Request for Records Disposition Authority

Records Schedule Number	DAA-0440-2015-0004
Schedule Status	Approved
Agency or Establishment	Centers for Medicare and Medicaid Services
Record Group / Scheduling Group	Records of the Centers for Medicare and Medicaid Services
Records Schedule applies to	Agency-wide
Schedule Subject	Bucket 3 - Financial Records
Internal agency concurrences will be provided	No
Background Information	CMS is proposing a big bucket approach to records scheduling and disposition, which will include the following buckets: Bucket 1 - Leadership and Operations Bucket 2 - Administrative Management Bucket 3 - Financial Records (programmatic) Bucket 4 - Enrollment Records Bucket 5 - Beneficiary Records Bucket 6 - Provider & Health Plan Records Bucket 7 - Research and Program Analysis (programmatic) Bucket 8 - Public Outreach and Engagement Bucket 9 - Compliance and Integrity A crosswalk is provided documenting the relationship of these buckets with previously approved disposition authorities.

Item Count

Number of Total Disposition Items	Number of Permanent Disposition Items	Number of Temporary Disposition Items	Number of Withdrawn Disposition Items
1	0	1	0

GAO Approval

Outline of Records Schedule Items for DAA-0440-2015-0004

Sequence Number	
1	Financial Records (Programmatic) Disposition Authority Number: DAA-0440-2015-0004-0001

Records Schedule Items

Sequence Number	
1	**Financial Records (Programmatic)**
	Disposition Authority Number: DAA-0440-2015-0004-0001
	Financial Records (non-GRS), regardless of CMS Program. Includes Medicare Part A, Part B, Part C, and Part D; Medicaid; CHIP; Affordable Health Care Act. See crosswalk for more detail.
	Final Disposition: Temporary
	Item Status: Active
	Is this item media neutral?: Yes
	Do any of the records covered by this item currently exist in electronic format(s) other than e-mail and word processing?: No
	GRS or Superseded Authority Citation: DAA-0440-2012-0007 / 0001 N1-440-00-03 / 1 N1-440-01-02 / 1/a N1-440-01-02 / 2/a NC1-440-79-01 / 7/2 N1-440-04-03 / 1/a N1-440-09-05 / 2 N1-440-09-08 / 2 N1-440-09-11 / 1/b N1-440-09-14 / 1 N1-440-09-16 / 2 N1-440-10-01 / C NC1-440-79-01 / 17 NC1-440-79-01 / 18 NC1-440-79-01 / 25 NC1-440-79-01 / 30 NC1-440-79-01 / 35 NC1-440-79-01 / 37 NC1-440-79-01 / 38 NC1-440-79-01 / 39 NC1-440-79-01 / 47 NC1-440-79-01 / 48 NC1-440-79-01 / 50 NC1-440-79-01 / 55 NC1-440-79-01 / 57 NC1-440-82-04 / 22 NC1-440-83-01 / 2/a

	NC1-440-83-01 / 2b NC1-440-83-02 / 1 NC1-440-84-01 / K NC1-440-85-01 / 1 N1-440-87-01 / 1 N1-440-91-01 / 1 N1-440-91-02 / 1 N1-440-96-01 / 1 N1-440-94-01 / 1 N1-440-94-01 / 2 N1-440-95-01 / 14 N1-440-95-01 / 1 N1-440-95-01 / 3 N1-440-95-01 / 8 N1-440-99-02 / 2/a NC1-440-79-01 / 7/26 N1-440-01-02 / 3/a N1-440-01-02 / 3/b N1-440-01-02 / 3/c/1/a N1-440-01-02 / 3/c/1/c N1-440-01-02 / 3/c/2
Disposition Instruction	
Retention Period	Destroy no sooner than 7 year(s) after cutoff but longer retention is authorized
Additional Information	
GAO Approval	Not Required

Agency Certification

I hereby certify that I am authorized to act for this agency in matters pertaining to the disposition of its records and that the records proposed for disposal in this schedule are not now needed for the business of the agency or will not be needed after the retention periods specified.

Signatory Information

Date	Action	By	Title	Organization
04/13/2015	Certify	Tony Tucker	Records Officer	Office of Strategic Operations and Regulatroy Affairs - OSORA
04/28/2017	Return for Revisio n	Sean Curry	Senior Appraisal Arc hivist	National Archives and Records Administration - Agency Services
05/01/2017	Submit For Certific ation	Carlos Simon	Records Officer	OSORA - IRISG
05/01/2017	Certify	Carlos Simon	Records Officer	OSORA - IRISG
07/06/2017	Submit for Concur rence	Sean Curry	Senior Appraisal Arc hivist	National Archives and Records Administration - Agency Services
07/11/2017	Concur	Margaret Hawkins	Director of Records Management Servic es	National Records Management Program - ACNR Records Management Serivces
07/11/2017	Concur	Margaret Hawkins	Director of Records Management Servic es	National Records Management Program - ACNR Records Management Serivces
07/13/2017	Approve	David Ferriero	Archivist of the Unite d States	Office of the Archivist - Office of the Archivist

DAA-0440-2015-0004				
Bucket 3 - Financial Records (Programmatic)				
3. Description: Financial Records (non-GRS), regardless of CMS Program. Includes Medicare Part A, Part B, Part C, and Part D; Medicaid; CHIP; Affordable Health Care Act. Temporary, destroy when 7 years				
Series	**Superseded Series Title / Description**	**Original Authority**	**Original Retention**	**Change**
3.1: Claims Records. All records related to the claims process, including creation, filing, and payment of claims for all CMS programs, as well as records related to claims appeals, services pricing, and validation. Applies to all records, regardless of media, including electronic systems that support or facilitate the processing of claims. Applies to all CMS programs, including Medicare Parts A, B and D; Medicaid; CHIP; and the Affordable Care Act.	**Part A & B Claims,** (A) Part A Medicare Claims Records Forms HCFA-1453, Inpatient Hospital and Skilled Nursing Facility Admission and Billing HCFA-1486, Inpatient Admission and Billing - Christian Science Sanatorium HCFA-1487, Home Health Agency Report and Billing and other documents used to support payments to providers of service, e.g., medical records or supporting documents. (B) Part B Medicare Claims Records All types HCFA-1500, of forms HCFA-1490, Request for Medicare Health Insurance Claims Forms HCFA-1554, Payments; Provider Billing for Patient Services by Physicians; HCFA-1556, Prepayment Plan for Group Medical Practices Dealing Through a Carrier; HCFA-1600, Request for Claim Number Verification; HCFA, 1606, Payments Record Transmittal; HCFA-1660, Request for Information, Medicare Payment for Services to a Patient Now Deceased; and similar forms. Also included are itemized bills, correspondence, and comparable documents used to support payments to beneficiaries, physicians, and other suppliers of service under the Supplementary Medical Insurance Program.	NC1-440-83-01, items 2a, and 2b	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
	Part A & B Claims.	NC1-440-83-02, item 1	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
	Part D Claims.	NEW	n/a	n/a
	Pre-Existing Condition Insurance Program (PCIP). Claims records from the PCIP, available under the Affordable Care Act (closed series)	NEW	n/a	n/a
	Medicaid and Medicare Data Match, Contained within Section 6202 of the Omnibus Budget Reconciliation Act of 1989 was a requirement for a data match between the Internal Revenue Service, the Social Security Administration and HCFA.	N1-440-91-01, item 1	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.

Medicare Parts A & B & C Claims Processing, CMS forms, correspondence and data created and maintained in the processing of claims for Medicare Part A, Band C. Forms may be requests for payments, Insurance claim forms, provider billing for patient services and other documentation to support payments to providers of services or to support payment to beneficiaries' physicians and other suppliers of services Electronic data may reside in databases referred to as Common Working Files.	N1-440-04-03, item 1a	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
Correspondence, General related to Claims; Query/Reply/Transaction/Activity Listings/Claims Control, requests for assistance	NC1-440-79-01, items 17, 18 and 25	Temporary, 4 years	No change in final disposition. Increase in retention.
Benefit Check Records	NC1-440-79-01, item 7/26	Temporary, 3 years	No change in final disposition. Increase in retention.
Check listings & reconciliations (printouts)	NC1-440-79-01, item 47	Temporary, 4 years	No change in final disposition. Increase in retention.
Listings, Interim Rate, Listings of interim rates in use by intermediaries in making interim payments to hospitals, skilled nursing facilities. home health agencies, and other providers of services. These listings are used as a source of information and for studies.	NC1-440-79-01, item 37	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.

Intermediary and Carrier Letter of Credit File and Payment Vouchers. Records authorizing a Federal Reserve Bank to disburse funds to designated intermediaries and carriers on behalf of HCFA upon presentation of payment vouchers to a commercial bank for collection through a Federal Reserve System. Included is SF-1193, Letter of Credit, or its equivalent, and amending letters. (A) Intermediary and Carrier Transmittal Files, Payment Vouchers and SF-218, Payment Voucher on Letter of Credit, and similar documents prepared by the Intermediaries and carriers to obtain Federal funds from selected commercial banks for expenses incurred in administering the Health Insurance and Supplementary Medical Insurance Programs. Also included is HCFA-1521,Payment Voucher on Letter of Credit Transmittal, a transmittal that forwards conies of payment vouchers to HCFA and shows the purpose for which funds were drawn, i.e., hospital insurance benef1ts, supplementary medical insurance benefits, administrative costs, and total amount of payment vouchers.	NC1-440-84-01, item K	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.

Healthcare Integrated General Ledger Accounting System (HIGLAS). HIGLAS is a dual-entry, general ledger accounting system that supports the Fee-For-Service Medicare contractor accounting systems with a single standardized system. CMS has 45 million providers and beneficiaries, and as of FY2010 it uses HIGLAS to process approximately 4.5 million claims per day. HIGLAS improves accountability for Medicare payments to physicians, hospitals and other providers servicing Medicare beneficiaries. HIGLAS is also used to support accounting for Medicaid and Children's Health Insurance Program (CHIP) grants and to generate the CMS Financial Statements, including all vendor payments, payables and receivables. In addition to processing Medicare claims HIGLAS replaces the legacy Financial Accounting and Control System (FACS)which accumulates CMS' financial activities, both programmatic and administrative, in its general ledger. Master Files - Includes but not limited to. Provider data, beneficiary data, claims and non-claims data, claim adjustments data, check register updates, one time conversion data (data is converted once at HIGLAS launch for each transitioning workload), check status, Medicare Secondary Payer (MSP) debtor data and case data, grants, obligations, and commitments; vendor match, vendor acknowledgment, payments data, batch reports and letters; Voids and manual payments, grants, obligations, commitments, accruals, fund balances and expenditures, vendor offset updates, vendor extracts.	N1-440-09-14, item 1	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
Payment Recovery Information System, Metadata associated with the collection of claims and supporting documentation submitted by a Medicare Part C or Part D Recovery Audit Contractor (RAC) in support of their analysis to identify and recover improper claim payments made to a Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), or a Prescription Drug (PDP) plan/sponsor.	DAA-0440-2012-0007, item 0001	Temporary, 10 years	No change in final disposition. Decrease in retention.

Medicare Pricing systems (Master Files), MPS is a family of subsystems that produce the pricing modules required to support the processing of claims via CMS' Shared Systems (Claims Processing Systems, Job NI-440-04-03) Medicare contractors (Carriers, Fiscal Intermediaries, MACs, Regional Home Health Intermediaries, and Durable Medical Equipment Regional Carriers) use the Shared Systems/Claims Processing Systems (FISS, MCS and VMS) to process claims from providers such as physicians, laboratories and suppliers. The pricing modules support this process and contain rates, prices and pricing algorithms according to the type of service After the pricing modules containing the Fee Schedules and Pricers have been produced by MPS, they are made available to the Shared Systems as files that can be downloaded from the CMS Mainframe. The modules or programs include the following: (1) Pricers - pricing programs which contain computer code (there are several Pricers, such as an Inpatient Pricer and a skilled nursing facility Pricer); (2) Fee Schedules - files which contain prices (there are Fee Schedules for items such as clinical laboratory services, durable medical equipment, and physician services); and (3) Grouper - software that translates variable such as age, diagnosis and surgical codes into a diagnosis related group (DRG). The Medicare program provides for annual updates to the pricing modules, which occur on January 1 or October 1, the beginning of the new fiscal year. The annual updates are based on new regulations set forth by the federal register, changes to the wage Index, and Congressional provisions Quarterly updates are not performed unless required.	N1-440-09-08. item 2	Temporary, 10 years	No change in final disposition. Decrease in retention.

Payment Quality Review System (Master Files), A collection of automated systems that supports the review of Medicare Program payments for medical goods and services Quality review areas Include, but may not be routed to overpayment, duplicate payment, fraud and abuse, monetary penalty tracking, and overall benefit savings. Includes but not limited to: (1) Fraud Investigation Database (FID; (2) Mistaken Payment Recovery Tracking System (MPARTS); (3)Provider Overpayment Recovery (POR) System; (4) Physician/Supplier Overpayment Recovery (PSOR)System; (5) Recovery Management and Accounting System (Re MAS); (6) System for MSP Automated Recovery and Tracking (SMART); (7) MSP Automated Recovery and Tracking Initiative (MARTI); and (8) Payment Error Rate Measurement (PERM) System. Data resides on mainframe system and is maintained in compliance With all Federal laws and regulations and Federal, HHS and CMS policies and standards as they relate to information security and data privacy SMART & MARTI data resides at the Birmingham Data Center PERM data (including medical records) resides on CMS contractors' servers.	N1-440-09-11, item 1b	Temporary, 10 years	No change in final disposition. Decrease in retention.
Medicare Financial Management/Payment system (Master File), The collection of automated systems that support Medicare Contractor workload and budget administration and provider cost reporting The systems track the behavior, financial and progress status and contract compliance of CMS' Medicare contractors, known as Medicare Administrative Contractors (MACs), previously the Fiscal Intermediaries (FIs) or Carriers Includes but not limited to: (1) Contractor Administrative Budget and Financial Management System (CAFM and CAFMII); (2) Contractor Audit and Settlement Reporting System (CASR); (3) Contractor Management Information System (CMIS); (4) CMS Activity Reporting and Tracking System (CMS-ART); (5) Contractor Reporting of Operational and Workload Data System (CROWD); (6) Demonstration Payment System (DPS); (7) Health Care Cost Report Information System (HCRSI); (8) Program Integrity Management Reporting (PIMR) System; (9) Production Performance Monitoring System (PULSE); (10) System Tracking for Audit and Reimbursement Medical Review System (STAR); (11) Coordination of Benefits (COB); (12) Recovery Audit Contract or Demo (RAC); and (13) Provider Statistical and Reimbursement System (PS&R).	N1-440-09-16, item 2	Temporary, 8 years	No change in final disposition. Decrease in retention.

Encounter Data Processing System (EDPS). System to support contractors in the processing and validation of claims.	NEW	n/a	n/a
Medicare Appeals system, The Medicare Appeals System is designed to support the new legislatively mandated appeals processes for traditional Medicare Fee-For-Service (FFS)and Managed Care (MC). The new FFS appeal process is required by the Benefits Improvement and Protection Act of 2000 (BIPA) where the methods of appeals for Part A and Part B claims are merged into one process. The Managed Care (Part C) process is required by the Balanced Budget Act of 1977 which required CMS ensure managed care enrollees have a formal appeals process to dispute an adverse determination by a Managed Care Organization (MCO). The Medicare Appeals System (MAS) is suite of applications designed to support the end-to-end level two and level three appeals process including associated reporting and analysts capabilities MAS end users are Qualified Independent Contractors (QICs), Independent Review Entities (IREs), Administrative Law Judges (AUs), and CMS employees.	N1-440-09-05, item 2	Temporary, 10 years	No change in final disposition. Decrease in retention.
Systems Plan Files (IEDS or MRAS)	N1-440-94-01, item 1	Temporary, 5 years	No change in final disposition. Increase in retention.
Medicaid, MMIS System, System Performance Review (SPR) Files on Mechanized Claims Processing Medicaid Management Information System (MMIS). The SPR is used for MMIS reapproval/disapproval and funding decisions. The Regional Office shall maintain a separate SPR file for each State MMIS in the region. Each SPR file shall contain all work papers, worksheets, review documentation, reports, correspondence, and other records relating to the annual review of each State's MMIS. The information retained shall fully document the Regional Office review findings and support Regional Office recommendations to Central Office on the reapproval/disapproval and funding for each State's MMIS.	NC1-440-85-01, item 1	Temporary, 1 years	No change in final disposition. Increase in retention.

	Overpayment and Duplicate Charge Detection Activity Report. Files Quarterly reports prepared by each carrier and sent to SSA (CMS) summarizing overpayment and duplicate charge detection activities carried out during each calendar quarter. The reports are used to tabulate data on the number of cases in which a carrier recovers an overpayment, the total dollar amount of money overpaid, causes of overpayments, number of duplicated charges detected, and similar information.	NC1-440-79-01, item 39	Temporary, 6 years	No change in final disposition. Increase to 7 years.
3.2: Financial Reporting Records. Facilitative and administrative financial reporting that relates to all CMS programs (Medicare Parts A, B, C, and D; Medicaid; CHIP). Primarily reports required to be filed by carriers and intermediaries and State governments on their expenditures under CMS programs, as well a other documents that support standard and routine reporting.	**Final Administrative Cost Proposal**	NC1-440-79-01, item 7/2	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
	Overpayment Report	NEW	n/a	n/a
	Waivers, Withdrawn or not pursued; Section 1115 Medicaid waiver concept papers or proposals received from a State which the State voluntarily withdrew or decided not to pursue.	N1-440-00-03, item 1	Temporary, 3 years	No change in final disposition. Increase in retention.
	Annual Contractor Evaluation Report (ACER)	N1-440-04-03, item 1a	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
	State Waiver Files, Includes approved waiver(s), correspondence, memoranda, background material and other working papers relating to State Waiver Programs maintained by Headquarters and the Regional Office.	N1-440-94-01, item 1	Temporary, 5 years	No change in final disposition. Increase in retention.
	Budget Requests, Final Administrative Cost Proposals (part of processing systems)	N1-440-04-03, item 1a	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
	Expenditure Report (Inter-Carrier) (part of processing systems)	N1-440-04-03, item 1a	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
	End Stage Renal Disease Cost Report, These cost reports are submitted by ESRD Medicare Providers (hospital based and free-standing) at the close of each provider's reporting year.	N1-440-87-01, item 1	Temporary, 5 years	No change in final disposition. Increase in retention.
	End stage Renal Disease (ESRD) Exception Requests. These exception files contain documentation for reimbursement for ESRD services and supplies and consist of the intermediary's preliminary recommendation and work papers and the provider's ESRD exception request and cost report.	N1-440-91-02, item 1	temporary, 7 years	No change.

Demonstration Cost Report, Cost reports are required for certain demonstrations to reimburse providers and collect data for the demonstration evaluation. The cost reports are unique to each demonstration. For cost type demonstrations, providers are granted hearing and appeal rights should they dispute the government's determination of program liability. Cost reports are currently utilized for the Municipal Health Services Program, Alzheimer Disease Demonstration and the Community Nursing Organization Demonstrations.	N1-440-95-01, item 14	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
Intermediary and Carrier Closing Agreements. The accepted final settlement for all intermediary and carrier costs of administration and consist of the Closing Agreement, Appendix, and Schedules of Balances due the intermediary, carrier, or Secretary.	N1-440-95-01, item 3	temporary, 10 years	No change in final disposition. Decrease in retention.
Pension & Employee Benefits Actuarial Analysis. Documents from completed actuarial analysis of Medicare contractors or provider special projects, e.g., provider pension issues, HMO loans, contract negotiations.	N1-440-95-01, item 8	Temporary, 6 years	No change in final disposition. Increase in retention.
Waivers and Exception Requests for Hospital Payment (Medicare), Medicare Waivers for Hospital Payments. Includes the records for the evaluation, approval and monitoring of HCFA waivers concerning payments for hospital services under the provisions of Section 1886 of the Medicare law.	N1-440-96-01, item 1	Temporary, 7 years	No change.
Compliance Files, Audited Financial Reports (HMO). Official Compliance Files. This file consists of material in support of the continuing compliance with the statutory and regulatory requirements of Title XIII of the Public Health Service Act and Title XVIII of the Social Security Act. These files include or relate to program correspondence on such matters as analyses, reports, evaluations, non-compliance, revocations, financial reports and other associated documentation. Financial reporting is accomplished through the use of the national data reporting requirements (NDRR) and audited financial reports.	N1-440-99-02, item 2a	Temporary, 7 years	No change.
Explanation of Medicare Benefit Records. Utilization benefit notices and reports; and forms that are developed locally by carriers regarding explanation of Medicare benefits.	NC1-440-79-01, item 17	Temporary, 7 years	No change in final disposition. Increase in retention.

Intermediary and Carrier Interim Expenditure Report Files. Quarterly reports of expenditures made by the intermediaries and carriers since the beginning of the fiscal year. Included are Forms SSA-1527,and SSA-1528.	NC1-440-79-01, item 30	Temporary, 3 years	No change in final disposition. Increase in retention.
Monthly Financial Reports. Intermediary and Carrier Monthly Report Files. Reports submitted monthly by the intermediaries and carriers to provide SSA with the basic data to reconcile its accounts with those maintained by intermediaries and carriers.	NC1-440-79-01, item 35	Temporary, after audit	No change in final disposition. Increase in retention.
Workload Reports (Intermediary). Monthly statistical reports on the status of intermediary workloads used by SSA to identify basic management data needed for budgeting, financing, work planning, and progress evaluation.	NC1-440-79-01, item 37	Temporary, 5 years	No change in final disposition. Increase in retention.
Medicare, Performance Reports, Form SSA-1565, Health Insurance for the Aged Program Carrier Performance Reports. Documents performance in processing claims under program.	NC1-440-79-01, item 38	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
Overpayment and Duplicate Charge Detection Activity Report Files. Quarterly reports prepared by each carrier and sent to SSA summarizing overpayment and duplicate charge detection activities carried out during ; each calendar quarter. The reports are used to I tabulate data on the number of cases in which ' carrier recovers an overpayment, the total I dollar amount of money overpaid, causes of overpayments, number of duplicated charges detected, and similar information.	NC1-440-79-01, item 39	Temporary, 3 years	No change in final disposition. Increase in retention.
Cost Report Files. Cost reports submitted by providers to intermediaries for the purpose of determining Medicare reimbursable costs. Each cost report contains a provider's statement of reimbursable cost, cost-finding documents/comments, auditor's final settlement letters and other data necessary to determine costs.	NC1-440-79-01, item 48	Temporary, 8 years	No change in final disposition. Decrease in retention.

	State Agency Budget and Financial Report Files. Files used to estimate, justify and approve State agency health insurance program costs and to account for funds received and expended by the State agencies. Included are Forms SSA-1465. State Agency Budget Request; SSA-1465A, State Agency Budget List of Positions; SSA-1466, State Agency Schedule for Equipment Purchases; SSA-1467 State Agency Budget Notice of Approval; SSA-1468. Notice to State Agency; SSA-1469, Financial Accountability Statement; SSA-1469A.	NC1-440-79-01, item 50	Temporary, 3 years	No change in final disposition. Increase in retention.
	Statistical and Reimbursement Reports (Overpayment). EDP printouts or microfilms showing summaries of payments to hospitals, skilled nursing facilities, home health agencies, and other providers of service. They are used to effect cost settlement.	NC1-440-79-01, item 55	Temporary, 3 years	No change in final disposition. Increase in retention.
	Interim Rate Listings. Listings of interim rates in use by intermediaries in making interim payments to hospitals, skilled nursing facilities. home health agencies, and other providers of services. These listing are used as a source of information and for studies.	NC1-440-79-01, item 57	Temporary, 5 years	No change in final disposition. Increase in retention.
	Medicaid, Accountable Expenditures. States Accountable Expenditures and Estimate of Account Files Includes quarterly expenditures reports and estimated expenditures reports from states for approved programs. Included are state payment vouchers, cash transaction reports and related documents, copies of HCFA grant awards approvals and computation sheets, review correspondence, decision letters and other related documents. Retained for HHS and GAO site audits.	NC1-440-82-04, item 22	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.
	MAC Monthly Cumulative Cost Report (forms 2584/2585)	NEW	Temporary, 3 years	No change in final disposition. Increase in retention.
3.3: Non-perm HCPCS codes. Records that support the development of permanent HCPCS codes.	**Meeting Files.** Consists of agendas, attendees, code requests, coding determinations, recommendations, meeting summaries, notices and related records documenting the meetings and accomplishments the CMS HCPC Workgroup, National Panel, and Durable Medical Equipment Group.	N1-440-01-02, item 1a	Temporary, 15 years	No change in final disposition. Decrease in retention.

	Code Files. Requests received by CMS for alpha numeric or carrier defined codes (HCPCS coding). May contain correspondence, FDA approval letter, modification questionnaire, decision letters and related records supporting actions or requests such as videos or products.	N1-440-01-02, item 2 (2,	Temporary, 5 - 15 years	No change in final disposition. Decrease / Increase in retention.
	Other versions of code summaries (main document is permanent), including public use versions	N1-440-01-02, items 3a, 3b, 3c1a, 3c1c, and 3c2	Temporary, 3 years	No change in final disposition. Increase in retention.
3.4: Other Financial Records.	**Loan Files.** This file is maintained for each loan made to or loan guarantee made on behalf of a Health Plan Organization. These records comprise the official file copy of the application, evaluation, recommendations, correspondence, standard commitment and loan closing documents (including certifications, promissory notes, Operating Cost Assistance Agreement, or Escrow Agreement, etc.) program narratives, and other related documentation. (A) Loans Paid in Full. (B) Uncollected Loans.	N1-440-10-01, item C	Temporary, 7 years	No change.
	Medicaid State Grants. State ADP Systems Plans Files (Integrated Eligibility Determination Systems or Medicaid Related Administrative Systems). Copies of all State requests for title XIX grant monies including Advance Planning Documents and Updates, Requests for Proposals, Contracts, and correspondence including progress information from the States, and headquarters approvals. HCFA Headquarters files are used in HCFA's approval of title XIX grant money to the States.	N1-440-94-01, item 2	Temporary, 6 years & 3 months	No change in final disposition. Increase in retention.