length	23	3	Num-3	423	423
Filler	26	1	AN -1		Space fill
Create Date	27	8	Num-8	20090617	File Creation Date Format = YYYYMMDD
Filler	35	7	AN -7		Space fill
Source System	42	5	AN-5		This field is necessary to identify the system producing the file. Allowed values are: • FISS • MCS • VMS • NONE (for files produced in-house by MACs/SMRC/ZPICs/UPICs, etc.)
Filler	47	377	AN-377		Space fill

Claim Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Claim Record-C
Claim Type	2	2	1-A	R	NCH MQA Record Identification Code For Part A reviews: 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health Agency For Part B reviews: 6 = Carrier For DME reviews: 7 = Durable Medical Equipment
Place of Service State Code	3	4	2-A	R	State Codes (for example, ME, CA) Also allow FC for foreign country For DME claims this should be the Supplier's State Code
Place of Service ZIP Code	5	9	5-AN	R	US Postal Code where service rendered. Allow 00000 if state is FC (foreign country) For DME claims this should be the Supplier's Zip Code
Ordering Provider State Code	10	11	2-A	S Only allowed, but not required, for DME claims, must be empty otherwise	State Codes (for example, ME, CA) Also allow FC for foreign country
Ordering Provider Zip Code	12	16	5-AN	S Only allowed, but not required, for DME claims,	Allow 00000 if state is FC (foreign country)

				must be empty otherwise	
Beneficiary Residence State Code	17	18	2-A	R for DME reviews	State Codes (for example, ME, CA) FC for foreign country
Beneficiary Residence ZIP Code	19	23	5-AN	R, for DME reviews Must be empty for Part A and B reviews	US Postal Code where service rendered. Allow 00000 if state is FC (foreign country)
Source Organization	24	28	5-AN	R	Organization that initiated the review or (for reviews tracked in the shared systems) entered the review into the shared system For prepayment reviews captured by the Shared Systems this should be the indicator of the responsible contractor: JK, JL, JM, JJ, JN, J15, J8, J6, J5, JH, JF, JE, DA, DB, DC, DD, Z1, Z2, Z3, Z4, Z5, Z6, Z7, UPIC1, UPIC2, UPIC3, UPIC4, UPIC5, CERT, SMRC, OIG, PERM, QIO, J
MAC Jurisdiction	29	31	3-AN	R	Jurisdiction of the claim-processing MAC: only JK, JL, JM, JJ, JN, J15, J8, J6, J5, JH, JF, JE, DA, DB, DC, DD, and J are allowed
Contractor ID (Workload Number)	32	36	5-AN	R	Claims processing contractor ID number
Original Claim ID	37	59	23-AN	R	Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim • For Claim Type 1 through 5 - length must be equal to or greater than 14. • For Claim Type 6 - length must be 15. • For Claim Type 7 - length must be 14. Note - This is known to the SSMs as the Document Control Number (DCN).
Type of Bill	60	63	4-AN	R/S	* Required for Claim Type 1 - 5. Should be blank for Part B and DME claims
Provider Legacy Number	64	76	13-AN	S	Unique Provider Legacy Number of the provider that performed the service and filed the claim. For Part A claims this is the CCN. For Part B claims this is the PTAN. For DME claims this is the NSC.
Provider NPI	77	86	10-AN	R	Unique Provider NPI of the provider that performed the service and filed the claim

					For DME claims this should be the supplier NPI.
DME Ordering Provider NPI	87	96	10-AN	S	NPI of Provider that prescribed the supplies. Required for DME claims Should be left empty for Part A and Part B claims
Billed Claim Amount	97	106	10-AN	R, for pre-pay reviews Must be left blank for post-pay reviews	Billed amount on the claim submitted to CMS Only need for pre-pay reviews (for post-pay reviews Claim Paid Amount is collected instead) We will not allow decimal points. The last 2 characters will be assumed to be cents. I.e. 10000 will be interpreted as $100.00
Allowed Claim Amount	107	116	10-AN	S, for pre-pay reviews Must be left blank for post-pay reviews	Allowed amount on the claim submitted to CMS Only need for pre-pay reviews (for post-pay reviews Claim Paid Amount is collected instead) We will not allow decimal points. The last 2 characters will be assumed to be cents. I.e. 10000 will be interpreted as $100.00
Claim Received Date	117	124	8-AN	R, for pre-pay reviews Must be left blank for post-pay reviews	Date claim was billed YYYYMMDD (date claim was received in the SSMs). Only needed for pre-pay reviews (for post-pay reviews Claim Paid Date is collected instead).
Original Claim Paid Amount	125	134	10-AN	R, for post-pay reviews	Amount of original payment made from Medicare fund Not applicable for prepayment reviews We will not allow decimal points. The last 2 characters will be assumed to be cents. I.e. 10000 will be interpreted as $100.00
Original Claim Paid Date	135	142	8-AN	R, for post-pay reviews	Date claim was paid YYYYMMDD Not applicable for pre-pay reviews
Statement Covers Period	143	146	4-AN	R/S	Length of Stay * Required for Claim Types 1 - Inpatient 2 - SNF 3 - Hospice

					Must be left blank for Part B and DME claims
Provider Type	147	148	2-AN	R	Type of Provider or Supplier Valid Values: 1 = Lab/Ambulance 2 = Outpatient Hospital 3 = Home Health (HHA) 4 = Hospice 5 = Professional Services (physician/non-physician practitioner) 6 = DME by Supplier 7 = Skilled Nursing (SNF) 8 = Inpatient Hospital 9 = Inpatient Rehabilitation (IRF) 10 = Critical Access Hospital (CAH) 11 = Long Term Care Hospital (LTCH) 12 = DME by Physician 13 = Ambulatory Surgery Center (ASC) 14 = Other 15 = Inpatient Psychiatric Facility 16 = Outpatient Rehab Facility 17 = Comprehensive Outpatient Rehab Facility Note - VMS should only use 6 or 12.
CMS Provider Specialty Code	149	150	2-AN	S	CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files Must be left blank for Part A claims
Original Patient Discharge Status Code	151	152	2-AN	S	Original Patient Discharge Status Code Must be left blank for Part B and DME claims
Final Patient Discharge Status Code	153	154	2-AN	S	Final Patient Discharge Status Code Must be left blank for Part B and DME claims
HICN	155	169	15-AN	S	Beneficiary HIC Number
Medicare Beneficiary Identifier (MBI)	170	184	15-AN	S	Beneficiary MBI
Serial Claim Indicator	185	185	1-A	S	Allowed Values: • Y • N Only applicable to DME claims
Review Type	186	187	2-AN	R	Automated Review-AR Complex Review-CR Prepayment Review-PR All prepayment reviews should have this field set to PR

Review Status	188	189	2-AN	S	X - if the review was abandoned after the ADR was sent; Spaces otherwise
Adjusted Claim ID	190	212	23-AN	S*	* Required when a claim number is changed based on the review results.
Extrapolation Case ID	213	235	23-AN	S*	Extrapolation Case ID * Required for claims reviewed as part of extrapolation
Date Code A	236	237	2-AN	R*	Type of date: 02-Request for medical records (required) 03-Received provider's request for extension to submit records 04-New deadline for provider to submit records request for extension 05-Received medical records from provider 06-review contractor asks CMS for extension to complete review 07-New deadline for review contractor to complete review 08-Improper payment notification sent to provider 09-Request for discussion received from provider 10-Finding sent for re-adjudication 11-Readjudication compete, re-adjudicated claim received from the MAC 12-Demand letter sent. (Once Date Code "12" has been uploaded, Demand Letter Amount is a required field on all subsequent uploads for this claim.) 13-Claim closed 14-No findings letter sent 15-Technical Denial Determination Date 16-Additional Documentation Received as part of Discussion 17-Discussion results sent to provider 19-Technical Denial Notification Sent 20-Prepayment Review Claim Finalized (applicable to Prepayment Reviews only)
Date A	238	245	8-AN	R	Date format YYYYMMDD
Date Code B	246	247	2-AN	S	Type of date:
Date B	248	255	8-AN	S	Date format YYYYMMDD
Date Code C	256	257	2-AN	S	Type of date:
Date C	258	265	8-AN	S	Date format YYYYMMDD
Date Code D	266	267	2-AN	S	Type of date:
Date D	268	275	8-AN	S	Date format YYYYMMDD
Demand Letter Amount (or	276	286	11-AN	S*	*Required when Date Code "12" comes in. Otherwise, it is an optional field.

Savings Amount for prepayment reviews)					* Submit negative amounts for underpayments We will not allow decimal points. The last 2 characters will be assumed to be cents. I.e. 10000 will be interpreted as $100.00 For post-pay reviews, Once Date Code "12" has been uploaded, Demand Letter Amount is a required field on all subsequent uploads for this claim. For pre-pay reviews this Amount does not depend on presence or absence of any date code Note - Calculate as the difference between the allowed amount and the paid amount. Do not include co-pay, deductible, coinsurance, or network discount in calculation.
Overpayment/ Underpayment Indicator	287	288	2-AN	S	Overpayment/ Underpayment Indicator Values: • OP: Overpayment (Demand Letter Amount > 0) • UP: Underpayment (Demand Letter Amount < 0) • NA: No Finding (Demand Letter Amount = 0) • blank: Review in progress (Demand Letter Amount is missing) **Required for post-pay reviews when:** **Demand Letter Date (Date 12) or No Findings Letter Sent Date (Date 14) is not missing** **Required for pre-pay reviews when:** **Improper Payment Notification Date (Date 8) or No Findings Letter Sent Date (Date 14) is not missing.**
Initial Documentation Delivery Route (for documentation submitted in response to RA Request for Medical Record)	289	289	1-AN	S	Values: • 1: esMD • 2: fax • 3: mail paper record • 4: mail electronic records on a disk • 5: other May be blank for pre-pay reviews
Probe and Educate Round Number	290	290	1-AN	S	Can be left blank for pre-pay reviews
Review Topic Code 1	291	295	5-AN	S	MACs should use the CART codes

Review Topic Code 2	296	300	5-AN	S	MACs should use the CART codes
Review Topic Code 3	301	305	5-AN	S	MACs should use the CART codes
Review Topic Code 4	306	310	5-AN	S	MACs should use the CART codes
Review Topic Code 5	311	315	5-AN	S	MACs should use the CART codes
PIMR Activity Code	316	321	6-AN	S	This is required when the claim is "finalized" (has date 8 or 14)
Record Id	322	327	6-N	R	Every record in the file (claim and line) should have a sequential record id (that is unique within a file – no two records in the file should ever have same record id). The header should not be counted The first record in the file after the header should have record id 1, next record should have record id 2, etc. For the purpose of assigning record id, there should be no distinction made between claim records and line records. So the first record in the file (which is always a claim record) will have id 1, the next record (which is always a line record) will have id 2, the next record (which could either be a claim record or a second line of the previous claim) will have id 3, etc.
Correcting File Name	328	417	90-AN (the following three non-AN characters are allowed as well: #.-)	S (only required if the record is intended to correct an earlier record that was rejected by RACDW with error)	This should always be present if the record is intended to correct an earlier record that was rejected by RACDW with error. The value should exactly match the name of the file that contained the previously-rejected record, exactly as recorded by RACDW (including the timestamp at the end) Example of valid file name: P#EFT.ON.RACDW.C07001.FSSPR.D200326.T0429471-NRC-1553-20200326043147402.txt If the record is not intended to correct an earlier failed upload, the field must be blank
Correcting Record Id	418	423	6-AN	S (only required if the record is intended to correct an earlier record that was rejected	This should only be present if the record is intended to correct an earlier record that was rejected by RACDW with error. The value should contain the record id of the **claim** record that is being corrected, and determine the exact position of that record in the file that receive the processing error If the record is not intended to correct an earlier failed upload, the field must be blank

				by RACDW with error)	

Claim Line Item Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Line-L
Line item number	2	4	3-AN	R	Claim line item number; 000 for institutional claims. If line number = 000, then no other lines are acceptable for that claim
Original Diagnosis Code Version Indicator	5	5	1-N	R	9 for ICD-9 or 0 for ICD-10;
Original Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	6	12	7-AN	R	Original ICD-9 or ICD-10. Decimal point(.) is not allowed.
Final Diagnosis Code Version Indicator	13	13	1-N	S	9 for ICD-9 or 0 for ICD-10;
Final Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	14	20	7-AN	S	Final diagnosis code after audit. Decimal point(.) is not allowed.
Original DRG	21	23	3-AN	S	Original DRG on claim. It must be three digit numbers. Line 000 only Must be left blank for Part B and DME claims
Final DRG	24	26	3-AN	S	Final DRG after audit. It must be three digit numbers. Line 000 only Must be left blank for Part B and DME claims
Original ICD Procedure Code	27	33	7-AN	S	Original ICD9/ICD10 Procedure Code on reviewed claim. Decimal point(.) is

					not allowed. Must be left blank for Part B and DME claims
Final ICD Procedure Code	34	40	7-AN	S	Final ICD9/ICD10 Procedure Code after audit. Decimal point(.) is not allowed. Must be left blank for Part B and DME claims
Original OPPS code for outpatient hospitals (APCs)	41	45	5-AN	S	Original HOPPS code for outpatient hospitals (APCs) Must be left blank for Part B and DME claims
Final OPPS code for outpatient hospitals (APCs)	46	50	5-AN	S	Final HOPPS code for outpatient hospitals (APCs) Must be left blank for Part B and DME claims
Original HIPPS code for SNFs (RUG/AIs)	51	55	5-AN	S	Original HIPPS code for SNFs (RUG/AIs) Must be left blank for Part B and DME claims
Final HIPPS code for SNFs (RUG/AIs)	56	60	5-AN	S	Final HIPPS code for SNFs (RUG/AIs) Must be left blank for Part B and DME claims
Original HIPPS code for HHAs (HHRGs)	61	65	5-AN	S	Original HIPPS code for HHAs (HHRGs) Must be left blank for Part B and DME claims
Final HIPPS code for HHAs (HHRGs)	66	70	5-AN	S	Final HIPPS code for HHAs (HHRGs) Must be left blank for Part B and DME claims

Original HIPPS code for IRFs (CMG/RICs)	71	75	5-AN	S	Original HIPPS code for IRFs (CMG/RICs) Must be left blank for Part B and DME claims
Final HIPPS code for IRFs (CMG/RICs)	76	80	5-AN	S	Final HIPPS code for IRFs (CMG/RICs) Must be left blank for Part B and DME claims
Original Level of Care code for hospice claims	81	85	5-AN	S	Original Level of Care code for hospice claims This field may be left blank if not tracked by the shared systems, however it will be retained in case if it is available for post-payment reviews.
Final Level of Care code for hospice claims	86	90	5-AN	S	Final Level of Care code for hospice claims This field may be left blank if not tracked by the shared systems, however it will be retained in case if it is available for post-payment reviews.
Original HCPCS	91	95	5-AN	S	Original HCPCS on claim. Not generally used for inpatient claims (exceptions do exist)
Final HCPCS	96	100	5-AN	S	Final HCPCS after audit. Not generally used for inpatient claims
Original Units of Service	101	106	6-AN	S	Original units of service on claim
Final Units of Service	107	112	6-AN	S	Final units of service on claims
Denial Reason Code 1	113	118	6-AN	S	Reason claim/line considered overpaid/underpaid.

					If claim-level denial, list denial reason on line level and repeat in necessary.
Denial Reason Code 2	119	124	6-AN	S	
Denial Reason Code 3	125	130	6-AN	S	
Denial Reason Code 4	131	136	6-AN	S	
Denial Reason Code 5	137	142	6-AN	S	
POS (Place of Service) code	143	144	2-AN	S	Should be blank for Part A claims.
PC/TC (Professional Component/Technical Component) Indicator	145	145	1-AN	S	Should be blank for DME claims
Modifier 1	146	147	2-AN	S	
Modifier 2	148	149	2-AN	S	
Modifier 3	150	151	2-AN	S	
Modifier 4	152	153	2-AN	S	
Modifier 5	154	155	2-AN	S	
Revenue Code	156	159	4-AN	S	Should be blank for Part B and DME claims
Date of Service Start	160	167	8-AN	R	Date service started/performed YYYYMMDD
Date of Service End	168	175	8-AN	R	Date service ended YYYYMMDD
Record Id	176	181	6-N	R	Every record in the file (claim and line) should have a sequential record id (that is unique within a file – no two records in the file should ever have same record id). The header should not be counted The first record in the file after the header should have record id 1, next record should have record id 2, etc.

					For the purpose of assigning record id, there should be no distinction made between claim records and line records. So the first record in the file (which is always a claim record) will have id 1, the next record (which is always a line record) will have id 2, the next record (which could either be a claim record or a second line of the previous claim) will have id 3, etc.
Filler	182	423	242-AN	R	Spaces