Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-00-29 **Date: MAY 2000**

CHANGE REQUEST 1173

SUBJECT: Comprehensive Error Rate Testing (CERT) Program -- Medicare Contractor Change Requirements and Medicare Part B/DMERC Standard System Change Requirements

Purpose

This document outlines: (1) Medicare contractor requirements for the CERT program and (2) the Part B/DMERC Standard Systems changes required to provide claims data to support the CERT program.

Background

The Health Care Financing Administration (HCFA), Office of Financial Management, Program Integrity Group, Division of Methods and Strategy have developed the CERT program to produce national, contractor specific, and benefit category specific paid claim error rates. The project will have independent reviewers periodically review a representative random sample of claims that are identified as soon as they are accepted into the claims processing system at carriers and intermediaries. Those sampled claims are then followed through the system to their final disposition. Paid claims are medically reviewed by the independent reviewers; denied claims are validated to ensure that the decision was appropriate. The decisions of the independent reviewers are entered into a tracking database. The outcomes HCFA anticipates from this project are a national paid claims error rate, a claims processing error rate, a provider compliance rate, and a paid claims benefit specific error rate. The tracking database will allow HCFA to quickly identify emerging trends. CERT will enhance HCFA's ability to take appropriate corrective actions and can be used to better manage contractor performance. Another byproduct of the CERT program is a large database of independently reviewed claims that HCFA can use to test new software technologies, such as data analysis tools or Commercial Off the Shelf claims editing software.

We will implement CERT in July 2000 at all durable medical equipment carrier (DMERC) sites. The goal is to implement CERT in October 2000 at all other VIPS Medicare System (VMS) users. Additional CERT locations will be considered for implementation depending on the availability of standard system programming time.

Overview of the CERT Process

The process begins at the contractor processing site, where claims that have entered the standard claims processing system on a given day, are extracted to create a *Claims Universe file*. This file is transmitted each day to the CERT operations center, where it is processed through a random sampling process. Claims that are selected as part of the sample, are downloaded to the *Sampled Claims database*. This database holds all sampled claims from all contractors. Periodically, sampled claim key data are extracted from the *Sampled Claims database* to create a *Sampled Claims Transaction file.* This file is transmitted back to the contractor and matched to the contractor's claims history and provider files. A *Sampled Claims Resolution file,* a *Claims History Replica file* and a *Provider Address file* are created by the contractor and transmitted to the CERT operations center. They are used to update the *Sampled Claims database* with claim resolutions and provider addresses; the *Claims History Replica* records are added to a database for future analysis.

A PC application at the CERT operations center is used to review, track and report on the sampled claims. Reports identifying incorrect claim payment are sent to the appropriate contractor for follow-up.

Impact on Carriers, Intermediaries, DMERCs, and Regional Home Health Intermediaries (RHHIs)

As CERT is implemented, HCFA will require carriers, intermediaries, DMERCs, and RHHIs to support the CERT project as follows:

- Coordinate with the CERT contractor to provide the requested information for claims identified in the sample in an electronic format (**NOTE:** These are changes to the standard system -- The sampling module will reside on the CERT operations center, which is a server in the HCFA Data Center);
- Submit a file daily to the CERT contractor (via Direct Connect) containing information on claims processed during the day;
- Provide the CERT contractor with all applicable materials (e.g., medical records) used to deny a claim for medical review reasons. (We expect the volume of such materials to be very low.) CERT will sample 200 claims per month from each contractor. We expect the contractors to have to supply additional materials on 10% or less of those claims) ;
- Receive overpayment referrals and undertake appropriate collection action on cases in which the CERT contractor has determined an error has occurred;
- Provide the CERT contractor with the status and amounts of overpayments that you have collected within 10 working days of a CERT request;
- Process appeals stemming from the CERT project, e.g., CERT decisions appealed by providers or beneficiaries;
- Provide the CERT contractor with the status of appeals and final decisions on appeals within 10 working days of a CERT contractor request;
- Provide answers to the CERT contractor on the status of claims that were identified in the sample, but, for which, there is no indication that claim has been adjudicated; and
- Provide clarification/coordination with the CERT contractor on issues arising as part of the CERT project.

The CERT contractor will discuss the results of its review with the Medicare contractor to insure that all information available for review has been considered.

Carriers, intermediaries, DMERCs, and RHHIs random review requirements contained in the Budget Performance Requirements will be reduced by an amount equal to the number of claims identified in the CERT sample.

Impact on Carrier and DMERC Standard System

The carrier and DMERC standard systems will be required to create and transmit 4 files and receive and process 1 file. The formats for these files for carrier and DMERC standard systems are described in the Attachment. Requirements for fiscal intermediary standard systems will be released at a later date.

Claims Universe file

The carrier and DMERC standard system will be required to create a daily *Claims Universe file*, which will be transmitted daily to the CERT operations center. The file will be processed through a sampling module at the CERT operations center. The *Claims Universe file* must contain all claims, except adjustments, that have entered the carrier and DMERC standard claims processing system on any given day. Any claim should be included only once and only on the day that it enters the system.

Sampled Claims Transaction file, Sampled Claims Resolution file and Claims History Replica file

The carrier and DMERC standard system will periodically receive a *Sampled Claims Transaction file* from the CERT operations center. This file will include claims that were sampled from the daily *Claims Universe files.* The carrier and DMERC standard system will be required to match the *Sampled Claims Transaction file* against the standard system claims history file to create a *Sampled Claims Resolution file* and a *Claims History Replica file.* The *Claims History Replica file* will be a 'dump' of the standard system claims history file in the standard system format. These files will be transmitted to the CERT operations center. The *Sampled Claims Resolution file* will be input to the CERT claim resolution process and the *Claims History Replica file* will be added to the *Sampled Claims History Replica database*. If a claim identified on the *Sampled Claims Transaction file* is not found on the standard system claims history file, no record should be created for that claim.

Provider Address file

The names and addresses of the billing providers must also be transmitted in a separate file to the CERT operations center along with the *Sampled Claims Resolution file*. The *Provider Address file* will contain the mailing information for each billing provider on the *Sampled Claims Resolution* file for all claims, assigned and non-assigned, which contain the same provider number on all claims lines. Each unique provider should be included only once on the *Provider Address file.*

Assumptions and Constraints

- Header and trailer records with zero counts must be created and transmitted in the event that a contractor has no data to submit.
- Files must be transmitted to the CERT operations center via CONNECT:Direct®
- HCFA will provide contractors with dataset names for all files that will be transmitted to the CERT operations center.
- Contractors will provide HCFA with the dataset name to which the *Sampled Claims Transaction file* should be transmitted.
- Contractor files that are rejected will result in a call from the CERT operations center indicating the reason for rejection. Rejected files must be corrected and retransmitted.
- Standard system will provide a data dictionary of the *Claims Replica file* to the CERT contractor upon implementation of CERT and will provide updates as necessary.

The *effective date* for this Program Memorandum (PM) is July 1, 2000 for DMERCs and October 1, 2000 for all Part B contractors that use the VIPS standard system. Additional PMs will be released for the remaining standard systems with future effective/implementation dates.

The *implementation date* for this PM is July 1, 2000 for DMERCs and October 1, 2000 for all Part B contractors that use the VIPS standard system. Additional PMs will be released for the remaining standard systems with future effective/implementation dates.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2001.

If you have any questions, contact George Mills on (410) 786-7450.

Attachments

ATTACHMENT

CERT Formats for Carrier and DMERC Standard Systems

File Formats

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'
Contractor Type	X(1)	7	7	Spaces
Universe Date	X(8)	8	15	Spaces

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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: **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 Standard System.
Validation: Must be a valid date not equal to a Universe Date sent on any previous *Claims Universe file.*
Remarks: Format is CCYYMMDD. May use Standard System batch processing date.
Requirement: Required.

Claims Universe File				
Claims Universe Claim Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Claim Control Number	X(15)	7	21	Spaces
Beneficiary HICN	X(12)	22	33	Spaces
Billing Provider	X(15)	34	48	Spaces
Line Item Count	S9(2)	49	50	Zeroes
Line Item group: The following group of fields occurs from 1 to 13 times (depending on Line Item Count)				
	From and **Thru** values relate to the 1st line item**.**			
Performing Provider Number	X(15)	51	65	Spaces
Performing Provider Specialty	X(2)	66	67	Spaces
HCPCS Procedure Code	X(5)	68	72	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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: **Claim Control Number**
Definition: Number assigned by the Standard 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 Standard System to identify the billing/pricing provider or supplier
Validation: NA
Remarks:A Must be present if claim contains the same billing/pricing provider number on all lines. Otherwise move all zeroes to this field
Requirement: Required.

Data Element: **Line Item Count**
Definition: Number indicating number of service lines on the claim.
Validation: Must be a number 01 - 13
Remarks: N/A
Requirement: Required.

Claim Line Item Fields

Data Element: **Performing Provider Number**
Definition: Number assigned by the Standard 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: N/A
Remarks: N/A
Requirement: Required.

Data Element: **HCPCS Procedure Code**
Definition: The HCPCS/CPT-4 code that describes the service.
Validation: Must be a valid HCPCS/CPT-4 code.
Remarks: N/A
Requirement: Required

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'
Number of Claims	S9(9)	7	15	Zeroes

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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: **Number of Claims**
Definition: Number of claim records on this file. (do not count header or trailer record)
Validation: Must be equal to the number of claims records on the file.
Remarks: N/A
Requirement: Required.

Sampled Claims Transaction File

Field Name	Picture	From	Thru
Contractor ID	X(5)	1	5
Claim Control Number	X(15)	6	20
Beneficiary HICN	X(12)	21	32

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.

Data Element: **Claim Control Number**
Definition: Number assigned by the Standard System to uniquely identify the claim.

Data Element: **Beneficiary HICN**
Definition: Beneficiary's Health Insurance Claim Number

Sampled Claims Resolution File

Sampled Claims Resolution Header Record (one record per file)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Contractor Type	X(1)	7	7	Spaces
File Date	X(8)	8	15	Spaces

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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: **Contractor Type**
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required.
Data Element: **File Date**
Definition: Date the *Sampled Claims Resolution file* was created.
Validation: Must be a valid date not equal to a File Date sent on any previous *Sampled Claims Resolution file.*
Remarks: Format is CCYYMMDD.
Requirement: Required.

Sampled Claims Resolution File

Sampled Claims Resolution Claim Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Claim Type	X(1)	7	7	Space
Assignment Indicator	X(1)	8	8	Space
Mode of Entry Indicator	X(1)	9	9	Space
Claim Control Number	X(15)	10	24	Spaces
Beneficiary HICN	X(12)	25	36	Spaces
Beneficiary Name	X(30)	37	66	Spaces
Billing Provider Number	X(15)	67	81	Spaces
Claim ANSI Reason Code 1	X(6)	82	87	Spaces
Claim ANSI Reason Code 2	X(6)	88	93	Spaces
Claim ANSI Reason Code 3	X(6)	94	99	Spaces
Claim Entry Data	X(8)	100	107	Spaces
Claim Adjudicated Date	X(8)	108	115	Spaces
Line Item Count	S9(2)	116	117	Zeroes
Line Item group: The following group of fields occurs from 1 to 13 times (depending on Line Item Count)				
	From and **Thru** values relate to the 1st line item**.**			
Performing Provider Number	X(15)	118	132	Spaces
Performing Provider Specialty	X(2)	133	134	Spaces
HCPCS Procedure Code	X(5)	135	139	Spaces
HCPCS Modifier 1	X(2)	140	141	Spaces
HCPCS Modifier 2	X(2)	142	135	Spaces
HCPCS Modifier 3	X(2)	144	145	Spaces
HCPCS Modifier 4	X(2)	146	147	Spaces
Number of Services	S9(3)	148	150	Spaces
Service From Date	X(8)	151	158	Spaces
Service To Date	X(8)	159	166	Spaces
Place of Service	X(2)	167	168	Spaces
Type of Service	X(2)	169	169	Spaces
Diagnosis Code	X(5)	170	174	Spaces
CMN Control Number	X(15)	175	189	Spaces
Submitted Charge	S9(9)v99	190	200	Zeroes
Medicare Initial Allowed Charge	S9(9)v99	201	211	Zeroes
ANSI Reason Code 1	X(6)	212	217	Spaces
ANSI Reason Code 2	X(6)	218	223	Spaces
ANSI Reason Code 3	X(6)	224	229	Spaces
ANSI Reason Code 4	X(6)	230	235	Spaces
ANSI Reason Code 5	X(6)	236	241	Spaces
ANSI Reason Code 6	X(6)	242	247	Spaces
ANSI Reason Code 7	X(6)	248	253	Spaces

Manual Medical Review Indicator	X(1)	254	254	Space
Resolution Code	X(3)	255	257	Spaces
Final Allowed Charge	S9(9)v99	258	268	Zeroes

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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: **Claim Type**
Definition: Type of claim.
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: **Claim Control Number**
Definition: Number assigned by the Standard 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 Name**
Definition: Name of the beneficiary.
Validation: N/A
Remarks: First, middle and last names must be strung together to form a formatted name. (e.g. John E Doe).
Requirement: Required.

Data Element: **Billing Provider Number**
Definition: Number assigned by the Standard System to identify the billing/pricing provider or supplier.
Validation: Must be present if claim contains the same billing/pricing provider number on all lines.
Remarks: N/A
Requirement: Required for all claims, assigned and non-assigned, containing the same billing/pricing provider on all lines.

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 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 GGRRRR where:
GG is the group code and RRRR 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 standard 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.
Remarks: Format must be CCYYMMDD.
Requirement: Required.

Data Element: **Line Item Count**
Definition: Number indicating number of service lines on the claim.
Validation: Must be a number 01 - 13
Remarks: N/A
Requirement: Required.

Claim Line Item Fields

Data Element: **Performing Provider Number**
Definition: Number assigned by the Standard 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: N/A
Remarks: N/A
Requirement: Required.

Data Element: **HCPCS Procedure Code**
Definition: The HCPCS/CPT-4 code that describes the service.
Validation: Must be a valid HCPCS/CPT-4 code.
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: Must be greater than 0.
Remarks: N/A
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: Must be a value in the range of 01 – 21 or 99.
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.
Remarks: N/A
Requirement: Required.

Data Element: **CMN Control Number**
Definition: Number assigned by the Standard System to uniquely identify a Certificate of Medical Necessity.
Validation: N/A
Remarks: N/A
Requirement: Required on DMERC claims, for services for which a CMN is required.

Data Element: **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: **Medicare Initial Allowed Charge**
Definition: Amount Medicare allowed for the service or equipment before any reduction or denial.
Validation: N/A
Remarks: N/A
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 GGRRRR where:
GG is the group code and RRRR is the adjustment reason code
Requirement: ANSI Reason Code 1 must be present on all claims with resolutions of 'DEN', 'DEO', 'RTP', 'RED', or 'REO'. Codes 2 – 7 should be sent if available.

Data Element: **Manual Medical Review Indicator**
Definition: Code indicating whether or not the service was manually medically reviewed.
Validation: Must be'Y' or blank.
Remarks: Set to 'Y' if service was subjected to manual medical review, else blank.
Requirement: Required.

Data Element: **Resolution Code**
Definition: Code indicating how the contractor resolved the line.
Validation: Must be 'APP', 'DEN', 'DEO', 'RTP', 'RED', or 'REO'.
Remarks: APP = Approved as a valid submission
DEN = Denied for medical review reasons, or for insufficient documentation of medical necessity.
RTP = Denied as unprocessable (return/reject)
DEO = Denied for non-medical reasons, other than denied as unprocessable.
RED = Reduced for medical review reasons or for insufficient documentation of medical necessity.
REO = Reduced for non-medical review reasons.
Requirement: Required.

Data Element: **Final Allowed Charge**
Definition: Final Amount allowed for this service or equipment after any reduction or denial.
Validation: N/A
Remarks: N/A
Requirement: Required.

Sampled Claims Resolution File

Sampled 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'
Number of Claims	S9(9)	7	15	Zeroes

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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: **Number of Claims**
Definition: Number of sampled claim resolution records on this file. (do not count header or trailer record)
Validation: Must be equal to the number of sampled claims resolution records on the file.
Remarks: N/A
Requirement: Required.

Provider Address File

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'
Contractor Type	X(1)	7	7	Spaces
File Date	X(8)	8	15	Spaces

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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: **Contractor Type**
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required.

Data Element: **File Date**
Definition: Date the *Provider Address file* was created.
Validation: Must be a valid date not equal to a File Date sent on any previous *Provider Address file.*
Remarks: Format is CCYYMMDD.
Requirement: Required.

Provider Address File				
Provider Address Detail Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Provider Number	X(15)	7	21	Spaces
Provider Name	X(25)	22	46	Spaces
Provider Address 1	X(25)	47	71	Spaces
Provider Address 2	X(25)	72	96	Spaces
Provider City	X(15)	97	111	Spaces
Provider State Code	X(2)	112	113	Spaces
Provider Zip Code	X(9)	114	122	Spaces

DATA ELEMENT DETAIL

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

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

Data Element: **Provider Number**
Definition: Number assigned by the Standard System to identify the billing/pricing provider or supplier.
Validation: N/A
Remarks: N/A
Requirement: Required.

Data Element: **Provider Name**
Definition: Provider's billing name.
Validation: N/A
Remarks: This is the payee name of the billing/pricing provider.
Must be formatted into a 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 billing address.
Validation: N/A
Remarks: This is the payee address1of the billing/pricing provider.
Requirement: Required.

Data Element: **Provider Address 2**
Definition: 2nd line of provider's billing address.
Validation: N/A
Remarks: This is the payee address2 of the billing/pricing provider.
Requirement: Required if available.

Data Element: **Provider City**
Definition: Provider's billing city name.
Validation: N/A
Remarks: This is the payee city of the billing/pricing provider
Requirement: Required.

Data Element: **Provider State Code**
Definition: Provider's billing state code.
Validation: Must be a valid state code.
Remarks: This is the payee state of the billing/pricing provider
Requirement: Required.

Data Element: **Provider Zip Code**
Definition: Provider's billing zip code.
Validation: Must be a valid postal zip code.
Remarks: This is the payee zip code of the billing/pricing provider
Provide 9-digit zip code if available, otherwise provide 5-digit zip code.
Requirement: Required.

Provider Address File

Provider Address 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'
Number of Records	S9(9)	7	15	Zeroes

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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: **Number of Records**
Definition: Number of provider address records on this file. (do not count header or trailer record)
Validation: Must be equal to the number of provider address records on the file.
Remarks: N/A
Requirement: Required.

Claims History Replica file

Claims History Record (one record per claim)

DATA ELEMENT DETAIL

This format of this file will be identical to each individual Standard System's claims history file. It should not include header or trailer records.