Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

# Accountable Care Organization – Operational System (ACO-OS) Claim and Claim Line Feed (CCLF)

## Information Packet (IP)

Version 18.0

01/25/2017

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# Approvals

The undersigned acknowledge that they have reviewed the Information Packet and agree with the information presented within this document. Changes to this Information Packet will be coordinated with, and approved by, the undersigned or their designated representatives.

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# Record of Changes

| Version | Date | Description of Change |
|---|---|---|
| 1.0 | 03/07/2012 | BIETL096_Pioneer_CCLF_IP_v1_0_F_20120307 |
| 2.0 | 11/06/12 | In Table 3, Element 3, corrected the format to X(06) because Online Survey Certification and Report System (OSCAR) numbers contain both letters and numbers.<br>Edited and renamed the document (removed the word "Pioneer," etc.) so that it applies to the entire ACO program.<br>Added additional Appendix to include Substance Abuse Codes.<br>Added the AMA copyright disclaimer to Table 4 – CPT Codes.<br>Added the Summary Statistics file.<br>Updated Appendix B – File Layouts<br>Updated Sections 2, 3, 4, and 5 to incorporate the change to the Debit/Credit version of the data feed.<br>Additional Section: Section 7. Deleted extra space between section 5.4 and 5.5. |
| 3.0 | 02/25/2013 | Final baselined version by NG. |

| Version | Date | Description of Change |
|---|---|---|
| 4.0 | 07/29/2013 | March 2013:<br>Revised to add new and additional fields and information as requested by CMS.<br>Updated Appendix B for the March 2013 release.<br>Updated and baselined versioning per customer's request and added change records from Maricom.<br>Updated and baselined versioning per CM/P3's request and removed duplicate rows in Table 16.<br>June 2013:<br>Updated the "Description of Change" to be more descriptive of changes for the June 2013 release.<br>Section 2.6:<br>Addition of text stating the file will be sent to Shared Savings Program and Pioneer<br>Part A Claims Revenue Center Detail File<br>Addition of "CLM_LINE" to Claim Field Label element 7 and 9<br>Part B Physicians File<br>Addition of "RNDRG" to Claim Field Label element 18<br>Finalized updates for the June 2013 release:<br>Changes to section 2.1.1 based on comments from CM received on June 26, 2013.<br>Minor edits to section 3.3 to improve readability.<br>Changes to section 2.1.1 based on comments from CM received on July 17, 2013. |
| 5.0 | 02/26/2014 | Updated Section 2.5.2.<br>Updated the format column of elements 23 and 24 in Appendix B, Table 6.<br>Revised Section 2.5.2<br>Updated Provider Specialty Codes hyperlink for Element #9 in Table 10. |
| 6.0 | 05/14/2014 | Added Table 6: ICD-10-PCS Inpatient Procedure Codes.<br>Added Table 7: ICD-10-CM Diagnosis Codes. |
| 7.0 | 06/24/2014 | Added additional Substance Abuse codes. |

| Version | Date | Description of Change |
|---|---|---|
| 8.0 | 09/30/2014 | Changes to the CCLF format effective October 2014.<br>Updated based on the September 2014 release:<br>Updated Table 9, Element #14-20.<br>Updated Table 12, Element #28-42.<br>Updated Table 14, Element #10-19.<br>Added additional fields for Table 15: Beneficiary Demographics File.<br>Updated based on customer.<br>Updated Table 14, Element #12 added “DEA” in Claim Field Description.<br>Updated Table 15, Elements #17 and #18.<br>Highlighted changes in Appendix B: CCLF File Layouts, including Tables 9, 12, 14, and 15. |
| 9.0 | 12/23/2014 | Added Notices and Disclaimers.<br>Updated Section 1.<br>Updated the Format column in Tables 8, 9, 12, 13, 14, and 19.<br>Update the Part B Physician File Table 18 Element 7 to include additional Provider Type Codes. |
| 10.0 | 07/17/2015 | Reworded the two lead-in paragraphs in Appendix A: Alcohol and Substance Abuse Codes.<br>Appendix A: Removed SA codes based on coordination with SAMHSA.<br>Updated the following sections to include the ICD codes of 9, 10, and “U”: 2.2.1, 2.2.3, 2.2.4, 2.3.1, and Appendix B: CCLF File Layouts.<br>Updated Table 13: ICD-10-CM-Diagnosis Codes with the updated list of ICD9/10 codes.<br>Updated Section 2.6. |

| Version | Date | Description of Change |
|---|---|---|
| 11.0 | 08/28/2015 | Updated Section 2.5.1 – Provided further information regarding the Beneficiary Demographics File.<br>Updated Section 3.2 – Clarified blank vs. non-blank value of the variable CCLFs.<br>Updated Section 4.0 and 4.1 – Revised text for clarity.<br>Updated Section 5.2.1 – Provided further information regarding the Natural Keys.<br>Updated typos on “BENE_EQTBL_BIC_HICN_NUM” where applicable.<br>Added Section 8: Best Practices for Protecting Beneficiary-Level Data.<br>Updated Appendix B – Added CCLF file number after each file name.<br>Updated Acronyms List. |
| 12.0 | 12/10/2015 | NGACO Model is included in this version of the IP.<br>Updated Overview.<br>Revised Section 1 text based on Final Rule 2015 changes.<br>Revised Section 2.6.<br>Revised Appendix A Description.<br>Appendix B CCLF File Layout – Updated the CCLF file name convention for Shared Savings Program, Pioneer and NGACO Programs that are sent to ACO Mailboxes.<br>Updated Sections 2.1.1, 2.1.2, 2.5.1, 2.5.2, 2.6, 4.1, 4.2.<br>Deleted the old field names that were part of previous published version of CCLF IP from Section 4.1.<br>Added New field “DGNS_PRCDR_ICD_IND” in Section 4.1.<br>Updated section 4.1.9 to state that no new fields were added to the file.<br>Updated the Appendix B Start Position, End Position, Data Length Format and Comments for Table 23: Summary Statistics Header Record (CCLF0) and Table 24: Summary Statistics Detail Records.<br>Updated Appendix B file layouts: Made corrections to several Claim Field Labels and Formats.<br>Added note to Appendix B to describe the significance of a minus “-” in a file format. |

| Version | Date | Description of Change |
|---|---|---|
| 13.0 | 12/17/2015 | Updated:<br>Section 2.5.1: Beneficiary Demographics File to include reference to claims data will not be shared on suppressed beneficiaries.<br>Section 2.5.2: (CCLF9) clarify Current HICN for only what is in CCLF8<br>Glossary |
| 14.0 | 03/15/2016 | Updated:<br>Overview<br>Section 2.1.2 to clarify descriptive text for entity relationship.<br>Section 2.5.1 to include text on CCLF sharing criteria with ACOs.<br>Section 2.5.2 to reword Beneficiary XREF File description.<br>Section 3.1 to update explanation of how to use the Beneficiary XREF File.<br>Section 3.2 to clarify descriptive text for dropping denied claims.<br>Section 6.1 to include references to reports.<br>Sections 6.2 and 7.1 to update outdated links. |
| 15.0 | 06/06/2016 | Updated:<br>Section 2.2.1 Part A Claims Header File to include Population-Based Payment information.<br>Section 2.3.1 Part B Physicians File to include Population-Based Payment information.<br>Table 14 to include Part A Population-Based Payment fields.<br>Table 18 to include Part B Population-Based Payment fields.<br>Section 2.5.1: Revised the Beneficiary Demographics File (CCLF8) description to describe the NGACO and Pioneer Suppression and Resumption logic for the sharing of beneficiary information based on the opt-out and opt-in rules.<br>Table 18: Part B Physicians File (CCLF5) Claim Field Label was updated.<br>Table 19: Part B DME File (CCLF6) Claim Field Label and Format were updated.<br>ResDAC links in Appendix B: CCLF File Layouts.<br>Added Sections 3.5 and 3.6.<br>Glossary |

| Version | Date | Description of Change |
|---|---|---|
| 16.0 | 07/20/2016 | Updated:<br>Section 2.2.1 Part A Claims Header File to include All-Inclusive Population-Based Payment information.<br>Section 2.3.1 Part B Physicians File to include All-Inclusive Population-Based Payment information.<br>Table 14 to include Part A All-Inclusive Population-Based Payment fields.<br>Table 18 to include Part B All-Inclusive Population-Based Payment fields.<br>Glossary |
| 17.0 | 11/18/2016 | Updated:<br>Section 1 to include CEC alignment report information.<br>Section 3.4 Claims run-out to include the latest IDR fields used for claims run-out reporting.<br>Section 4 to capture the latest field changes.<br>Section 6.1: Assignment/Alignment Report to include information about CEC alignment data.<br>Section 7 and Appendix B, CCLF5, Element 20 to provide or update the Carrier Denial Codes link.<br>Removed references to Pioneer Demonstration based on the Pioneer Model Close Out.<br>Updated Section 7.1 to add a reference to SSP Data Exchange User Guide.<br>Appendix A: Alcohol and Substance Abuse Code Tables for CEC substance abuse codes.<br>Appendix B: CCLF File Layouts for CEC file naming convention.<br>Acronyms |

| Version | Date | Description of Change |
|---|---|---|
| 18.0 | 01/25/2017 | Added:<br>Section 2.6 Part A Claims Benefit Enhancement and Demonstration Codes File overview.<br>Section 2.7 Part B Claims Benefit Enhancement and Demonstration Codes File overview.<br>Table 23 Part A Benefit Enhancement Enhancement and Demonstration Codes File.<br>Table 24 Part B Benefit Enhancement Enhancement and Demonstration Codes File.<br>Updated:<br>Section 2.2.1 Part A Claims Header File to move PBP/AIPBP information to section 2.6.<br>Section 2.3.1 Part B Physician File to move PBP/AIPBP information to section 2.7.<br>Table 1 Summary Statistics File in Microsoft Excel Spreadsheet Format to include CCLFs 10 and 11.<br>Section 4 Fields in the CCLF Data Files for changes to CCLFs 1, 5, 10, and 11.<br>Table 23 and Table 24 to remove mention of tildes (~) for document consistency.<br>Table 26 Summary Statistics Detail Records for changes as a result of the introduction of CCLFs 10 and 11.<br>Section 2.5.1 with CEC Suppression/Resumption check<br>Moved PII/PHI notation to the Description column in the tables in “Appendix B – CCLF File Layouts.”<br>Removed notes globally that CCLF 0 (Summary Statistics File) will only contain nine CCLFs for CEC. CEC ESCOs will receive all 11 CCLF file names in the CCLF 0 file.<br>Updated Section 2.5.1 to explain how the newly aligned flag takes precedence over Suppression status for CEC monthly CCLF generation.<br>Corrected Table 23 start and end positions.<br>Glossary<br>Acronyms |

# Table of Contents

# List of Figures



# List of Tables

# 1 Overview

The purpose of this information packet (IP) is to describe the content and basic operations of the Program Claim and Claim Line Feed (CCLF) Reports sent to Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program and Next Generation ACO (NGACO) Model, and the End-Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs) participating in the Comprehensive ESRD Care (CEC) Model. For the purpose of this document, the term "ACO" will be used to refer to both ESCOs and ACOs.

The Centers for Medicare & Medicaid Services (CMS) will gather a data feed for certain beneficiaries, according to data sharing preferences as determined by each Medicare ACO program, to share their claims data with the ACO. For the appropriate beneficiaries, the data feed provided to the ACO will include claims for all services covered by Part A (Hospital Insurance) and Part B (Supplemental Medical Insurance) that were provided and processed during the prior month. Claims data will also include prescriptions covered by a Prescription Drug Program in which the beneficiary is enrolled. Medicare Claims are submitted by a broad range of facilities (institutional providers), professionals, and suppliers, including hospitals (both inpatient and outpatient claims); physicians; home health agencies (HHA); skilled nursing facilities (SNFs); hospices; and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers. Some of these provide services that are covered by Part A and/or Part B (e.g., hospitals and SNFs); others provide services that are covered only by Part B.

Medicare Administrative Contractors (MACs) (formerly Fiscal Intermediaries [FI] and Carriers) are responsible for processing Medicare claims. Different payment methods and claims processing systems are used depending upon the type of facility where services are received. For example, the inpatient prospective payment system (IPPS) is used to price acute hospital inpatient services, the Physician Fee Schedule is used to price physician office visits, and the outpatient prospective payment system (OPPS) is used to price outpatient services received in an outpatient setting. Medicare claims processing entities are responsible for following the rules of the various payment systems and pricing the claims.

The data files ACOs will receive consist of five Part A files, three Part B files, one Part D file, one beneficiary demographics file, and one beneficiary Health Insurance Claim Number (HICN) cross-reference file. These files are described in Section 2: Structure and Content. For NGACO ACOs, the Initial Alignment Report (Report 1-1) and the Quarterly Report on Excluded Beneficiaries (Report 1-2) provide identifying information (including names and contact information) for each of the ACO's prospectively-aligned beneficiaries. For Shared Savings Program ACOs, the Assignment Reports provided routinely during a performance year (PY) by CMS include beneficiary identifiable information on each of the ACO's assigned population. For CEC ACOs, the Monthly Beneficiary Alignment Reports provided during a performance year (PY) by CMS include beneficiary identifiable information on each of the ACO's aligned population. These reports are important sources of information that will be used in conjunction with the data contained in these CCLF Reports.

The term "claim" refers to a bill that is submitted by a provider for services rendered to a Medicare beneficiary over a period of time. A single claim can be associated with multiple services provided on one or more dates. Individual services are reported on the claim form as separate claim lines. Some data files will be at the claim level, and some will be at the line level.

This document includes the following appendices:

- Appendix A: Alcohol and Substance Abuse Code Tables
- Appendix B: CCLF File Layouts

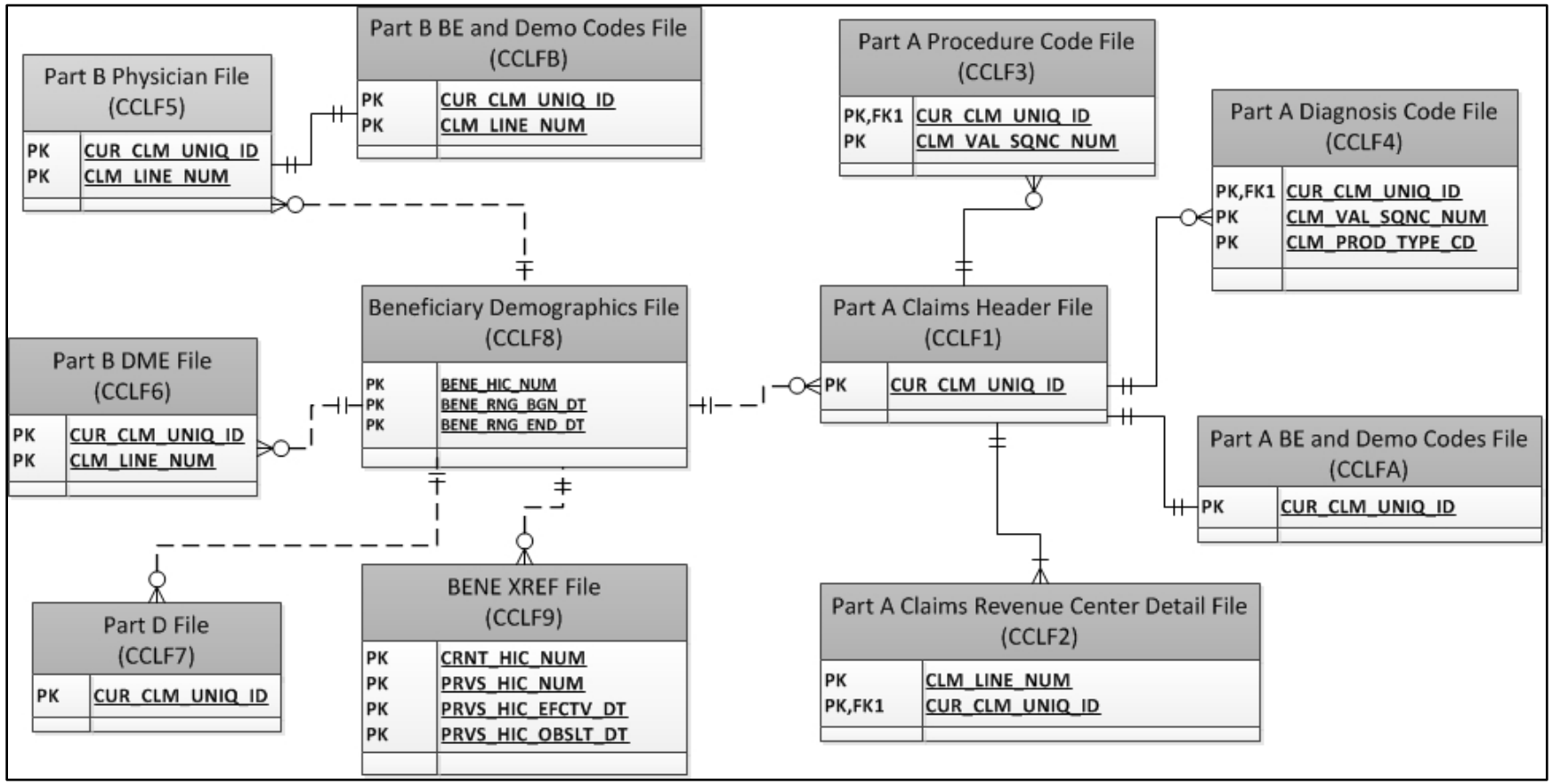
# 2 Structure and Content

This section provides a brief set of directions for users to get started using the CCLF.

## 2.1 High-Level Relationships among the Claim Files

Figure 1 shows, at a very high level, the relationships among the nine files that the ACOs will receive.

**Figure 1: Entity Relationship Diagram**



### 2.1.1 Keys

The Beneficiary Demographics File is the starting point of Figure 1. The file contains information, such as Primary Key (PK) and variables, to assist an ACO in identifying a record from the Beneficiary Demographics File. A record in a given file (i.e., a row from the file) can be uniquely identified by the use of a PK; that is, a PK consists of exactly enough information to uniquely identify a row from a file. Depending upon the nature/structure of a data file, a PK can consist of multiple variables. For the Beneficiary Demographics File, the PK consists of BENE_HIC_NUM, BENE_RNG_BGN_DT, and BENE_RNG_END_DT. Using these three fields, a record can be identified in the Beneficiary Demographics File.

A PK with a singular value is a PK that can be identified by just one column in a table. The PK for the Part A claims header is CUR_CLM_UNIQ_ID. Each row in this file can be identified by just one column value. Each claim header is uniquely identified by a different CUR_CLM_UNIQ_ID value.

The Foreign Key (FK) signals that the variable is used as a PK in another file. For example, BENE_HIC_NUM is a FK in the Part D File, signaling that it is a PK in another file (i.e., the Beneficiary Demographics File).

### 2.1.2 Defining Relationships between Files

In Figure 1, the lines connecting the files define the relationship(s) between the files (i.e., entities). There are two types of relationships in the diagram:

- Zero-to-many: A dotted line (which means optional relationship) that ends in a circle with three lines indicates that the entity closest to symbol represents "zero, one, or many" attributes for the relationship. An example of this relationship is the line connecting the Beneficiary Demographics File and the Part B Physician File. This means that there is one and only one row in the Beneficiary Demographic Files which can be associated with zero, one, or many rows in the Part B Physician File.
- One-to-many: A solid line (that indicates a mandatory relationship) that splits into three lines indicates a one-to-many relationship. An example of this relationship is the line connecting the Part A Claims Header File and the Part A Claims Revenue Center Detail File. This means that one and only one row in the Part A Claims Header File must be associated with at least one row, or can be associated with many rows from the Part A Claims Revenue Center Detail File.

## 2.2 Part A Claims Data

Part A claim data files contain claims submitted by facilities such as hospitals, SNFs, HHAs, rehabilitation facilities, and dialysis facilities. These files are referred to as institutional or facility files. The Part A claims file contains claims for services that are covered under Part A as well as claims for some services that are covered under Part B of Medicare. An example of a Part B-covered service appearing in the Part A file would be a visit to the emergency department of an acute care hospital that did not result in an admission. In this situation, the hospital would file a Part A claim form for a Part B-covered service. As a result, the Part B covered service would be included in the Part A claim record.

### 2.2.1 Part A Claims Header File

The Part A Claims Header File (CCLF1) contains summary claims from HHAs, SNFs, acute care hospitals (inpatient and outpatient claims), and hospice facilities. This file is at the summary claim level and does NOT contain line item information. From this file, an ACO can obtain beneficiary-level spending on facility services (overall, by diagnostic related group [DRG], or by principal diagnosis), the national provider identifier (NPI) corresponding to the provider and/or facility associated with the claim, and the beneficiary's identification number, which is referred to as a HICN. This file can also be used to calculate the proportion of services (as measured by payment amount) rendered to an ACO's beneficiaries that are provided by the ACO versus non-ACO providers.

Institutional providers are identified in the Part A Claims Header File by both the facility NPI (FAC_PRVDR_NPI_NUM) and the older Online Survey Certification and Reporting System (OSCAR) number (also referred to as the CMS Certification Number or CCN). Data describing the individual or organization identified by the NPI may be obtained from the National Plan and Provider Enumeration System (NPPES).

The Part A Claims Header File also provides the NPI of the attending, operating, and other provider.

The International Classification of Diseases (ICD) Version Indicator can be found in the Claim Header File. This indicator is a single character denotation of whether the codes received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data.

For information on the Part A Claims Header File layout, refer to Table 14: Part A Claims Header File.

### 2.2.2 Part A Claim Revenue Center Detail File

The Part A Claims Revenue Center Detail File (CCLF2) contains line-item level detail for each claim from the Part A Claims Header File. This file contains codes from the healthcare common procedure coding system (HCPCS) for each service received as well as the date the service was received. For outpatient claims, the file contains the payment amount and allowed charge amount for individual services. The file can be used to ascertain the proportion of an ACO's beneficiaries who received a particular service.

For information on the Part A Claim Revenue Center Detail File layout, refer to Table 15: Part A Claims Revenue Center Detail File.

### 2.2.3 Part A Procedure Code File

The Part A Procedure Code File (CCLF3) contains detailed information regarding the claims from the Part A Claims Header File, such as the type of surgical procedure performed and the date it was performed. This file can be used in conjunction with the Part A Claims Header File to identify and compare surgical procedures that are associated with a given principal diagnosis for both ACO and non-ACO providers. For example, for a beneficiary diagnosed with X, a beneficiary is more likely to receive surgical procedure Y from an ACO provider, whereas surgical procedure Z is more likely to be performed by a non-ACO provider.

The ICD Version Indicator can be found in the Part A Procedure Code File. This indicator is a single character denotation of whether the codes received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data. For information on the Part A Procedure Code File layout, refer to Table 16: Part A Procedure Code File.

### 2.2.4 Part A Diagnosis Code File

The Part A Diagnosis Code File (CCLF4) contains the diagnosis codes for the principal diagnosis as well as all secondary diagnoses that correspond with a given claim from the Part A Claims Header File. For a given claim, the associated secondary diagnoses can be distinguished from one another by the use of the variables CLM_VAL_SQNC_NUM and CLM_PROD_TYPE_CD. This file can be used in conjunction with the Part A Claims Header File to identify secondary diagnoses that are associated with a given principal diagnosis.

The ICD Version Indicator can be found in the Part A Diagnosis Code File. This indicator is a single character denotation of whether the codes received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data.

For information on the Part A Diagnosis Code File layout, refer to Table 17: Part A Diagnosis Code File.

## 2.3 Part B Claims Data

The following subsections provide information on the Part B Claim Data Files.

### 2.3.1 Part B Physician File

The Part B Physician File (CCLF5) contains information on services delivered by physicians, practitioners, and suppliers. The file contains both claim-level and line-level information. At the claim level, the file contains date of service, HICN, header level diagnosis codes, disposition code, and type of claim (DMEPOS or non-DMEPOS). At the line level, the file contains provider specialty, date of service, HCPCS code, HCPCS modifier codes, payment amount, allowed charge amount, line-level diagnosis code (i.e., the "pointer" to the header level diagnosis), units of service, primary payer, provider Taxpayer Identification Number (TIN), and rendering NPI number. This information allows you to identify the proportion of total Part B services (or a particular type of Part B service) being supplied to your beneficiaries by the ACO versus non-ACO providers.

The ICD Version Indicator can be found in the Part B Physician File. This indicator is a single character denotation of whether the codes received derived from ICD-9 (9) or ICD-10 (0). The value of "U" indicates an unknown indicator from source data.

For information on the Part B Physician File layout, refer to Table 18: Part B Physicians File.

### 2.3.2 Part B DME File

The Part B DME File (CCLF6) consists of claim-line records, but includes both claim-level and line-level information. Claim-level information includes date of service, disposition code, and type of claim submitted (DMEPOS versus non-DMEPOS). Line-level information includes date of service, HCPCS code, payment amount, allowed charge amount, ordering NPI number, and "paid to" NPI number.

For information on the Part B DME File layout, refer to Table 19: Part B DME File.

## 2.4 Part D Claims Data

The Part D File (CCLF7) contains prescription drug information at the beneficiary level. Some of the data elements in this file include the National Drug Code (NDC), quantity dispensed, days supplied, prescribing provider ID, service provider ID, and patient payment amount.

For information on the Part D Claims Data File layout, refer to Table 20: Part D File.

## 2.5 Beneficiary Data

The following subsections provide information on the beneficiary data files.

### 2.5.1 Beneficiary Demographics File

The Beneficiary Demographics file (CCLF8) contains the list of beneficiaries for whom the ACO is qualified to receive claims data. For Shared Savings Program ACOs, this will be limited to beneficiaries who have consented to share their claims information and have not been excluded by CMS. For Track 1 or Track 2 Shared Savings Program ACOs, the CCLF8 file will include beneficiaries who had a qualifying primary care visit with the specific ACO within the previous 12 months. For Track 3 Shared Savings Program ACOs, the CCLF8 will include beneficiaries present on an ACO's current prospective assignment list. The CCLFs will be sent to Shared Savings Program ACOs for a beneficiary (with a current data sharing preference of Opt-in and not excluded by CMS) who died prior to the Shared Savings Program ACO's agreement date.

Claims data for a beneficiary aligned to an NGACO ACO will be suppressed (will not be sent) after a quarterly check, regardless of the beneficiary's data sharing preference, when the beneficiary's paid claims for any services are associated with a terminated and/or removed provider and that beneficiary has no paid claims with any other currently active providers of the NGACO ACO within the last 12 months.

Claims data for a beneficiary, with a data sharing preference of Opt-in, will be resumed (included within the CCLFs) with the aligned NGACO ACO when there is at least one paid claim for any services within the last 12 months with a currently active provider. Even if a beneficiary's status is reflected as "resumed" in the Next Generation Monthly Beneficiary Data Sharing Status file, that beneficiary's claims will not be included in the CCLFs if the beneficiary opts out of sharing claims data.

Detailed claims data reports provided to NGACO ACOs shall not include data for Next Generation beneficiaries who have opted out of data sharing with the ACO. Substance abuse data will be shared with ACOs for only those beneficiaries who have opted in to this specific type of data sharing.

Detailed claims data reports provided to CEC ACOs will include data for CEC beneficiaries who have not opted out of beneficiary-level data sharing. Currently for CEC, beneficiaries do not have the option to opt-in to data sharing of substance abuse claims.

Claims data for a CEC beneficiary aligned to an ESCO will be suppressed (will not be sent) after a quarterly check, regardless of the beneficiary's data sharing preference, when the beneficiary's paid claims for any services are not associated with an active provider within the last 12 months. However, when a suppressed beneficiary who has opted in to share data is identified as newly aligned during a reporting month, then the beneficiary claims are sent regardless of the suppression status of the beneficiary in the CEC Suppressed and Resumed Beneficiaries List file from the ACO-OS to the CEC Operations Contractor.

Claims data for a currently-suppressed beneficiary, with a data sharing preference of Opt-in, will be resumed (included within the CCLFs) with the aligned ESCO when there is at least one paid claim for any services within the last 12 months with an active provider. Even if a beneficiary's status is reflected as "resumed" in the CEC Suppressed and Resumed Beneficiaries List file from ACO-OS to CEC Operations Contractor, that beneficiary's claims will not be included in the CEC CCLFs if the beneficiary opts out of sharing claims data.

This file contains the beneficiary's current HICN, first/middle/last name, ZIP code, date of birth, sex, race, age, Medicare Status Code, dual eligibility status, hospice begin/end dates, and date of death if a decedent.

The Beneficiary Demographics File may contain multiple rows for the same beneficiary. This is because the beneficiary may have services with varying BENE_RNG_BGN_DT and BENE_RNG_END_DT dates. In this case, each row will have its own relationship to the rows of the CCLF 1, CCLF5, CCLF6, and CCLF7. This is represented in Figure 1: Entity Relationship Diagram as each row in the Beneficiary Demographics File has an association with zero or many rows of each of the four other CCLF files.

For information on the Beneficiary Demographics File layout, refer to Table 21: Beneficiary Demographics File.

### 2.5.2 HICN Crosswalk – Beneficiary Cross-Reference (XREF) File

The HICN Crosswalk-Beneficiary cross-reference (XREF) File (subsequently referred to as the "Beneficiary XREF File" or CCLF9) contains the list of aligned beneficiaries who have at least one HICN change and have not opted out of data sharing, as described in Section 2.5.1 above. The beneficiaries' current HICN and any previous HICNs, along with their associated start/end dates, can be used to identify the historical claims that should be linked to the new HICN or vice versa. For example, if a beneficiary becomes a widow/widower or remarries, the beneficiary's HICN is likely to change. Any claims submitted after the HICN change occurs will carry the new HICN.

The Beneficiary XREF File provides the Retirement Board (RRB) number for the reported beneficiary when the beneficiary's current HICN is in the RRB format. If the beneficiary's current HICN is based on an SSN, this field will be blank. For information on the Beneficiary XREF File layout, refer to Table 22: Beneficiary XREF File.

## 2.6 Part A Claims Benefit Enhancement and Demonstration Codes File

The Part A Claims Benefit Enhancement (BE) and Demonstration Codes File (CCLFA) will only be available for Shared Savings Program and NGACO ACOs. CCLFA contains BE codes and Medicare Demonstration Special Processing Numbers associated with Part A claims, Population-Based Payment (PBP)/ All-Inclusive Population-Based Payment (AIPBP) Part A reduction amounts, and PBP/AIPBP Part A inclusion amounts. The file will contain a row for each unique claim that is processed with one or more of the following BEs: PBP, AIPBP, SNF 3-Day Waiver, Telehealth, and/or Post Discharge Home Visit. All BE codes present for each claim will display in the file. Additionally, the file will display all available Medicare Demonstration Special Processing Numbers for each Part A claim; up to five numbers will be available. To view more information for each claim in CCLFA, such as claim amounts, please use the Current Claim Unique ID to map to CCLF1.

For NGACO ACOs, PBP is a payment mechanism where a percentage of payments to the Providers are withheld from the Medicare fee-for-service (FFS) payments. The projected total amount withheld from Providers is then distributed to NGACO ACOs on a monthly basis through per-beneficiary, per-month (PBPM) payments.

AIPBP is a payment mechanism where all (100%) of payments to Providers are withheld from the FFS payments. CMS makes a monthly AIPBP payment to NGACO ACOs, with which NGACO ACOs are responsible for paying claims for NGACO Providers receiving 100% reduced FFS payments.

For those Providers that have entered into an agreement with an NGACO ACO to participate in the PBP/AIPBP mechanism, the Medicare Part A PBP/AIPBP Reduction Amount and PBP/AIPBP Inclusion Amount are provided in CCLFA. The PBP/AIPBP Inclusion Amount is the amount that would have been paid in the absence of a PBP/AIPBP reduction. PBP/AIPBP data are derived directly from the IDR and are only available at the header-level for Part A claims. For information on Part B PBP/AIPBP data, please refer to Section 2.3.1, Part B Physician File.

## 2.7 Part B Claims Benefit Enhancement and Demonstration Codes File

The Part B Claims BE and Demonstration Codes File (CCLFB) will only be available for Shared Savings Program and NGACO ACOs. CCLFB contains BE codes and Medicare Demonstration Special Processing Numbers associated with Part B claim lines, PBP/AIPBP Part B reduction amounts, and PBP/AIPBP Part B inclusion amounts. The file will contain a row for each unique claim line that is processed with one or more of the following BEs: PBP, AIPBP, SNF 3-Day Waiver, Telehealth, and/or Post Discharge Home Visit. All BE codes present for each claim line will display in the file. Additionally, the file will display all available Medicare Demonstration Special Processing Numbers for each Part B claim line; up to five numbers will be available. To view more information for each claim line in CCLFB, such as claim amounts, please use the Current Claim Unique ID and Claim Line Number to map to CCLF5.

For those Providers that have entered into an agreement with an NGACO ACO to participate in the PBP/AIPBP payment mechanism, the Medicare Part B PBP/AIPBP Reduction Amount and PBP/AIPBP Inclusion Amount are provided in CCLFB. The PBP/AIPBP Inclusion Amount is the amount that would have been paid in the absence of a PBP/AIPBP reduction. PBP/AIPBP data are derived directly from the IDR and are available at the claim line-level for Part B claims. For information on Part A PBP/AIPBP data, please refer to Section 2.2.1, Part A Claims Header File.

## 2.8 Summary Statistics Data

The Summary Statistics File (CCLF0) contains the record count for each of the 11 CCLF files. This file can be used to verify the receipt of all of a file's records. This file is implemented for Shared Savings Program, NGACO, and CEC ACOs.

The file is delivered to the user as a pipe-delimited text file, which can be downloaded into a Microsoft Excel spreadsheet, as shown in Table 1.

Note: The total record count varies each month for the files in Table 1.

**Table 1: Summary Statistics File in Microsoft Excel Spreadsheet Format**

| File Number | File Description | Total Record Count | Record Length |
|---|---|---|---|
| CCLF1 | Part A Claims Header File | xxxxxxxxx | xxx |
| CCLF2 | Part A Claims Revenue Center Detail File | xxxxxxxxx | xxx |
| CCLF3 | Part A Procedure Code File | xxxxxxxxx | xxx |
| CCLF4 | Part A Diagnosis Code File | xxxxxxxxx | xxx |
| CCLF5 | Part B Physicians File | xxxxxxxxx | xxx |
| CCLF6 | Part B DME File | xxxxxxxxx | xxx |
| CCLF7 | Part D File | xxxxxxxxx | xxx |
| CCLF8 | Beneficiary Demographics File | xxxxxxxxx | xxx |
| CCLF9 | BENE XREF File | xxxxxxxxx | xxx |

| File Number | File Description | Total Record Count | Record Length |
|---|---|---|---|
| CCLFA | Part A BE and Demo Codes File | xxxxxxxxx | xxx |
| CCLFB | Part B BE and Demo Codes File | xxxxxxxxx | xxx |
| CCLF0 | Summary Statistics Header Record | xxxxxxxxx | xxx |

For information on the Summary Statistics Header Record and Summary Statistics Detail Record File layouts, refer to Table 25: Summary Statistics Header Record and Table 26: Summary Statistics Detail Records.

# 3 Limitations and Cautions

This section describes limitations and cautions for ACOs to consider when using the CCLF.

## 3.1 Matching HICNs

A beneficiary's HICN is unique to that beneficiary but may change over time. CCLFs1 through 9, A, and B, as they are provided each month, contain the beneficiaries' most current HICN. When records from multiple months are being combined, the Beneficiary XREF File (CCLF9) can be used each month to cross reference records associated with the current HICN to records associated with old (previous) HICNs.

The steps below detail instructions for merging CCLF data, and provide an example of merging data for the months of January and February of a particular PY:

1. Use the February Beneficiary XREF File to identify the current and previous HICN(s).
2. After identifying the previous HICNs in the February Beneficiary XREF File, locate the same previous HICNs in the January CCLF data.
3. Replace the previous HICNs in the January CCLF data with the current HICNs from the February CCLF data. The file will now have only one unique HICN per beneficiary across time (over January and February in this example).

## 3.2 Dropping Denied Claims

Depending on your use of the data for analysis, you may want to drop denied and corrected claims from the Part A and B CCLF data. For Part B Physician/DME claims, some individual line-items can be denied, whereas other line-items are not denied. Part B claims need to be dropped depending upon the value of the variable CLM_CARR_PMT_DNL_CD, and Part B line-items need to be dropped depending upon the value of the variable CLM_PRCSG_IND_CD. For Part A claims, the variable CLM_MDCR_NPMT_RSN_CD identifies claims that have been denied. Unlike Part B claims, Part A claims are either accepted in their entirety or denied in their entirety.

## 3.3 Part D Data Limitations

The Part D data file will only include records for beneficiaries who are enrolled in a Prescription Drug Plan (PDP). Many beneficiaries have Part D prescription drug coverage through an employer-sponsored retiree drug plan. Part D data does not include prescription data for these beneficiaries due to differences in the data that are required to be submitted by a PDP and a retiree drug plan. Furthermore, Part D data only reflect expenditures for filled prescriptions.

The Part D claims contained in the CCLF are "final action" claims, unlike the other claims-related files in the CCLF, which are debit/credit claims. In any given set of monthly CCLF files, only "final action" claims will be contained in the Part D file. Furthermore, the Part D cancelation claims (i.e., delete claims) always are submitted with a $0 payment amount. As you create a claims record over time by combining many monthly CCLF data feeds for Part D claims, you will need to identify for any given set of Related Claims (i.e., claims that all represent the same event) the most recent claim and delete/ignore all of the previous related claims for that event. That is, you need to identify the "final action" claims.

Lastly, note that the NDC code is not populated for "delete" prescription drug events (PDEs); all cancelation claims in the Part D file will have blank values for the NDC code field.

## 3.4 Claims Run-out

Claims for services that are rendered towards the end of the PY are generally not processed until the beginning of the following PY. As a result of this, the IDR claim load date (CLM_IDR_LD_DT) and the Claim Through Date (CLM_THRU_DT) should be used to identify claims loaded at a later time for services rendered for the prior PY.

Monthly claims data will not include claims for services that have not yet been submitted to the MAC by the provider. Similarly, monthly claims data will not include claims that have been received by the MAC but are not fully processed at the time the claims feeds are generated.

Two variables are used to control claims run-out: CLM_THRU_DT and CLM_IDR_LD_DT.

- The CLM_THRU_DT is the last day on the billing statement that covers services rendered to the beneficiary.
- The CLM_IDR_LD_DT is the date the claim was loaded into the Integrated Data Repository (IDR), the CMS data warehouse or repository. The CLM_IDR_LD_DT is generally a Monday.

For a given claim, there is typically a time gap between the CLM_THRU_DT and the CLM_IDR_LD_DT. However, in some cases, a claim is "pended" (i.e., held back) and not loaded into the IDR immediately. As a result, some claims loaded into the IDR on a given Monday (from CLM_IDR_LD_DT) will actually include claims whose CLM_THRU_DT is weeks or in a small number of cases, months in the past. Therefore, to control claims run-out, both of these variables are needed. For example, to capture all of the claims rendered for a particular month that were loaded during the run-out period, you would use the CLM_THRU_DT with a date range from the beginning of the PY until the end of the PY, and an IDR_LD_DT for the given reporting month. For the given example, you would need to specify the following:

1. CLM_IDR_LD_DT on or before March 31, 2016.
2. CLM_THRU_DT for any month within CY2015.

## 3.5 Part A Header Expenditures versus Part A Revenue Center Expenditures

Both the Part A Header file (CCLF1) and the Part A Revenue Center file (CCLF2) contain a payment related field, entitled CLM_PMT_AMT and CLM_LINE_CVRD_PD_AMT, respectively. The revenue center payment amounts should only be relied on if they sum to the header level payment amount. If the revenue center level payment amounts do not sum to the header level payment amount, then the revenue center level payment amounts should be ignored. The reasons for the discrepancy between revenue center and header level payments are that some

claims do not have revenue center level payments (e.g., inpatient claims which are paid at claim level using the DRG payment system), some claims are not required to report at the revenue center level (and thus sometimes yield inconsistent reporting at the revenue center level compared to the header level), and for some claims the revenue center amounts reported were not actually those used for payment.

## 3.6 Date fields

There are various date-related fields in the CCLF data files. In some instances, the date field is not required or is not available in the source. In these cases, that date field is commonly filled in with “1000-01-01” or “9999-12-31.” These dates should be treated as “missing” or “null” values. Also note that line-level service dates on inpatient claims can fall outside of the time period of the header level from/thru dates.

## 3.7 Other Limitations/Cautions

The Medicare dataset supplied to you is a subset of the full set of Medicare data. The variables were chosen because they were deemed to be the most useful information for you.

The data does not reflect the use and expenditures for beneficiaries who have not given permission for their data to be shared with ACOs. In addition, substance abuse data are not shared when the beneficiary has opted out of data sharing (SSP and CEC beneficiaries are always opted out). As a result, this data may not include 100% of the claims data for every beneficiary.

# 4 Fields in the CCLF Data Files

## 4.1 Fields and Descriptive Text Changes to Version 18.0 of the Claims Line Feed

### 4.1.1 Part A Header File

The following fields were moved to the Part A Claims Benefit Enhancement and Demonstration Codes File:

- CLM_PBP_INCLSN_AMT
- CLM_PBP_RDCTN_AMT

### 4.1.2 Part A Revenue Center File

No fields were added or removed in this file.

### 4.1.3 Part A Procedure Code File

No fields were added or removed in this file.

### 4.1.4 Part A Diagnosis Code File

No fields were added or removed in this file.

### 4.1.5 Part B Physician File

The following fields were moved to the Part B Claims Benefit Enhancement and Demonstration Codes File:

- CLM_PBP_INCLSN_AMT
- CLM_PBP_RDCTN_AMT

### 4.1.6 Part B DME File

No fields were added or removed in this file.

### 4.1.7 Part D File

No fields were added or removed in this file.

### 4.1.8 Beneficiary Demographics File

No fields were added or removed in this file.

### 4.1.9 Beneficiary XREF File

No fields were added or removed in this file.

### 4.1.10 *NEW* Part A Claims Benefit Enhancement and Demonstration Codes File

This is a new file that will be provided to Shared Savings Program and NGACO ACOs beginning in April 2017. Please refer to Table 23 for a complete list of fields for this file.

### 4.1.11 *NEW* Part B Claims Benefit Enhancement and Demonstration Codes File

This is a new file that will be provided to Shared Savings Program and NGACO ACOs beginning in April 2017. Please refer to Table 24 for a complete list of fields for this file.

## 4.2 Description of the Additional Fields

Please refer to Table 23 and Table 24 for a complete description of each new field associated with the Part A and Part B Benefit Enhancement and Demonstration Codes Files.

## 4.3 Beneficiary Equitable BIC Health Insurance Claim Number vs. Health Insurance Claim Number

The Health Insurance Claim Number (BENE_HIC_NUM) has two elements: a nine-byte field called Beneficiary Claim Account Number (CAN) and a two-byte field called the Beneficiary Identification Code (BIC). The CAN is a number that represents the person who earned the Medicare benefits by working and paying Medicare taxes (i.e., the wage earner), and is often a Social Security Number (SSN). A spouse who is entitled to Medicare benefits under their wife's/husband's work history would have the same CAN as their wife/husband. The BIC identifies the relationship of the beneficiary and the wage earner. For example, the "first wife" of a CAN-owner would be identified by a BIC of "B." If the husband dies, then the "first wife" changes to the BIC of "first widow." The CAN for the wife/widow does not change in this example.

The Beneficiary Equitable BIC Health Insurance Claim Number (BENE_EQTBL_BIC_HICN_NUM) is an “umbrella” HICN, meaning that it groups certain HICNs together, at the beneficiary level. Whenever the CAN for a beneficiary changes, the BENE_EQTBL_BIC_HICN_NUM will change. However, whenever the BIC changes (holding the CAN constant) for a beneficiary, the BENE_EQTBL_BIC_HICN_NUM will NOT change. For example, the beneficiary cited above, whose status changed from a “first wife” to a “first widow” upon the death of her husband, would have the same value for BENE_EQTBL_BIC_HICN_NUM before and after this life event.

## 4.4 Debit/Credit Method and the Identification of Cancelation/Adjustment Claims

The Debit/Credit method gives a full account/history of the claims processed over time. This means that the universe of claims is included in the claims line feed, including adjustment and cancelation claims. The variable CLM_ADJSMT_TYPE_CD identifies which of the following categories that any individual claim falls into:

1. CLM_ADJSMT_TYPE_CD= 0 signifies an Original Claim.
2. CLM_ADJSMT_TYPE_CD= 1 signifies a Cancelation Claim.
3. CLM_ADJSMT_TYPE_CD= 2 signifies an Adjustment Claim (claim that is an adjustment to an original claim).

# 5 Application Notes

The following subsections provide application notes.

## 5.1 Identification of Related Claims Using the Natural Key

### 5.1.1 Natural Keys

“Related Claims” refer to all of the claims associated with a single episode of service (i.e., event). This includes the original claim(s) and any corresponding cancelation and adjustment claims. A natural key allows you to identify/group Related Claims. The natural key for each of the files is as follows:

Part A Claim Header File/Revenue Center/Procedure/Diagnosis files:

- PRVDR_OSCAR_NUM
- CLM_FROM_DT
- CLM_THRU_DT
- BENE_EQTBL_BIC_HICN_NUM.

Part B Physician/DME files:

- CLM_CNTL_NUM
- BENE_EQTBL_BIC_HICN_NUM

Part D File:

- CLM_LINE_FROM_DT, PRVDR_SRVC_ID_QLFYR_CD

- CLM_SRVC_PRVDR_GNRC_ID_NUM
- CLM_DSPNSNG_STUS_CD
- CLM_LINE_RX_SRVC_RFRNC_NUM
- CLM_LINE_RX_FILL_NUM

### 5.1.2 Example: Linking Related Claims in the Part A Header File Using the Natural Key

Suppose you are looking at a claim with CUR_CLM_UNIQ_ID=3589734591235. To identify all related claims, first find the values for the natural key that are associated with CUR_CLM_UNIQ_ID=3589734591235 (i.e., find the values for PRVDR_OSCAR_NUM, CLM_FROM_DT, CLM_THRU_DT, and BENE_EQTBL_BIC_HICN_NUM when CUR_CLM_UNIQ_ID=3589734591235). Suppose that, for this example claim, the values for the natural key are as follows:

- PRVDR_OSCAR_NUM=654321
- CLM_FROM_DT= 07/01/12
- CLM_THRU_DT= 7/04/12
- BENE_EQTBL_BIC_HICN_NUM= 123456789B

Using these values for the natural key, we can now identify all claims in the Part A Header File that have the same values for the natural key. Suppose we obtain the following from Table 2:

**Table 2: Part A Header File**

| CUR_CLM_UNIQ_ID | PRVDR_OSCAR_NUM | CLM_FROM_DT | CLM_THRU_DT | BENE_EQTBL_BIC_HICN_NUM |
|---|---|---|---|---|
| 2222222222222 | 654321 | 07/01/12 | 7/04/12 | 123456789B |
| 3589734591235 | 654321 | 07/01/12 | 7/04/12 | 123456789B |
| 1313274894021 | 654321 | 07/01/12 | 7/04/12 | 123456789B |
| 1111111111111 | 654321 | 07/01/12 | 7/04/12 | 123456789B |
| 3333333333333 | 654321 | 07/01/12 | 7/04/12 | 123456789B |

This group of claims consists of five records that are all related to one another. Specifically, they all involve a claim for services provided to a beneficiary by a single Part A provider during the time period July 1, 2012, through July 4, 2012. Further information is needed to distinguish among the claims and identify the “final action” claim(s). In this particular example, it will be useful to obtain information on the claim effective date and the claim adjustment type code. In Table 3, this additional information is added. (The PK is dropped to reduce the number of columns displayed; however, one can assume that those columns shown in the above table are simply not displayed here).

**Table 3: Claim Effective Date and the Claim Adjustment Type Code**

| ROW | BENE_HIC_NUM | CUR_CLM_UNIQ_ID | CLM_EFCTV_DT | CLM_ADJSMT_TYPE_CD |
|---|---|---|---|---|
| 1 | 123456789B | 2222222222222 | 07/30/12 | 0 (original claim) |

| ROW | BENE_HIC_NUM | CUR_CLM_UNIQ_ID | CLM_EFCTV_DT | CLM_ADJSMT_TYPE_CD |
|---|---|---|---|---|
| 2 | 123456789B | 3589734591235 | 08/01/12 | 1 (cancelation claim) |
| 3 | 123456789B | 1313274894021 | 08/01/12 | 2 (adjustment claim) |
| 4 | 123456789D | 1111111111111 | 08/07/12 | 1 (cancelation claim) |
| 5 | 123456789D | 3333333333333 | 08/07/12 | 2 (adjustment claim) |

In the above table, you will find that the record in Row 2 cancels the record in Row 1. Likewise, the record in Row 4 cancels the record in Row 3. The remaining record in Row 5 is the "final action" claim. Note that in this example, sorting by CLM_EFCTV_DT and then by CLM_ADJSMT_TYPE_CD, yields the final action claim as the last record in this sort. This is a unique example, and it is NOT always true that related claims sorted in this way will yield the "final action" claim(s). As detailed in Section 5.2 below, there is variation across the claims-related files (Part A, Part B, Part D) in the appropriate use of the variables CLM_EFCTV_DT and CLM_ADJSMT_TYPE_CD in distinguishing among related claims.

## 5.2 Occurrences of Related Claims in the Various Claims-Related Files

### 5.2.1 Related Claims in the Part A Header File

In the Part A Header File, you will find original claims, cancelation claims, and adjustment claims (i.e., claims with CLM_ADJSMT_TYPE_CD=0, 1, or 2 respectively). Related claims found in the Part A Header File may exhibit a number of patterns, including (but not limited to), the following:

1. An original claim with no other related claims.
2. An adjustment claim with no other related claims.
3. A set of related claims consisting of an original claim and a cancelation claim.
4. A set of related claims including two original claims (and no other related claims).
5. A set of related claims including an original claim, a cancelation claim, and an adjustment claim.

The timing of the processing of the related claims is not always straightforward. In all instances, an original claim will be processed before its corresponding adjustment and cancelation claim(s). In many instances, the cancelation claim is processed at the same time as the adjustment claim. However, in some instances, the cancelation claim is processed weeks (or even months) *after* the adjustment claim is processed. In other instances, the cancelation claim is processed weeks (or even months) *before* the adjustment claim. As a result, it is not always straightforward (or possible) to distinguish among all of the beneficiary's related claims.

In order to identify the "final action" or "non-canceled" claims in a related set of claims, it is necessary to match each cancelation claim with one of the following:

- An original claim
- An adjustment claim

All original/cancelation and adjustment/cancelation matched pairs should be removed/ignored, yielding only final action claim(s). It is possible that there is more than one final action claim among a related set of claims.

In the event a Claim Through Date (CLM_THRU_DT) is submitted incorrectly and must be revised, the following will happen:

1. A cancellation claim will be generated identical to the original claim, and will have the same incorrect through date.
2. An adjustment claim will be submitted with the correct Claim Through Date. In this instance, the natural key cannot be used to link the related claims together. When one of the fields of the natural key changes, the natural key is no longer useful in linking related claims together.

### 5.2.2 Related Claims in the Part B Physician File

In the Part B Physician File, you will find original claims and cancelation claims. You will not find any adjustment claims in these files. A variety of related claims are found in the Part B Physician File, including (but not limited to) the following:

1. An original claim with no other related claims.
2. A set of related claims consisting of an original claim and a cancelation claim.
3. A set of related claims consisting of two original claims and one cancelation claim.
4. A set of related claims consisting of three original claims and two cancelation claims.

### 5.2.3 Related Claims in the Part B DME File

In the Part B DME File, you will find original claims and cancelation claims. You will not find any adjustment claims in these files. A variety of related claims are found in the Part B DME File, including (but not limited to) the following:

1. An original claim with no other related claims.
2. A set of related claims consisting of one original claim and one cancelation claim.
3. A set of related claims consisting of two original claims and one cancelation claim.
4. A set of related claims consisting of three original claims and two cancelation claims.

### 5.2.4 Related Claims in the Part D File

In the Part D File, you will find original claims, cancelation claims, and adjustment claims. A variety of related claims are found in the Part D File, including (but not limited to) an original claim with no other related claims.

## 5.3 Calculating Beneficiary-Level Expenditures

### 5.3.1 Calculating Total Part A and B Expenditures

Calculating total expenditures for a beneficiary using debit/credit data is a conceptually simple process of adding up all of the debit and credit amounts associated with the claims incurred by a beneficiary during a specific time period.

However, it is slightly more complicated for two reasons: First, the payment amounts on each record are not “signed” to indicate whether the payment amount is a payment to the provider or a recovery from the provider. Therefore, it is necessary to use the CLM_ADJSMT_TYPE_CD to

determine whether to “add” or “subtract” the payment amount from the running total. Second, different HICNs may appear on the claims for a single beneficiary at different points in time.

To correctly “sign” the payment amounts as a payment to a provider, or a recovery from a provider, follow the steps below to identify beneficiary-level expenditures for Part A and Part B services:

1. Identify the canceled claims in the Part A Header file. These claims are identified by CLM_ADJSMT_TYPE_CD=1. Change the “sign” of the variable CLM_PMT_AMT for each of these cancelation claims (i.e., multiply the CLM_PMT_AMT by -1). For example, if on a given cancelation claim the value for CLM_PMT_AMT=$30.18, then change this to equal -$30.18.
2. Identify all the canceled records (line items) in the Part B Physician file. The canceled line items are identified by CLM_ADJSMT_TYPE_CD=1. Change the “sign” of the variable CLM_LINE_CVRD_PD_AMT for each of these canceled line items.
3. Identify all the canceled records (line items) in the Part B DME file. The canceled line items are identified by CLM_ADJSMT_TYPE_CD=1. Change the “sign” of the variable CLM_LINE_CVRD_PD_AMT for each of these canceled line items.

To identify all claims incurred by a single beneficiary, regardless of changes in the beneficiary’s HICN, follow the steps below:

1. Replace all old HICNs in the previous datasets (if any) with the current HICN using information from the Beneficiary XREF File.
2. For each current HICN (after making the changes from step 1), identify the Part A claims from the Part A Claims Header File. Identify total Part A Header level expenditures for each HICN after accounting for the potential “sign” changes in Step 1.
3. For each current HICN (after making the changes from step 1), identify the Part B Physician line-items. Identify the total Part B Physician expenditures (summing across line-items) for each HICN after accounting for the potential “sign” changes in Step 2.
4. For each current HICN (after making the changes from Step 1), identify the Part B DME line-items. Identify the total Part B DME expenditures (summing across line-items) for each HICN after accounting for the potential “sign” changes in Step 3.
5. Sum the values in 2, 3, and 4 above to get total Part A and B expenditures at the beneficiary-level (year-to-date or for whatever time period you prefer).

### 5.3.2 Example of Calculating Total Part A and Part B Expenditures

1. Starting from your initial assignment list (or Initial Alignment Report, depending on the Medicare ACO program you participate in), suppose you have a beneficiary with a current HICN of 123123123B. Going to the Beneficiary XREF File, you find the beneficiary does not have any previous HICNs. Suppose also that the beneficiary’s BENE_EQTBL_BIC_HICN_NUM=123123123B.
2. For this beneficiary, suppose you finds claims in the Part A Header File and the Part B Physician File, but no claims in the Part B DME File.
3. Calculating total Part A Expenditures: Table 4 contains the full set of Part A Header Records for the beneficiary.

**Table 4: Part A Header Records**

| CLM# | CCN | FROM | THRU | EQ_HICN | PAID | ADJ_TYPE | EFCTV_DT |
|---|---|---|---|---|---|---|---|
| 1 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $200 | 0 | 7/20/12 |
| 2 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $0 | 2 | 9/20/12 |
| 3 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $200 | 1 | 8/7/12 |
| 4 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $210 | 2 | 9/20/12 |
| 5 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $0 | 2 | 8/7/12 |
| 6 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $0 | 1 | 10/7/12 |
| 7 | 654321 | 8/20/12 | 8/29/12 | 123123123B | $50 | 0 | 9/20/12 |

Many of the variables' names were shortened in order to make the table fit better. The following contains a list of the variables' names that were changed, with their "new" names in parentheses: CUR_CLM_UNIQ_ID (CLM#), PRVDR_OSCAR_NUM (CCN), CLM_FROM_DT (FROM), CLM_THRU_DT (THRU), BENE_EQTBL_BIC_HICN_NUM (EQ_HICN), CLM_PMT_AMT (PAID), CLM_ADJSMT_TYPE_CD (ADJ_TYPE), and CLM_EFCTV_DT (EFCTV_DT).

Changing the sign for CLM_PMT_AMT on all cancelation claims (i.e., those claims with CLM_ADJSMT_TYPE_CD=1) yields the following:

**Table 5: Part A Header Records**

| CLM# | CCN | FROM | THRU | EQ_HICN | PAID | ADJ_TYPE | EFCTV_DT |
|---|---|---|---|---|---|---|---|
| 1 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $200 | 0 | 7/20/12 |
| 2 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $0 | 2 | 9/20/12 |
| 3 | 654321 | 7/1/12 | 7/8/12 | 123123123B | -$200 | 1 | 8/7/12 |
| 4 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $210 | 2 | 9/20/12 |
| 5 | 654321 | 7/1/12 | 7/8/12 | 123123123B | $0 | 2 | 8/7/12 |
| 6 | 654321 | 7/1/12 | 7/8/12 | 123123123B | -$0 | 1 | 10/7/12 |
| 7 | 654321 | 8/20/12 | 8/29/12 | 123123123B | $50 | 0 | 9/20/12 |

Summing across the values of the variable CLM_PMT_AMT yields: $200 + $0 + -$200 +$210 + $0 + -$0 + $50=$260. Note that Claim #3 (i.e., claim where CLM#=3) cancels Claim #1. It is unclear which claim (Claim #2 or Claim #5) that Claim #6 is canceling. However, if there are any data elements contained in the claims line feed that vary between Claim #2 and Claim #5, then these data elements could potentially be used to identify which claim is being canceled by Claim #6. This may not always be possible, and hence you will not know which claim (#2 or #5) should be canceled; you will simply need to pick one in this case. Lastly, note that Claims #1-#6 are a set of Related Claims (i.e., they all have the same natural key), whereas Claim #7 is a separate un-related claim.

For utilization measurement purposes, you may want to identify the claims that represent the most recent (i.e., final action) data. In this instance, this would include three Part A claims: Claim #4, Claim #7, and either Claim #2 or Claim #5, but not both.

4. Calculating Part B Physician Expenditures: The following table contains the full set of Part B Physician records for the beneficiary:

**Table 6: Part B Line-Item Records**

| CLM# | LINE_NUM | CNTL_NUM | EQ_HICN | PAID | ADJ_TYPE | EFCTV_DT |
|---|---|---|---|---|---|---|
| 1 | 3 | 7 | 123123123B | $0 | 1 | 9/2/12 |
| 1 | 1 | 7 | 123123123B | $380 | 1 | 9/2/12 |
| 1 | 2 | 7 | 123123123B | $227 | 1 | 9/2/12 |
| 2 | 1 | 7 | 123123123B | $380 | 0 | 9/2/12 |
| 2 | 2 | 7 | 123123123B | $227 | 0 | 9/2/12 |
| 2 | 3 | 7 | 123123123B | $100 | 0 | 9/2/12 |
| 3 | 3 | 7 | 123123123B | $0 | 0 | 8/15/12 |
| 3 | 1 | 7 | 123123123B | $380 | 0 | 8/15/12 |
| 3 | 2 | 7 | 123123123B | $227 | 0 | 8/15/12 |

Some variables have been renamed in a similar fashion as in the Part A Header record table from Part 3. The following additional variable renaming was done to conserve space in the table, where the "new" names are in parentheses: CLM_LINE_CVRD_PD_AMT (PAID), CLM_LINE_NUM (LINE_NUM), and CLM_CNTL_NUM (CNTL_NUM).

Changing the sign for CLM_LINE_CVRD_PD_AMT on all cancelation claims (i.e., those claims with CLM_ADJSMT_TYPE_CD=1) yields the following:

**Table 7: Part B Line-Item Records**

| CLM# | LINE_NUM | CNTL_NUM | EQ_HICN | PAID | ADJ_TYPE | EFCTV_DT |
|---|---|---|---|---|---|---|
| 1 | 3 | 7 | 123123123B | -$0 | 1 | 9/2/12 |
| 1 | 1 | 7 | 123123123B | -$380 | 1 | 9/2/12 |
| 1 | 2 | 7 | 123123123B | -$227 | 1 | 9/2/12 |
| 2 | 1 | 7 | 123123123B | $380 | 0 | 9/2/12 |
| 2 | 2 | 7 | 123123123B | $227 | 0 | 9/2/12 |
| 2 | 3 | 7 | 123123123B | $100 | 0 | 9/2/12 |
| 3 | 3 | 7 | 123123123B | $0 | 0 | 8/15/12 |
| 3 | 1 | 7 | 123123123B | $380 | 0 | 8/15/12 |
| 3 | 2 | 7 | 123123123B | $227 | 0 | 8/15/12 |

Summing across the values of the variable CLM_LINE_CVRD_PD_AMT yields the following:

$0 + -$380 + -$227 + $380 + $227 + $100 + $0 + $380 + $227 = $100 + $380 + $227

= $707.

5. To calculate total Part A and B expenditures, sum the amount from steps 3 and 4. Total Part A and B expenditures=$260+$707=$967.

## 5.4 Part A vs. Part B Claims

To identify the total expenditure incurred and paid under the Hospital Insurance (Part A) program and the Supplemental Medical Insurance (Part B) program, it is important to know that the Part A claims files will include Medicare provider payments for some services covered under both Part A and Part B.

To distinguish Part A claims that are covered and paid under the Hospital Insurance program from those covered under the Supplemental Medical Insurance program, you must use the Claim Facility Type Code and the Claim Service Classification Code.

All claims in the Part B physician and Part B DMEPOS files are covered under the Supplemental Medical Insurance program.

## 5.5 Identifying Sources of Care for the Assigned/Aligned Population

Follow the steps below to determine the percentage of care being provided by your ACO, as measured by number of Part A line items, for the beneficiaries included in your CCLF:

1. Use the Part A Claim Revenue Center Detail File to identify the number of line items for a beneficiary. Each row in this table represents a separate line item.
2. Identify the rows in the file that correspond to each beneficiary (using the current BENE_HIC_NUM). For a given beneficiary-claim combination, each row (line-item) can be distinguished by the claim line number (CLM_LINE_NUM). For a given claim (and its associated line items), the determination of who provided the service (ACO or non-ACO) provider can be determined by looking at the claim facility NPI (FAC_PRVDR_NPI_NUM) and the operating physician NPI (OPRTG_PRVDR_NPI_NUM) from the Part A Claims Header File.
3. Calculate the total line items for Part A services, line items for Part A services provided by the ACO, and line items for Part A services provided by non-ACO providers.

# 6 Combining Claims Data with Other Data Sources

The monthly claims data feed provides data on Medicare expenditures for services covered by Parts A, B, and D. It also provides a limited set of demographic variables for each beneficiary. Additional data sources that may be merged into the claims data are listed below.

## 6.1 Assignment/Alignment Report

For NGACO ACOs, the NGACO Initial Alignment Report (Report 1-1) includes identifying information for each beneficiary. These data are updated each quarter, after the excluded beneficiaries have been identified, and are reflected in the NGACO Quarterly Report on Excluded Beneficiaries (Report 1-2).

For Shared Savings Program ACOs, the Assignment Report includes identifying information for each beneficiary. These data are also updated each quarter.

For CEC ACOs, the Beneficiary Alignment Report includes identifying information for each beneficiary. These data are updated each month.

These reports are the source of beneficiary identifying information for the claims data.

## 6.2 Provider Data

The claims data identifies providers by NPI (or in some cases the OSCAR number or CCN). Information to identify providers by name must be merged with the claims data. One source for this information is the public-use NPPES file (https://npiregistry.cms.hhs.gov/).

# 7 Useful Resources

## 7.1 Useful Resources Regarding Medicare Claims Data

The Research Data Assistance Center (ResDAC) website (http://www.resdac.org) is a useful source of information regarding Medicare claims data. The CMS Manual System, publication 100-04 Medicare Claims Processing Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R470CP.pdf) is a useful source of information regarding Carrier Payment Denial Codes. Other useful sources of information are the National Claims History documentation (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/DataAdmin/Downloads/NCH_RIF2014.zip) and the Research Data Assitance Center (ResDAC) website (http://resdac.org).

For Shared Savings Program ACOs, the CMS Enterprise Portal (https://portal.cms.gov/) provides helpful resources like the Data Exchange Uer Guide and additional publically available Shared Savings Program Data. The Data Exchange User Guide is available on the "Resources" section of the Portal, and provides information on the January CCLF generation month when the ACOs receive one or two sets of CCLFs depending on their track.

# 8 Best Practices for Protecting Beneficiary-Level Data

CMS takes protecting the data of millions of Medicare beneficiaries very seriously. It is important to ensure that necessary steps are taken to keep the data secure. By implementing the below listed best practices, we can all help to better protect beneficiary data:

1. Do not click on a link or attachment until you have talked to the sender or are expecting the attachment.
2. Never share your password.
3. Avoid sharing Personally Identifiable Information (PII), Protected Health Information (PHI), or sensitive data by email. If you must share, encrypt it, and do not send the password through email.
4. Never send work information to or from your personal account.
5. Forward suspicious email to your organization's IT administrator. If you believe Medicare beneficiary (or provider) data has been compromised, report the incident to the CMS IT Service Desk at 1-800-562-1963.

More information on CMS security, privacy guidance, and best practices are available at CMS Information Security Overview (http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/index.html?redirect=/informationsecurity/).

# Appendix A: Alcohol and Substance Abuse Code Tables

The following tables contain codes for alcohol and substance abuse-related diagnoses, which CMS will exclude from Shared Savings Program Claims Line Feeds.

Codes for alcohol and substance abuse-related diagnoses will be excluded from Claims Line Feeds generated for NGACO ACOs for beneficiaries who have not opted in to Alcohol and Substance Abuse sharing with that NGACO ACO.

Substance abuse codes in the following tables will be excluded from the ESRD Claims Line Feeds for CEC.

**Table 8: MS-DRGs**

| MS-DRGs | Description |
|---|---|
| MS-DRG 522 | Alcohol/drug abuse or dependence w rehabilitation therapy w/o CC |
| MS-DRG 523 | Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o CC |
| MS-DRG 895 | Alcohol/drug abuse or dependence w rehabilitation therapy |
| MS-DRG 896 | Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC |
| MS-DRG 897 | Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC |

**Table 9: CPT Codes**

| CPT Codes | Description |
|---|---|
| 4320F | Patient counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence |
| H0005 | Alcohol and/or drug services; Group counseling by a clinician |
| H0006 | Alcohol and/or drug services; case management |
| H0007 | Alcohol and/or drug services; crisis intervention (outpatient) |
| H0008 | Alcohol and/or drug services; sub-acute detox (hospital inpatient) |
| H0009 | Alcohol and/or drug services; Acute detox (hospital inpatient) |
| H0010 | Alcohol and/or drug services; Sub-acute detox (residential addiction program inpatient) |
| H0011 | Alcohol and/or drug services; acute detox (residential addiction program inpatient) |
| H0012 | Alcohol and/or drug services; Sub-acute detox (residential addiction program outpatient) |
| H0013 | Alcohol and/or drug services; acute detox (residential addiction program outpatient) |
| H0014 | Alcohol and/or drug services; ambulatory detox |
| H0015 | Alcohol and/or drug services; intensive outpatient |
| H0050 | Alcohol and/or Drug Service, Brief Intervention, per 15 minutes |
| 99408 | Alcohol and substance (other than tobacco) abuse structure screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; 15-30 minutes |
| 99409 | Alcohol and substance (other than tobacco) abuse structure screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; Greater than 30 minutes |

| CPT Codes | Description |
|---|---|
| H0034 | Alcohol and/or drug abuse halfway house services, per diem |
| H0047 | Alcohol and/or Drug abuse services, not otherwise specified |
| H2035 | Alcohol and/or drug treatment program, per hour |
| H2036 | Alcohol and/or drug treatment program, per diem |
| H0020 | Alcohol and/or drug services; methadone administration and/or service (provisions of the drug by a licensed program) |
| S9475 | Ambulatory Setting substance abuse treatment or detoxification services per diem |
| T1006 | Alcohol and/or substance abuse services, family/couple counseling |
| T1007 | Alcohol and/or substance abuse services, treatment plan development and or modification |
| T1008 | Day Treatment for individual alcohol and/or substance abuse services |
| T1009 | Child sitting services for children of individuals receiving alcohol and/or substance abuse services |
| T1010 | Meals for individuals receiving alcohol and/or substance abuse services (when meals are not included in the program |
| T1011 | Alcohol and/or substance abuse services not otherwise classified |
| T1012 | Alcohol and/or substance abuse services, skill development |

**Table 10: ICD-9-CM Procedure Codes**

| ICD-9-CM Procedure Codes | Description |
|---|---|
| 94.45 | Drug Addict Counseling |
| 94.46 | Alcoholism Counseling |
| 94.53 | Referral Alcohol Rehab |
| 94.54 | Referral for Drug Rehab |
| 94.6 | Alcohol and drug rehabilitation and detoxification |
| 94.61 | Alcohol rehabilitation |
| 94.62 | Alcohol detoxification |
| 94.63 | Alcohol rehabilitation and detoxification |
| 94.64 | Drug rehabilitation |
| 94.65 | Drug detoxification |
| 94.66 | Drug rehabilitation and detoxification |
| 94.67 | Combined alcohol and drug rehabilitation |
| 94.68 | Combined alcohol and drug detoxification |
| 94.69 | Combined alcohol and drug rehabilitation and detoxification |

**Table 11: ICD-9-CM Diagnosis Codes**

| ICD-9-CM Diagnosis Codes | Description |
|---|---|
| 291 | Alcohol-induced mental disorders |
| 291.0 | Alcohol withdrawal delirium |
| 291.1 | Alcohol-induced persisting amnestic disorder |
| 291.2 | Alcohol-induced persisting dementia |

| ICD-9-CM Diagnosis Codes | Description |
|---|---|
| 291.3 | Alcohol-induced psychotic disorder with hallucinations |
| 291.4 | Idiosyncratic alcohol intoxication |
| 291.5 | Alcohol-induced psychotic disorder with delusions |
| 291.81 | Alcohol withdrawal |
| 291.82 | Alcohol induced sleep disorders |
| 291.89 | Other alcohol-induced mental disorders |
| 291.9 | Unspecified alcohol-induced mental disorders |
| 292 | Drug-induced mental disorders |
| 292.0 | Drug withdrawal |
| 292.1 | Drug-induced psychotic disorders |
| 292.11 | Drug-induced psychotic disorder with delusions |
| 292.12 | Drug-induced psychotic disorder with hallucinations |
| 292.2 | Pathological drug intoxication |
| 292.8 | Other specified drug-induced mental disorders |
| 292.81 | Drug-induced delirium |
| 292.82 | Drug-induced persisting dementia |
| 292.83 | Drug-induced persisting amnestic disorder |
| 292.84 | Drug-induced mood disorder |
| 292.85 | Drug induced sleep disorders |
| 292.89 | Other specified drug-induced mental disorders |
| 292.9 | Unspecified drug-induced mental disorder |
| 303 | Alcohol dependence syndrome |
| 303.0 | Acute alcoholic intoxication |
| 303.00 | Acute alcoholic intoxication in alcoholism, unspecified |
| 303.01 | Acute alcoholic intoxication in alcoholism, continuous |
| 303.02 | Acute alcoholic intoxication in alcoholism, episodic |
| 303.03 | Acute alcoholic intoxication in alcoholism, in remission |
| 303.9 | Other and unspecified alcohol dependence |
| 303.90 | Other and unspecified alcohol dependence, unspecified |
| 303.91 | Other and unspecified alcohol dependence, continuous |
| 303.92 | Other and unspecified alcohol dependence, episodic |
| 303.93 | Other and unspecified alcohol dependence, in remission |
| 304 | Drug Dependence |
| 304.0 | Opioid type dependence |
| 304.00 | Opioid type dependence, unspecified |
| 304.01 | Opioid type dependence, continuous |
| 304.02 | Opioid type dependence, episodic |
| 304.03 | Opioid type dependence, in remission |
| 304.1 | Sedative, hypnotic or anxiolytic dependence |
| 304.10 | Sedative, hypnotic or anxiolytic dependence, unspecified |
| 304.11 | Sedative, hypnotic or anxiolytic dependence, continuous |
| 304.12 | Sedative, hypnotic or anxiolytic dependence, episodic |
| 304.13 | Sedative, hypnotic or anxiolytic dependence, in remission |
| 304.2 | Cocaine dependence |
| 304.20 | Cocaine dependence, unspecified |
| 304.21 | Cocaine dependence, continuous |

| ICD-9-CM Diagnosis Codes | Description |
|---|---|
| 304.22 | Cocaine dependence, episodic |
| 304.23 | Cocaine dependence, in remission |
| 304.3 | Cannabis dependence |
| 304.30 | Cannabis dependence, unspecified |
| 304.31 | Cannabis dependence, continuous |
| 304.32 | Cannabis dependence, episodic |
| 304.33 | Cannabis dependence, in remission |
| 304.4 | Amphetamine and other psychostimulant dependence |
| 304.40 | Amphetamine and other psychostimulant dependence, unspecified |
| 304.41 | Amphetamine and other psychostimulant dependence, continuous |
| 304.42 | Amphetamine and other psychostimulant dependence, episodic |
| 304.43 | Amphetamine and other psychostimulant dependence, in remission |
| 304.5 | Hallucinogen dependence |
| 304.50 | Hallucinogen dependence, unspecified |
| 304.51 | Hallucinogen dependence, continuous |
| 304.52 | Hallucinogen dependence, episodic |
| 304.53 | Hallucinogen dependence, in remission |
| 304.6 | Other specified drug dependence |
| 304.60 | Other specified drug dependence, unspecified |
| 304.61 | Other specified drug dependence, continuous |
| 304.62 | Other specified drug dependence, episodic |
| 304.63 | Other specified drug dependence, in remission |
| 304.7 | Combinations of opioid type drug with any other drug dependence |
| 304.70 | Combinations of opioid type drug with any other drug dependence, unspecified |
| 304.71 | Combinations of opioid type drug with any other drug dependence, continuous |
| 304.72 | Combinations of opioid type drug with any other drug dependence, episodic |
| 304.73 | Combinations of opioid type drug with any other drug dependence, in remission |
| 304.8 | Combinations of drug dependence excluding opioid type drug |
| 304.80 | Combinations of drug dependence excluding opioid type drug, unspecified |
| 304.81 | Combinations of drug dependence excluding opioid type drug, continuous |
| 304.82 | Combinations of drug dependence excluding opioid type drug, episodic |
| 304.83 | Combinations of drug dependence excluding opioid type drug, in remission |
| 304.9 | Unspecified drug dependence |
| 304.90 | Unspecified drug dependence, unspecified |
| 304.91 | Unspecified drug dependence, continuous |
| 304.92 | Unspecified drug dependence, episodic |
| 304.93 | Unspecified drug dependence, in remission |
| 305 | Nondependent abuse of drugs |
| 305.0 | Alcohol abuse |
| 305.00 | Alcohol abuse, unspecified |
| 305.01 | Alcohol abuse, continuous |
| 305.02 | Alcohol abuse, episodic |
| 305.03 | Alcohol abuse, in remission |
| 305.2 | Cannabis abuse |
| 305.20 | Cannabis abuse, unspecified |
| 305.21 | Cannabis abuse, continuous |

| ICD-9-CM Diagnosis Codes | Description |
|---|---|
| 305.22 | Cannabis abuse, episodic |
| 305.23 | Cannabis abuse, in remission |
| 305.3 | Hallucinogen abuse |
| 305.30 | Hallucinogen abuse, unspecified |
| 305.31 | Hallucinogen abuse, continuous |
| 305.32 | Hallucinogen abuse, episodic |
| 305.33 | Hallucinogen abuse, in remission |
| 305.4 | Sedative, hypnotic or anxiolytic abuse |
| 305.40 | Sedative, hypnotic or anxiolytic abuse, unspecified |
| 305.41 | Sedative, hypnotic or anxiolytic abuse, continuous |
| 305.42 | Sedative, hypnotic or anxiolytic abuse, episodic |
| 305.43 | Sedative, hypnotic or anxiolytic abuse, in remission |
| 305.5 | Opioid abuse |
| 305.50 | Opioid abuse, unspecified |
| 305.51 | Opioid abuse, continuous |
| 305.52 | Opioid abuse, episodic |
| 305.53 | Opioid abuse, in remission |
| 305.6 | Cocaine abuse |
| 305.60 | Cocaine abuse, unspecified |
| 305.61 | Cocaine abuse, continuous |
| 305.62 | Cocaine abuse, episodic |
| 305.63 | Cocaine abuse, in remission |
| 305.7 | Amphetamine or related acting sympathomimetic abuse |
| 305.70 | Amphetamine or related acting sympathomimetic abuse, unspecified |
| 305.71 | Amphetamine or related acting sympathomimetic abuse, continuous |
| 305.72 | Amphetamine or related acting sympathomimetic abuse, episodic |
| 305.73 | Amphetamine or related acting sympathomimetic abuse, in remission |
| 305.8 | Antidepressant type abuse |
| 305.80 | Antidepressant type abuse, unspecified |
| 305.81 | Antidepressant type abuse, continuous |
| 305.82 | Antidepressant type abuse, episodic |
| 305.83 | Antidepressant type abuse, in remission |
| 305.9 | Other, mixed, or unspecified drug abuse |
| 305.90 | Other, mixed, or unspecified drug abuse, unspecified |
| 305.91 | Other, mixed, or unspecified drug abuse, continuous |
| 305.92 | Other, mixed, or unspecified drug abuse, episodic |
| 305.93 | Other, mixed, or unspecified drug abuse, in remission |
| 790.3 | Excessive blood level of alcohol |
| V65.42 | Counseling on substance use and abuse |

**Table 12: ICD-10-PCS Inpatient Procedure Codes**

| ICD-10-PCS Codes | Description |
|---|---|
| HZ2ZZZZ | Detoxification Services for Substance Abuse Treatment |
| HZ30ZZZ | Individual Counseling for Substance Abuse Treatment, Cognitive |

| ICD-10-PCS Codes | Description |
|---|---|
| HZ31ZZZ | Individual Counseling for Substance Abuse Treatment, Behavioral |
| HZ32ZZZ | Individual Counseling for Substance Abuse Treatment, Cognitive-Behavioral |
| HZ33ZZZ | Individual Counseling for Substance Abuse Treatment, 12-Step |
| HZ34ZZZ | Individual Counseling for Substance Abuse Treatment, Interpersonal |
| HZ35ZZZ | Individual Counseling for Substance Abuse Treatment, Vocational |
| HZ36ZZZ | Individual Counseling for Substance Abuse Treatment, Psychoeducational |
| HZ37ZZZ | Individual Counseling for Substance Abuse Treatment, Motivational Enhancement |
| HZ38ZZZ | Individual Counseling for Substance Abuse Treatment, Confrontational |
| HZ39ZZZ | Individual Counseling for Substance Abuse Treatment, Continuing Care |
| HZ3BZZZ | Individual Counseling for Substance Abuse Treatment, Spiritual |
| HZ40ZZZ | Group Counseling for Substance Abuse Treatment, Cognitive |
| HZ41ZZZ | Group Counseling for Substance Abuse Treatment, Behavioral |
| HZ42ZZZ | Group Counseling for Substance Abuse Treatment, Cognitive-Behavioral |
| HZ43ZZZ | Group Counseling for Substance Abuse Treatment, 12-Step |
| HZ44ZZZ | Group Counseling for Substance Abuse Treatment, Interpersonal |
| HZ45ZZZ | Group Counseling for Substance Abuse Treatment, Vocational |
| HZ46ZZZ | Group Counseling for Substance Abuse Treatment, Psychoeducation |
| HZ47ZZZ | Group Counseling for Substance Abuse Treatment, Motivational Enhancement |
| HZ48ZZZ | Group Counseling for Substance Abuse Treatment, Confrontational |
| HZ49ZZZ | Group Counseling for Substance Abuse Treatment, Continuing Care |
| HZ4BZZZ | Group Counseling for Substance Abuse Treatment, Spiritual |
| HZ50ZZZ | Individual Psychotherapy for Substance Abuse Treatment, Cognitive |
| HZ51ZZZ | Individual Psychotherapy for Substance Abuse Treatment, Behavioral |
| HZ52ZZZ | Individual Psychotherapy for Substance Abuse Treatment, Cognitive-Behavioral |
| HZ53ZZZ | Individual Psychotherapy for Substance Abuse Treatment, 12-Step |
| HZ54ZZZ | Individual Psychotherapy for Substance Abuse Treatment, Interpersonal |
| HZ55ZZZ | Individual Psychotherapy for Substance Abuse Treatment, Interactive |
| HZ56ZZZ | Individual Psychotherapy for Substance Abuse Treatment, Psychoeducation |
| HZ57ZZZ | Individual Psychotherapy for Substance Abuse Treatment, Motivational Enhancement |
| HZ58ZZZ | Individual Psychotherapy for Substance Abuse Treatment, Confrontational |
| HZ59ZZZ | Individual Psychotherapy for Substance Abuse Treatment, Supportive |
| HZ5BZZZ | Individual Psychotherapy for Substance Abuse Treatment, Psychoanalysis |
| HZ5CZZZ | Individual Psychotherapy for Substance Abuse Treatment, Psychodynamic |
| HZ5DZZZ | Individual Psychotherapy for Substance Abuse Treatment, Psychophysiological |
| HZ63ZZZ | Family Counseling for Substance Abuse Treatment |
| HZ80ZZZ | Medication Management for Substance Abuse Treatment, Nicotine Replacement |
| HZ81ZZZ | Medication Management for Substance Abuse Treatment, Methadone Maintenance |
| HZ82ZZZ | Medication Management for Substance Abuse Treatment, Levo-alpha-acetyl-methadol (LAAM) |
| HZ83ZZZ | Medication Management for Substance Abuse Treatment, Antabuse |

| ICD-10-PCS Codes | Description |
|---|---|
| HZ84ZZZ | Medication Management for Substance Abuse Treatment, Naltrexone |
| HZ85ZZZ | Medication Management for Substance Abuse Treatment, Naloxone |
| HZ86ZZZ | Medication Management for Substance Abuse Treatment, Clonidine |
| HZ87ZZZ | Medication Management for Substance Abuse Treatment, Bupropion |
| HZ88ZZZ | Medication Management for Substance Abuse Treatment, Psychiatric Medication |
| HZ89ZZZ | Medication Management for Substance Abuse Treatment, Other Replacement Medication |
| HZ90ZZZ | Pharmacotherapy for Substance Abuse Treatment, Nicotine Replacement |
| HZ91ZZZ | Pharmacotherapy for Substance Abuse Treatment, Methadone Maintenance |
| HZ92ZZZ | Pharmacotherapy for Substance Abuse Treatment, Levo-alpha-acetyl-methadol (LAAM) |
| HZ93ZZZ | Pharmacotherapy for Substance Abuse Treatment, Antabuse |
| HZ94ZZZ | Pharmacotherapy for Substance Abuse Treatment, Naltrexone |
| HZ95ZZZ | Pharmacotherapy for Substance Abuse Treatment, Naloxone |
| HZ96ZZZ | Pharmacotherapy for Substance Abuse Treatment, Clonidine |
| HZ97ZZZ | Pharmacotherapy for Substance Abuse Treatment, Bupropion |
| HZ98ZZZ | Pharmacotherapy for Substance Abuse Treatment, Psychiatric Medication |
| HZ99ZZZ | Pharmacotherapy for Substance Abuse Treatment, Other Replacement Medication |

**Table 13: ICD-10-CM Diagnosis Codes**

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F10.10 | Alcohol abuse, uncomplicated |
| F10.14 | Alcohol abuse with alcohol-induced mood disorder |
| F10.19 | Alcohol abuse with unspecified alcohol-induced disorder |
| F10.20 | Alcohol dependence, uncomplicated |
| F10.21 | Alcohol dependence, in remission |
| F10.24 | Alcohol dependence with alcohol-induced mood disorder |
| F10.26 | Alcohol dependence with alcohol-induced persisting amnestic disorder |
| F10.27 | Alcohol dependence with alcohol-induced persisting dementia |
| F10.29 | Alcohol dependence with unspecified alcohol-induced disorder |
| F10.94 | Alcohol use, unspecified with alcohol-induced mood disorder |
| F10.96 | Alcohol use, unspecified with alcohol-induced persisting amnestic disorder |
| F10.97 | Alcohol use, unspecified with alcohol-induced persisting dementia |
| F10.99 | Alcohol use, unspecified with unspecified alcohol-induced disorder |
| F10.120 | Alcohol abuse with intoxication, uncomplicated |
| F10.121 | Alcohol abuse with intoxication delirium |
| F10.129 | Alcohol abuse with intoxication, unspecified |
| F10.150 | Alcohol abuse with alcohol-induced psychotic disorder with delusions |
| F10.151 | Alcohol abuse with alcohol-induced psychotic disorder with hallucinations |
| F10.159 | Alcohol abuse with alcohol-induced psychotic disorder, unspecified |
| F10.180 | Alcohol abuse with alcohol-induced anxiety disorder |
| F10.181 | Alcohol abuse with alcohol-induced sexual dysfunction |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F10.182 | Alcohol abuse with alcohol-induced sleep disorder |
| F10.188 | Alcohol abuse with other alcohol-induced disorder |
| F10.220 | Alcohol dependence with intoxication, uncomplicated |
| F10.221 | Alcohol dependence with intoxication delirium |
| F10.229 | Alcohol dependence with intoxication, unspecified |
| F10.230 | Alcohol dependence with withdrawal, uncomplicated |
| F10.231 | Alcohol dependence with withdrawal delirium |
| F10.232 | Alcohol dependence with withdrawal with perceptual disturbance |
| F10.239 | Alcohol dependence with withdrawal, unspecified |
| F10.250 | Alcohol dependence with alcohol-induced psychotic disorder with delusions |
| F10.251 | Alcohol dependence with alcohol-induced psychotic disorder with hallucinations |
| F10.259 | Alcohol dependence with alcohol-induced psychotic disorder, unspecified |
| F10.280 | Alcohol dependence with alcohol-induced anxiety disorder |
| F10.281 | Alcohol dependence with alcohol-induced sexual dysfunction |
| F10.282 | Alcohol dependence with alcohol-induced sleep disorder |
| F10.288 | Alcohol dependence with other alcohol-induced disorder |
| F10.920 | Alcohol use, unspecified with intoxication, uncomplicated |
| F10.921 | Alcohol use, unspecified with intoxication delirium |
| F10.929 | Alcohol use, unspecified with intoxication, unspecified |
| F10.950 | Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions |
| F10.951 | Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations |
| F10.959 | Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified |
| F10.980 | Alcohol use, unspecified with alcohol-induced anxiety disorder |
| F10.981 | Alcohol use, unspecified with alcohol-induced sexual dysfunction |
| F10.982 | Alcohol use, unspecified with alcohol-induced sleep disorder |
| F10.988 | Alcohol use, unspecified with other alcohol-induced disorder |
| F11.10 | Opioid abuse, uncomplicated |
| F11.14 | Opioid abuse with opioid-induced mood disorder |
| F11.19 | Opioid abuse with unspecified opioid-induced disorder |
| F11.20 | Opioid dependence, uncomplicated |
| F11.21 | Opioid dependence, in remission |
| F11.23 | Opioid dependence with withdrawal |
| F11.24 | Opioid dependence with opioid-induced mood disorder |
| F11.29 | Opioid dependence with unspecified opioid-induced disorder |
| F11.90 | Opioid use, unspecified, uncomplicated |
| F11.93 | Opioid use, unspecified with withdrawal |
| F11.94 | Opioid use, unspecified with opioid-induced mood disorder |
| F11.99 | Opioid use, unspecified with unspecified opioid-induced disorder |
| F11.120 | Opioid abuse with intoxication, uncomplicated |
| F11.121 | Opioid abuse with intoxication delirium |
| F11.122 | Opioid abuse with intoxication with perceptual disturbance |
| F11.129 | Opioid abuse with intoxication, unspecified |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F11.150 | Opioid abuse with opioid-induced psychotic disorder with delusions |
| F11.151 | Opioid abuse with opioid-induced psychotic disorder with hallucinations |
| F11.159 | Opioid abuse with opioid-induced psychotic disorder, unspecified |
| F11.181 | Opioid abuse with opioid-induced sexual dysfunction |
| F11.182 | Opioid abuse with opioid-induced sleep disorder |
| F11.188 | Opioid abuse with other opioid-induced disorder |
| F11.220 | Opioid dependence with intoxication, uncomplicated |
| F11.221 | Opioid dependence with intoxication delirium |
| F11.222 | Opioid dependence with intoxication with perceptual disturbance |
| F11.229 | Opioid dependence with intoxication, unspecified |
| F11.250 | Opioid dependence with opioid-induced psychotic disorder with delusions |
| F11.251 | Opioid dependence with opioid-induced psychotic disorder with hallucinations |
| F11.259 | Opioid dependence with opioid-induced psychotic disorder, unspecified |
| F11.281 | Opioid dependence with opioid-induced sexual dysfunction |
| F11.282 | Opioid dependence with opioid-induced sleep disorder |
| F11.288 | Opioid dependence with other opioid-induced disorder |
| F11.920 | Opioid use, unspecified with intoxication, uncomplicated |
| F11.921 | Opioid use, unspecified with intoxication delirium |
| F11.922 | Opioid use, unspecified with intoxication with perceptual disturbance |
| F11.929 | Opioid use, unspecified with intoxication, unspecified |
| F11.950 | Opioid use, unspecified with opioid-induced psychotic disorder with delusions |
| F11.951 | Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations |
| F11.959 | Opioid use, unspecified with opioid-induced psychotic disorder, unspecified |
| F11.981 | Opioid use, unspecified with opioid-induced sexual dysfunction |
| F11.982 | Opioid use, unspecified with opioid-induced sleep disorder |
| F11.988 | Opioid use, unspecified with other opioid-induced disorder |
| F12.10 | Cannabis abuse, uncomplicated |
| F12.19 | Cannabis abuse with unspecified cannabis-induced disorder |
| F12.20 | Cannabis dependence, uncomplicated |
| F12.21 | Cannabis dependence, in remission |
| F12.29 | Cannabis dependence with unspecified cannabis-induced disorder |
| F12.90 | Cannabis use, unspecified, uncomplicated |
| F12.99 | Cannabis use, unspecified with unspecified cannabis-induced disorder |
| F12.120 | Cannabis abuse with intoxication, uncomplicated |
| F12.121 | Cannabis abuse with intoxication delirium |
| F12.122 | Cannabis abuse with intoxication with perceptual disturbance |
| F12.129 | Cannabis abuse with intoxication, unspecified |
| F12.150 | Cannabis abuse with psychotic disorder with delusions |
| F12.151 | Cannabis abuse with psychotic disorder with hallucinations |
| F12.159 | Cannabis abuse with psychotic disorder, unspecified |
| F12.180 | Cannabis abuse with cannabis-induced anxiety disorder |
| F12.188 | Cannabis abuse with other cannabis-induced disorder |
| F12.220 | Cannabis dependence with intoxication, uncomplicated |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F12.221 | Cannabis dependence with intoxication delirium |
| F12.222 | Cannabis dependence with intoxication with perceptual disturbance |
| F12.229 | Cannabis dependence with intoxication, unspecified |
| F12.250 | Cannabis dependence with psychotic disorder with delusions |
| F12.251 | Cannabis dependence with psychotic disorder with hallucinations |
| F12.259 | Cannabis dependence with psychotic disorder, unspecified |
| F12.280 | Cannabis dependence with cannabis-induced anxiety disorder |
| F12.288 | Cannabis dependence with other cannabis-induced disorder |
| F12.920 | Cannabis use, unspecified with intoxication, uncomplicated |
| F12.921 | Cannabis use, unspecified with intoxication delirium |
| F12.922 | Cannabis use, unspecified with intoxication with perceptual disturbance |
| F12.929 | Cannabis use, unspecified with intoxication, unspecified |
| F12.950 | Cannabis use, unspecified with psychotic disorder with delusions |
| F12.951 | Cannabis use, unspecified with psychotic disorder with hallucinations |
| F12.959 | Cannabis use, unspecified with psychotic disorder, unspecified |
| F12.980 | Cannabis use, unspecified with anxiety disorder |
| F12.988 | Cannabis use, unspecified with other cannabis-induced disorder |
| F13.10 | Sedative, hypnotic or anxiolytic abuse, uncomplicated |
| F13.14 | Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder |
| F13.19 | Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder |
| F13.20 | Sedative, hypnotic or anxiolytic dependence, uncomplicated |
| F13.21 | Sedative, hypnotic or anxiolytic dependence, in remission |
| F13.24 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder |
| F13.26 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder |
| F13.27 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia |
| F13.29 | Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder |
| F13.90 | Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated |
| F13.94 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder |
| F13.96 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder |
| F13.97 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia |
| F13.99 | Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder |
| F13.120 | Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated |
| F13.121 | Sedative, hypnotic or anxiolytic abuse with intoxication delirium |
| F13.129 | Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified |
| F13.150 | Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F13.151 | Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations |
| F13.159 | Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified |
| F13.180 | Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder |
| F13.181 | Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction |
| F13.182 | Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder |
| F13.188 | Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder |
| F13.220 | Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated |
| F13.221 | Sedative, hypnotic or anxiolytic dependence with intoxication delirium |
| F13.229 | Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified |
| F13.230 | Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated |
| F13.231 | Sedative, hypnotic or anxiolytic dependence with withdrawal delirium |
| F13.232 | Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance |
| F13.239 | Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified |
| F13.250 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions |
| F13.251 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations |
| F13.259 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified |
| F13.280 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder |
| F13.281 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction |
| F13.282 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder |
| F13.288 | Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder |
| F13.920 | Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated |
| F13.921 | Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium |
| F13.929 | Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified |
| F13.930 | Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated |
| F13.931 | Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium |
| F13.932 | Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances |
| F13.939 | Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F13.950 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions |
| F13.951 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations |
| F13.959 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified |
| F13.980 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder |
| F13.981 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction |
| F13.982 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder |
| F13.988 | Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder |
| F14.10 | Cocaine abuse, uncomplicated |
| F14.14 | Cocaine abuse with cocaine-induced mood disorder |
| F14.19 | Cocaine abuse with unspecified cocaine-induced disorder |
| F14.20 | Cocaine dependence, uncomplicated |
| F14.21 | Cocaine dependence, in remission |
| F14.23 | Cocaine dependence with withdrawal |
| F14.24 | Cocaine dependence with cocaine-induced mood disorder |
| F14.29 | Cocaine dependence with unspecified cocaine-induced disorder |
| F14.90 | Cocaine use, unspecified, uncomplicated |
| F14.94 | Cocaine use, unspecified with cocaine-induced mood disorder |
| F14.99 | Cocaine use, unspecified with unspecified cocaine-induced disorder |
| F14.120 | Cocaine abuse with intoxication, uncomplicated |
| F14.121 | Cocaine abuse with intoxication with delirium |
| F14.122 | Cocaine abuse with intoxication with perceptual disturbance |
| F14.129 | Cocaine abuse with intoxication, unspecified |
| F14.150 | Cocaine abuse with cocaine-induced psychotic disorder with delusions |
| F14.151 | Cocaine abuse with cocaine-induced psychotic disorder with hallucinations |
| F14.159 | Cocaine abuse with cocaine-induced psychotic disorder, unspecified |
| F14.180 | Cocaine abuse with cocaine-induced anxiety disorder |
| F14.181 | Cocaine abuse with cocaine-induced sexual dysfunction |
| F14.182 | Cocaine abuse with cocaine-induced sleep disorder |
| F14.188 | Cocaine abuse with other cocaine-induced disorder |
| F14.220 | Cocaine dependence with intoxication, uncomplicated |
| F14.221 | Cocaine dependence with intoxication delirium |
| F14.222 | Cocaine dependence with intoxication with perceptual disturbance |
| F14.229 | Cocaine dependence with intoxication, unspecified |
| F14.250 | Cocaine dependence with cocaine-induced psychotic disorder with delusions |
| F14.251 | Cocaine dependence with cocaine-induced psychotic disorder with hallucinations |
| F14.259 | Cocaine dependence with cocaine-induced psychotic disorder, unspecified |
| F14.280 | Cocaine dependence with cocaine-induced anxiety disorder |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F14.281 | Cocaine dependence with cocaine-induced sexual dysfunction |
| F14.282 | Cocaine dependence with cocaine-induced sleep disorder |
| F14.288 | Cocaine dependence with other cocaine-induced disorder |
| F14.920 | Cocaine use, unspecified with intoxication, uncomplicated |
| F14.921 | Cocaine use, unspecified with intoxication delirium |
| F14.922 | Cocaine use, unspecified with intoxication with perceptual disturbance |
| F14.929 | Cocaine use, unspecified with intoxication, unspecified |
| F14.950 | Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions |
| F14.951 | Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations |
| F14.959 | Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified |
| F14.980 | Cocaine use, unspecified with cocaine-induced anxiety disorder |
| F14.981 | Cocaine use, unspecified with cocaine-induced sexual dysfunction |
| F14.982 | Cocaine use, unspecified with cocaine-induced sleep disorder |
| F14.988 | Cocaine use, unspecified with other cocaine-induced disorder |
| F15.10 | Other stimulant abuse, uncomplicated |
| F15.14 | Other stimulant abuse with stimulant-induced mood disorder |
| F15.19 | Other stimulant abuse with unspecified stimulant-induced disorder |
| F15.20 | Other stimulant dependence, uncomplicated |
| F15.21 | Other stimulant dependence, in remission |
| F15.23 | Other stimulant dependence with withdrawal |
| F15.24 | Other stimulant dependence with stimulant-induced mood disorder |
| F15.29 | Other stimulant dependence with unspecified stimulant-induced disorder |
| F15.90 | Other stimulant use, unspecified, uncomplicated |
| F15.93 | Other stimulant use, unspecified with withdrawal |
| F15.94 | Other stimulant use, unspecified with stimulant-induced mood disorder |
| F15.99 | Other stimulant use, unspecified with unspecified stimulant-induced disorder |
| F15.120 | Other stimulant abuse with intoxication, uncomplicated |
| F15.121 | Other stimulant abuse with intoxication delirium |
| F15.122 | Other stimulant abuse with intoxication with perceptual disturbance |
| F15.129 | Other stimulant abuse with intoxication, unspecified |
| F15.150 | Other stimulant abuse with stimulant-induced psychotic disorder with delusions |
| F15.151 | Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations |
| F15.159 | Other stimulant abuse with stimulant-induced psychotic disorder, unspecified |
| F15.180 | Other stimulant abuse with stimulant-induced anxiety disorder |
| F15.181 | Other stimulant abuse with stimulant-induced sexual dysfunction |
| F15.182 | Other stimulant abuse with stimulant-induced sleep disorder |
| F15.188 | Other stimulant abuse with other stimulant-induced disorder |
| F15.220 | Other stimulant dependence with intoxication, uncomplicated |
| F15.221 | Other stimulant dependence with intoxication delirium |
| F15.222 | Other stimulant dependence with intoxication with perceptual disturbance |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F15.229 | Other stimulant dependence with intoxication, unspecified |
| F15.250 | Other stimulant dependence with stimulant-induced psychotic disorder with delusions |
| F15.251 | Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations |
| F15.259 | Other stimulant dependence with stimulant-induced psychotic disorder, unspecified |
| F15.280 | Other stimulant dependence with stimulant-induced anxiety disorder |
| F15.281 | Other stimulant dependence with stimulant-induced sexual dysfunction |
| F15.282 | Other stimulant dependence with stimulant-induced sleep disorder |
| F15.288 | Other stimulant dependence with other stimulant-induced disorder |
| F15.920 | Other stimulant use, unspecified with intoxication, uncomplicated |
| F15.921 | Other stimulant use, unspecified with intoxication delirium |
| F15.922 | Other stimulant use, unspecified with intoxication with perceptual disturbance |
| F15.929 | Other stimulant use, unspecified with intoxication, unspecified |
| F15.950 | Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions |
| F15.951 | Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations |
| F15.959 | Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified |
| F15.980 | Other stimulant use, unspecified with stimulant-induced anxiety disorder |
| F15.981 | Other stimulant use, unspecified with stimulant-induced sexual dysfunction |
| F15.982 | Other stimulant use, unspecified with stimulant-induced sleep disorder |
| F15.988 | Other stimulant use, unspecified with other stimulant-induced disorder |
| F16.10 | Hallucinogen abuse, uncomplicated |
| F16.14 | Hallucinogen abuse with hallucinogen-induced mood disorder |
| F16.19 | Hallucinogen abuse with unspecified hallucinogen-induced disorder |
| F16.20 | Hallucinogen dependence, uncomplicated |
| F16.21 | Hallucinogen dependence, in remission |
| F16.24 | Hallucinogen dependence with hallucinogen-induced mood disorder |
| F16.29 | Hallucinogen dependence with unspecified hallucinogen-induced disorder |
| F16.90 | Hallucinogen use, unspecified, uncomplicated |
| F16.94 | Hallucinogen use, unspecified with hallucinogen-induced mood disorder |
| F16.99 | Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder |
| F16.120 | Hallucinogen abuse with intoxication, uncomplicated |
| F16.121 | Hallucinogen abuse with intoxication with delirium |
| F16.122 | Hallucinogen abuse with intoxication with perceptual disturbance |
| F16.129 | Hallucinogen abuse with intoxication, unspecified |
| F16.150 | Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions |
| F16.151 | Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F16.159 | Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified |
| F16.180 | Hallucinogen abuse with hallucinogen-induced anxiety disorder |
| F16.183 | Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks) |
| F16.188 | Hallucinogen abuse with other hallucinogen-induced disorder |
| F16.220 | Hallucinogen dependence with intoxication, uncomplicated |
| F16.221 | Hallucinogen dependence with intoxication with delirium |
| F16.229 | Hallucinogen dependence with intoxication, unspecified |
| F16.250 | Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions |
| F16.251 | Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations |
| F16.259 | Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified |
| F16.280 | Hallucinogen dependence with hallucinogen-induced anxiety disorder |
| F16.283 | Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks) |
| F16.288 | Hallucinogen dependence with other hallucinogen-induced disorder |
| F16.920 | Hallucinogen use, unspecified with intoxication, uncomplicated |
| F16.921 | Hallucinogen use, unspecified with intoxication with delirium |
| F16.929 | Hallucinogen use, unspecified with intoxication, unspecified |
| F16.950 | Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions |
| F16.951 | Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations |
| F16.959 | Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified |
| F16.980 | Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder |
| F16.983 | Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks) |
| F16.988 | Hallucinogen use, unspecified with other hallucinogen-induced disorder |
| F18.10 | Inhalant abuse, uncomplicated |
| F18.14 | Inhalant abuse with inhalant-induced mood disorder |
| F18.17 | Inhalant abuse with inhalant-induced dementia |
| F18.19 | Inhalant abuse with unspecified inhalant-induced disorder |
| F18.20 | Inhalant dependence, uncomplicated |
| F18.21 | Inhalant dependence, in remission |
| F18.24 | Inhalant dependence with inhalant-induced mood disorder |
| F18.27 | Inhalant dependence with inhalant-induced dementia |
| F18.29 | Inhalant dependence with unspecified inhalant-induced disorder |
| F18.90 | Inhalant use, unspecified, uncomplicated |
| F18.94 | Inhalant use, unspecified with inhalant-induced mood disorder |
| F18.97 | Inhalant use, unspecified with inhalant-induced persisting dementia |
| F18.99 | Inhalant use, unspecified with unspecified inhalant-induced disorder |
| F18.120 | Inhalant abuse with intoxication, uncomplicated |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F18.121 | Inhalant abuse with intoxication delirium |
| F18.129 | Inhalant abuse with intoxication, unspecified |
| F18.150 | Inhalant abuse with inhalant-induced psychotic disorder with delusions |
| F18.151 | Inhalant abuse with inhalant-induced psychotic disorder with hallucinations |
| F18.159 | Inhalant abuse with inhalant-induced psychotic disorder, unspecified |
| F18.180 | Inhalant abuse with inhalant-induced anxiety disorder |
| F18.188 | Inhalant abuse with other inhalant-induced disorder |
| F18.220 | Inhalant dependence with intoxication, uncomplicated |
| F18.221 | Inhalant dependence with intoxication delirium |
| F18.229 | Inhalant dependence with intoxication, unspecified |
| F18.250 | Inhalant dependence with inhalant-induced psychotic disorder with delusions |
| F18.251 | Inhalant dependence with inhalant-induced psychotic disorder with hallucinations |
| F18.259 | Inhalant dependence with inhalant-induced psychotic disorder, unspecified |
| F18.280 | Inhalant dependence with inhalant-induced anxiety disorder |
| F18.288 | Inhalant dependence with other inhalant-induced disorder |
| F18.920 | Inhalant use, unspecified with intoxication, uncomplicated |
| F18.921 | Inhalant use, unspecified with intoxication with delirium |
| F18.929 | Inhalant use, unspecified with intoxication, unspecified |
| F18.950 | Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions |
| F18.951 | Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations |
| F18.959 | Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified |
| F18.980 | Inhalant use, unspecified with inhalant-induced anxiety disorder |
| F18.988 | Inhalant use, unspecified with other inhalant-induced disorder |
| F19.10 | Other psychoactive substance abuse, uncomplicated |
| F19.14 | Other psychoactive substance abuse with psychoactive substance-induced mood disorder |
| F19.16 | Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder |
| F19.17 | Other psychoactive substance abuse with psychoactive substance-induced persisting dementia |
| F19.19 | Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder |
| F19.20 | Other psychoactive substance dependence, uncomplicated |
| F19.21 | Other psychoactive substance dependence, in remission |
| F19.24 | Other psychoactive substance dependence with psychoactive substance-induced mood disorder |
| F19.26 | Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder |
| F19.27 | Other psychoactive substance dependence with psychoactive substance-induced persisting dementia |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F19.29 | Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder |
| F19.90 | Other psychoactive substance use, unspecified, uncomplicated |
| F19.94 | Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder |
| F19.96 | Other psychoactive substance use, unspecified with psychoactive substance-induced persisting amnestic disorder |
| F19.97 | Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia |
| F19.99 | Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder |
| F19.120 | Other psychoactive substance abuse with intoxication, uncomplicated |
| F19.121 | Other psychoactive substance abuse with intoxication delirium |
| F19.122 | Other psychoactive substance abuse with intoxication with perceptual disturbances |
| F19.129 | Other psychoactive substance abuse with intoxication, unspecified |
| F19.150 | Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions |
| F19.151 | Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations |
| F19.159 | Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified |
| F19.180 | Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder |
| F19.181 | Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction |
| F19.182 | Other psychoactive substance abuse with psychoactive substance-induced sleep disorder |
| F19.188 | Other psychoactive substance abuse with other psychoactive substance-induced disorder |
| F19.220 | Other psychoactive substance dependence with intoxication, uncomplicated |
| F19.221 | Other psychoactive substance dependence with intoxication delirium |
| F19.222 | Other psychoactive substance dependence with intoxication with perceptual disturbance |
| F19.229 | Other psychoactive substance dependence with intoxication, unspecified |
| F19.230 | Other psychoactive substance dependence with withdrawal, uncomplicated |
| F19.231 | Other psychoactive substance dependence with withdrawal delirium |
| F19.232 | Other psychoactive substance dependence with withdrawal with perceptual disturbance |
| F19.239 | Other psychoactive substance dependence with withdrawal, unspecified |
| F19.250 | Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions |
| F19.251 | Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations |
| F19.259 | Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified |

| ICD-10-CM Diagnosis Codes | Description |
|---|---|
| F19.280 | Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder |
| F19.281 | Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction |
| F19.282 | Other psychoactive substance dependence with psychoactive substance-induced sleep disorder |
| F19.288 | Other psychoactive substance dependence with other psychoactive substance-induced disorder |
| F19.920 | Other psychoactive substance use, unspecified with intoxication, uncomplicated |
| F19.921 | Other psychoactive substance use, unspecified with intoxication with delirium |
| F19.922 | Other psychoactive substance use, unspecified with intoxication with perceptual disturbance |
| F19.929 | Other psychoactive substance use, unspecified with intoxication, unspecified |
| F19.930 | Other psychoactive substance use, unspecified with withdrawal, uncomplicated |
| F19.931 | Other psychoactive substance use, unspecified with withdrawal delirium |
| F19.932 | Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance |
| F19.939 | Other psychoactive substance use, unspecified with withdrawal, unspecified |
| F19.950 | Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions |
| F19.951 | Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations |
| F19.959 | Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified |
| F19.980 | Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder |
| F19.981 | Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction |
| F19.982 | Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder |
| F19.988 | Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder |
| F55.0 | Abuse of antacids |
| F55.1 | Abuse of herbal or folk remedies |
| F55.2 | Abuse of laxatives |
| F55.3 | Abuse of steroids or hormones |
| F55.4 | Abuse of vitamins |
| F55.8 | Abuse of other non-psychoactive substances |
| R78.0 | Finding of alcohol in blood |
| Z71.41 | Alcohol abuse counseling and surveillance of alcoholic |
| Z71.51 | Drug abuse counseling and surveillance of drug abuser |

# Appendix B: CCLF File Layouts

Following is the list of data elements present on the CCLF Files. The records in the text file are fixed width. The filename Convention for CCLFs sent to ACO mailbox is listed prior to each table.

The filename convention for the Medicare Shared Savings Program in Table 14 is P.A****.ACO.CCLF1.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 14 is P.V***.ACO.CCLF1.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 14 is P.CEC.CCLF1.Dyymmdd.Thhmmsst.

***NOTES**:*

*Where applicable in the file layouts, a minus "-" in the beginning of the format description indicates that if the value is negative, the first character will display as "-". For all other values, a blank will display as the first character.*

*Data Fields marked with an I contain Personally Identifiable Information (PII).*

*Data Fields marked with an H contain Protected Health Information (PHI).*

**Table 14: Part A Claims Header File (CCLF1)**

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 1 | CUR_CLM_UNIQ_ID | Current Claim Unique Identifier | 1 | 13 | 13 | 9(13) | A unique identification number assigned to the claim. I H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 2 | PRVDR_OSCAR_NUM | Provider OSCAR Number | 14 | 19 | 6 | X(06) | A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service. H |
| 3 | BENE_HIC_NUM | Beneficiary HIC Number | 20 | 30 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. I H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 4 | CLM_TYPE_CD | Claim Type Code | 31 | 32 | 2 | 9(02) | Signifies the type of claim being submitted through the Medicare or Medicaid programs. H<br>Claim type codes are:<br>10=HHA claim<br>20=Non swing bed SNF claim<br>30=Swing bed SNF claim<br>40=Outpatient claim<br>50=Hospice claim<br>60=Inpatient claim<br>61=Inpatient “Full-Encounter” claim |
| 5 | CLM_FROM_DT | Claim From Date | 33 | 42 | 10 | YYYY-MM-DD | The first day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as “Statement Covers From Date.” |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 6 | CLM_THRU_DT | Claim Thru Date | 43 | 52 | 10 | YYYY-MM-DD | The last day on the billing statement that covers services rendered to the beneficiary. H<br><br>Also known as the "Statement Covers Through Date." |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 7 | CLM_BILL_FAC_TYPE_CD | Claim Bill Facility Type Code | 53 | 53 | 1 | X(01) | The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). H<br>Claim Facility Type Codes are:<br>1=Hospital<br>2=SNF<br>3=HHA<br>4=Religious non-medical (hospital)<br>5=Religious non-medical (extended care)<br>6=Intermediate care<br>7=Clinic or hospital-based renal dialysis facility<br>8=Specialty facility or Ambulatory Surgical Center (ASC) surgery<br>9=Reserved |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 8 | CLM_BILL_CLSFCTN_CD | Claim Bill Classification Code | 54 | 54 | 1 | X(01) | The second digit of the type of bill (TOB2) is used to indicate with greater specificity where the service was provided (e.g., a department within a hospital). H<br><br>Find Claim Service Classification Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code). |
| 9 | PRNCPL_DGNS_CD | Principal Diagnosis Code | 55 | 61 | 7 | X(07) | The ICD-9/10 diagnosis code identifies the beneficiary's principal illness or disability. H |
| 10 | ADMTG_DGNS_CD | Admitting Diagnosis Code | 62 | 68 | 7 | X(07) | The ICD-9/10 diagnosis code identifies the illness or disability for which the beneficiary was admitted. H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 11 | CLM_MDCR_NPMT_RSN_CD | Claim Medicare Non-Payment Reason Code | 69 | 70 | 2 | X(02) | Indicates the reason payment on an institutional claim is denied.<br>Find Medicare Non-Payment Reason Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/claim-medicare-non-payment-reason-code). |
| 12 | CLM_PMT_AMT | Claim Payment Amount | 71 | 87 | 17 | -9(13).99 | Amount that Medicare paid on the claim. H |
| 13 | CLM_NCH_PRMRY_PYR_CD | Claim NCH Primary Payer Code | 88 | 88 | 1 | X(01) | If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer. H<br>If this field is blank, Medicare is the primary payer for the beneficiary.<br>Find NCH Primary Payer Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/NCH-Primary-Payer-Code). |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 14 | PRVDR_FAC_FIPS_ST_CD | Federal Information Processing Standards (FIPS) State Code | 89 | 90 | 2 | X(02) | Identifies the state where the facility providing services is located. |
| 15 | BENE_PTNT_STUS_CD | Beneficiary Patient Status Code | 91 | 92 | 2 | X(02) | Indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home, another facility) or the circumstances of a discharge (e.g., against medical advice, or patient death). I H<br>Find Patient Discharge Status Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/patient-discharge-status-code). |
| 16 | DGNS_DRG_CD | Diagnosis Related Group Code | 93 | 96 | 4 | X(04) | Indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes. I H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 17 | CLM_OP_SRVC_TYPE_CD | Claim Outpatient Service Type Code | 97 | 97 | 1 | X(01) | Indicates the type and priority of outpatient service. IH<br>Claim Outpatient Service Type Codes are:<br>0=Blank<br>1=Emergency<br>2=Urgent<br>3=Elective<br>5-8=Reserved<br>9=Unknown |
| 18 | FAC_PRVDR_NPI_NUM | Facility Provider NPI Number | 98 | 107 | 10 | X(10) | Identifies the facility associated with the claim. Each facility is assigned its own unique NPI. |
| 19 | OPRTG_PRVDR_NPI_NUM | Operating Provider NPI Number | 108 | 117 | 10 | X(10) | Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI. |
| 20 | ATNDG_PRVDR_NPI_NUM | Attending Provider NPI Number | 118 | 127 | 10 | X(10) | Identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 21 | OTHR_PRVDR_NPI_NUM | Other Provider NPI Number | 128 | 137 | 10 | X(10) | Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI. |
| 22 | CLM_ADJSMT_TYPE_CD | Claim Adjustment Type Code | 138 | 139 | 2 | X(02) | Indicates whether the claim is an original, cancelation, or adjustment claim.<br>Claim Adjustment Type Codes are:<br>0=Original Claim<br>1=Cancelation Claim<br>2=Adjustment claim |
| 23 | CLM_EFCTV_DT | Claim Effective Date | 140 | 149 | 10 | YYYY-MM-DD | Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date. H |
| 24 | CLM_IDR_LD_DT | Claim IDR Load Date | 150 | 159 | 10 | YYYY-MM-DD | When the claim was loaded into the IDR. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 25 | BENE_EQTBL_BIC_HICN_NUM | Beneficiary Equitable BIC HICN Number | 160 | 170 | 11 | X(11) | This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event, using the natural key. IH |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 26 | CLM_ADMSN_TYPE_CD | Claim Admission Type Code | 171 | 172 | 2 | X(2) | Indicates the type and priority of inpatient services. IH<br>Claim Admission Type Codes are:<br>0=Blank<br>1=Emergency<br>2=Urgent<br>3=Elective<br>4=Newborn<br>5=Trauma Center<br>6-8=Reserved<br>9=Unknown |
| 27 | CLM_ADMSN_SRC_CD | Claim Admission Source Code | 173 | 174 | 2 | X(2) | Indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility).<br>Find Admission Source Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Claim-Source-Inpatient-Admission-Code). |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 28 | CLM_BILL_FREQ_CD | Claim Bill Frequency Code | 175 | 175 | 1 | X(1) | The third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided).<br>Find Claim Frequency Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code). |
| 29 | CLM_QUERY_CD | Claim Query Code | 176 | 176 | 1 | X(1) | Indicates the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator).<br>Claim Query Codes are:<br>0=Credit adjustment<br>1=Interim bill<br>2=HHA benefits exhausted<br>3=Final bill<br>4=Discharge notice<br>5=Debit adjustment |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 30 | DGNS_PRCDR_ICD_IND | ICD Version Indicator | 177 | 177 | 1 | X(1) | 9 = ICD-9<br>0 = ICD-10<br>U = any value other than “9” or “0” in the source data. |

The filename convention for the Medicare Shared Savings Program in Table 15 is P.A****.ACO.CCLF2.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 15 is P.V***.ACO.CCLF2.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 15 is P.CEC.CCLF2.Dyymmdd.Thhmmsst.

**Table 15: Part A Claims Revenue Center Detail File (CCLF2)**

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 1 | CUR_CLM_UNIQ_ID | Current Claim Unique Identifier | 1 | 13 | 13 | 9(13) | A unique identification number assigned to the claim. IH |
| 2 | CLM_LINE_NUM | Claim Line Number | 14 | 23 | 10 | 9(10) | A sequential number that identifies a specific claim line. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 3 | BENE_HIC_NUM | Beneficiary HIC Number | 24 | 34 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. IH |
| 4 | CLM_TYPE_CD | Claim Type Code | 35 | 36 | 2 | 9(02) | Signifies the type of claim being submitted through the Medicare or Medicaid programs. H<br>Claim type codes are:<br>10=HHA claim<br>20=Non swing bed SNF claim<br>30=Swing bed SNF claim<br>40=Outpatient claim<br>50=Hospice claim<br>60=Inpatient claim<br>61=Inpatient "Full-Encounter" claim |
| 5 | CLM_LINE_FROM_DT | Claim Line From Date | 37 | 46 | 10 | YYYY-MM-DD | The date the service associated with the line item began. H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 6 | CLM_LINE_THRU_DT | Claim Line Thru Date | 47 | 56 | 10 | YYYY-MM-DD | The date the service associated with the line item ended. H |
| 7 | CLM_LINE_PROD_REV_CTR_CD | Product Revenue Center Code | 57 | 60 | 4 | X(04) | The number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies).<br>A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).<br>Find Revenue Center Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/revenue-center-code).<br>Revenue center code 0001 represents the total of all revenue centers included on the claim. |
| 8 | CLM_LINE_INSTNL_REV_CTR_DT | Claim Line Institutional Revenue Center Date | 61 | 70 | 10 | YYYY-MM-DD | The date that applies to the service associated with the Revenue Center code. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 9 | CLM_LINE_HCPCS_CD | HCPCS Code | 71 | 75 | 5 | X(05) | The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary. |
| 10 | BENE_EQTBL_BIC_HICN_NUM | Beneficiary Equitable BIC HICN Number | 76 | 86 | 11 | X(11) | This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key. IH |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 11 | PRVDR_OSCAR_NUM | Provider OSCAR Number | 87 | 92 | 6 | X(6) | A facility's Medicare/Medicaid identification number, also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services. H |
| 12 | CLM_FROM_DT | Claim From Date | 93 | 102 | 10 | YYYY-MM-DD | The first day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as the "Statement Covers From Date." |
| 13 | CLM_THRU_DT | Claim Thru Date | 103 | 112 | 10 | YYYY-MM-DD | The last day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as the "Statement Covers Through Date." |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 14 | CLM_LINE_SRVC_UNIT_QTY | Claim Line Service Unit Quantity | 113 | 136 | 24 | -9(18).9999 | Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units). H |
| 15 | CLM_LINE_CVRD_PD_AMT | Claim Line Covered Paid Amount | 137 | 153 | 17 | -9(13).99 | The amount Medicare reimbursed the provider for covered services associated with the claim-line. H |
| 16 | HCPCS_1_MDFR_CD | HCPCS First Modifier Code | 154 | 155 | 2 | X(2) | The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |
| 17 | HCPCS_2_MDFR_CD | HCPCS Second Modifier Code | 156 | 157 | 2 | X(2) | The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 18 | HCPCS_3_MDFR_CD | HCPCS Third Modifier Code | 158 | 159 | 2 | X(2) | The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |
| 19 | HCPCS_4_MDFR_CD | HCPCS Fourth Modifier Code | 160 | 161 | 2 | X(2) | The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |
| 20 | HCPCS_5_MDFR_CD | HCPCS Fifth Modifier Code | 162 | 163 | 2 | X(2) | The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |

The filename convention for the Medicare Shared Savings Program in Table 16 is P.A****.ACO.CCLF3.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 16 is P.V***.ACO.CCLF3.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 16 is P.CEC.CCLF3.Dyymmdd.Thhmmsst.

**Table 16: Part A Procedure Code File (CCLF3)**

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 1 | CUR_CLM_UNIQ_ID | Current Claim Unique Identifier | 1 | 13 | 13 | 9(13) | A unique identification number assigned to the claim. IH |
| 2 | BENE_HIC_NUM | Beneficiary HIC Number | 14 | 24 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. IH |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 3 | CLM_TYPE_CD | Claim Type Code | 25 | 26 | 2 | 9(02) | Signifies the type of claim being submitted through the Medicare or Medicaid programs. H<br>Claim type codes are:<br>10=HHA claim<br>20=Non swing bed SNF claim<br>30=Swing bed SNF claim<br>40=Outpatient claim<br>50=Hospice claim<br>60=Inpatient claim<br>61=Inpatient “Full-Encounter” claim |
| 4 | CLM_VAL_SQNC_NUM | Claim Value Sequence Number | 27 | 28 | 2 | 9(2) | An arbitrary sequential number that uniquely identifies a procedure code record within the claim. |
| 5 | CLM_PRCDR_CD | Procedure Code | 29 | 35 | 7 | X(07) | The ICD-9/10 code that indicates the procedure performed during the period covered by the claim. H |
| 6 | CLM_PRCDR_PRFRM_DT | Procedure Performed Date | 36 | 45 | 10 | YYYY-MM-DD | The date the indicated procedure was performed. H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 7 | BENE_EQTBL_BIC_HICN_NUM | Beneficiary Equitable BIC HICN Number | 46 | 56 | 11 | X(11) | This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key. I H |
| 8 | PRVDR_OSCAR_NUM | Provider OSCAR Number | 57 | 62 | 6 | X(6) | A facility’s Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services. H |
| 9 | CLM_FROM_DT | Claim From Date | 63 | 72 | 10 | YYYY-MM-DD | The first day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as “Statement Covers From Date.” |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 10 | CLM_THRU_DT | Claim Thru Date | 73 | 82 | 10 | YYYY-MM-DD | The last day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as the “Statement Covers Through Date.” |
| 11 | DGNS_PRCDR_ICD_IND | ICD Version Indicator | 83 | 83 | 1 | X(1) | 9 = ICD-9<br>0 = ICD-10<br>U = any value other than “9” or “0” in the source data. |

The filename convention for the Medicare Shared Savings Program in Table 17 is P.A****.ACO.CCLF4.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 17 is P.V***.ACO.CCLF4.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 17 is P.CEC.CCLF4.Dyymmdd.Thhmmsst.

**Table 17: Part A Diagnosis Code File (CCLF4)**

| Element # | Element Name | Data Description | Start Position | End Position | Data Length | Format | Comments |
|---|---|---|---|---|---|---|---|
| 1 | CUR_CLM_UNIQ_ID | Current Claim Unique Identifier | 1 | 13 | 13 | 9(13) | A unique identification number assigned to the claim. IH |

| Element # | Element Name | Data Description | Start Position | End Position | Data Length | Format | Comments |
|---|---|---|---|---|---|---|---|
| 2 | BENE_HIC_NUM | Beneficiary HIC Number | 14 | 24 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. I H |
| 3 | CLM_TYPE_CD | Claim Type Code | 25 | 26 | 2 | 9(02) | Signifies the type of claim being submitted through the Medicare or Medicaid programs. H<br>Claim type codes are:<br>10=HHA claim<br>20=Non swing bed SNF claim<br>30=Swing bed SNF claim<br>40=Outpatient claim<br>50=Hospice claim<br>60=Inpatient claim<br>61=Inpatient "Full-Encounter" claim |
| 4 | CLM_PROD_TYPE_CD | Claim Product Type Code | 27 | 27 | 1 | X(01) | Codes classifying the diagnosis category. H<br>Category codes are:<br>E=Accident diagnosis code<br>1=First diagnosis E code<br>D=Other diagnosis codes |

| Element # | Element Name | Data Description | Start Position | End Position | Data Length | Format | Comments |
|---|---|---|---|---|---|---|---|
| 5 | CLM_VAL_SQNC_NUM | Claim Value Sequence Number | 28 | 29 | 2 | 9(2) | An arbitrary sequential number that uniquely identifies a procedure code record within the claim. |
| 6 | CLM_DGNS_CD | Diagnosis Code | 30 | 36 | 7 | X(07) | The ICD-9/10 diagnosis code identifying the beneficiary's illness or disability. I H |
| 7 | BENE_EQTBL_BIC_HICN_NUM | Beneficiary Equitable BIC HICN Number | 37 | 47 | 11 | X(11) | This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key. I H |

| Element # | Element Name | Data Description | Start Position | End Position | Data Length | Format | Comments |
|---|---|---|---|---|---|---|---|
| 8 | PRVDR_OSCAR_NUM | Provider OSCAR Number | 48 | 53 | 6 | X(6) | The OSCAR is a facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services. H |
| 9 | CLM_FROM_DT | Claim From Date | 54 | 63 | 10 | YYYY-MM-DD | The first day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as the "Statement Covers From Date." |
| 10 | CLM_THRU_DT | Claim Thru Date | 64 | 73 | 10 | YYYY-MM-DD | The last day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as the "Statement Covers Through Date." |

| Element # | Element Name | Data Description | Start Position | End Position | Data Length | Format | Comments |
|---|---|---|---|---|---|---|---|
| 11 | CLM_POA_IND | Claim Present-on-Admission Indicator | 74 | 80 | 7 | X(7) | Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility. IH<br>Find Present-on-Admission values at the ResDAC website<br>(http://www.resdac.org/cms-data/variables/claim-diagnosis-code-i-diagnosis-present-admission-indicator-code). |
| 12 | DGNS_PRCDR_ICD_IND | ICD Version Indicator | 81 | 81 | 1 | X(1) | 9 = ICD-9<br>0 = ICD-10<br>U = any value other than “9” or “0” in the source data. |

The filename convention for the Medicare Shared Savings Program in Table 18 is P.A****.ACO.CCLF5.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 18 is P.V***.ACO.CCLF5.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 18 is P.CEC.CCLF5.Dyymmdd.Thhmmsst.

**Table 18: Part B Physicians File (CCLF5)**

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 1 | CUR_CLM_UNIQ_ID | Current Claim Unique Identifier | 1 | 13 | 13 | 9(13) | A unique identification number assigned to the claim. IH |
| 2 | CLM_LINE_NUM | Claim Line Number | 14 | 23 | 10 | 9(10) | A sequential number that identifies a specific claim line within a given claim. |
| 3 | BENE_HIC_NUM | Beneficiary HIC Number | 24 | 34 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. IH |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 4 | CLM_TYPE_CD | Claim Type Code | 35 | 36 | 2 | 9(02) | Signifies the type of claim being submitted through the Medicare or Medicaid programs. H<br>Claim type codes are:<br>71=RIC O local carrier non-DMEPOS claim<br>72=RIC O local carrier DMEPOS claim |
| 5 | CLM_FROM_DT | Claim From Date | 37 | 46 | 10 | YYYY-MM-DD | The first day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as the "Statement Covers From Date." |
| 6 | CLM_THRU_DT | Claim Thru Date | 47 | 56 | 10 | YYYY-MM-DD | The last day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as the "Statement Covers Through Date." |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 7 | RNDRG_PRVDR_TYPE_CD | Rendering Provider Type Code | 57 | 59 | 3 | X(03) | Indicates the type of provider who provided the service associated with this line item on the claim.<br>Provider Type Codes are:<br>0=Clinics, groups, associations, partnerships, or other entities<br>1=Physicians or suppliers reporting as solo practitioners<br>2=Suppliers (other than sole proprietorship)<br>3=Institutional provider<br>4=Independent laboratories<br>5=Clinics (multiple specialties)<br>6=Groups (single specialty)<br>7=Other entities<br>UI= UPIN Identification<br>N2= National Council for Prescription Drug Programs<br>D= National Supplier Clearinghouse<br>BP= PIN Individual<br>BG= PIN Group<br>A= Online Survey, Certification and Reporting |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 8 | RNDRG_PRVDR_FIPS_ST_CD | Rendering Provider FIPS State Code | 60 | 61 | 2 | X(02) | Identifies the state that the provider providing the service is located in. |
| 9 | CLM_PRVDR_SPCLTY_CD | Claim-Line Provider Specialty Code | 62 | 63 | 2 | X(02) | Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item.<br>Find Provider Specialty Codes at the Medicare website<br>(http://www.resdac.org/cms-data/variables/Line-HCFA-Provider-Specialty-Code) |
| 10 | CLM_FED_TYPE_SRVC_CD | Claim Federal Type Service Code | 64 | 64 | 1 | X(01) | Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.<br>Find Types of Service Codes at the ResDAC website<br>(http://www.resdac.org/cms-data/variables/Line-HCFA-Type-Service-Code). |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 11 | CLM_POS_CD | Claim Place of Service Code | 65 | 66 | 2 | X(02) | Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual.<br>Find Place of Service Codes at the ResDAC website<br>(http://www.resdac.org/cms-data/variables/line-place-service-code). |
| 12 | CLM_LINE_FROM_DT | Claim Line From Date | 67 | 76 | 10 | YYYY-MM-DD | The date the service associated with the line item began. |
| 13 | CLM_LINE_THRU_DT | Claim Line Thru Date | 77 | 86 | 10 | YYYY-MM-DD | The date the service associated with the line item ended. |
| 14 | CLM_LINE_HCPCS_CD | HCPCS Code | 87 | 91 | 5 | X(05) | The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary. IH |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 15 | CLM_LINE_CVRD_PD_AMT | Claim Line NCH Payment Amount | 92 | 106 | 15 | X(15) | The amount of payment made by Medicare on behalf of the beneficiary for the indicated service after deductible and coinsurance amounts have been paid. |
| 16 | CLM_LINE_PRMRY_PYR_CD | Claim Primary Payer Code | 107 | 107 | 1 | X(01) | If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code. I H<br><br>If this field is blank, Medicare is the primary payer for the beneficiary.<br><br>Find Primary Payer Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Line-Beneficiary-Primary-Payer-Code). |
| 17 | CLM_LINE_DGNS_CD | Diagnosis Code | 108 | 114 | 7 | X(07) | The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability. I H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 18 | CLM_RNDRG_PRVDR_TAX_NUM | Claim Provider Tax Number | 115 | 124 | 10 | X(10) | The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service. |
| 19 | RNDRG_PRVDR_NPI_NUM | Rendering Provider NPI Number | 125 | 134 | 10 | X(10) | A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. |
| 20 | CLM_CARR_PMT_DNL_CD | Claim Carrier Payment Denial Code | 135 | 136 | 2 | X(02) | Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied.<br>Find Carrier Payment Denail Codes in the CMS Manual System, Publication 100-04 Medicare Claims Processing (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R470CP.pdf). |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 21 | CLM_PRCSG_IND_CD | Claim-Line Processing Indicator Code | 137 | 138 | 2 | X(02) | Indicates whether the service indicated on the claim line was allowed or the reason it was denied.<br>Find Processing Indicator Code at the ResDAC website<br>(http://www.resdac.org/cms-data/variables/Line-Processing-Indicator-Code). |
| 22 | CLM_ADJSMT_TYPE_CD | Claim Adjustment Type Code | 139 | 140 | 2 | X(02) | Indicates whether the claim an original, cancelation, or adjustment claim.<br>Claim Adjustment Type Codes are:<br>0=Original Claim<br>1=Cancelation Claim<br>2=Adjustment claim |
| 23 | CLM_EFCTV_DT | Claim Effective Date | 141 | 150 | 10 | YYYY-MM-DD | The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date. |
| 24 | CLM_IDR_LD_DT | Claim IDR Load Date | 151 | 160 | 10 | YYYY-MM-DD | When the claim was loaded into the IDR. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 25 | CLM_CNTL_NUM | Claim Control Number | 161 | 200 | 40 | X(40) | A unique number assigned to a claim by the Medicare carrier.<br>This number allows CMS to associate each line item with its respective claim. |
| 26 | BENE_EQTBL_BIC_HICN_NUM | Beneficiary Equitable BIC HICN Number | 201 | 211 | 11 | X(11) | This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key. IH |
| 27 | CLM_LINE_ALOWD_CHRG_AMT | Claim Line Allowed Charges Amount | 212 | 228 | 17 | X(17) | The amount Medicare approved for payment to the provider. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 28 | CLM_LINE_SRVC_UNIT_QTY | Claim Line Service Unit Quantity | 229 | 252 | 24 | -9(18).9999 | Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units). |
| 29 | HCPCS_1_MDFR_CD | HCPCS First Modifier Code | 253 | 254 | 2 | X(2) | The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |
| 30 | HCPCS_2_MDFR_CD | HCPCS Second Modifier Code | 255 | 256 | 2 | X(2) | The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |
| 31 | HCPCS_3_MDFR_CD | HCPCS Third Modifier Code | 257 | 258 | 2 | X(2) | The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 32 | HCPCS_4_MDFR_CD | HCPCS Fourth Modifier Code | 259 | 260 | 2 | X(2) | The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |
| 33 | HCPCS_5_MDFR_CD | HCPCS Fifth Modifier Code | 261 | 262 | 2 | X(2) | The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. H |
| 34 | CLM_DISP_CD | Claim Disposition Code | 263 | 264 | 2 | X(2) | Information regarding payment actions on the claim.<br>Claim Disposition Codes are:<br>01=Debit accepted<br>02=Debit accepted (automatic adjustment)<br>03=Cancel accepted |
| 35 | CLM_DGNS_1_CD | Claim Diagnosis First Code | 265 | 271 | 7 | X(7) | The first of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. I H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 36 | CLM_DGNS_2_CD | Claim Diagnosis Second Code | 272 | 278 | 7 | X(7) | The second of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. IH |
| 37 | CLM_DGNS_3_CD | Claim Diagnosis Third Code | 279 | 285 | 7 | X(7) | The third of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. IH |
| 38 | CLM_DGNS_4_CD | Claim Diagnosis Fourth Code | 286 | 292 | 7 | X(7) | The fourth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. IH |
| 39 | CLM_DGNS_5_CD | Claim Diagnosis Fifth Code | 293 | 299 | 7 | X(7) | The fifth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. IH |
| 40 | CLM_DGNS_6_CD | Claim Diagnosis Sixth Code | 300 | 306 | 7 | X(7) | The sixth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. IH |
| 41 | CLM_DGNS_7_CD | Claim Diagnosis Seventh Code | 307 | 313 | 7 | X(7) | The seventh of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. IH |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 42 | CLM_DGNS_8_CD | Claim Diagnosis Eighth Code | 314 | 320 | 7 | X(7) | The eighth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. IH |
| 43 | DGNS_PRCDR_ICD_IND | ICD Version Indicator | 321 | 321 | 1 | X(1) | 9 = ICD-9<br>0 = ICD-10<br>U = any value other than "9" or "0" in the source data. |

The filename convention for the Medicare Shared Savings Program in Table 19 is P.A****.ACO.CCLF6.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 19 is P.V***.ACO.CCLF6.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 19 is P.CEC.CCLF6.Dyymmdd.Thhmmsst.

**Table 19: Part B DME File (CCLF6)**

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 1 | CUR_CLM_UNIQ_ID | Current Claim Unique Identifier | 1 | 13 | 13 | 9(13) | A unique identification number assigned to the claim. IH |
| 2 | CLM_LINE_NUM | Claim Line Number | 14 | 23 | 10 | 9(10) | A sequential number that identifies a specific claim line. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 3 | BENE_HIC_NUM | Beneficiary HIC Number | 24 | 34 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. I H |
| 4 | CLM_TYPE_CD | Claim Type Code | 35 | 36 | 2 | 9(02) | Signifies the type of claim being submitted through the Medicare or Medicaid programs. H<br>Claim type codes are:<br>81=RIC M DMERC non-DMEPOS claim<br>82=RIC M DMERC DMEPOS claim |
| 5 | CLM_FROM_DT | Claim From Date | 37 | 46 | 10 | YYYY-MM-DD | The first day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as the "Statement Covers From Date." |
| 6 | CLM_THRU_DT | Claim Thru Date | 47 | 56 | 10 | YYYY-MM-DD | The last day on the billing statement that covers services rendered to the beneficiary. H<br>Also known as the "Statement Covers Through Date." |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 7 | CLM_FED_TYPE_SRVC_CD | Claim Federal Type Service Code | 57 | 57 | 1 | X(01) | Indicates the type of service (e.g., consultation, surgery), provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual. H<br>Find Types of Service Codes at the ResDAC website<br>(http://www.resdac.org/cms-data/variables/Line-HCFA-Type-Service-Code). |
| 8 | CLM_POS_CD | Claim Place of Service Code | 58 | 59 | 2 | X(02) | Indicates place where the indicated service was provided (e.g., ambulance, school). H<br>Find Place of Service Codes at the ResDAC website.<br>(http://www.resdac.org/cms-data/variables/line-place-service-code). |
| 9 | CLM_LINE_FROM_DT | Claim Line From Date | 60 | 69 | 10 | YYYY-MM-DD | The date the service associated with the line item began. H |
| 10 | CLM_LINE_THRU_DT | Claim Line Thru Date | 70 | 79 | 10 | YYYY-MM-DD | The date the service associated with the line item ended. H |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 11 | CLM_LINE_HCPCS_CD | HCPCS Code | 80 | 84 | 5 | X(05) | The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary. H |
| 12 | CLM_LINE_CVRD_PD_AMT | Claim Line NCH Payment Amount | 85 | 99 | 15 | -9(11).99 | The amount of payment made by Medicare on behalf of the beneficiary for the indicated service after deductible and coinsurance amounts have been paid. H |
| 13 | CLM_PRMRY_PYR_CD | Claim Primary Payer Code | 100 | 100 | 1 | X(01) | If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code.<br><br>If this field is blank, Medicare is the primary payer for the beneficiary.<br><br>Find Primary Payer Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Line-Beneficiary-Primary-Payer-Code). |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 14 | PAYTO_PRVDR_NPI_NUM | Pay-to Provider NPI Number | 101 | 110 | 10 | X(10) | A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI. |
| 15 | ORDRG_PRVDR_NPI_NUM | Ordering Provider NPI Number | 111 | 120 | 10 | X(10) | A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI. |
| 16 | CLM_CARR_PMT_DNL_CD | Claim Carrier Payment Denial Code | 121 | 122 | 2 | X(02) | Indicates to whom payment was made (e.g., physician, beneficiary) or if the claim was denied<br>Find Carrier Payment Denial Codes at the ResDAC website<br>(http://www.resdac.org/cms-data/variables/Carrier-Claim-Payment-Denial-Code). |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 17 | CLM_PRCSG_IND_CD | Claim Processing Indicator Code | 123 | 124 | 2 | X(02) | Indicates whether the service indicated on the claim line was allowed or the reason it was denied.<br>Find Processing Indicator Codes at the ResDAC website<br>(http://www.resdac.org/cms-data/variables/Line-Processing-Indicator-Code). |
| 18 | CLM_ADJSMT_TYPE_CD | Claim Adjustment Type Code | 125 | 126 | 2 | X(02) | Indicates whether the claim an original, cancelation, or adjustment claim.<br>Claim Adjustment Type Codes are:<br>0=Original Claim<br>1=Cancelation Claim<br>2=Adjustment claim |
| 19 | CLM_EFCTV_DT | Claim Effective Date | 127 | 136 | 10 | YYYY-MM-DD | The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date. H |
| 20 | CLM_IDR_LD_DT | Claim IDR Load Date | 137 | 146 | 10 | YYYY-MM-DD | When the claim was loaded into the IDR. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 21 | CLM_CNTL_NUM | Claim Control Number | 147 | 186 | 40 | X(40) | A unique number assigned to a claim by the Medicare carrier.<br>This number allows CMS to associate each line item with its respective claim. |
| 22 | BENE_EQTBL_BIC_HICN_NUM | Beneficiary Equitable BIC HICN Number | 187 | 197 | 11 | X(11) | This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key. IH |
| 23 | CLM_LINE_ALOWD_CHRG_AMT | Claim Line Allowed Charges Amount | 198 | 214 | 17 | -9(14).99 | The amount Medicare approved for payment to the provider. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 24 | CLM_DISP_CD | Claim Disposition Code | 215 | 216 | 2 | X(2) | Contains information regarding payment actions on the claim.<br>Claim Disposition Codes are:<br>01=Debit accepted<br>02=Debit accepted (automatic adjustment)<br>03=Cancel accepted |

The filename convention for the Medicare Shared Savings Program in Table 20 is P.A****.ACO.CCLF7.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 20 is P.V***.ACO.CCLF7.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 20 is P.CEC.CCLF7.Dyymmdd.Thhmmsst.

**Table 20: Part D File (CCLF7)**

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 1 | CUR_CLM_UNIQ_ID | Current Claim Unique Identifier | 1 | 13 | 13 | 9(13) | A unique identification number assigned to the claim. IH |
| 2 | BENE_HIC_NUM | Beneficiary HIC Number | 14 | 24 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. IH |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 3 | CLM_LINE_NDC_CD | NDC Code | 25 | 35 | 11 | X(11) | A universal unique product identifier for human drugs. H |
| 4 | CLM_TYPE_CD | Claim Type Code | 36 | 37 | 2 | 9(02) | Signifies the type of claim being submitted through the Medicare or Medicaid programs. H<br>Claim type codes are:<br>01=Part D - Original without resubmitted PDE<br>02=Part D - Adjusted PDE<br>03=Part D - Deleted Claims<br>04=Part D - Resubmitted PDE |
| 5 | CLM_LINE_FROM_DT | Claim Line From Date | 38 | 47 | 10 | YYYY-MM-DD | The date the service associated with the line item began (i.e., the date upon which the prescription was filled). |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 6 | PRVDR_SRVC_ID_QLFYR_CD | Provider Service Identifier Qualifier Code | 48 | 49 | 2 | X(02) | Indicates the type of number used to identify the pharmacy providing the services:<br>01= NPI Number<br>06=Unique Physician Identification Number (UPIN)<br>07=National Council for Prescription Drug Programs (NCPDP) Number<br>08=State License Number<br>11=TIN<br>99=Other mandatory for Standard Data Format |
| 7 | CLM_SRVC_PRVDR_GNRC_ID_NUM | Claim Service Provider Generic ID Number | 50 | 69 | 20 | X(20) | The number associated with the indicated code in the Provider Service Identification Qualifier Code field. |
| 8 | CLM_DSPNSNG_STUS_CD | Claim Dispensing Status Code | 70 | 70 | 1 | X(01) | Indicates the status of prescription fulfillment.<br>Dispensing Codes are:<br>P=Partially filled<br>C=Completely filled |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 9 | CLM_DAW_PROD_SLCTN_CD | Claim Dispense as Written (DAW) Product Selection Code | 71 | 71 | 1 | X(01) | Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed.<br>DAW Product Selection Codes are:<br>0=No product selection indicated<br>1=Substitution not allowed by prescriber<br>2=Substitution allowed – Patient requested that brand be dispensed<br>3=Substitution allowed – Pharmacist selected product dispensed<br>4=Substitution allowed – Generic not in stock<br>5=Substitution allowed – Brand drug dispensed as generic<br>6=Override<br>7=Substitution not allowed – Brand drug mandated by law<br>8=Substitution allowed – Generic drug not available in marketplace<br>9=Other |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 10 | CLM_LINE_SRVC_UNIT_QTY | Claim Line Service Unit Quantity | 72 | 95 | 24 | -9(18).9999 | Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units). |
| 11 | CLM_LINE_DAYS_SUPLY_QTY | Claim Line Days' Supply Quantity | 96 | 104 | 9 | 9(09) | The number of days the supply of medication dispensed by the pharmacy will cover. |
| 12 | PRVDR_PRSBNG_ID_QLFYR_CD | Provider Prescribing ID Qualifier Code | 105 | 106 | 2 | X(02) | Indicates the type of number used to identify the prescribing provider:<br>01= NPI Number<br>06= UPIN<br>07= NCPDP Number<br>08=State License Number<br>11=TIN<br>12=DEA<br>99=Other mandatory for Standard Data Format |
| 13 | CLM_PRSBNG_PRVDR_GNRC_ID_NUM | Claim Prescribing Provider Generic ID Number | 107 | 126 | 20 | X(20) | The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 14 | CLM_LINE_BENE_PMT_AMT | Claim Line Beneficiary Payment Amount | 127 | 139 | 13 | -9(9).99 | The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts). H |
| 15 | CLM_ADJSMT_TYPE_CD | Claim Adjustment Type Code | 140 | 141 | 2 | X(02) | Indicates whether the claim an original, cancelation, or adjustment claim.<br>Claim Adjustment Type Codes are:<br>0=Original Claim<br>1=Cancelation Claim<br>2=Adjustment claim |
| 16 | CLM_EFCTV_DT | Claim Effective Date | 142 | 151 | 10 | YYYY-MM-DD | The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date. H |
| 17 | CLM_IDR_LD_DT | Claim IDR Load Date | 152 | 161 | 10 | YYYY-MM-DD | When the claim was loaded into the IDR. |
| 18 | CLM_LINE_RX_SRVC_RFRNC_NUM | Claim Line Prescription Service Reference Number | 162 | 173 | 12 | 9(12) | Identifies a prescription dispensed by a particular service provider on a particular service date. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 19 | CLM_LINE_RX_FILL_NUM | Claim Line Prescription Fill Number | 174 | 182 | 9 | X(09) | Assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription. |

The filename convention for the Medicare Shared Savings Program in Table 21 is P.A****.ACO.CCLF8.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 21 is P.V***.ACO.CCLF8.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 21 is P.CEC.CCLF8.Dyymmdd.Thhmmsst.

**Table 21: Beneficiary Demographics File (CCLF8)**

| Element # | Beneficiary Field Label | Beneficiary Field Name | Start Position | End Position | Data Length | Format | Beneficiary Field Description |
|---|---|---|---|---|---|---|---|
| 1 | BENE_HIC_NUM | Beneficiary HIC Number | 1 | 11 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. IH |
| 2 | BENE_FIPS_STATE_CD | Beneficiary FIPS State Code | 12 | 13 | 2 | 9(02) | Identifies the state where the beneficiary receiving services resides. IH |
| 3 | BENE_FIPS_CNTY_CD | Beneficiary FIPS County Code | 14 | 16 | 3 | 9(03) | Identifies the county where the beneficiary receiving services resides. IH |

| Element # | Beneficiary Field Label | Beneficiary Field Name | Start Position | End Position | Data Length | Format | Beneficiary Field Description |
|---|---|---|---|---|---|---|---|
| 4 | BENE_ZIP_CD | Beneficiary ZIP Code | 17 | 21 | 5 | X(05) | The beneficiary's ZIP code as indicated in their Medicare enrollment record. IH |
| 5 | BENE_DOB | Beneficiary Date of Birth | 22 | 31 | 10 | YYYY-MM-DD | The month, day, and year of the beneficiary's birth. IH |
| 6 | BENE_SEX_CD | Beneficiary Sex Code | 32 | 32 | 1 | X(01) | The beneficiary's sex. IH<br>Codes are:<br>1=Male<br>2=Female<br>0=Unknown |
| 7 | BENE_RACE_CD | Beneficiary Race Code | 33 | 33 | 1 | X(01) | The beneficiary's race. IH<br>Codes are:<br>0=Unknown<br>1=White<br>2=Black<br>3=Other<br>4=Asian<br>5=Hispanic<br>6=North American Native |
| 8 | BENE_AGE | Beneficiary Age | 34 | 36 | 3 | 9(03) | The beneficiary's current age, as calculated by subtracting the beneficiary's date of birth from the current date. IH |

| Element # | Beneficiary Field Label | Beneficiary Field Name | Start Position | End Position | Data Length | Format | Beneficiary Field Description |
|---|---|---|---|---|---|---|---|
| 9 | BENE_MDCR_STUS_CD | Beneficiary Medicare Status Code | 37 | 38 | 2 | X(02) | Indicates the reason for a beneficiary's entitlement to Medicare benefits as of a particular date, broken down by the following categories: IH<br>Old Age & Survivors Insurance (OASI), Disabled, and ESRD, and by appropriate combinations of these categories:<br>10=Aged without ESRD<br>11=Aged with ESRD<br>20=Disabled without ESRD<br>21=Disabled with ESRD<br>31=ESRD only |
| 10 | BENE_DUAL_STUS_CD | Beneficiary Dual Status Code | 39 | 40 | 2 | X(02) | Identifies the most recent entitlement status of beneficiaries eligible for a program(s) in addition to Medicare (e.g., Medicaid). IH<br>Find Dual Status Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Dual-Status-Code-occurs-12-times). |
| 11 | BENE_DEATH_DT | Beneficiary Death Date | 41 | 50 | 10 | YYYY-MM-DD | The month, day, and year of a beneficiary's death. IH |

| Element # | Beneficiary Field Label | Beneficiary Field Name | Start Position | End Position | Data Length | Format | Beneficiary Field Description |
|---|---|---|---|---|---|---|---|
| 12 | BENE_RNG_BGN_DT | Date beneficiary enrolled in Hospice | 51 | 60 | 10 | YYYY-MM-DD | The date the beneficiary enrolled in Hospice. IH |
| 13 | BENE_RNG_END_DT | Date beneficiary ended Hospice | 61 | 70 | 10 | YYYY-MM-DD | The date the beneficiary is-enrolled in hospice. IH |
| 14 | BENE_1ST_NAME | Beneficiary First Name | 71 | 100 | 30 | X(30) | The first name of the beneficiary. IH |
| 15 | BENE_MIDL_NAME | Beneficiary Middle Name | 101 | 115 | 15 | X(15) | The middle name of the beneficiary. IH |
| 16 | BENE_LAST_NAME | Beneficiary Last Name | 116 | 155 | 40 | X(40) | The last name of the beneficiary. IH |
| 17 | BENE_ORGNL_ENTLMT_RSN_CD | Beneficiary Original Entitlement Reason Code | 156 | 156 | 1 | X(01) | The reason for the beneficiary's original entitlement to Medicare benefits. IH<br>0 - Old Age and Survivors Insurance (Oasi)<br>1 - Disability Insurance Benefits (DIB)<br>2 - ESRD<br>3 - Both DIB and ESRD<br>4 - Unknown |

| Element # | Beneficiary Field Label | Beneficiary Field Name | Start Position | End Position | Data Length | Format | Beneficiary Field Description |
|---|---|---|---|---|---|---|---|
| 18 | BENE_ENTLMT_BUYIN_IND | Beneficiary Entitlement Buy-in Indicator | 157 | 157 | 1 | X(01) | Indicates for each month of the denominator reference year, the entitlement of the beneficiary to Medicare Part A, Medicare Part B, or Medicare Parts A and B both, as well as whether or not the beneficiary's state of residence was liable and paid for the beneficiary's Medicare Part B monthly premiums. IH<br>0 Not Entitled<br>1 Part A Only<br>2 Part B Only<br>3 Part A and Part B<br>A Part A, State Buy-In<br>B Part B, State Buy-In<br>C Parts A and B, State Buy-In |

The filename convention for the Medicare Shared Savings Program in Table 22 is P.A****.ACO.CCLF9.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 22 is P.V***.ACO.CCLF9.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 22 is P.CEC.CCLF9.Dyymmdd.Thhmmsst.

**Table 22: Beneficiary XREF File (CCLF9)**

| Element # | Beneficiary Field Label | Beneficiary Field Name | Start Position | End Position | Data Length | Format | Beneficiary Field Description |
|---|---|---|---|---|---|---|---|
| 1 | CRNT_HIC_NUM | Current HIC Number | 1 | 11 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. IH |
| 2 | PRVS_HIC_NUM | Previous HIC Number | 12 | 22 | 11 | X(11) | The HICN that appears in this field is the beneficiary's previous HICN. IH |
| 3 | PRVS_HICN_EFCTV_DT | Previous HICN Effective Date | 23 | 32 | 10 | YYYY-MM-DD | The date the previous HICN became active. |
| 4 | PRVS_HICN_OBSLT_DT | Previous HICN Obsolete Date | 33 | 42 | 10 | YYYY-MM-DD | The date the previous HICN ceased to be active. |
| 5 | BENE_RRB_NUM | Beneficiary Railroad Board Number | 43 | 54 | 12 | X(12) | The external (to Medicare) HICN for beneficiaries that are RRB members. IH |

The filename convention for the Medicare Shared Savings Program in Table 23 is P.A****.ACO.CCLFA.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 23 is P.V***.ACO.CCLFA.Dyymmdd.Thhmmsst.

***NOTE**: This file will only be produced for Shared Savings Program and NGACO ACOs.*

**Table 23: Part A Claims Benefit Enhancement and Demonstration Codes File (CCLFA)**

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 1 | CUR_CLM_UNIQ_ID | Current Claim Unique Identifier | 1 | 13 | 13 | 9(13) | A unique identification number assigned to the claim. IH |
| 2 | BENE_HIC_NUM | Beneficiary HIC Number | 14 | 24 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. IH |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 3 | CLM_TYPE_CD | Claim Type Code | 25 | 26 | 2 | 9(02) | Signifies the type of claim being submitted through the Medicare or Medicaid programs. H<br>Claim type codes are:<br>10=HHA claim<br>20=Non swing bed SNF claim<br>30=Swing bed SNF claim<br>40=Outpatient claim<br>50=Hospice claim<br>60=Inpatient claim<br>61=Inpatient “Full-Encounter” claim |
| 4 | CLM_ACTV_CARE_FROM_DT | Claim Admission Date | 27 | 36 | 10 | YYYY-MM-DD | On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or Christian science sanatorium. IH |
| 5 | CLM_NGACO_PBPMT_SW | PBP Benefit Enhancement Indicator | 37 | 37 | 1 | X(1) | A single character code of “Y” or “N” that indicates whether a particular claim is tied to a PBP benefit enhancement. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 6 | CLM_NGACO_PDSCHRG_HCBS_SW | Post Discharge Home Visit Benefit Enhancement Indicator | 38 | 38 | 1 | X(1) | A single character code of “Y” or “N” that indicates whether a particular claim is tied to a Post Discharge Home Visit benefit enhancement. |
| 7 | CLM_NGACO_SNF_WVR_SW | SNF 3-Day Waiver Benefit Enhancement Indicator | 39 | 39 | 1 | X(1) | A single character code of “Y” or “N” that indicates whether a particular claim is tied to a SNF 3-Day Waiver benefit enhancement. |
| 8 | CLM_NGACO_TLHLTH_SW | Telehealth Benefit Enhancement Indicator | 40 | 40 | 1 | X(1) | A single character code of “Y” or “N” that indicates whether a particular claim is tied to a Telehealth benefit enhancement. |
| 9 | CLM_NGACO_CPTATN_SW | AIPBP Benefit Enhancement Indicator | 41 | 41 | 1 | X(1) | A single character code of “Y” or “N” that indicates whether a particular claim is tied to an AIPBP benefit enhancement. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 10 | CLM_DEMO_1ST_NUM | First Program Demonstration Number | 42 | 43 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a first demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |
| 11 | CLM_DEMO_2ND_NUM | Second Program Demonstration Number | 44 | 45 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a second demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 12 | CLM_DEMO_3RD_NUM | Third Program Demonstration Number | 46 | 47 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a third demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |
| 13 | CLM_DEMO_4TH_NUM | Fourth Program Demonstration Number | 48 | 49 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a fourth demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 14 | CLM_DEMO_5TH_NUM | Fifth Program Demonstration Number | 50 | 51 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a fifth demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |
| 15 | CLM_PBP_INCLSN_AMT | PBP/AIPBP Inclusion Amount | 52 | 70 | 19 | -9(15).99 | The amount that would have been paid in the absence of PBP/ AIPBP Reduction.<br>The value for the PBP/AIPBP Inclusion Amount is derived from the table and column called “CMS_VIEW_CLM_PRD.CLM_VAL_AMT” when the value code within the field called “CLM_VAL_CD” equals “Q0.” |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 16 | CLM_PBP_RDCTN_AMT | PBP/AIPBP Reduction Amount | 71 | 89 | 19 | -9(15).99 | The PBP/AIPBP Reduction Amount withheld from payment to the Provider.<br>The value for the PBP/AIPBP Reduction Amount is derived from the table and column called "CMS_VIEW_CLM_PRD.CLM_VAL_AMT" when the value code within the field called "CLM_VAL_CD" equals "Q1." |

The filename convention for the Medicare Shared Savings Program in Table 24 is P.A****.ACO.CCLFB.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 24 is P.V***.ACO.CCLFB.Dyymmdd.Thhmmsst.

***NOTE**: This file will only be produced for Shared Savings Program and NGACO ACOs.*

**Table 24: Part B Claims Benefit Enhancement and Demonstration Codes File (CCLFB)**

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 1 | CUR_CLM_UNIQ_ID | Current Claim Unique Identifier | 1 | 13 | 13 | 9(13) | A unique identification number assigned to the claim. IH |
| 2 | CLM_LINE_NUM | Claim Line Number | 14 | 23 | 10 | 9(10) | A sequential number that identifies a specific claim line within a given claim. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 3 | BENE_HIC_NUM | Beneficiary HIC Number | 24 | 34 | 11 | X(11) | A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim. IH |
| 4 | CLM_TYPE_CD | Claim Type Code | 35 | 36 | 2 | 9(02) | Signifies the type of claim being submitted through the Medicare or Medicaid programs<br>Claim type codes are:<br>71=RIC O local carrier non-DMEPOS claim<br>72=RIC O local carrier DMEPOS claim |
| 5 | CLM_LINE_NGACO_PBPMT_SW | PBP Benefit Enhancement Indicator | 37 | 37 | 1 | X(1) | A single character code of "Y" or "N" that indicates whether a particular claim line is tied to a PBP benefit enhancement. |
| 6 | CLM_LINE_NGACO_PDSCHRG_HCBS_SW | Post Discharge Home Visit Benefit Enhancement Indicator | 38 | 38 | 1 | X(1) | A single character code of "Y" or "N" that indicates whether a particular claim line is tied to a Post Discharge Home Visit benefit enhancement. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 7 | CLM_LINE_NGACO_SNF_WVR_SW | SNF 3-Day Waiver Benefit Enhancement Indicator | 39 | 39 | 1 | X(1) | A single character code of “Y” or “N” that indicates whether a particular claim line is tied to a SNF 3-Day Waiver benefit enhancement. |
| 8 | CLM_LINE_NGACO_TLHLTH_SW | Telehealth Benefit Enhancement Indicator | 40 | 40 | 1 | X(1) | A single character code of “Y” or “N” that indicates whether a particular claim line is tied to a Telehealth benefit enhancement. |
| 9 | CLM_LINE_NGACO_CPTATN_SW | AIPBP Benefit Enhancement Indicator | 41 | 41 | 1 | X(1) | A single character code of “Y” or “N” that indicates whether a particular claim line is tied to an AIPBP benefit enhancement. |
| 10 | CLM_DEMO_1ST_NUM | First Program Demonstration Number | 42 | 43 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a first demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 11 | CLM_DEMO_2ND_NUM | Second Program Demonstration Number | 44 | 45 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a second demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |
| 12 | CLM_DEMO_3RD_NUM | Third Program Demonstration Number | 46 | 47 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a third demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 13 | CLM_DEMO_4TH_NUM | Fourth Program Demonstration Number | 48 | 49 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a fourth demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |
| 14 | CLM_DEMO_5TH_NUM | Fifth Program Demonstration Number | 50 | 51 | 2 | X(2) | Medicare Demonstration Special Processing Number (SPN).<br>This is a fifth demonstration number<br>This field will be used to hold the 2-byte number for future use with the Bundled Payments for Care Improvement initiative. |

| Element # | Claim Field Label | Claim Field Name | Start Position | End Position | Data Length | Format | Claim Field Description |
|---|---|---|---|---|---|---|---|
| 15 | CLM_PBP_INCLSN_AMT | PBP/AIPBP Inclusion Amount | 52 | 66 | 15 | -9(11).99 | The amount that would have been paid in the absence of PBP/AIPBP Reduction.<br>The value for the PBP/AIPBP Inclusion Amount is derived from the table and column called "CMS_VIEW_CLM_PRD.CLM_LINE_OTHR_APLD_AMT" when the value code within the field called "CLM_LINE_OTHR_APLD_CD" equals "J." |
| 16 | CLM_PBP_RDCTN_AMT | PBP/AIPBP Reduction Amount | 67 | 81 | 15 | -9(11).99 | The PBP/AIPBP Reduction Amount withheld from payment to the Provider.<br>The value for the PBP/AIPBP Reduction Amount is derived from the table and column called "CMS_VIEW_CLM_PRD.CLM_LINE_OTHR_APLD_AMT" when the value code within the field called "CLM_LINE_OTHR_APLD_CD" equals "L." |

The filename convention for the Medicare Shared Savings Program in Table 25 and Table 26 is P.A****.ACO.CCLF0.Dyymmdd.Thhmmsst.

The filename convention for the NGACO Model in Table 25 and Table 26 is P.V***.ACO.CCLF0.Dyymmdd.Thhmmsst.

The filename convention for the CEC Model in Table 25 and Table 26 is P.CEC.CCLF0.Dyymmdd.Thhmmsst.

**Table 25: Summary Statistics Header Record (CCLF0)**

| Element # | Element Name | Data Description | Start Position | End Position | Data Length | Format | Comments |
|---|---|---|---|---|---|---|---|
| 1 | File Number Label | Title | 1 | 13 | 13 | X(13) | "File Number"<br>This field will be left-justified and right-padded with spaces. |
| 2 | Delimiter | Delimiter | 14 | 14 | 1 | X(1) | "\|" |
| 3 | File Description Label | Title | 15 | 34 | 20 | X(20) | "File Description"<br>This field will be left-justified and right-padded with spaces. |
| 4 | Delimiter | Delimiter | 35 | 35 | 1 | X(1) | "\|" |
| 5 | Total Records Count Label | Title | 36 | 55 | 20 | X(20) | "Total Records Count"<br>This field will be left-justified and right-padded with spaces. |
| 6 | Delimiter | Delimiter | 56 | 56 | 1 | X(1) | "\|" |
| 7 | Record Length Label | Title | 57 | 69 | 13 | X(13) | "Record Length"<br>This field will be left-justified and right-padded with spaces. |

**Table 26: Summary Statistics Detail Records**

| Element # | Element Name | Data Description | Start Position | End Position | Data Length | Format | Comments |
|---|---|---|---|---|---|---|---|
| 1 | File Type | Type of CCLF file | 1 | 7 | 7 | X(7) | Field will contain either “CCLF1”, “CCLF2”, “CCLF3”, “CCLF4”, “CCLF5”, “CCLF6”, “CCLF7”, “CCLF8”, “CCLF9”, “CCLFA”, or “CCLFB”.<br>This field will be left-justified and right-padded with spaces. |
| 2 | Delimiter | Delimiter | 8 | 8 | 1 | X(1) | “\|” |

| Element # | Element Name | Data Description | Start Position | End Position | Data Length | Format | Comments |
|---|---|---|---|---|---|---|---|
| 3 | File Name | Name of CCLF file | 9 | 51 | 43 | X(43) | For file CCLF1, this field will contain “Part A Claims Header File”.<br>For file CCLF2, this field will contain “Part A Claims Revenue Center Detail File”.<br>For file CCLF3, this field will contain “Part A Procedure Code File”.<br>For file CCLF4, this field will contain “Part A Diagnosis Code File”.<br>For file CCLF5, this field will contain “Part B Physicians File”.<br>For file CCLF6, this field will contain “Part B DME File”.<br>For file CCLF7, this field will contain “Part D File”.<br>For file CCLF8, this field will contain “Beneficiary Demographics File”.<br>For file CCLF9, this field will contain “BENE XREF File”.<br>For file CCLFA, this field will contain “Part A BE and Demo Codes File”.<br>For file CCLFB, this field will contain “Part B BE and Demo Codes File”.<br>This field will be left-justified and right-padded with spaces. |

| Element # | Element Name | Data Description | Start Position | End Position | Data Length | Format | Comments |
|---|---|---|---|---|---|---|---|
| 4 | Delimiter | Delimiter | 52 | 52 | 1 | X(1) | “\|” |
| 5 | Number of records | Contains the number of records in the file | 53 | 63 | 11 | X(11) | This field will be right-justified and left-padded with spaces. |
| 6 | Delimiter | Delimiter | 64 | 64 | 1 | X(1) | “\|” |
| 7 | Length of record | Contains the length of the record in the file. | 65 | 69 | 5 | X(5) | This field will be right-justified and left-padded with spaces. |
| 8 | Filler | Filler | 70 | 70 | 1 | X(1) | Blank |

# Glossary

| Term | Definition |
|---|---|
| **Accountable Care Organization** | ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve.<br>For the purpose of this document, the term “ACO” encompasses CEC ESCOs. |
| **All-Inclusive Population-Based Payments (AIPBP)** | AIPBP will function by estimating total annual expenditures for aligned beneficiaries and paying that projected amount to the NGACO ACO in a per-beneficiary, per-month (PBPM) payment, with some money withheld to cover anticipated care by providers not participating in AIPBP. An NGACO ACO participating in AIPBP will be responsible for paying claims for its NGACO Participants (Providers/Suppliers and Preferred Providers) with whom the NGACO ACO has written agreements regarding AIPBP. |
| **AIPBP Reduction** | The percentage by which Medicare FFS payments to selected NGACO Participants (Providers/Suppliers and Preferred Providers) for services furnished to NGACO Beneficiaries are reduced to account for the monthly payments made by CMS to the NGACO under AIPBP.<br>The AIPBP percentage reduction will always be 100%. |
| **Centers for Medicare & Medicaid Services** | CMS is a Federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children’s Health Insurance Program, and health insurance portability standards. |
| **Electronic File Transfer** | EFT is the act of transmitting files over a computer network or the Internet. |
| **End-Stage Renal Disease** | ESRD is an irreversible decline in kidney function that is severe enough to be fatal without dialysis or transplantation. |
| **Healthcare Common Procedure Coding System** | HCPCS is a set of health care procedure codes based on the American Medical Association’s Current Procedural Terminology (Commonly pronounced Hick-Picks). |
| **Integrated Data Repository** | The IDR is a single source database system containing CMS beneficiary and claim data. |

| Term | Definition |
|---|---|
| **NGACO ACO** | An ACO entity participating in the Next Generation ACO Model. |
| **Population-Based Payment** | An estimate of the total amount by which FFS payments will be reduced for Medicare Part A and B services rendered by PBP-participating NGACO Providers who agree to accept Reduced FFS Payments when providing care to aligned beneficiaries during the upcoming PY. This estimate will be based on available data on payments to NGACO Providers participating in PBP for the applicable PY for services that were provided to aligned beneficiaries during the 12-month period immediately prior to the PY. |
| **Shared Savings Program** | The Shared Savings Program promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Participating entities that meet quality and performance standards, referred to as Medicare ACOs, are eligible to receive payments for shared savings. |
| **Suppress/Resume CEC CCLFs** | Claims data for a beneficiary aligned to an ESCO will be suppressed (will not be sent) as part of the CCLFs after a quarterly check, regardless of the beneficiary's data sharing preference, when the beneficiary's paid claims for any services are not associated with an active provider within the last 12 months.<br>Claims data for a currently-suppressed beneficiary, with data sharing preference of Opt-in, will be resumed (included within the CCLFs) with the aligned ESCO when there is at least one paid claim for any services within the last 12 months with an active provider. |
| **Suppress/Resume NGACO CCLFs** | Claims data for a beneficiary aligned to an NGACO ACO will be suppressed (will not be sent) as part of the CCLFs after a quarterly check, regardless of the beneficiary's data sharing preference, when the beneficiary's paid claims for any services are associated with a terminated and/or removed provider and that beneficiary has no paid claims with any other currently active providers of the NGACO ACO within the last 12 months.<br>Claims data for a beneficiary, with data sharing preference of Opt-in, will be resumed (included within the CCLFs) with the aligned NGACO ACO when there is at least one paid claim for any services within the last 12 months with a currently active provider. |

# Acronyms

| Acronym | Description |
|---|---|
| **ACO** | Accountable Care Organization |
| **ACO-OS** | Accountable Care Organization – Operational System |
| **AIPBP** | All-Inclusive Population-Based Payment |
| **ASC** | Ambulatory Surgical Center |
| **BE** | Benefit Enhancement |
| **BENE** | Beneficiary |
| **BIC** | Beneficiary Identification Code |
| **CAN** | Claim Account Number |
| **CCLF** | Claim and Claim Line Feed |
| **CCN** | CMS Certification Number |
| **CEC** | Comprehensive ESRD Care |
| **CMS** | Centers for Medicare & Medicaid Services |
| **DAW** | Dispense As Written |
| **DIB** | Disability Insurance Benefits |
| **DME** | Durable Medical Equipment |
| **DMEPOS** | Durable Medical Equipment, Prosthetics, Orthotics, and Supplies |
| **DMERC** | Durable Medical Equipment Regional Carrier |
| **DRG** | Diagnostic Related Group |
| **EFT** | Electronic File Transfer |
| **EIN** | Employer Identification Number |
| **ESCO** | ESRD Seamless Care Organization |
| **ESRD** | End-Stage Renal Disease |
| **FFS** | Fee-for-Service |
| **FI** | Fiscal Intermediaries |
| **FIPS** | Federal Information Processing Standards |
| **FK** | Foreign Key |
| **HCPCS** | Healthcare Common Procedure Coding System |
| **HHA** | Home Health Agency |

| Acronym | Description |
|---|---|
| **HICN** | Health Insurance Claim Number |
| **ICD** | International Classification of Diseases |
| **IDR** | Integrated Data Repository |
| **IP** | Information Packet |
| **IPPS** | Inpatient Prospective Payment System |
| **MAC** | Medicare Administrative Contractors |
| **NCH** | National Claims History |
| **NCPDP** | National Council for Prescription Drug Programs |
| **NDC** | National Drug Code |
| **NGACO** | Next Generation Accountable Care Organization |
| **NGC** | Northrop Grumman Corporation |
| **NPI** | National Provider Identifier |
| **NPPES** | National Plan and Provider Enumeration System |
| **OASI** | Old Age & Survivors Insurance |
| **OPPS** | Outpatient Prospective Payment System |
| **OSCAR** | Online Survey Certification and Reporting System |
| **PBP** | Population-Based Payment |
| **PBPM** | Per-beneficiary, per-month |
| **PDE** | Prescription Drug Event |
| **PDP** | Prescription Drug Plan |
| **PHI** | Protected Health Information |
| **PII** | Personally Identifiable Information |
| **PK** | Primary Key |
| **RRB** | Railroad Retirement Board |
| **SNF** | Skilled Nursing Facility |
| **SSN** | Social Security Number |
| **TIN** | Taxpayer Identification Number |
| **TOB** | Type Of Bill |
| **UPIN** | Unique Physician Identification Number |

| Acronym | Description |
|---|---|
| **XLC** | eXpedited Life Cycle |
| **XREF** | Cross-Reference |