CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11933	**Date: March 30, 2023**
	Change Request 12881

Transmittal 11697 issued November 09, 2022, is being rescinded and replaced by Transmittal 11933, dated March 30, 2023, to add the MAC Postpayment Review File Layout attachment. All other information remains the same.

SUBJECT: Update to Process and Responsibility for Tracking Medicare Contractors' Prepayment and Post Payment Reviews in the RAC Data Warehouse (RACDW)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the process for Medicare Administrative Contractors (MAC) to upload Post Payment claims monthly into the RACDW.

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

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
R	3/3.5/3.5.4/Tracking Medicare Contractors' Prepayment and Postpayment Reviews

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 11933	Date: March 30, 2023	Change Request: 12881

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SUBJECT: Update to Process and Responsibility for Tracking Medicare Contractors' Prepayment and Post Payment Reviews in the RAC Data Warehouse (RACDW)

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

I. GENERAL INFORMATION

A. Background: MACs upload Post Payment claims monthly into the RACDW. The Shared System Maintainers automatically transfer the Prepayment claims daily by Enterprise File Transfer to the RACDW. The verbiage in section 3.5.4 of Chapter 3 in Publication (Pub.) 100-08 describes the old process prior to the implementation of CR 11256. This CR corrects the verbiage to reflect the new process outlined in CR 11256.

B. Policy: Section 302 of the Tax Relief Act and Health Care 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	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12881.1	The contractors shall be aware of revisions to chapter 3 in section 3.5.4 of Pub. 100-08.	X	X	X	X					
12881.2	The contractor shall input all post payment complex reviews into the RACDW.	X	X	X	X					
12881.2.1	The contractor shall include all claims chosen for review by the contractor where an additional documentation	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	request letter was issued to the provider before or after payment was made.									
12881.2.2	The contractor shall include all reviews, even those that did not result in an improper payment.	X	X	X	X					
12881.2.3	The contractor shall manually upload claims into the data warehouse or submit them by flat file.	X	X	X	X					
12881.3	The contractor shall use the file layout provided by CMS for claims uploaded to the RACDW.	X	X	X	X					
12881.4	The contractor shall submit post-payment claims to the RACDW by the 20th day of every month for the previous month.	X	X	X	X					
12881.5	The contractor shall contact RAC@cms.hhs.gov to acquire access for staff.	X	X	X	X					
12881.6	The contractor shall conduct testing to ensure that the files are loaded properly.									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): Eric Miller, 410-786-0060 or eric.miller@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: 2

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

Table of Contents

(Rev. 11933; Issued: 03-30-23)

3.5.4 - Tracking Medicare Contractors' Prepayment and Postpayment Reviews

(Rev. 11933; Issued: 03-30-23; Effective: 04-01-23; Implementation: 04-03-23)

*Shared System Maintainers shall create a pre-payment claim file that is automatically uploaded to the RACDW by the VDC. Medicare Administrative Contractors (*MACs) shall input all postpayment complex reviews into the Recovery Audit Data Warehouse. All claims chosen for review by the MAC where an additional documentation request letter was issued to the provider before or after payment was made shall be included. MACs shall include all reviews, even those that did not result in an improper payment.

Claims may be manually uploaded into the data warehouse or submitted by flat file. The *Shared System Maintainers and* MACs shall use the file layout provided by CMS for claims uploaded to the Recovery Audit Data Warehouse. Postpayment claims shall be submitted to the Recovery Audit Data Warehouse by the 20th day of every month for the previous month. Prepayment claims shall be submitted to the Recovery Audit Data Warehouse *daily.*

MAC staff who need access to the Data Warehouse shall contact RAC@cms.hhs.gov.

Non-RAC Claim Review File Format

Last Modified Date: 11/19/2021

***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/ QIOs, etc.) QIOs should use NONE
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

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					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, must be empty otherwise	Allow 00000 if state is FC (foreign country)
Beneficiary Residence State Code	17	18	2-A	R for DME reviews	State Codes (for example, ME, CA) FC for foreign country Not required for SMRC or QIO reviews
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) Not required for SMRC or QIO reviews

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
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, QIOT3, J If it is uploaded by SMRC users, the value must be "SMRC".
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

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
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 Not required for SMRC or QIO reviews
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

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					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. Not required for SMRC or QIO reviews.
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: 01-Initially selected record for audit (required for SMRC and QIO reviews, and should be the same as initial upload date) 02-Request for medical records (required for non-SMRC and non-QIO reviews) 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

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					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 Savings Amount for prepayment reviews)	276	286	11-AN	S*	*Required when Date Code "12" comes in. Otherwise, it is an optional field. * Submit negative amounts for underpayments We will not allow decimal points. The last 2 characters will be assumed to be cents. I.e. 10000 will be interpreted as $100.00 For post-pay reviews, Once Date Code "12" has been uploaded, Demand Letter Amount is a required field on all subsequent uploads for this claim. For pre-pay reviews this Amount does not depend on presence or absence of any date code Note - Calculate as the difference between the allowed amount and the paid amount. Do not include co-pay, deductible, coinsurance, or network discount in calculation.
Overpayment/ Underpayment Indicator	287	288	2-AN	S	Overpayment/ Underpayment Indicator Values: • OP: Overpayment (Demand Letter Amount > 0) • UP: Underpayment (Demand Letter Amount < 0) • NA: No Finding (Demand Letter Amount = 0)

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					• 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.** Not required for SMRC and QIO reviews.
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	R*/S	MACs should use the CART codes. * Required for SMRC. SMRC should use a valid SMRC Issue Code. * Required for QIO. QIO should use a valid QIO Topic Code.
Review Topic Code 2	296	300	5-AN	S	MACs should use the CART codes. SMRC should use a valid SMRC Issue Code. QIO should use a valid QIO Topic Code.
Review Topic Code 3	301	305	5-AN	S	MACs should use the CART codes. SMRC should use a valid SMRC Issue Code. QIO should use a valid QIO Topic Code.
Review Topic Code 4	306	310	5-AN	S	MACs should use the CART codes. SMRC should use a valid SMRC Issue Code. QIO should use a valid QIO Topic Code.
Review Topic Code 5	311	315	5-AN	S	MACs should use the CART codes. SMRC should use a valid SMRC Issue Code. QIO should use a valid QIO Topic Code.
PIMR Activity Code	316	321	6-AN	S	This is required when the claim is "finalized" (has date 8 or 14) Not required for SMRC or QIO reviews.
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,

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					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	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. The following three non-AN characters are allowed as well: #.-
Correcting Record Id	418	423	6-N	S (only required if the record is intended to correct an earlier record that was rejected by RACDW with error)	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.

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/S*	9 for ICD-9 or 0 for ICD-10; * Not required for SMRC Reviews.
Original Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	6	12	7-AN	R/S*	Original ICD-9 or ICD-10. Decimal point(.) is not allowed. * Not required for SMRC Reviews.

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
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

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					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)

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
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

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					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

MAC Postpayment Claim Review Upload File Format

Last Modified Date: 10/10/13

***Please note that all layouts detailed here pertain to the same Postpayment claim file. The header is the first record in the file, followed by the Postpayment 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	004 or 005	Value: 004 or 005
Filler	15	1	AN -1		Space fill
Record Count	16	6	Num-6	000102	Number of records contained in file. Right justified, zero fill
Filler	22	1	AN-1		Space fill
Record Length	23	3	Num-3	188 or 200	188 for version 004, 200 for version 005
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 ID	42	5	AN-5		Values = Contractor ID of the user who created the file. Left Justified
Filler	47	1	AN-1		Space fill
MAC Jurisdiction	48	1	AN-1	F	A-N

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 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					Agency 6 = Carrier 7 = Durable Medical Equipment
Out-of-Jurisdiction Flag	3	3	1-A	S	Use "Z" for claims from out-of-jurisdiction providers. All other cases, use space.
State Code	4	5	2-A	R	State Codes: ME, CA
Place of Service ZIP Code	6	10	5-AN	R	US Postal Code where service rendered.
Workload ID	11	15	5-AN	R	Claims processing contractor ID number
Original Claim ID	16	38	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.
Type of Bill	39	42	4-AN	R/S	* Required for Claim Type 1 - 5.
Provider Legacy Number	43	55	13-AN	S	Unique Provider Legacy Number of the provider that performed the service and filed the claim.
Provider NPI	56	65	10-AN	R	Unique Provider NPI of the provider that performed the service and filed the claim
DME Ordering Provider NPI	66	75	10-AN	S	NPI of Provider that prescribed the supplies.
Original Claim Paid Amount	76	84	9.2-N	R	Amount of original payment made from Medicare fund ex: 999999.99
Original Claim Paid Date	85	92	8-N	R	Date claim was paid YYYYMMDD
Date of	93	100	8-N	R	Date service

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Service Start					started/performed YYYYMMDD
Date of Service End	101	108	8-N	R	Date service ended YYYYMMDD
Provider Type	109	110	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
CMS Provider Specialty Code	111	112	2-AN	S	CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files
Review Type	113	114	2-AN	R	Automated Review-AR Complex Review-CR Semi-Automated Review-SA
Review Status	115	116	2-AN	S	Valid Values: UP = Underpayment Reimbursed in Full; OP = Overpayment Paid in Full; AP = Appealed Claim; RC = Review Concluded without identification of improper payment; CR = Debt Resolved by Contractor. Example: MAC notifies RAC that provider has declared bankruptcy or has disappeared. PR = Debt Resolved by Provider. Example: Provider supplies new evidence in discussion period; RAC agrees and reverses improper payment finding. TR = Terminated by

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					CMS. Example: Claim was excluded while under review. ER = Closed due to error in record (can be reloaded as new corrected record) RE = Reopen claim(to activate a closed claim)
Adjustment ID	117	139	23-AN	R*	Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim
Date Code A	140	141	2-AN	R*	Type of date: 01-Initial selection of record for audit 02-Request for medical records 03-Received medical records from provider 04-Results letter sent to provider (complex review) 05-Demand letter sent. 06-Claim closed 07-No findings letter sent. * Date Code 01 is always required.
Date A	142	149	8-N	R	Date format YYYYMMDD
Date Code B	150	151	2-AN	S	Type of date:
Date B	152	159	8-N	S	Date format YYYYMMDD
Date Code C	160	161	2-AN	S	Type of date:
Date C	162	169	8-N	S	Date format YYYYMMDD
Date Code D	170	171	2-AN	S	Type of date:
Date D	172	179	8-N	S	Date format YYYYMMDD
Demand Letter Amount	180	188	9.2-N	R*	ex: 999999.99 * Submit negative amounts for underpayments
Extrapolation Case Id	189	200	12-AN	O*	* This should not be in the version 004. This is only valid and optional field in the version 005

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
Final DRG	24	26	3-AN	S	Final DRG after audit. It must be three digit numbers. Line 000 only
Original ICD Procedure Code	27	33	7-AN	S	Original ICD9/ICD10 Procedure Code on RAC identified claim. Decimal point(.) is not allowed.
Final ICD Procedure Code	34	40	7-AN	S	Final ICD9/ICD10 Procedure Code after audit. Decimal point(.) is not allowed.
Original Non-DRG PPS/Hospice LOC Code	41	45	5-AN	S	Original HOPPS code for outpatient hospitals (APCs), HIPPS code for SNFs

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
					(RUG/AIs), HHAs (HHRGs) or IRFs (CMG/RICs), or Level of Care code for hospice claims.
Final Non-DRG PPS/Hospice LOC Code	46	50	5-AN	S	Final APC/HIPPS/LOC after audit
Original HCPCS	51	55	5-AN	S	Original HCPCS on claim. Not generally used for inpatient claims (exceptions do exist)
Final HCPCS	56	60	5-AN	S	Final HCPCS after audit. Not generally used for inpatient claims
Original Units of Service	61	63	3-N	S	Original units of service on claim
Final Units of Service	64	66	3-N	S	Final units of service on claims
Original BETOS Code	67	69	3-AN	S	Original Berenson-Eggers type of service (BETOS) code for the given HCPCS
Final BETOS Code	70	72	3-AN	S	Final BETOS code for the given HCPCS
Filler	73	188 or 200 *	116-AN or 128-AN **	R	Spaces * 188 for version 004, 200 for version 005 ** 116-AN for version 004, 128-AN for version 005